National Research Journal of Social Sciences (NRJSS)
Volume-1, Issue-1, Year-2016 PP: 32-64 ISSN No: 2348-473X

Development in Bangladesh: How Inclusive?

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Introduction

Development is a complex issue. Economists generally interpret it in terms of improvement in economic condition of the people. However, in a broader context, development includes social and human development as well. Social development is about putting people at the centre of development. That is, development processes need to benefit people across all strata of the society. It implies that everyone has equal access to society's goods such as health and education as well as equal opportunities to decent jobs.

The objective of this paper is to examine the different aspects of development in Bangladesh; and assess how inclusive these are. The paper is divided into seven sections. Sections 1-6 each deals with a particular aspect of development in the country. Section 7 puts forward concluding remarks and makes a number of recommendations to address how development in Bangladesh could be made more inclusive in the future.

1. Economic Growth[1]:

With a per capita income of only around US$100 in 1972, the country has moved forward in its path to economic growth. Over the past several decades, Bangladesh has been experiencing steady economic growth.

We examine economic growth in Bangladesh in terms of national income and per capita GDP, based on official statistics generated by the Bangladesh Bureau of Statistics (BBS) and other concerned agencies.

Income

Between 1980s and 2000s, the GDP increased four-fold. The annual GDP growth rates increased from 3.4 percent during the 1980s to around 5 percent during the 1990s and further to over 6 percent during most of the years since 2005-06 [2](Table 1).

Economic growth in Bangladesh has proceeded in three distinct growth phases [3] (Figure 1; Government of Bangladesh 2013 a). The first phase (1990-1996) witnessed subdued growth rate expansion (less than 4% annually in aggregate terms and less than 3% in per capita terms). The second phase (1996-2003) witnessed growth rate fluctuating between 4 and over 5 percent and around

[1] A more detailed discussion is contained in Khuda and Barkat 2015 a.

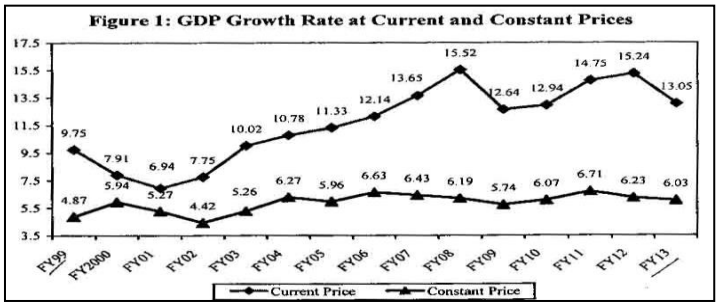
[2] According to the World Bank (2014 a), Afghanistan was projected to have the lowest growth rate in 2013 of only 3.1 percent down from 14.4 percent in an exceptional 2012, mainly driven by increased uncertainty stemming from political and security transition. Bangladesh's projected growth for 2013 at 6 percent was a 0.2 percentage point decline compared to 2012, reflecting political uncertainties, supply side constraints and lower investment. Bhutan's real GDP growth was projected to be 6.9 percent in 2012/13 down from 8.1 percent. Nepal's real GDP growth was projected to decline to 3.6 percent in 2013 from 4.9 percent in 2012. Pakistan growth rate was projected to be 3.5 percent in 2013, a 0.1 percentage point decline compared to 2012. On the other hand, Maldives and Sri Lanka were projected to have a slight increase in their growth rates. Maldives real GDP growth was projected to increase from 3.4 percent in 2012 to 4.3 percent in 2013; and Sri Lanka was projected to increase from 6.4 percent in 2012 to 6.8 percent in 2013. See also Khuda, Barkat and Roy 2014; Government of Bangladesh 2013a

[3] See also Ahmed 2012.

4 percent per capita. The third phase (2004-13) witnessed an annual growth rate of around 6 percent and per capita growth of around 5 percent.

Like in most of South Asia, economic growth in Bangladesh was triggered by greater global integration, macroeconomic stabilization, and economic deregulation (Ahmed 2006). Trade restrictions, including import tariffs, were reduced. The scope and role of the private sector, as the engine of growth, was being increasingly recognized. These reforms made Bangladesh more stable, competitive, and adaptable.

Agriculture, industry and services sectors contributed to the process of economic growth. The growth of agricultural, industrial and services GDP increased from 2.5 percent in the 1980s to 3.35 percent in 2013-14, 5.8 to over 8.0 percent, and 3.7 to about 6 percent respectively. Since the 1990s, the services sector accounts for around half of the GDP[4], followed by the industrial sector and agriculture. The sectoral shares of GDP show persistent increase in the services and industrial sectors, while that in the agriculture sector has been on the decline[5].



Source: BBS 2013, National Accounts Statistics, 2013, Government of Bangladesh (GOB), 2013 a. See also GOB 2014 b

Table 1: Annual Average Growth Rate in Real GDP in Bangladesh, 1991/95-2001/10

Period	1991-1995	1996-2000	2001-2005	2006-2010	1991-2000	2001-2010
Real GDP Growth Rate	4.38	5.2	5.46	6.14	4.79	5.8

Source: World Development Indicators 2011.

The growth in large-scale manufacturing has been led predominantly by the ready-made garments (RMG) sector. During the 1990s, medium and large-scale manufacturing increased at about 7 percent per annum; however, excluding the RMG sector the growth rate was only about 4 percent (Mahmud 2013).

[4] There has been considerable growth in the service sector in South Asia, especially India. The growth in the services sector has enabled South Asia to grow almost as fast as East Asia in this century, with growth of just under 7 percent per annum between 2000 and 2007. Growth rates in South Asia and East Asia have converged. The South Asian experience of growth in this century is remarkable, since it contradicts the conventional wisdom, according to which industrialization is the only route to rapid economic development. The South Asian experience suggests that rapid growth and poverty reduction led by the services sector is now possible; and this can fundamentally change the pattern of development for many developing countries (World Bank, 2009).

[5] Since the early 1980s, the share of the agricultural sector to the GDP has been declining in the four South Asian countries for which data are available (Bangladesh, India, Pakistan and Sri Lanka). Its share declined from around one-third in the 1980s to less than one-fifth to the GDP in 2008. Services sector is the dominant sector contributing to the GDP, with its share rising from over two-fifths in the 1980s to over one-half in 2008. The share of the industries sector increased from over one-quarter in the 1980s to around one-third in 2008 (Nayar et al 2012). See also Raihan and Khondker 2012.

Since the late 1970s when the RMG sector started in a limited scale in Bangladesh, considerable expansion has taken place in this sector by taking advantage of export quotas and preferential access in the major markets (i.e. the US and the EU) and abundance of cheap female labour. Today, the RMG is the most important industry in the country; and Bangladesh is second only to China, the world's second-largest apparel exporter of western brands. In the 1980s, there were only 50 factories employing only a few thousand people. By 2001, the RMG sector employed about 3 million workers, 90 percent of whom were women (Begum 2001). By 2013, there were around 5,000 garment factories, employing around 4.5 million people (World Bank 2014 b). Around 80 percent of the garment workers are young, unmarried migrant women from rural areas. The RMG sector has been a major source of employment for rural migrant women in a country experiencing limited employment opportunities in rural areas and where women migrants have been largely excluded from formal sector jobs in the urban areas (Kabeer and Mahmud 2004).

The RMG sector accounts for around 80 percent of total exports[6] and 13 percent of the GDP (Berg, et al. 2011). Bangladesh's garment exports increased from US$ 6.8 billion in 2005 to around US$ 20 billion last year[7]. Export earnings from the RMG sector may exceed US$ 30 billion in the next five years[8]. The impressive growth of the RMG sector has brought about important structural transformations in the economy: (i) increasing importance of export earnings compared to declining reliance on foreign aid; (ii) a complete change in the export structure which is predominantly dominated by manufactured goods from the earlier dependence on primary goods; and (iii) providing wage employment to the female workforce. The latter has, in turn, contributed to the process of enhancing the social and economic position of women, especially among the poor and the less educated ones. Also, the RMG sector has contributed to reduction of poverty in the country (Government of Bangladesh 2011 a). Further, it has helped remittance-receiving households in saving. About three-fifths of such households saved part of the remittances they received, though not substantial; and about one-quarter of such households invested part of their remittances (Government of Bangladesh 2014 a).

Due to the limited capacity of the country to absorb the increasing size of the labour force, a large number of Bangladeshis have been going abroad in search of jobs (Hussain 2009). Officially, manpower export from Bangladesh started in 1976 (Ahmed 2010), with only around 14,000 Bangladeshis who had gone to the Middle East in search of jobs. There are now around 9 million Bangladeshis working abroad (Rahim and Alam 2013). Most migrant workers are males, although there has recently been a boost in sending Bangladeshi female workers abroad. From 20,842 female migrant workers in 2008, it has more than doubled to 48,463 as of August 2014. Since 2008, a total of 243,528 Bangladeshi females went abroad for jobs (Biplob 2014).

With increase in the number of migrant workers, the amount of annual remittance to the country increased considerably. From only $ 339 million in 1980, the amount of annual remittances increased to $ 10.9 billion in 2010 (Barai 2012). It reached US$ 12.87 billion up to November 2012[9], and further

[6] Till affected by the 2001 global recession, Bangladesh experienced robust and sustained growth of export earnings, averaging about 15 percent annually in nominal US dollar terms in the 1990s. This resulted in the ratio of export earnings to GDP doubling from 7 percent to about 14 percent. In 2001-02, export earnings declined in dollar terms for the first time since 1985-86. Although there was a recovery in the subsequent year, the medium term outlook is that it will be difficult to regain the export momentum of the 1990s (Mahmud, 2013).

[7] A detail discussion on the growth and contribution of the garment sector in Bangladesh are given in Khondker, Razzaque and Ahmed 2005; Quddus and Rashid 2000.

[8] Financial Express, March 01, 2014.

[9] About 64 percent of the remittances are coming from migrants working in the Middle Eastern countries (Hussain 2009).

increased to about US$ 14.5 billion as of June 2013[10]. The remittance is the second largest source of income for Bangladesh, next to the earnings from the RMG sector. Remittances account for around 11 percent of the GDP of Bangladesh (Rahim and Alam 2013).[11] Also, remittances increase the country's foreign currency reserves; and contribute to the process of economic development and poverty reduction in the country (Osmani 2004; Rahim and Alam 2013).

Remittances play an important role as a source of income, both at the national and household levels. In 2010, both the rural and urban areas experienced an increase in the percentage share of remittances received. Remittances represent the third largest share of income for the rural households (more than doubling from 7.8% in 1995 to 17.3% in 2010) (Government of Bangladesh 2011a).

Per capita GDP

Despite its economic growth, Bangladesh is the third poorest country in South Asia with GDP PPP per capita of US$ 2,080. Maldives has the highest GDP PPP per capita of US$ 9,173, followed by Sri Lanka and Bhutan. In terms of total GDP (PPP), India has the highest (US$5,069, 200), followed by Pakistan and Bangladesh[12] (Appendix Table 1)**.**

However, Bangladesh increased its per capita GDP over time. Between 1980s and 2000s, the per capita GDP increased by 2.6 times. In 1980, the per capita GDP was only US$206, which increased subsequently to US$ 620 in 2008-09. The increasing trend continued during the subsequent years; and in 2014 it is US$ 1,190. The acceleration in the growth of per capita income was due to both a slowing down in population growth rate and a sustained increase in GDP growth rate. During 2008-13, the average annual growth rate in per capita GDP was close to 5 percent, except in 2010-11 (Table 2).

Table 2: Per Capita GDP and GNI at Constant Prices in Bangladesh, 2008-2013 (Base: 1995-96)

Item	2008-09	2009-10	2010-11	2011-12	2012-13 (p)
GDP (Million Tk.)	3401968	3608446	3850504	4090532	4337201
GNI (Million Tk.)	3711298	3944194	4200965	4488393	4773820
Per Capita GDP (Tk.)	23588	24705	25730	26986	28237
Growth rate (per capita GDP)	4.40	4.73	4.15	4.88	4.64
Per Capita GNI (Tk.)	25733	27003	28072	29611	31080
Growth rate (per capita GNI)	4.62	4.94	3.96	5.48	4.96

Note: "p" denotes provisional estimates

Source: GoB, BBS 2013, National Accounts Statistics, 2013

Despite improvement in overall economic condition, there are major constraints impeding the process of further acceleration of economic growth in the country.

It is important to note that it took two decades for Bangladesh to achieve a 6 percent growth rate from its previous 4 percent, and further that the growth rate hovered at around 6 percent during the past financial year compared to the target of 7 percent. Moreover, the government aims to achieve another

[10] Remittances are 7 times higher than the amount the government receives as foreign aid and 13 times higher than what the government receives as foreign investment (Khuda and Barkat 2014 a).

[11] The position of Bangladesh is 7th in the world remittance income, next to India, China, Philippines, Mexico, Nigeria and Egypt (Rahim and Alam 2013).

[12] Since the 1980s, South Asian countries achieved impressive economic growth. During the period 1980–2000, two of the South Asian countries (India and Bangladesh) increased their GDP growth rates by around 2 percentage points annually relative to the rates they had sustained during the two decades prior to 1980. Although average output growth declined after 1980 in Pakistan, it remained about 5 per cent annually. Growth rates of these magnitudes are impressive achievements that have helped these countries to reduce poverty rates, and thereby, raise living standards. Indeed, South Asia grew more rapidly than any other region, except East Asia. However, unlike East Asia, the South Asian countries have not been characterized by high rates of investment. As a matter of fact, as a share of output, investment has averaged just one-half to two-thirds of the East Asian levels during its sustained periods of high growth. This indicates that capital accumulation has been a relatively less important factor in the South Asia's growth experience.

2 percent increase in the GDP rate (8%) by 2015.This seems unlikely, considering the previous growth patterns and the prevailing investment in the country.

The investment-GDP ratio is low, especially in the public sector which accounts for only one-third of total investment. The investment- GDP ratio remained below the targeted level in most years, including the previous year of 32 percent (Government of Bangladesh 2014 c). Achieving the target has been a challenging task for the government, given that the investment-GDP ratio remained at around 27 percent since 2004.

As noted above, the industrial sector contributes around 30 percent to the country's GDP. The government expects this to increase to 40 percent by 2021 as a result of: modernizing the economy, transforming it structurally, diversifying the economic base, enhancing productivity, and promoting small and medium enterprises (SME). The major impediments to investment, however, consist of infrastructural deficit, lack of good governance and political instability. This is especially affecting the private sector (Government of Bangladesh 2014 c).

2. Poverty

One of the most critical challenges faced by Bangladesh is poverty[13]. A major cause of rural poverty is due to the country's geographical and demographic characteristics. A large part of the country is low-lying, and thus, is flood-prone, which cause huge damage to crops, homes and livelihoods, and reduce employment opportunities. Under such circumstances, many have to incur debts to rebuild their homes and other assets, thereby forcing them to fall deeper into poverty. Also, such natural disasters cause outbreaks of waterborne and diarrheal diseases, which affect them physically and lower their productivity levels, in addition to incurring expenditure for medical treatment, which forces them further into deeper poverty (Mujeri 2000; World Bank, 2002 and 2012).

Another cause of poverty in Bangladesh is its large population size. Due to the large population size, the country has been losing annually, on average, one percent of cultivable landholding (Khuda, Barkat and Roy 2014). Also, there is inequitable distribution of land and other productive assets, and lack of adequate employment opportunities throughout the year. Furthermore, death and/or disability of an adult earning member, especially the principal wage earner, place the household at a great disadvantage (Alam and Khuda 2014).

The causes of urban poverty are due to limited employment opportunities, degraded environment, and bad housing and sanitation. The large majority of the urban poor are employed in low-productive, low-wage, informal sector (Khuda 2014). Therefore, the urban poor find themselves in a difficult situation to come out of poverty (Japan Bank for International Cooperation, 2011).

Since the First Five Year Plan (1973-78), Bangladesh has been attaching high priority to poverty reduction to improve the standard of living of its people.

In this section, we examine the poverty situation in Bangladesh, based on official statistics generated by the BBS and other concerned agencies.

Trend in Poverty Reduction

With acceleration in the growth of per capita income, there has been considerable progress in poverty reduction. Between 1991 and 2010, poverty declined sharply from 56.7 percent to 31.5 percent at the national level[14]-- from 61 percent to 35 percent in rural areas and from 45 percent to 21 percent in

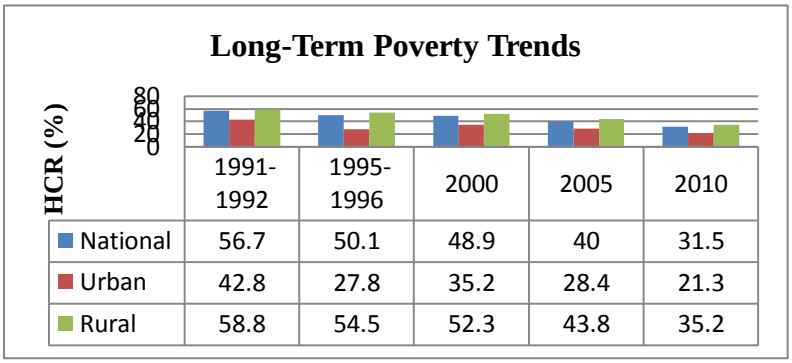
[13] A more detail discussion is contained in Khuda and Barkat 2015 b.

[14] The Household Income and Expenditure Survey (HEIS) has been providing data on the incidence of poverty by using the Cost of Basic Needs (CBN) method. The Cost of Basic Needs (CBN) method, recommended by the World Bank and used by planners, policymakers and international agencies, is the standard method used by the Bangladesh Bureau of Statistics (BBS) for estimating incidence of poverty. With the CBN method, poverty lines represent the per capita expenditures at which the

urban areas (Figure 2). The annual average rate of decline was greater during the present decade (2001-2010), and especially during 2005 and 2010 (Raihan and Khondkar 2012, Table 8.1, page 248). The 2010 HEIS data show that the incidence of poverty declined, on average, by 1.74 percentage points during 2000-2010 compared to the MDG targeted decline of 1.20 percentage points in each year. The estimated poverty headcount ratio was 26.2 percent in 2013. Hence, the MDG target of halving the population living under the poverty line (from 56.7 % to 29%) has already been achieved (Government of Bangladesh 2014 d).

Based on information from the World Bank, the proportion of population living below $1.25 (PPP) per day is shown in Figure 3. The head count ratio declined, on average, at 1.49 percentage points annually during 1992-2010 compared to the required rate of 1.53 percentage points. The evidence, thus, shows a consistent decline in the incidence of poverty by almost similar rates, irrespective of whether poverty is measured by national poverty line or $1.25 (PPP) per day; however, there are differences in levels because of absolute differences in poverty line measures.

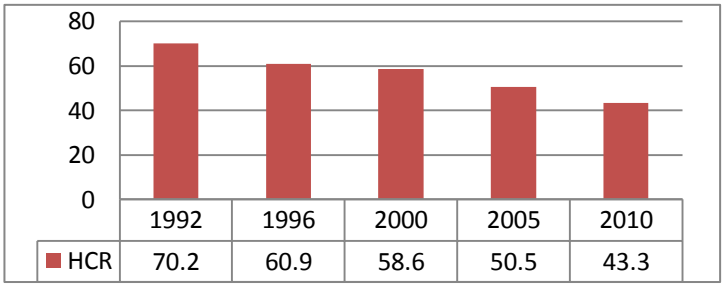
Figure 2: Long Term Poverty Trends (Headcount Ratio) in Bangladesh, 1991-2010



	1991-1992	1995-1996	2000	2005	2010
National	56.7	50.1	48.9	40	31.5
Urban	42.8	27.8	35.2	28.4	21.3
Rural	58.8	54.5	52.3	43.8	35.2

Source: Government of Bangladesh 2006 and 2011 a

Figure 3: Proportion of Population below $ 1.25 (PPP) Per Day in Bangladesh, 1991-2010



	1992	1996	2000	2005	2010
HCR	70.2	60.9	58.6	50.5	43.3

Source: unstats.un.org/unsd/mdg/data.aspx

Considerable reduction in poverty over the past two decades, especially the past decade, has been made possible by sustained economic growth (helped by export earnings from the RMG sector and remittances sent by Bangladeshi workers), decline in the rate of population growth and changing

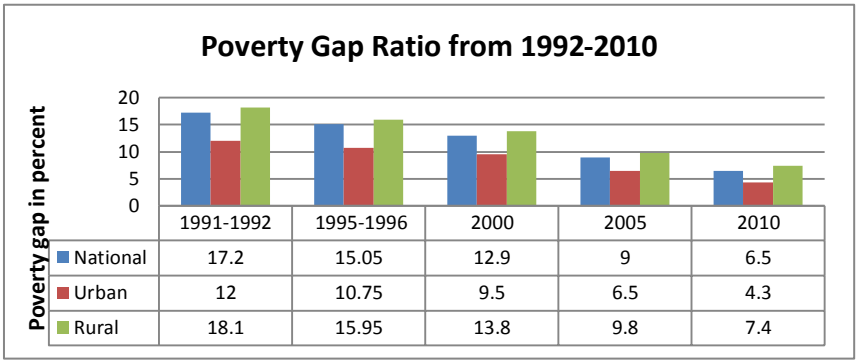
members of a household can be expected to meet their basic needs, comprising food and non-food items. The concept of absolute poverty is the minimum level of income needed for physical survival. The extreme poor households are those households whose total expenditures are equal to the food poverty line (Lower poverty line); and the moderate poor households are those households whose food expenditure is at the level of food poverty line (Upper poverty line) (Government of Bangladesh 2011 a).

population structure, changing industrial mix, increase in labour income, improved infrastructural facilities, and the government's safety net programmes[15].

As a result of considerable decline in poverty, especially during 2001-10, the number of poor people declined, with the number of people below the upper poverty and lower poverty lines declining by around 8.58 million and 8.61 million respectively (Government of Bangladesh 2014 d).

There has been a significant decline in the poverty gap ratio[16]. From 17.20 in 1991-92, the ratio declined to 6.5 in 2010; however, the poverty gap is higher in rural than urban areas[17] (Figure 4). Thus, at the national level and in urban areas, Bangladesh has already achieved one of the indicators of Target 1 by bringing down the poverty gap ratio to 6.5 compared to the MDG target of 8.0 in 2015[18]. However, there continues to be concentration of income among the richer households (Table 3). The richest 5 percent of the households own around one-quarter of the total income, while the poorest 5 percent own less than one percent of the total income, and the situation has remained largely unchanged between 2005 and 2010.

Figure 4: Poverty Gap Ratio using Upper Poverty Line in Bangladesh, 1991-2010



	1991-1992	1995-1996	2000	2005	2010
National	17.2	15.05	12.9	9	6.5
Urban	12	10.75	9.5	6.5	4.3
Rural	18.1	15.95	13.8	9.8	7.4

Sources: Government of Bangladesh 2006 and 2011 a

The share of the poorest quintile in national income declined from 6.5 percent in 1991-92 to 5.2 in 2010 (Figure 5), suggesting that income inequality has worsened over time. Although there is no one-to-one correspondence between the movement of the share of the poorest quintile in national income and the extent of income inequality as can be seen from the Gini coefficient, there is a close relationship between the two. A better measure of inequality is given by Gini coefficient, which shows that income inequality increased in Bangladesh over the past two decades, although the level of inequality has remained largely unchanged over the past decade (Table 4). Income inequality is, however, greater in most South Asian countries compared to Bangladesh (Appendix Table 2).

[15] The government's safety net programmes have contributed to poverty reduction in the country; however, because of the various shortcomings of such programmes such as overlap and duplication between and among the various implementing agencies, wrong selection of beneficiaries, leakages and wastages, etc., the desired progress could not be achieved (World Bank 2006; Khuda 2011).

[16] The poverty gap ratio is a key indicator that measures how far the extreme poor fall below the poverty line and reflects both the depth and incidence of poverty.

[17] Analysis of past trends in income inequality, however, shows that there was more unequal income in the relatively rapidly growing parts of the economy such as the urban/organized sector than in the rural/informal sector or in the rural non-farm sector compared to agriculture (Mahmud 2003, Osmani et. al. 2003).

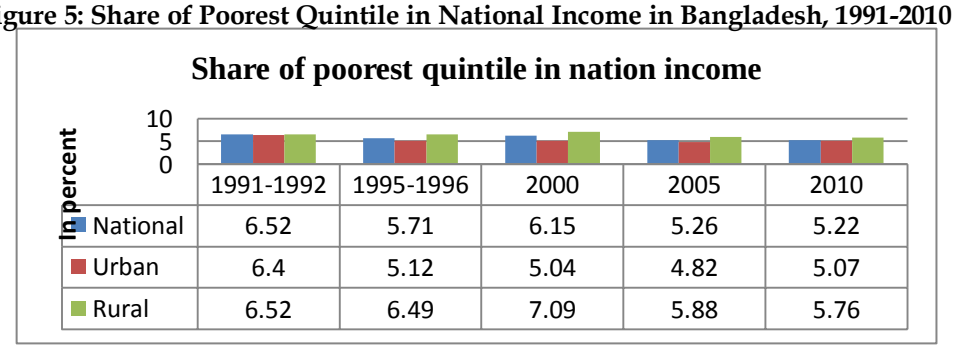
[18] In most Asian countries, the poverty gap has narrowed down during the last decade and a half. The highest poverty gap ratios exist in the low income countries, confirming that pockets of extreme poverty are concentrated among the poorest and most vulnerable countries (World Bank 2014 a).

Table 3: Percentage Distribution of Income Accruing to Household in Groups (Deciles) in Bangladesh, 2005 and 2010

Household Income Deciles	2010			2005		
	National	Rural	Urban	National	Rural	Urban
Total / Deciles	100.00	100.00	100.00	100.00	100.00	100.00
Lower 5%	0.78	0.88	0.76	0.77	0.88	0.67
Decile- 1	2.00	2.23	1.98	2.00	2.25	1.80
Decile- 2	3.22	3.53	3.09	3.26	3.63	3.02
Decile- 3	4.10	4.49	3.95	4.10	4.54	3.87
Decile-4	5.00	5.43	5.01	5.00	5.42	4.61
Decile-5	6.01	6.43	6.31	5.96	6.43	5.66
Decile-6	7.32	7.65	7.64	7.17	7.63	6.78
Decile-7	9.06	9.31	9.30	8.73	9.27	8.53
Decile-8	11.50	11.50	11.87	11.06	11.49	10.18
Decile-9	15.94	15.54	16.08	15.07	15.43	14.48
Decile-10	35.84	33.89	34.77	37.64	33.92	41.08
Top 5%	24.61	22.93	23.39	26.93	23.03	30.37

Sources: Government of Bangladesh 2006 and 2011 a

Figure 5: Share of Poorest Quintile in National Income in Bangladesh, 1991-2010



Sources: Government of Bangladesh 2006 and 2011 a

Table 4: Income Gini Coefficients for Bangladesh: 1991-2010

	1991-92	1995-96	2000	2005	2010
Gini	Income	Income	Income	Income	Income
National	0.388	0.432	0.451	0.467	0.458
Urban			0.497	0.497	0.452
Rural			0.393	0.428	0.430

Sources: Government of Bangladesh 2006 and 2011 a

Differentials in Poverty Reduction

Using the upper poverty line (i.e. the moderate poor households), the incidence of poverty declined from 40 percent in 2005 to around 32 percent in 2010. The extent of poverty decline was about the same, using the lower poverty line (i.e. extremely poor households). The rate of poverty reduction was slightly lower in urban than rural areas (Table 5).

Table 5: Head Count Rate (CBN) of Incidence of Poverty in Bangladesh, 2010 and 2005

Residence	Upper Poverty Line		Lower Poverty Line	
	2010	2005	2010	2005
National	31.5	40.0	17.6	25.1
Rural	35.2	43.8	21.1	28.6
Urban	21.3	28.4	7.7	14.6

Source: Government of Bangladesh 2006 and 2011 a

There are regional differences in the incidence of poverty. Using either poverty line, the highest incidence of poverty is in Rangpur division, while the lowest is in Chittagong division. The incidence of poverty is also relatively high in Barisal and Rajshahi divisions. Poverty declined at a faster rate in Khulna, Rajshahi and Barisal divisions, while Dhaka division recorded the slowest decline (Table 6). The slower rate of decline in Dhaka could be because most rural migrants come to Dhaka city and end up in low-productive, low-paid jobs in the informal sector (Alam and Khuda 2011).

The incidence of poverty is higher among the widowed/divorced household heads. Such households are at greater disadvantage in terms of assets and other sources of livelihood, especially among females. In 2005, Non-Muslim households had higher incidence of poverty compared to the Muslim households; however, such a difference largely disappeared in 2010 (Table 7).

The incidence of poverty is considerably higher among the illiterates (about three times) than the literates, and the difference is considerably greater in urban than rural areas. The incidence of poverty declines sharply with educational status[19]. It is about six times higher among those with no education than those with completed Secondary School Certificate (Class 10) and higher levels of education (Table 8).

Historically, the poor, especially in rural areas, are land poor. Not surprisingly, therefore, the incidence of poverty is quite pronounced among such households, most of who are engaged in agricultural activities[20].The incidence of poverty declines sharply with increase in the size of landholding (Table 9).

Table 6: Incidence of Poverty by Division in Bangladesh, 2010 and 2005

Poverty Line and Division	2010			2005		
	National	Rural	Urban	National	Rural	Urban
Using the Lower Poverty Line						
National	17.6	21.1	7.7	25.1	28.6	14.6
Barisal	26.7	27.3	24.2	35.6	37.2	26.4
Chittagong	13.1	16.2	4.0	16.1	18.7	8.1
Dhaka	15.6	23.5	3.8	19.9	26.1	9.6
Khulna	15.4	15.2	16.4	31.6	32.7	27.8
Rajshahi (Former)	21.6	22.7	15.6	34.5	35.6	28.4
Rajshahi (New)	16.0	16.4	14.4			
Rangpur	27.7	29.4	17.2			
Sylhet	20.7	23.5	5.5	20.8	22.3	11.0
Using the Upper Poverty Line						
National	31.5	35.2	21.3	40.0	43.8	28.4
Barisal	39.4	39.2	39.9	52.0	54.1	40.4
Chittagong	26.2	31.0	11.8	34.0	36.0	27.8
Dhaka	30.5	38.8	18.0	32.0	39.0	20.2
Khulna	32.1	31.0	35.8	45.7	46.5	43.2
Rajshahi (Former)	35.7	36.6	30.7	51.2	52.3	45.2
Rajshahi (New)	29.7	29.0	32.6			
Rangpur	42.3	44.5	27.9			
Sylhet	28.1	30.5	15.0	33.8	36.1	18.6

Sources: Government of Bangladesh 2006 and 2011 a

[19] Evidence suggests that widening differential in earnings of the college-educated individuals compared to the less-educated individuals is, by and large, the single most important factor accounting for increasing inequality (see, e.g. ADB 2005 and 2007).

[20] The relatively slow growth of agriculture relative to the growth of industry and services is one explanation for uneven growth across sectors (rural/urban, agriculture/non-agriculture). Since the bulk of the poor in much of developing Asia rely on agriculture for their livelihoods, its slow growth can also account for relatively slow growth in their incomes (see, e.g. ADB 2005 and 2007).

Table 7: Incidence of Poverty by Selected Household Characteristics in Bangladesh, 2010 and 2005

Characteristics of Households	Percentage of Population Below Poverty Line					
	2010			2005		
	National	Rural	Urban	National	Rural	Urban
Using the Lower Poverty Line						
Marital Status						
Married	17.5	21.1	7.6	25.0	28.5	14.4
Unmarried	10.7	9.6	13.5	17.2	19.7	11.1
Widowed/ Divorced	19.4	22.9	7.6	29.6	32.3	20.0
Religion						
Muslim	17.8	21.4	8.0	24.9	28.3	15.0
Non Muslim	15.5	18.8	4.5	16.6	30.3	10.4
Using the Upper Poverty Line						
National	31.5	35.2	21.3	40.0	43.8	28.4
Gender of Head						
Male	32.1	35.9	21.7	40.8	44.9	28.7
Female	26.6	29.3	17.5	29.5	31.0	24.4
Marital Status						
Married	31.4	35.1	21.1	40.3	44.1	28.4
Unmarried	23.3	22.4	25.5	29.9	32.7	22.8
Widowed/ Divorced	33.9	37.2	22.8	39.2	42.0	28.9
Religion						
Muslim	31.6	35.2	21.6	39.2	42.9	28.7
Non Muslim	31.1	34.7	18.7	45.7	50.4	25.0

Sources: Government of Bangladesh 2006 and 2011 a

Table 8: Incidence of Poverty by Educational Status in Bangladesh, 2010 and 2005

Characteristics of Households	2010			2005		
	National	Rural	Urban	National	Rural	Urban
Using the Lower Poverty Line						
National	17.6	21.1	7.7	25.1	28.6	14.6
Literacy status						
Illiterate	25.1	27.2	15.6	36.3	37.5	29.9
Literate	9.2	12.4	3.3	12.3	15.3	6.7
Education level						
No education	25.1	27.1	15.6	36.3	37.4	30.3
Completed class I-IV	15.8	18.4	7.9	19.3	21.8	12.6
Completed class V-IX	11.4	13.8	5.4	15.8	17.5	11.1
Completed class SSC+	3.4	6.1	0.8	4.4	7.1	1.9
Using the Upper Poverty Line						
National	31.5	35.2	21.3	40.0	43.8	28.4
Literacy status						
Illiterate	42.8	43.5	39.4	54.7	55.1	52.3
Literate	19.0	23.3	11.4	23.0	27.0	15.7
Education level						
No education	42.8	43.5	39.4	54.7	55.0	52.8
Completed class I-IV	35.7	38.1	28.3	37.5	39.2	33.0
Completed class V-IX	22.6	24.9	16.7	29.0	30.9	23.8
Completed class SSC+	7.50	11.2	3.90	9.30	12.2	6.50

Sources: Government of Bangladesh 2006 and 2011 a

Table 9: Incidence of Poverty by Land Ownership in Bangladesh, 2010 and 2005

Size of Land Holding (Acres)	Percentage of Population Below Poverty Line					
	2010			2005		
	National	Rural	Urban	National	Rural	Urban
Using the Lower Poverty Line						
All size	17.6	21.1	7.60	25.1	28.6	14.6
No land	19.8	33.8	9.90	25.2	49.3	17.8
<0.05	27.8	35.9	12.3	39.2	47.8	23.7
0.05-0.49	17.7	22.1	5.4	28.2	33.3	11.4

0.50-1.49	13.3	15.2	2.4	20.8	22.8	9.1
1.50-2.49	7.6	8.6	1.8	11.2	12.8	2.7
2.50-7.49	4.1	4.3	2.7	7.0	7.7	3.0
7.50+	3.7	4.2	0	1.7	2.0	0.0
Using the Upper Poverty Line						
All size	31.5	35.2	21.3	40.0	43.8	28.4
No land	35.4	47.5	26.9	46.3	66.6	40.1
<0.05	45.1	53.1	29.9	56.4	65.7	39.7
0.05-0.49	33.3	38.8	17.4	44.9	50.7	25.7
0.50-1.49	25.3	27.7	12.1	34.3	37.1	17.4
1.50-2.49	14.4	15.7	6.6	22.9	25.6	8.8
2.50-7.49	10.8	11.6	5.5	15.4	17.4	4.2
7.50+	8.0	7.1	14.6	3.1	3.6	0.0

Sources: Government of Bangladesh 2006 and 2011 a

3. Labour Force and Employment

In this section, we analyze labour force and employment in Bangladesh between 2000 and 2010. More specifically, we examine: (i) labour force participation; (ii) structure of labour force in terms of: occupation, industry and employment status; and (iii) underutilization of labour force in terms of un-employment and under-employment[21]. We use data from the 1999-2000 and 2010 Bangladesh Labour Force Surveys of the BBS.

Growth in Size of Working Age Population and Labour Force

Between 2000 and 2010, the total working age population (15 years+) increased by about 22 million, i.e. over 2 million annually, from 74 million (males 38 million and females 36 million) to 95.6 million (males 47.9 million and females 47.7 million). In urban areas, it increased to 23 million (11.5 million each males and females), and in rural areas to 72 million (36 million each males and females) (Khuda 2014).

Compared to an increase of 22 million in the total working age population, the total labour force increased by about 16 million from about 41 million in 2000 to about 57 million in 2010 (Table 10). Although the increase was greater among females than males (8.6 million compared to 7 million), the total number of females in the labour force was less than half of that of males. The increase was much greater in rural areas (12 million) than in urban areas (4 million).

Table 10: Labour Force (aged 15 years and above) by place of residence and gender in Bangladesh: 2000-10 (in millions)

Place of Residence	2000			2010		
	Total	Male	Female	Total	Male	Female
Bangladesh	40.7	32.2	8.6	56.7	39.5	17.2
Urban	9.2	7.1	2.2	13.3	9.3	4.0
Rural	31.5	25.1	6.4	43.4	30.2	13.2

Sources: GOB 2002 and 2011 b.

Labour Force Participation

Among males, the labour force participation rate (LFPR) remained almost unchanged at around 54 percent until 1985-86, and then, increased sharply to over 80 percent since 2000. The female LFPR was quite negligible until 1985-86, and then increased sharply to 36 percent in 2010 (Table 11). Despite the sharp increase in female LFPR, it was less than half of the male LFPR.

The increase in both the male and female LFPR is due to changes in definitions used in the different censuses and labour force surveys; however, part of the increase is real reflecting increased

[21] A more detailed discussion is contained in Khuda and Barkat 2015 c.

participation among females and young males. In 2006, the garment industry provided jobs to 4.5 million people, 80 percent of whom were females, mostly young and unmarried (Asian Development Bank 2006).

Table 11: Labour Force Participation Rate by gender in Bangladesh, 1974-2010

Year	Gender		
	Male	Female	Both Sexes
1974 (Census)	53.0	2.5	28.5
1979 (LFS)	62.0	2.3	35.6
1981 (Census)	52.7	3.4	28.8
1984-85(LFS)	53.8	5.6	30.2
1985-86 (LFS)	53.6	6.4	30.3
1989 (LFS)	81.0	10.6	47.0
1990-91 (LFS)	79.6	14.1	48.8
1995-96 (LFS)	89.0	15.8	52.0
1999-2000 (LFS)	73.5	22.8	49.2
2002-03 (LFS)	87.4	26.1	57.3
2005-06 (LFS)	86.8	29.2	58.5
2010 (LFS)	82.5	36.0	59.3

Note: LFPR is for population aged 10+ until the 2002-03 Labour Force Survey.

Sources: Khuda 1982, 1988; and GOB 2002 (Summary Table pp 81-82) and 2011b.

Growth in Employment

Between 2000 and 2010, total employment increased by over 15 million, from 39 million to 54 million, i.e. 1.5 million annually. The point to emphasize is that the increase in employment was lower than the increase in the working age population and also lower than the increase in labour force. Male employment increased by about 7 million from 31 million to about 38 million, while female employment doubled from 8 million to 16 million[22]. The increase in employment was largely in the informal sector due to relatively limited number of jobs created in the formal sector[23]. Formal sector employment accounted for only 12.5 percent of all jobs and informal sector accounted for 87.5 percent of all jobs in 2010. The evidence, thus, indicates that the employment structure of Bangladesh is characterized by the predominance of the low-productivity, low-wage, informal sector.

[22] Female employment is largely poverty-driven, resulting from poor economic household condition and high rates of female headships (see, e.g. Safilos-Rothschild and Mahmood 1980; BIDS 1990; Rahman and Hossain 1991). Although the percentage of the population living below the poverty line has declined considerably, still around one-quarter of the population lives below the poverty line, which explains why poverty continues to be a major determinant of female employment. Also, it is partly aspiration-driven, i.e. the poor are no longer willing to accept that poverty is their fate, and are therefore, willing to struggle to escape from poverty, including through finding jobs for female household members. Further, it is likely that there is a spill-over effect from those who are working for those who are not, and thereby, encouraging the latter group to enter the labour market.

[23] The definition of formal and informal sectors has not been uniform in the different Labour Force Surveys. In fact, the change in definition in the 2010 Labour Force Survey resulted in a sharp decline in jobs in the formal sector in 2010, from 9.6 million in 2000 to only 5.4 million in 2010 (Govt. of Bangladesh 2011b). Thus, the decline was not real. In fact, there was a small increase in the total number of jobs created in the formal sector in 2010 compared to 2006, while the increase was considerably larger in the informal sector (Government of Bangladesh 2011 b; Asian Development Bank and Government of Bangladesh 2012).

It is worth mentioning that informal sector employment is widespread in most low-income countries, though there are regional variations. South and South East Asian countries have very large proportions in the informal sector, reaching up to 90 percent in some countries. In addition to the informal sector workers, there are informal workers (contractual and casual) in the formal sector, who get paid lower wages and do not have job security. The predominance of the informal sector, and thus, lack of formal employment opportunities is a major barrier to further reduction in poverty in South and South-East Asian countries (ILO 2014).

Structural aspects of Labour Force

A three-way classification is often used to identify the structure of the labour force: by occupation, industry and employment status[24].

Employment by Major Occupation

Between 2000 and 2010, there has been no marked change in the occupational structure of the employed population (Table 12). Agriculture, forestry and fisheries continue to be the primary occupation of about half of the total employed population, followed by production and transport workers; sales workers; service workers; professionals, technical, administrative and managerial workers; and clerical workers.

There are wide variations by place of residence. In 2010, the major occupational categories in urban areas were production and transport labourers (36%), followed by agriculture, forestry and fisheries (24%) and sales workers (17%); whereas in rural areas those were agriculture, forestry and fisheries (55%), followed by production and transport labourers (19%) and sales workers (14%). Eleven percent was employed in professional, technical, administrative and managerial occupations in urban areas compared to only 4 percent in rural areas. Also, there are differentials by gender. Production and transport labourers (40%) and agricultural workers (48%) are the major occupation categories respectively among urban and rural males, while agricultural workers are the major occupational category among both urban females (49%) and rural females (70%) (Government of Bangladesh 2011b).

Employment by Major Industry

There has been no marked change in the industrial structure of the employed population (Table 13). Agriculture, forestry and fisheries accounted for about half of the total employed population, followed by trade, hotel and restaurant; manufacturing; and transport, storage and communication. The low employment in the manufacturing sector is due to limited number of manufacturing industries. At the same time, the employment structure of Bangladesh continues to become more service sector oriented, predominantly outside of the formal sector. Thus, even after more than three decades of economic development, the Lewisian transformation of the economy remains elusive in Bangladesh (Islam, 2009).

There are gender differentials in employment by industries[25]. Around half of the males were engaged in agriculture in 2000 compared to two-fifths in 2010, indicating movement of some males out of the agriculture sector, both as a result of push factors and on account of economic growth and urbanization. However, the percentage of females engaged in this sector increased from less than half (47%) to about three-fifths (65%). Three plausible explanations can be put forward: (i) more females are getting employed in the agriculture sector; (ii) an increasing recognition and acknowledgement by the survey respondents of women's work in the agriculture sector; and (iii) improvement in the quality of data over time[26]. In the manufacturing sector, the percentage of males increased from 7 percent to 13 percent, while among females it declined from 18 percent to 12 percent. In the trading sector, the percentage of males remained unchanged at around 17 percent, while among females it declined from about 8 percent to 6 percent. No noticeable change was discernible in the other industrial categories.

[24] Occupation refers to the type of work one does, irrespective of the industry. Industry refers to the activity of the establishment or enterprise in which the worker is engaged. Occupation is, thus, distinguished by the process of production, whereas industry is distinguished by the product. Employment status refers to the worker's position vis-à-vis other workers. For more elaborate discussion on the structure of labour force, see Khuda 1978, 1980, 1982 and 2014.

[25] Worldwide, women are more limited in their choices for employment (ILO 2012).

[26] However, it is not possible to say exactly the extent to which the above explanations might have affected the reported increase.

Table 12: Employed persons aged 15 years and above by major occupation and gender in Bangladesh: 2000-10 (%)

Major Industries	2000			2010		
	Total	Male	Female	Total	Male	Female
1.Professional, technical	4.0	3.8	4.7	4.4	3.8	4.7
2.Administration/ managerial	0.5	0.6	0.2	1.3	0.6	0.2
3. Clerical workers	3.1	3.5	1.7	1.9	3.5	1.7
4. Sales workers	14.8	17.1	5.6	5.5	17.1	5.6
5. Service workers	5.7	3.2	15.7	15.0	3.2	15.7
6. Agri. Forestry fisheries	51.1	51.8	48.4	47.4	51.8	48.4
7. Production, transport laborers and others	20.8	20.0	23.7	22.8	20.0	23.7
8. Others				2.0	2.5	0.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Sources: GOB 2002 and 2011 b.

Table 13: Employed persons aged 15 years and above by major industry and gender in Bangladesh: 2000-10

Major Industry	1999-2000			2010		
	Total	Male	Female	Total	Male	Female
Total	100.0	100.0	100.0	100.0	100.0	100.0
Agriculture, forestry, Fishing and related workers	50.8	51.8	46.8	47.6	40.2	64.8
Mining & quarrying	0.3	0.3	0.0	0.2	0.3	0.1
Manufacturing	9.5	7.4	17.7	12.5	12.8	11.8
Electricity, gas, water	0.5	0.6	0.0	0.2	0.3	0.0
Construction	2.8	2.9	2.5	4.8	6.3	1.4
Wholesale & retail trade	14.9	16.7	7.6	14.0	17.2	6.3
Hotel & restaurant	1.3	1.6	0.0	1.5	2.0	0.3
Transport, storage, communication services	6.4	8.0	0.0	7.5	10.0	1.5
Banks, insurance & finance	0.5	0.6	0.0	0.7	0.8	0.3
Real estate, rent, business activities	0.5	0.6	0.0	1.2	1.5	0.4
Public administration	2.1	2.3	1.3	1.0	1.3	0.2
Education services	2.6	2.6	2.5	2.4	2.5	2.0
Health & social workers	0.5	0.6	0.0	0.9	0.9	1.1
Community, personal service household sectors and Others	7.4	3.9	21.5	6.2	4.8	9.6

Table prepared by Labour Force Wing, BBS, based on data from the 1999-2000 and the 2010 LFS.

In 2010, two-fifths of those employed in different industries had no education, followed by about one-quarter each with primary and secondary schooling, and the rest with higher levels of education. A similar picture is discernible, when looking at educational level among major occupational groups (Government of Bangladesh 2011 b, Table 4.9).

Employment Status

Between 2000 and 2010, there has been no overall change in the relative shares of the different employment status categories. Self-employed workers, the dominant group, declined from about half (47%) in 2000 to two-fifths (41%) in 2010; day labourers remained at around 23 percent; and employees hovered at around 15-17 percent. In contrast, unpaid family workers increased its share

from 12 percent to 22 percent (Table 14). The evidence, thus, indicates predominance of vulnerable employment, especially among females[27]: (males 62% and females over 80%).

Table 14: Employed persons aged 15 years and above by employment status and gender in Bangladesh: 2000-10 (%)

Employment Status	2000			2010		
	Total	Male	Female	Total	Male	Female
1.Employee	16.7	15.8	20.3	14.6	17.0	8.9
2. Employer	0.3	0.3	0	0.2	0.2	0.2
3. Self-employed	46.7	51.4	26.6	40.8	47.5	25.1
4. Day Laborers	24.3	26.1	19.0	22.6	28.2	9.5
5. Unpaid family workers	12.0	6.4	34.1	21.8	7.1	56.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0

Sources: GOB 2002 and 2011 b.

There are gender differentials. Among males, the self-employed continue to be the dominant group, followed by day labourers, employees and unpaid family workers. Among females, unpaid family worker is the dominant category, followed by self-employed, employees and day labourers.

There are variations by place of residence. Over one-quarter in urban areas and over two-fifths in rural areas are self-employed. In urban areas, the percentage of employees declined from 37 percent in 2000 to 30 percent in 2010, while it remained at around 10 percent in rural areas. The percentage of unpaid family workers increased in urban areas (from 7% to 17%) and also in rural areas (from 14% to 23%). In urban areas, the percentage of day labourers increased from 15 percent to 19 percent, while in rural areas it declined from 28 percent to 21 percent (Govt. of Bangladesh 2011 b, Table 4.11). The evidence indicates that vulnerable employment is more pronounced in rural than urban areas.

Employment status varies with occupation. In professional and technical occupation, the relative share of employees increased from 67 percent in 2000 to 71 percent in 2010. The other dominant employee categories in 2010 were clerical workers (62%), administrative and managerial staff (29%), and production and transport workers (24%). In contrast, the self-employed were the dominant group among sales workers (66%); service workers (41%); those engaged in agriculture, forestry and fisheries (37%); and production and transport workers (31%). Unpaid family workers were predominant in agriculture, forestry and fisheries (37%), followed by service workers (22%) (Govt. of Bangladesh 2011 b, Table 4.12).

Underutilization of Labour Force

Unemployment

In 2010, the unemployment rate was only 4.5 percent[28], which, however, increased from 2.5 percent in 1995-96 (Islam, 2009). Unemployment was higher in urban than rural areas, and among females than males (Table 15).

Highest unemployment was recorded among the more educated-- those with engineering/medical degrees and those with Higher Secondary School Certificate—12 years of schooling--(14%). In contrast, lowest unemployment was recorded among those with no education (2%) (Govt. of Bangladesh 2011 b, Table 5.3, page 77). While those with no education are poor and cannot afford the luxury of remaining unemployed, the higher unemployment among the relatively educated

[27] In developing countries, vulnerable employment is more prevalent among females than males. In 2012, over half of employed women were in vulnerable employment compared to 48 percent among males. A larger percentage of women were unpaid family workers, while a larger percentage of men were self-employed (ILO 2012).

[28] The reported low unemployment rate is on account of the ILO definition of unemployment used in the Bangladesh Labour Force Surveys.

population, in itself, is a disturbing finding, indicating that the educated manpower is not fully utilized in the production process of the country, thereby having an adverse effect on the growth of the economy.

Table 15: Unemployment rate of population aged 15 years and above by gender and place of residence in Bangladesh: 2000-10 (%)

Place of Residence	Labor Force (2000)			Labor Force (2010)		
	Total	Male	Female	Total	Male	Female
Bangladesh	4.3	3.4	7.8	4.5	4.1	5.7
Urban	5.8	5.0	8.3	6.5	5.7	8.3
Rural	3.9	2.9	7.6	4.0	3.6	4.9

Sources: GOB 2002 and 2011 b.

Underemployment

There is considerable underemployment in Bangladesh. It increased from around 17 percent in 2000 to over 20 percent in 2010. Underemployment is considerably higher in rural areas and among females (Table 16).

Table 16: Underemployment rate of population aged 15 years and above by gender and place of residence in Bangladesh: 2000-10 (%)

Place of Residence	Labor Force (2000)			Labor Force (2010)		
	Total	Male	Female	Total	Male	Female
Bangladesh	16.6	7.4	52.8	20.3	14.4	34.2
Urban	12.2	4.7	38.2	12.4	6.9	25.6
Rural	17.8	8.1	57.7	22.7	16.7	36.6

Sources: GOB 2002 and 2011 b

4. Health

In this section, we examine what has been happening in the health sector in Bangladesh[29], specifically insofar as achievements and gaps in MDG 4 and 5 are concerned, based on an extensive review of all relevant documents and data sources.

Family Planning

The Bangladesh Family (FP) Programme began in the early 1950s, and evolved in phases[30]. From about 4 percent of married couples using FP in the 1960s (Sirageldin et. al., 1975; Stoeckel and Chowdhury, 1973), the contraceptive prevalence rate (CPR) slowly increased during the 1970s (Mia et.al. 1978; Bhuiyan 1980; Khan, Huber and Rahman1977; Khuda 1981 and 1984). From the CPR of 8 percent in 1975, it increased almost six-fold to 45 percent in 1994. In 2011, it was 61 percent[31] (Figure 6).

The Bangladesh Family Planning (FP) Programme achieved impressive success until the mid-1990s, which can be attributed to strong political will and commitment since the launching of the First Five-Year Plan of Bangladesh in 1973, increase in the demand for FP services, provision of such services by the FP programme, favourable political environment, and socio-economic development (see, e.g.

[29] A more detailed discussion is contained in Khuda and Barkat 2014 a.

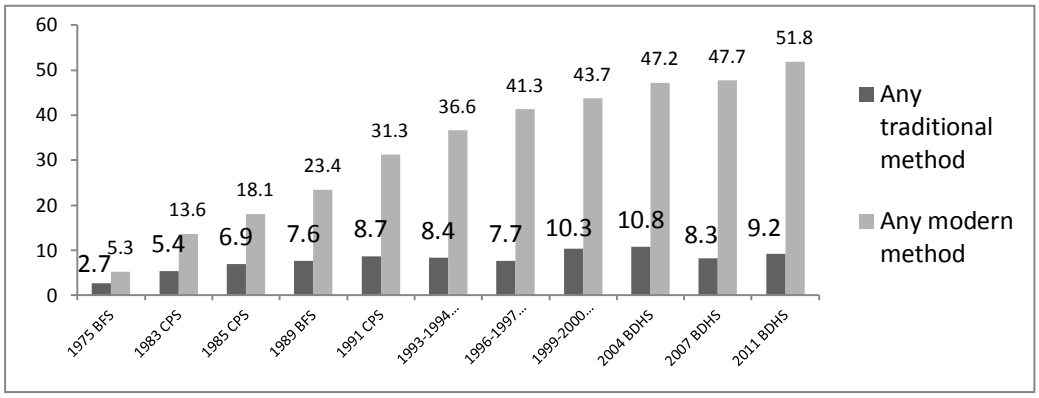
[30] A more detail discussion is contained in Khuda 1981 and 1984; Khuda and Barkat 2012 a and b; 2014 a.

[31] The CPR in Bangladesh is higher than in most South Asian countries, except Sri Lanka (64%) and India (64%) (Khuda and Barkat 2012 b). In 2011, 62% of women in developing countries who were married or in union were using some form of contraception, 90% using modern methods. In developing regions, including Southern Asia, tubectomy and the IUD are the most widely used methods, together accounting for more than half of all contraceptive use (UN 2013).

Cleland et.al 1994; Caldwell et.al 1999; Caldwell and Khuda 2000; Khuda et al 1994b; Khuda et.al 2001; Khuda 2004; Khuda and Barkat 2012 a and b; UNFPA 2010).

Since mid-1990s, however, the Programme is faced with a number of challenges: slowing down in the rate of increase in CPR, regional variations in contraceptive use, low contraceptive use among married adolescents, declining share of longer-acting and permanent methods (LAPM), high discontinuation rate, and sizeable unmet need for contraception. [32]

Figure 6: Trends in Contraceptive Prevalence Rate (CPR) among Currently Married Women Age 10-49 in Bangladesh, 1975-2011

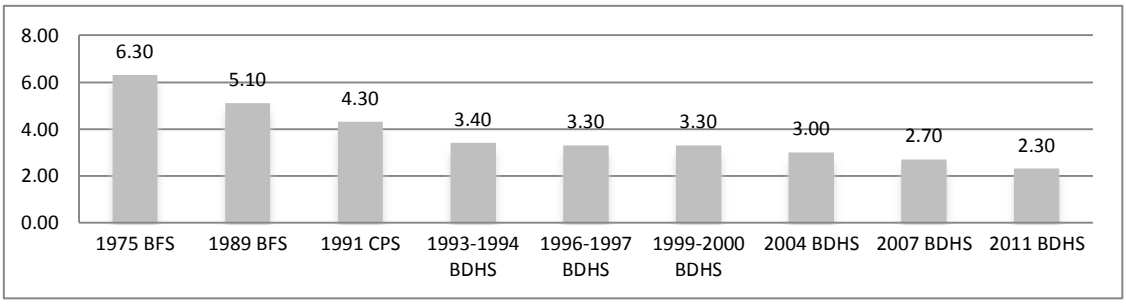


Source: NIPORT, Mitra & Associates and ICF International 2013

Fertility

During the 1960s, Bangladesh had high fertility, with the total fertility rate (TFR) of over 7. It declined to 6.3 in 1975, and remained above 6 until 1981. Fertility declined to 5.1 in 1989; and between 1989 and 1993-94, it declined sharply to 3.4. However, after a stalled decline at around 3.3 during 1994-2000, it declined to 2.3 in 2011[33](Figure 7). Thus, the Bangladesh fertility transition can be divided into four phases: (i) high fertility until the mid-1980s; (ii) rapid decline in fertility between 1989 and 1993-94; (iii) plateuing of fertility decline between 1994 and 2000; and (iv)substantial decline in fertility since the 2000s (Khuda and Barkat 2014 a).

Figure 7: Trends in Total Fertility Rates (TFR) in Bangladesh, 1975-2011



[32] The challenges are similar to those faced by most South Asian countries (Khuda and Barkat 2012 b and 2014 b).

[33] Fertility is lower in Bangladesh than in most South Asian countries (Khuda and Barkat 2012 b). See also, Haub and Gribble 2011, which gives a TFR of 2.6 for India in 2009; and the Pakistan Demographic and Health Survey 2012-13 gives a TFR of 3.8 for Pakistan.

Although Bangladesh has achieved near replacement level fertility, there are differentials in fertility levels, regionally and by socio-economic characteristics of the women. Chittagong and Sylhet divisions, accounting for around one-fifth of the country's population, have higher fertility (TFR of over 3). Rural women give birth to half a child more than urban women (2.5 compared with 2.0 per woman).Women with completed secondary schooling or higher education have already achieved below replacement level fertility (about 2), while those with no education have high fertility (2.9). Women in the highest wealth quintile have already achieved below replacement level fertility (1.9), while those in the lowest wealth quintile have high fertility (3.1) (Khuda and Barkat 2014 a). Also, fertility is higher among non-working women, women belonging to landless households, women without access to mass media, and women belonging to households without electricity connection, an indicator of not only economic condition of the household but also its level of modernization (Khuda 2004; Neaz et al 2004).

A major concern relates to extremely high adolescent fertility in Bangladesh, one of the highest in the world[34]. Thirty percent of adolescent married women have begun childbearing. Childbearing among adolescents is higher in rural areas, among those with no education and those in the lowest wealth quintile (Khuda and Barkat 2014 a).

Nutrition

There has been some improvement in the nutritional status of under-5 Bangladeshi children[35]. Between 2004 and 2011, the level of stunting declined from 51 percent to 41 percent, underweight from 43 percent to 36 percent[36], while wasting remained unchanged at around 16 percent (Figure 8).

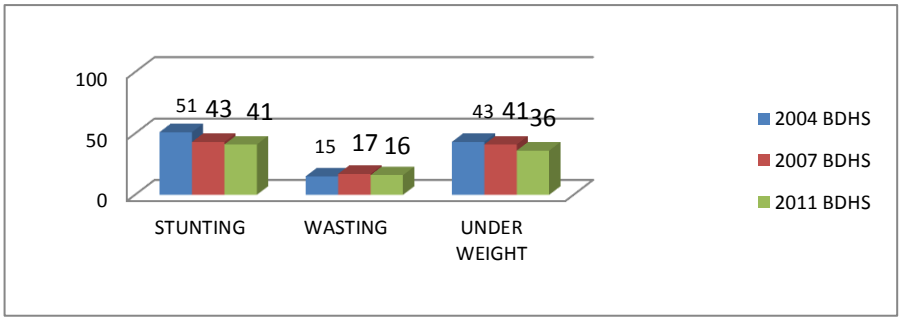
Among ever-married women, malnutrition has recorded some decline over time. The mean BMI for ever-married women aged 15-49 years is 21.4, which falls in the normal BMI classification. The proportion of women with BMI below 18.5 declined from 34 percent in 2004 to 24 percent in 2011. The percentage of women with height less than 145 cm. ranged between 13 percent and 16 percent (NIPORT et.al, 2013, Table 11.10).

[34] Adolescent fertility presents a major challenge in developing countries. However, between 1990 and 2010, adolescent fertility declined globally, with the most pronounced decline in Southern Asia. Nevertheless, one in nine (15 million out of 135 million) live births are among adolescent women worldwide, indicating relatively high adolescent fertility, especially in developing countries (UN 2013). Further, in many of the countries with high TFR or high MMR, births to younger women (15–24 years) account for 30-50% of all births. An early transition to motherhood can not only reduce young women's opportunities for their schooling and future employment opportunities, but also, in turn, affect their children's schooling opportunities as well as their children's health and nutrition outcomes (World Bank 2010).

[35] Globally, one in eight people (about 870 million) did not consume enough food on a regular basis to cover their minimum dietary energy requirements during 2010-12, the vast majority (852 million) of whom lived in developing countries. While their numbers continue to be quite high, the proportion of undernourished people in the total population declined from 23 percent in 1990–1992 to 15 percent in 2010–2012, indicating that the target of halving the percentage of people suffering from hunger by 2015 is within reach. However, there are large disparities in the rate of reduction in undernourishment among regions and countries. Progress has been relatively swift in South-Eastern Asia, Eastern Asia, and Central Asia; however, the pace of change in Southern Asia appears to be too slow to meet the MDG target (UN 2014).

[36] Around 101 million under-5 children (16% of all under-5 children), worldwide, were underweight in 2011.Between 1990 and 2011, the number of underweight children declined by 36 per cent; however, the prevalence of underweight in 2011 was highest in Southern Asia (57 million or 31%) (UN 2013)

Figure 8: Trends in Nutritional States of Children under Five in Bangladesh, 2004-2011



Source: NIPORT, Mitra & Associates and ICF International 2013

However, despite some improvement, poor nutritional status continues to be a major health problem for many in Bangladesh[37], especially among young children and women of reproductive ages, who are more vulnerable to nutritional and micronutrient deficiencies than adult males.

Stunting, underweight and wasting among under-5 children are higher in rural areas, in Sylhet; and are inversely associated with mother's education and household wealth status (NIPORT et.al, 2013, Table 20).

Anemia is a major health problem in Bangladesh, especially among young children and pregnant women. Half of children aged 6-59 months suffer from some level of anemia. It is inversely associated with mother's education and household wealth status (NIPORT et.al, 2013, Table 11.7).

Over two-fifths of ever-married women aged 15-49 years are anemic. Rural women, those with little or no education and those in the lowest wealth quintile tend to be shorter and undernourished (NIPORT et.al, 2013, Table 11.11).

Child Health

The MDG targeted that child mortality rate should be reduced by two-thirds by 2015[38]. The targets for Bangladesh are to reduce under-5 mortality and IMR from 133 and 94 respectively in 1990 to 45 and 31.3 respectively by 2015; and to increase the proportion of children immunized against measles from 54 percent in 1990 to 100 percent by 2015 (Government of Bangladesh 2014 d).

Bangladesh achieved considerable success in reducing childhood mortality. Between 1989 and 2011, the IMR declined by half from 87 deaths per 1,000 live births to 43 deaths per 1,000 live births;[39] and the under-5 mortality declined by 60 percent from 133 to 53[40](Figure 9). Thus, Bangladesh has already achieved the MDG 4 target for under-5 mortality.

[37] One of the major problems hindering success in the nutrition sector in Bangladesh is lack of effective coordination among the concerned ministries, especially agriculture, food, and health (Nahar et.al. 2014).

[38] Globally, the under-5 mortality rate declined by 41% during the last two decades (from 87 deaths per 1,000 live births in 1990 to 51 in 2011).However, around 6.9 million children (i.e. 19,000 a day) died from mostly preventable diseases in 2011. The overwhelming majority of such deaths occurred in the poorest countries, and in the most disadvantaged areas within countries. Therefore, more rapid progress is needed to meet the 2015 MDG target of a two-third reduction in child mortality, especially in Southern Asia. Despite steep challenges, however, a number of countries in South Asia (Bangladesh achieving two-third reduction and Bhutan and Nepal 60% each) with very high rates of child mortality in 1990 have defied the odds, showing that progress for all children is within reach (UN 2013).

[39] The IMR in Bangladesh is lower than in all countries of South Asia, except Maldives (14) and Sri Lanka (14) (UNICEF, WHO, The World Bank and UN Population Division, 2011).

[40] The under-5 mortality rate in Bangladesh is lower than in all countries of South Asia, except Maldives (15) and Sri Lanka (17) (UNICEF, WHO, The World Bank and UN Population Division, 2011).

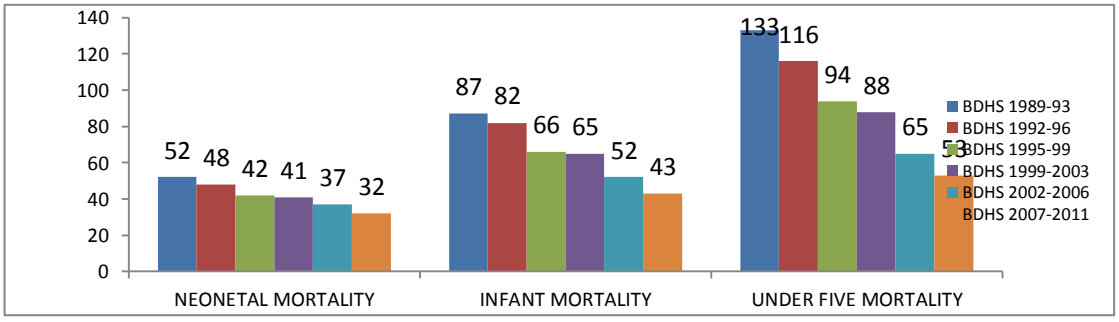
As a result of considerable reduction in childhood mortality, life expectancy at birth increased from 58 years (males: 58.2 years and females: 57.9 years) in 1994 to 69 years in 2011 (males: 67.9 years and females: 70.3 years). The increase was greater in rural areas from 57.7 years (males: 57.9 years and females: 57.7 years) to 68.6 years (males: 67.4 years and females: 69.8 years) compared to urban areas from 60 years (males: 61.3 years and females: 60.6 years) to 69.9 years (males: 68.9 years and females: 71.1 years) (Khuda and Barkat 2015 d). The evidence indicates that life expectancy at birth increased by 11 years, i.e., on average, by about 0.7 years annually during 1994-2011[41].

A matter of concern relates to the slow decline in neonatal mortality (38%); and further that neonatal mortality (32)[42] accounts for three-quarters of infant mortality. Also, neonatal mortality, IMR and under-5 mortality rates are higher in rural areas, and are inversely associated with mother's education and wealth status (NIPORT et.al, 2013, Table 8.3).

Vaccination coverage among under-2 children increased from 59 percent in 1994 to 86 percent in 2011. The corresponding increases for BCG, DPT3, Polio3 and measles were from 85 to 98 percent, 66 to 93 percent, 67 to 93 percent, and 69 to 88 percent respectively (NIPORT et.al, 2013, Figure 10.1). The Health, Population, Nutrition Development Sector Programme (HPNDSP) has set a target of achieving 90 percent coverage of measles vaccine by 12 months of age by 2016 (Government of Bangladesh 2011 c).

There are, however, differentials in vaccination coverage among children. Both measles and all basic vaccinations are negatively associated with the birth order of children, while they are positively associated with mother's education and wealth status (NIPORT et.al, 2013, Table 10.3).

Figure 9: Trends in Childhood Mortality in Bangladesh, 1989-2011



Source: NIPORT, Mitra & Associates and ICF International 2013

Maternal Health

The HPNDSP has set the target of reducing the MMR to 143 deaths per 100,000 live births by 2015, in line with the MDG goal of reducing MMR by three-quarters between 1990 and 2015[43].

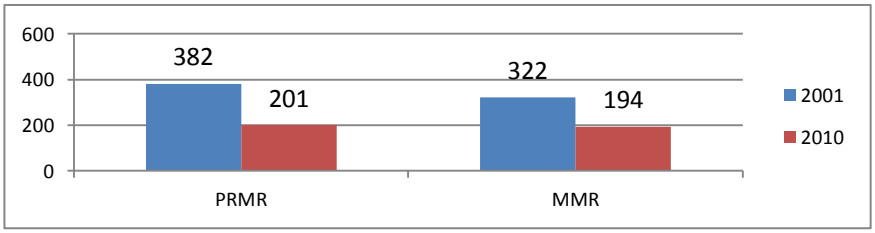
[41] Between 1960 and 2011, life expectancy at birth in South Asia increased from 43.25 years to 65.61 years. Female life expectancy increased from 42.49 to 67.06. Male life expectancy increased from 43.97 years to 64.23 years. Compared to South Asian averages, Bangladesh has higher life expectancy for both females and males. Maldives has the highest life expectancy in South Asia (76.59 years), followed by Sri Lanka (74.56 years) and Bangladesh. It is lowest in Afghanistan (59.62 years).

[42] The neonatal mortality rate in Bangladesh is lower than in all countries of South Asia, except Maldives (9) and Sri Lanka (10) (UNICEF, WHO, The World Bank and UN Population Division, 2011).

[43] Under the HPNSDP, two OPs, one each, being implemented vertically by the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP), are being implemented with a strong emphasis on improving access and equity in utilization of essential maternal and neonatal health services.

The MMR declined from 322 deaths per 100,000 live births in 2001 to 194 in 2010[44], 40 percent decline[45]. During the same period, the pregnancy-related MMR declined by 47 percent from 382 deaths per 100,000 live births to 201(Figure 10; NIPORT et.al 2012).

Figure 10: Pregnancy-related and Maternal Mortality Ratios (per 100,000 live births) in Bangladesh, 2001-2010



Source: NIPORT, MEASURE Evaluation and ICDDR, B 2012

The MMR is, however, not uniform among Bangladeshi women. It rises steeply with age. Compared to an MMR of 130 among women aged 20-24 years, it was 1,798 among women aged 45-49 years in 2010. The MMR is higher in rural (199) than urban areas (178), in Sylhet (425) than Khulna (64), among women with no education (439) than those with secondary or higher education (90), and twice as high among women in the lower wealth quintile (234) than those in the highest wealth quintile (123) (NIPORT et.al 2012, Table 3.3).

Antenatal Care (ANC): The increase in ANC coverage was more rapid between 1997 and 2001, after which the rate of increase slowed down[46]. The percentage of last births that received at least one ANC from a medically trained provider increased from 30 percent in 1997 to 55 percent in 2010. In 2010, the major source of ANC was doctors (38%) (NIPORT et.al 2012, Figure 4.1 and Table 4.1). The proportion of women receiving four or more ANC visits increased between 2005 and 2009 from 18 percent to 26 percent[47], though still quite low[48]. About one-fifth of the women received ANC at home; and it is more common among women with high birth order, and is inversely associated with mother's education and household wealth status ((NIPORT et.al 2012, Table 4.4).

Almost 90 percent of mothers received TT injections; and 42 percent received two or more TT injections during their last pregnancy in 2011. However, the percentage of pregnant women receiving at least one TT decreases with age and birth order of child; and is lower in rural areas, in Sylhet,

[44] The MMR in Bangladesh is lower than in all countries of South Asia, except Sri Lanka (74) (WHO 2011a and b). See also Government of Bangladesh 2014 d.

[45] Globally, the maternal mortality ratio declined by 45% between 1990 and 2013, from 380 to 210 deaths per 100,000 live births. Worldwide, almost 300,000 women died in 2013 from causes related to pregnancy and childbirth. In Southern Asia, the decline was 64%. However, meeting the MDG target of reducing the MMR by three-quarters will require accelerated interventions, including improved access to emergency obstetric care, assistance from skilled health personnel at delivery and the provision of antiretroviral therapy to all pregnant women who need it (WHO, UNICEF, UNFPA and The World Bank 2012; UN 2013 and 2014).

[46] Between 1990 and 2011, ANC coverage (at least one visit with a doctor, nurse or midwife during pregnancy) increased from 63 per cent to 81 per cent in the developing regions. Most progress was made in Southern Asia, Northern Africa and Western Asia over the past decade, while the Caribbean, Eastern Asia, Latin America and South-Eastern Asia already achieved coverage rates of 90 per cent or more (UN 2013).

[47] It is lower than the averages of the developing countries (half) and that of South Asia (36%) (UN 2013). Over half of pregnant (52%) women in Bangladesh had four or more antenatal care visits during pregnancy in 2012, rising from 37% in 1990 (UN 2014).

[48]Although the number of women who receive at least four ANC has increased, these gains will not be sufficient to reach the MDG target set for 2015 (Government of Bangladesh 2014 d).

among women with no education and those in the lowest wealth quintile. The relationship is in the same direction, though weaker, when pregnant women receiving two or more TT injections are considered (NIPORT et.al, 2013, Table 9.4).

Inequalities in ANC coverage exist by mother's age at birth, place of residence, and household wealth status (Government of Bangladesh 2013 d). The proportions of women receiving ANC from a medically trained provider decline with the mother's age at birth; and are lower in rural areas, in Sylhet, among women with no education, and those in the lowest wealth quintile ((NIPORT et.al 2012, Table 4.1).

Delivery Care: Increasing the proportion of births delivered by skilled personnel is one of the important indicators of maternal health in MDG5 (UNFPA 2003). The percentage of all live births delivered by medically trained provider increased from 12 percent in 2001 to about 27 percent in 2010[49], though still quite low. The percentage of births delivered in a facility increased from 9 percent in 2001 to 23 percent in 2010, though still quite low.

There are differentials in the proportion of births attended by medically trained providers in Bangladesh, as in various other countries. It was less than half among older women aged 40 years and above (12%) than among women aged 20-29 years. It was twice as low in rural (22%) than urban areas, six times lower among women with no education (11%) than those with secondary complete or higher education, and six times lower among women in the lowest wealth quintile (9%) than those in the highest wealth quintile. Furthermore, two-thirds of all births were delivered by traditional birth attendants, more common in rural areas, among older women, and among mothers with little or no education and those in the lowest wealth quintile (NIPORT et.al. 2012, Table 4.9).

Facility-based delivery varied by characteristics of mothers. It was 2.5 times lower among women aged 40-44 years (10%) than those aged 20-29 years. It was 6 times lower among higher order births (6%) than for first order parity. It was half in rural (19%) than urban areas, and half in Sylhet (15%) compared to Khulna. It was one-sixth among women with no education (10%) than those with secondary and higher education, and one-seventh among women in the lowest wealth quintile (8%) than those in the highest wealth quintile (NIPORT et.al. 2012, Table 4.8).

Postnatal Coverage (PNC): In 2010, about one-quarter of women with recent deliveries had a postnatal check-up both for themselves and their babies by a medically trained provider, though quite low (NIPORT et.al. 2012, Tables 4.13 and 4.16). Among mothers seeking postnatal check-up for themselves by qualified doctors, it declines sharply with birth order (from 27% at birth order of one to 5% at birth order of 6+); half in rural (14%) than urban areas; and lower in Barisal (8%) than Dhaka (23%), among those with no education (6%) than those with secondary or higher education (48%), and among those in the poorest quintile (5%) than those in the highest wealth quintile (44%) (NIPORT et.al. 2012, Table 4.13). A similar picture is discernible regarding seeking postnatal check-up for babies (NIPORT et.al. 2012, Table 4.16).

Systemic Problems in the Health Sector

The health, population and nutrition sector programme in Bangladesh is faced with a number of major challenges[50]. These include: (i) lack of a sector-wide approach, with a number of Operational Plans (OPs) being designed and implemented vertically without any meaningful integration between the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning

[49]In developing regions, the proportion of deliveries attended by skilled personnel increased from 55% in 1990 to 68% in 2012, although only about 50 per cent in Southern Asia, reinforcing the need for rapid expansion of increased access to ANC services; referral to higher levels of care, when required; skilled birth attendance; and emergency obstetric care (UN 2013 and 2014). See also World Bank 2010.

[50] For detailed discussion, see Khuda and Barkat 2012 a and 2014 a.

(DGFP), resulting in duplication of efforts and wastage of resources[51]; (ii) weak stewardship role of the Ministry of Health and Family Welfare (MOHFW); (iii) inadequate monitoring and supervision, with limited delegation of authority at lower levels, resulting in poor quality of service and lack of good governance and weak accountability; (iv) gaps in commodity security, including reproductive health and family planning; (v) lack of a coherent national behavior change communication (BCC) strategy[52]; (vi) gaps in programme efficiency (due to lack of integration between DGHS and DGFP, infighting between medical and non-medical staff within DGFP, staff vacancies, absence of career planning, low staff morale, inadequate training, lack of leadership and management, weak implementation capacity, and non-involvement of other concerned ministries), resulting in considerable system loss; and (vii) limited funding and expenditure, with one of the lowest per capita spending on health [53]and high out-of-pocket spending by households,[54] followed by government spending and external resources (Khuda and Barkat 2012a; Table 17).

The trend during 1997-2012 shows: (i) continuing low levels of public spending[55] (including donors) compared to other South Asian countries and other Asian countries; and (ii) high out-of-pocket spending. The implication of low public spending is that it forces households to spend more on healthcare. In Bangladesh where social protection is inadequate, the low public spending on health leads to further impoverishment of households.

Table 17: Data on Health Expenditure in Bangladesh, 1997-2012

	1997	2012
Total Health Expenditure (THE)	**Tk.46.36 billion (USS 1.1 billion)**	**Tk. 325.09 billion (USS 4.1 billion)**
THE as % of GDP	**2.6**	**3.5**
Per capita spending on health	**TK. 379 (US$9)**	**TK. 2,144 (US$27)**
Households' share of health spending as % of THE	**59.9**	**63.3**
GOB's share of health expenditure as % of THE	**37**	**23**

Source: Government of Bangladesh, 2015

[51] For more elaborate discussion, see Government of Bangladesh 2011d.

[52] See also Government of Bangladesh 2008.

[53] The WHO Report of the Commission on Macroeconomics and Health (2001) strongly recommended increasing investment in health to promote economic development and poverty reduction. According to the report, the least developed countries need a minimum of US$34 per capita to introduce the essential health interventions. According to a more recent estimate, US$54 per capita is needed to attain a fully functioning health system and to cover a basic package of services, including interventions targeting non-communicable diseases by 2015 (WHO 2010).The results of the MDG Needs Assessment and Costing study (2009-15) show that US$19 per capita is required to achieve only the health related MDGs during 2009-15 in Bangladesh (Government of Bangladesh 2010). According to the latest NHA (2012), only $27 is spent per capita on health, which is half of what is recommended by the more WHO estimate.

[54] In Bangladesh, the well-off pay more out of pocket for health care; spend proportionally more of their household resources on health care; and receive more or better care. The poor pay less because they cannot afford to pay, and hence, and cannot often seek treatment, and therefore, receive less health care (O'Donnell et al 2008). As a consequence, they experience loss of health, with its adverse effects on productive capacity. Furthermore, although the government has targeted 60-65 percent of total resources towards upazilla and lower administrative levels providing primary health care, the proportion of development expenditure going to upazilla and lower levels to total development expenditure has actually declined from 65 percent in 2001/02 to 52 percent in 2007 (Government of Bangladesh 2010 b). In most cases subsidies to hospital care is pro-rich, while non-hospital care is pro-poor (O'Donnell et al, 2007**).** Also, the utilization of out-patient services by the poor is likely to be affected because of their reliance on unqualified providers (O'Donnell et al 2008).

[55] Only 4.4% and 5.3% percent respectively of the total and the development budget have been allocated to the health sector in the Bangladesh 2014-15 budget (Government of Bangladesh 2014 c).

5. Education

Bangladesh has been attaching high priority to increase literacy and educational levels of its people to turn them into skilled workforce[56]. The MDG targets for Bangladesh are to: (i) increase net enrolment in primary school from 60.5 percent in 1990-91 to 100 percent by 2015; (ii) increase the percentage of pupils starting grade 1 who reach grade 5 from 43 percent to 100 percent; (iii) increase literacy rate of 15-24 years old (both genders, females and males) to 100 percent; and (iv) raise adult literacy rate of 15 years and above from 37.2 percent to 100 percent (Government of Bangladesh 2014 d).

The education sector has witnessed considerable improvements over time in increasing access to education and attaining gender parity.

During 1961-1974, literacy was quite low, especially among females. The overall literacy rate (for population aged 5 years +) increased from around 22 percent in 1961 to around 27 percent in 1974 and to 32 percent in 1991. It was higher in urban than rural areas and among males than females (Adnan 1998).

Between 1999 and 2011, the literacy rate (for adults aged 15 years+) increased from around 53 percent in 1998 to 59 percent in 2011. While the female rate increased from around 43 percent to 55 percent, the male rate increased from 59 percent to about 63 percent, though still higher than among females. In rural areas, it increased from 48 percent to around 52 percent, while in urban areas it increased from 68 percent to about 71 percent (Table 18).

Table 18: Adult literacy Rate of Population 15 Years and Over by Gender and Locality, Bangladesh: 1998- *2011(%)*

Year	Both Sex	National	Rural	Urban
1998	Both Sex	52.60	48.20	68.30
	Male	59.40	56.80	75.90
	Female	42.50	38.20	60.40
1999	Both Sex	52.70	48.40	68.90
	Male	60.70	56.90	76.00
	Female	42.80	38.30	61.90
2011	Both Sex	58.8	52.0	70.6
	Male	62.5	55.8	74.2
	Female	55.1	45.2	67.0

Sources: Population & Housing Census, 2011, BBS, SVRS, BBS; 2012 Statistical Yearbook of Bangladesh, Table 12.44

Between 2000 and 2011, the number of primary and secondary schools increased from 76,809 to 78,685 and from 15,720 to 19,070 respectively (Government of Bangladesh 2013 b). Between 1985 and 2011, primary school enrollment increased from 10 million (6 million boys and 4 million girls) to about 17 million (8.4 million boys and 8.6 million girls), and secondary school enrolment increased almost three-fold from 2.6 million (1.9 million boys and 0.7 million girls) to 7.5 million (3.5 million boys and 4.0 million girls).

Bangladesh is well on track of the MDG target as the net enrolment ratio in 2013 was 97.3 percent (girls: 98.2 percent, boys: 96.2 percent) (Table 19). Bangladesh has already achieved the target for gender parity in primary school enrolment, and also has achieved gender parity at secondary level since 2000[57] (Table 20).

[56] A more detail discussion is contained in Khuda and Barkat 2015 d.

[57] However, at the secondary level, the gender parity index in the slums is quite high (126), and even higher in Dhaka (150). Further, there is a much larger gender parity index among the poor (153) compared to the richest households (93). Two

Table 19: Trends in Net Enrolment Ratio at primary level in Bangladesh, 1990-2013

Year	Total	Girls	Boys
1990	60.48	50.76	69.43
1995	75.75	73.86	77.53
2000	85.52	85.83	85.22
2005	87.2	90.1	84.44
2010	94.8	97.6	92.2
2011	98.7	99.4	97.2
2012	98.7	98.1	95.4
2013	97.3	98.2	96.2

Source: Government of Bangladesh 2014 d

Table 20: Gender Parity Index at Primary Education in Bangladesh, 1990-2013

Year	GPI (PE)	GPI (SE)
1990	0.82	---
1991	---	0.52
1995	0.90	0.82
2000	0.96	1.06
2005	1.01	1.04
2010	1.02	1.14
2011	1.02	1.13
2012	1.01	1.14
2013	1.00	---

Source: Government of Bangladesh 2014 d

Between 1991 and 2011, school attendance increased among population aged 5-24 years, except those aged 20-24 years. The rate of increase was greater among females than males, and greater in rural than urban areas (Khuda and Barkat 2015 d).

Enrolment in colleges (12 years of schooling and higher) increased from 1,368,960 in 1997 to 3,044,320) in 2012. Also, between 1983 and 2012, the number of students in public universities increased almost ten-fold, and the increase was greater among girls than boys. Regarding enrolment in professional educational institutions, over two-fifths of the medical and dental college students and over three-fifths in nursing college/institute were females in 2012. Thus, the gender parity is in favour of males at medical and dental colleges, while the reverse is true in case of nursing college/institute, indicating the bias towards females for nursing and males for medical/dental graduates.

(Khuda and Barkat 2015 d).

The completion rates declines with higher grades, especially after 15 and more years of schooling (degree levels and above). The completion rates are higher among females and in rural areas in the junior classes; however, the reverse is true in the higher classes (Table 21). The gender parity index at the tertiary level was 0.73 in 2012 (Government of Bangladesh 2014 d).

Table 21: Completion Rates at different Educational Levels by Gender and Locality, Bangladesh, 2011

Both Sex	Total	Class (I - V)	Class (VI - IX)	S.S.C & H.S.C.	Degree & above
Percent					
Bangladesh					

plausible reasons have been given for the disparity in gender parity by wealth quintile: (i) high opportunity cost for older boys from poor families to invest time in education; and (ii) only girls, but not boys, receive government stipend, thus, serving as an incentive for girls to go to school. In city corporation areas, however, the opportunity cost of going to school is higher than the stipend, since the girls can bring higher income for the family from employment in the garment industry or even ad paid domestic workers (UNICEF 2011).

Both	**100**	**48.52**	**31.95**	**31.90**	**12.68**
Male	**100**	**47.71**	**29.30**	**36.32**	**19.32**
Female	**100**	**49.39**	**34.81**	**27.29**	**6.65**
Rural					
Both	**100**	**53.02**	**32.93**	**23.00**	**5.62**
Male	**100**	**52.83**	**30.14**	**26.87**	**9.41**
Female	**100**	**53.22**	**35.84**	**19.01**	**2.30**
Urban					
Both	**100**	**36.77**	**29.38**	**65.41**	**33.35**
Male	**100**	**35.12**	**27.23**	**71.29**	**46.30**
Female	**100**	**38.72**	**31.92**	**59.10**	**20.29**

Sources: Population & Housing Census, 2011, BBS; 2012 Statistical Yearbook of Bangladesh, Table 12.46

Not much information is available on the quality of education in Bangladesh. The 2011 Bangladesh Literacy Assessment Survey provided limited information on the quality of education. Just over two-fifths of boys (44%) and slightly over one-third of girls (36%) completing primary education were considered functionally literate. Even among those with completed secondary education, the functional literacy rate was only around 70 percent among both boys and girls (Government of Bangladesh 2013 c, Table 4.4). The evidence, thus, indicates poor quality of education.

The above evidence indicates that are clear areas for improvement in the field of education, especially with regards to quality of education and drop-out rates. Also, there is lower level of female enrolment at the higher secondary and tertiary levels. Furthermore, expenditure on education as percent of GDP was only 2.2 percent, the lowest among the South Asian countries (World Bank 2013).

6. Human Development

Between 1980 and 2012, life expectancy at birth in Bangladesh increased from 55 years to 69 years; mean years of schooling increased from 2.0 years to 4.8 years; and expected years of schooling increased from 4.4 years to 8.1 years. The GNI per capita increased from 649 to 1,785, i.e. by about 275 percent. Bangladesh's HDI value increased from 0.312 in 1980 to 0.515 in 2012, i.e. an increase of 65 percent or average annual increase of about 1.6 percent (Table 22).

However, Bangladesh still continues to be in the low human development category[58]. Although Bangladesh's HDI of 0.515 in 2012 was above the average of 0.466 for the low HDI group countries, it was below the average of 0.558 for South Asian countries (Table 23).

Bangladesh's HDI of 0.515 in 2012, when discounted for inequality (IHDI), drops to 0.374, i.e. a loss of 27.4 percent. Bangladesh's loss is lower than the averages of low HDI countries and for South Asian countries. Bangladesh had a Gender Inequality Index (GII)[59] value of 0.518. Bangladesh's MPI value was 0.292[60].

Table 22: HDI Trends in Bangladesh, 1980-2012

Year	Life expectancy	Expected years of schooling	Mean years of Schooling	GNI per capita (2005 PPP$)	HDI value
1980	55.2	4.4	2 .0	649	0.312
1985	56.9	4.5	2.4	715	0.333
1990	59.5	5 .0	2.9	762	0.361

[58] A more detail discussion is contained in Khuda and Barkat 2015 d.

[59] The GII replaced the previous Gender-related Development Index and Gender Empowerment Index.

[60] The 2010 Human Development Report introduced the Multidimensional Poverty Index (MPI), which identifies multiple deprivations in the same households in terms of education, health and living standard. The education and health dimensions are based on two indicators each, while the standard of living dimension is based on six indicators.

1995	62.1	6 .0	3.3	860	0.397
2000	64.7	7 .0	3.7	1,003	0.433
2005	66.9	8 .0	4.2	1,220	0.472
2010	68.6	8.1	4.8	1,631	0.508
2011	68.9	8.1	4.8	1,701	0.511
2012	69.2	8.1	4.8	1,785	0.515

Source: Human Development Report 2013

Table 23: HDI and other related indicators for Bangladesh and selected South Asian countries

Countries/Region	HDI value	HDI rank	IHDI	Overall Loss (%)	GII value	GII Rank	MPI value
Bangladesh	0.515	146	0.374	27.4	0.518	111	0.292
Pakistan	0.515	146	0.356	30.9	0.567	123	0.264
Nepal	0.463	157	0.304	34.2	0.485	102	0.217
South Asia	0.558	–	0.395	29.1	0.568	–	–
Low HDI	0.466	–	0.31	33.5	0.578	–	–

IHDI=Inequality Adjusted Human Development Index

GII=Gender Inequality Index

MPI=Multidimensional Poverty Index

Source: Human Development Report 2013

Appendix Table 1: GDP and per capita GDP of South Asian Countries

Country or territory	GDP (nominal USD millions)	GDP PPP (USD millions)	GDP PPP per capita USD
Afghanistan	20,735	35,100	1150
Bangladesh	141,275	325,100	2,080
Bhutan	1,985	4,700	6,370
India	1,870,651	5,069,200	4,077
Maldives	2,276	3,100	9,173
Nepal	19,341	42,100	1,508
Pakistan	238,737	575,000	3,149
Sri Lanka	65,833	136,000	6,531

Source: World Development Indicators

Appendix Table 2: Gini Index in South Asian Countries

Country	Level	Units	As Of
Afghanistan	27.82	Index	2008
Bangladesh	32.12	Index	2010
Bhutan	38.73	Index	2012
India	33.90	Index	2010
Maldives	37.37	Index	2004
Nepal	32.82	Index	2010
Pakistan	30.02	Index	2008
Sri Lanka	36.40	Index	2010

Source: World Bank 2014

Conclusion and Recommendation:

Since independence in 1971, Bangladesh has made considerable progress in its socio-economic development. Both the GDP and per capita GDP increased quite appreciably. Also, there has been a sharp reduction in poverty. The MDG target of halving the population living under the poverty line has already been achieved. However, the fruits of growth and development have not reached

everyone. There is a very high concentration of income among the richest group. Income inequality persists, and has worsened over the past years. Further, there are major constraints impeding the process of further acceleration of economic growth in the country.

Despite increase in female LFPR, women's participation is considerably lower than that of males. Most employment is in the low-productive, low-wage, informal sector. That is, most do not have decent jobs, especially among women and in rural areas. There has been no major shift in the structure of labour force. Agriculture, which contributes only about 18 percent of the GDP, is the primary occupation and industry, employing over two-fifths of the labour force, especially among females and in rural areas. Vulnerable employment is quite prevalent, more so among females and in rural areas. There is considerable under-utilization of labour force, especially among females and in rural areas. The annual labour force growth rate (over 3%) is higher than the annual population growth rate (1.4%). Worse still, the current employment generating capacity is unable to provide employment to those un- and underemployed and absorb the incremental labour force in productive employment.

The low employment in the manufacturing sector is due to limited number of manufacturing industries. At the same time, the employment structure continues to become more service sector oriented, predominantly outside of the formal sector. Without major expansion in the manufacturing sector, most people will continue to be employed in the informal sector jobs; and the desired level of economic growth will not be achieved.

Bangladesh had achieved considerable progress in reducing child and maternal mortality and increase in life expectancy. It has achieved MDG 4, and is likely to achieve MDG 5. However, child and maternal mortality are considerably higher in certain regions of the country and among the less-educated and the relatively poor. Also, access to ANC, safe delivery and PNC are quite low, more so among the less-educated and the relatively poor.

The health sector programme is inefficient due to a number of systemic problems: (i) lack of integration between the DGHS and the DGFP; (ii) infighting between medical and non-medical personnel within DGFP; (iii) issues relating to human resource; (iv)inadequate monitoring and supervision; (v) lack of leadership and management; (vi) limited funding; and (vii) weak implementation capacity. All these result in considerable system loss, and adversely affect the desired achievements in the health sector.

Bangladesh made considerable progress in the education sector in terms of enrolment, attendance and completion in different grades. There is gender parity in favour of girls at the primary and secondary education levels, although the reverse is true in respect of tertiary education, including medical and dental colleges. The success in the education sector, however, is masked by disparities, regionally and by socio-economic condition of the households to which the school-going children belong.

The completion rates declines with higher grades, especially after 15 and more years of schooling (degree levels and above). The grade completion rates are higher among females and in rural areas in the junior classes; however, the reverse is true in the higher classes.

Bangladesh has made considerable progress in human development. The Bangladesh's HDI value increased from 0.312 in 1980 to 0.515 in 2012, though still in the low human development category. When discounted for inequality, the HDI drops to 0.374. Bangladesh had a Gender Inequality Index value of 0.518, ranking 111 out of 148 countries.

In Bangladesh, about three-fifths of the population lived in multidimensional poverty, while another over one-fifth were vulnerable to multiple deprivations. Over half of the population experienced the intensity of deprivation. Bangladesh's MPI value was 0.292. The multidimensional poverty headcount

is 14.5 percentage points higher than income poverty, implying that Bangladeshis living above the income poverty line may still suffer deprivations in education, health and other living conditions.

Recommendations

The government needs to attach high priority to address the major constraints to development to improve the standard of living of its people, especially the poor and the disadvantaged groups.

A pragmatic way forward would be to focus on policies that would help increase the incomes of the poor by enabling them to have greater access to the opportunities that reforms and integration bring. Also, the government should take appropriate measures to address circumstance-based inequalities. Further, policies that improve productivity and incomes in the rural areas (both farm and non-farm) and the urban informal economy are vital for generating greater employment opportunities for the poor to help them raise their income levels, and thereby, reduce income inequality. This is an area that the government should attach high priority.

For Bangladesh to increase income levels and reduce inequality, the government should pursue both types of strategies, i.e. the growth of self-employment as well as wage employment in relatively more productive jobs. Also, there is a need for greater integration with the global economy, especially in view of the increasing importance of the export-oriented RMG sector and manpower export overseas. Therefore, the government should take all necessary measures to protect and further strengthen the RMG sector, so that it can earn higher earnings from this sector and also contribute to further empowerment of women. Also, the government should vigorously pursue strategies to increase the number of Bangladeshis who can go abroad for jobs; and arrange provision of training for the potential migrants to enhance their skills to enable them to get better paying jobs, and thereby increase the volume of remittances.

The government should give top priority to higher and more employment intensive economic growth by vigorously pursuing a number of strategies: (i) expansion of large scale manufacturing industries; (ii) rapid growth of small and medium enterprises (SMEs), especially in small towns; (iii) giving special emphasis to education and training of the youth to ease the school-to-work transition and prevent labour market mismatches; (iv) adopting labour market policies to target employment of disadvantaged youth, and promote entrepreneurship among the youth; (iv) widening micro credit based and targeted employment generation programmes, especially for poor women, expanding social protection measures to reduce women's vulnerability, and investing in their education and skills; (v) strengthening the various special employment generation programmes to provide employment during lean seasons and at times of natural disasters (World Bank 2006; Khuda 2011); (vi) providing credit and training for self-employment; (vii) adopting policies to promote labour rights, based on international labour standards, to ensure that women, youth and disadvantaged people at work receive equal treatment; and (viii) vigorously tapping overseas employment opportunities, both in the existing receiving countries and in other countries.

While progress has been made in the health sector, there is need for accelerated action to reduce inequalities. The political will and commitment to strengthening the health sector must be clearly reflected in the official policy documents, enhanced budgetary allocations, and needed reforms, thereby enhancing implementation capacity to achieve the desired results in the sector.

Greater priority must be given to improved coverage and quality of services, with major emphasis given to policies and programmes to reduce inequities in access to services and health outcomes. Also, there is need to integrate service delivery, especially insofar as RH is concerned, by ensuring that OPs dealing with RH services under DGHS and DGFP are brought under a unified command to not only enable more people to get services but also considerably reduce overlap and wastage of resources. The RH care should be provided through the primary health-care (PHC) system, and the government should work to increase the accessibility, availability, acceptability and affordability of

health care services and facilities to provide access to basic health care for all. Therefore, there is need to ensure that health systems support integration of RH in PHC and improved coordination in support of the full continuum of care, and to further ensure that services are expanded to reach poor and vulnerable population groups. In addition, greater emphasis should be given to health systems strengthening and health sector reform. Further, health systems should be made gender- and culturally-sensitive and community-oriented, and transparency and accountability should be ensured.

More specifically, the MOHFW should: (i) improve access to quality services, especially among the priority groups and in under-served areas, including urban slums; (ii) strengthen overall supervision, monitoring and evaluation; (iii) address human resource issues: filling in vacant posts, ensuring required training and re-training, developing career path to boost staff morale; (iv)ensure commodity security and logistics; (v) implement a coherent BCC strategy; (vi) increase budgetary allocation; (vii) enhance programme efficiency; and (viii) enhance implementation capacity.

The relatively poor quality of education deserves serious consideration of the policymakers and planners.

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