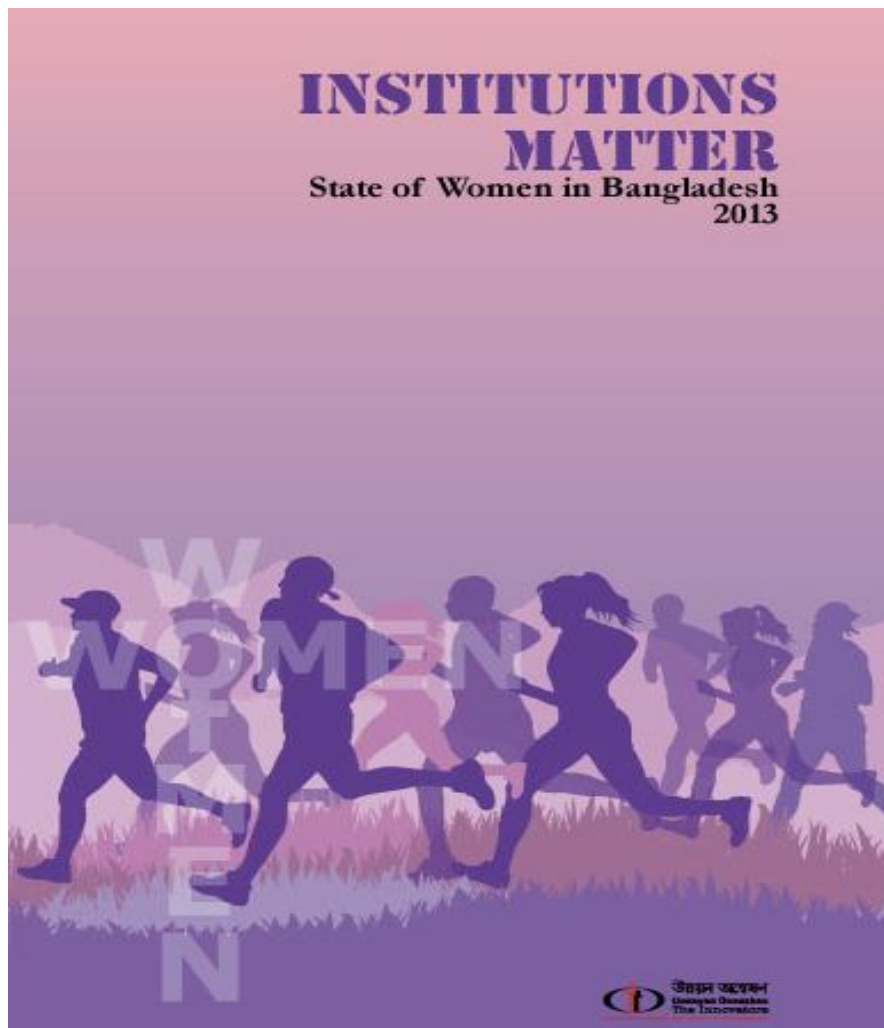


# Women and Health

Sarker Obaida Nasrin & K. M. Mustafizur Rahman



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# **WOMEN AND HEALTH**

**Sarker Obaida Nasrin & K. M. Mustafizur Rahman**

## **1. INTRODUCTION**

The health status of women is an important concern as in many societies, most of the time women are found in a disadvantageous state by discrimination rooted by the socio-cultural factors. Like many other parts of the world, women in Bangladesh are relatively disadvantageous in terms of their economic, social and health conditions. Millions of women are experiencing poor health conditions as well as various forms of malnutrition. Although, men and women have some similar challenges regarding health facilities in Bangladesh, women are generally being deprived of getting such facilities. Their health needs, insurance options, usage of health care services etc. are shaped by an ample range of factors including their age, income, race and ethnicity, level of education, family structure, employment status, etc. Therefore in most of the cases, women have to struggle with poor health by facing considerable economic and social barriers in obtaining healthcare. Over the past decades, much progress has been made in the health status of women. In Bangladesh, however, these advancements are overridden by gender-based discrimination. Moreover, women are generally live longer than their male counterparts but with a poorer health condition. Again, some health challenges have a different impact on women compared to men which also creates difficulties to get proper healthcare when they need. Furthermore, gender inequalities, indifferent segments like education, income, employment etc. minimizes the ability of women to protect their health.

The health status of the women is one of the fundamental determinants of health care system of a country and consequently to build up a healthier nation as well. Poor health status of women not only affects them but also passes from generation to generation. Additionally, the ability of women to be productive members of their communities, to care for themselves and their families, and to contribute to the work force is jeopardized without good access to health care. The health issue is at the heart of the Millennium Development Goals (MDGs) as well. It is represented in three of the eight goals, and makes an agreed contribution to the achievement of all the other goals; in particular, those related to the eradication of extreme poverty and hunger, education, and gender equality. Therefore, the progress of health status of women in Bangladesh requires an in-depth analysis. There is, however, always a lack of frequent systematic efforts in the matter. Thus, this study intends to make an assessment of the health status of women in Bangladesh and examines whether it corresponds the targets of MDGs or not.

This study is based on data mainly collected from Bangladesh Bureau of Statistics (BBS) and Bangladesh Demographic Health Survey (BDHS). Projections have been made for future scenarios using these data. Different statistical reports, relevant research papers, books and many national and international journals have also been reviewed for conducting this study.

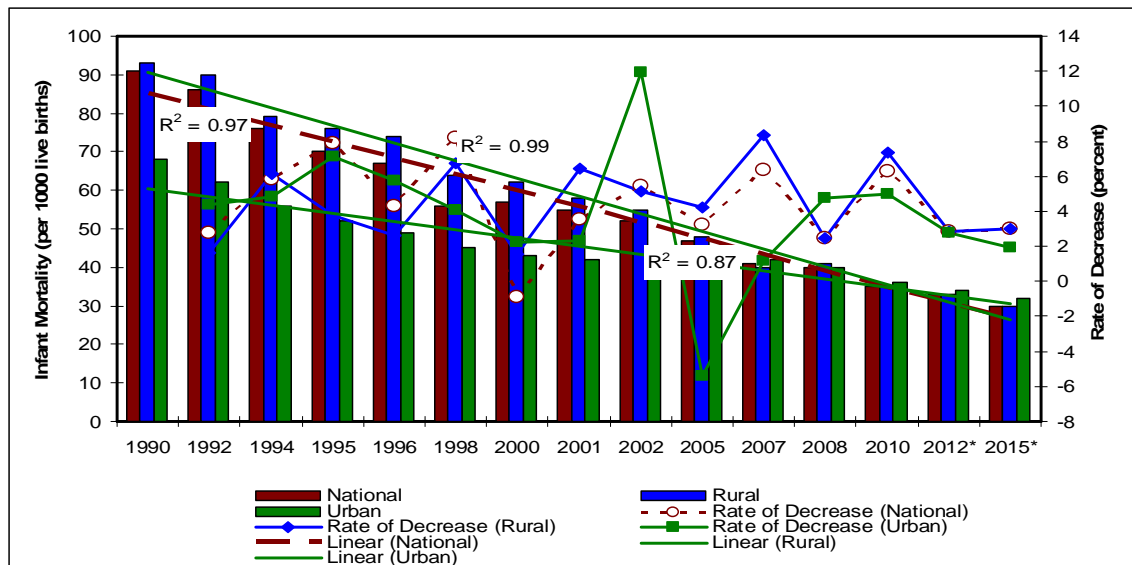
## **2. INFANT MORTALITY RATE FOR FEMALE**

Infant mortality rate (IMR) is an indication of the level in life security to infants under 1 year of age. There is, however, some progress in reducing infant mortality rate over the last few

decades in Bangladesh but it still remains high, which is a concerning matter. The infant mortality rate in Bangladesh for females has reduced from 91 per 1,000 live births in 1990 to 35 per 1,000 live births in 2010 at a rate of 3.1 per cent per annum. Based on the historical track record, the infant mortality for females might stand at 30 per 1,000 live births in 2015, which indicates that the country is well on track to achieve the MDG target of 31 per 1,000 live births. It is apparent that the infant mortality rate for females in the rural area was higher than that in the urban areas. In the case of rural areas, the infant mortality was 93 per 1,000 live births in 1990 which has been reduced to 35 per 1,000 live births in 2010 with an annual rate of 3.1 per cent. Continuation of this rate indicates that the infant mortality would be 30 per 1,000 live births by 2015. On the other hand, infant mortality in urban area was 68 per 1,000 live births in 1990 that has reduced to 36 per 1,000 live births in 2010 with a rate of 2.4 per cent per annum. Based upon the historical track record, the infant mortality might stand at 32 per live births by 2015 (Figure 1).

One interesting finding here is that the rate of reduction in infant mortality for female is higher in rural areas than that of the urban areas. The effect of accelerated socio-economic change in the rural areas might be the reason behind it. Rural poverty has also decreased due to multiple effects. For example, there is an increased trend of flow of remittance (both internal and external) over the years which have resulted in increased consumption. Export has also increased; Bangladesh has become the second largest exporter of ready-made garments in the world, creating a huge impact on the employment situation, particularly for rural females. The agriculture sector has witnessed a significant change in practices, with changes associated with seed-water-fertiliser technology and multiple cropping intensities in the same piece of land in the recent years. All of these factors, amongst others have created positive impacts in reducing poverty which resulted in such changes.

**Figure 1: Current situation and future projection of infant mortality for female (per 1,000 live births)**



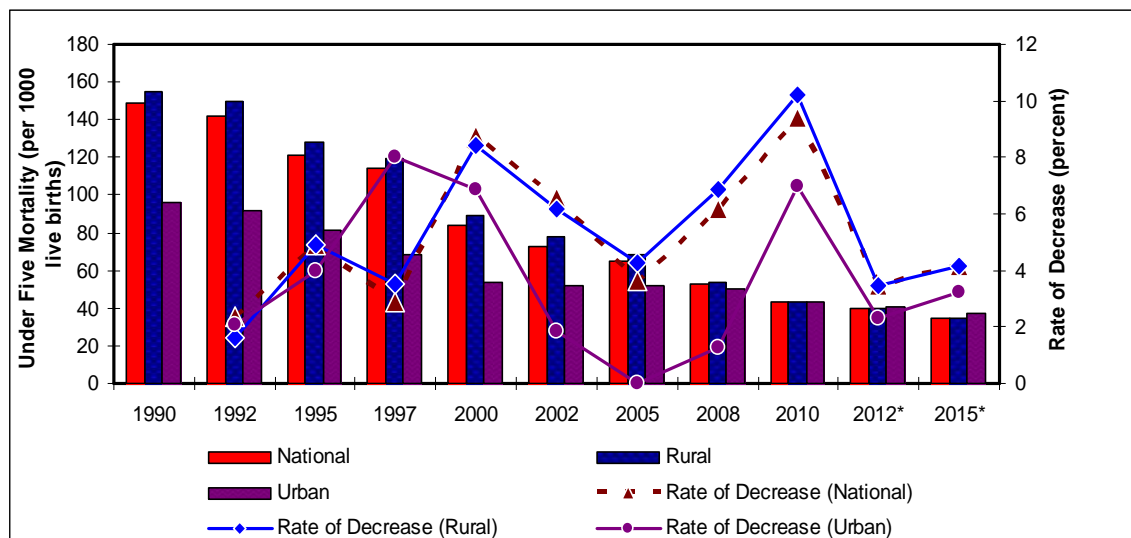
Source: Author's calculation based on the Report on Sample Vital Registration System, (2010), Bangladesh Bureau of Statistics, 2011

### 3. CHILD MORTALITY RATE FOR FEMALE

Child mortality rate is the number of deaths of children under 5 years in per 1000 live births in the concerned year. Despite considerable progress over the past two decades, child mortality in Bangladesh is still high. In Bangladesh, child mortality rate for females was 149 per 1,000 live births in 1990 which has decreased to 43 per 1,000 live births in 2010 at a rate of 3.6 per cent per annum. According to historical track record, if this rate of reduction remains the same, the child mortality might stand at 35 per 1,000 live births by 2015. This indicates that Bangladesh has already achieved the MDG targets in child mortality rate of 48 per 1,000 live births before the deadline of 2015. It is evident that, the child mortality rate for females in the rural area is comparatively higher than that of the urban areas. On the other hand, this rate in rural area has reduced from 155 per 1,000 live births in 1990 to 43 per 1,000 live births in 2010 with an annual rate of 3.6 per cent. According to historical track record, if this rate continues the child mortality for females would stand at 35 per 1,000 live births by 2015. On the other hand, in urban areas child mortality has decreased from 96 per 1,000 live births in 1990 to 43 per 1,000 live births in 2010 at a rate of 2.8 per cent per year. Continuation of this rate indicates that, child mortality might stand at 37 per 1,000 live births by 2015 (Figure 2).

Like infant mortality, child mortality has also reduced at an accelerated pace in the rural areas than that of the urban areas. The recent socio-economic development in the rural areas has made a positive impact on such improvements.

**Figure 2: Current situation and future projection of child mortality for female (per 1,000 live births)**



Source: Author's calculation based on the Report on Sample Vital Registration System, 2010, Bangladesh Bureau of Statistics, 2011

### 4. CAUSES OF INFANT AND CHILD MORTALITY

The major causes of infant and child mortality are acute respiratory infections, neonatal and prenatal problems, diarrhoea, pneumonia etc. According to the Bangladesh Demographic and Health Survey (BDHS) 2007, each year 1.2 lakh new-born babies die within 28 days. Now, the amount of neonatal deaths is a substantial 57 per cent to overall mortality of children aged less than five years (BDHS, 2007). Therefore, neonatal and prenatal care for the mother is very important. Around four of ten women are not receiving antenatal care. In

the rural areas, about 90 per cent of natal practices occur at home; whereas in the urban areas, little over one-fourth of this practice is done at health care centre (BDHS, 2007). Only 24.4 per cent of the total births are delivered by skilled health personnel (MICS, 2009).

There is a strong association between child mortality and education of the mother (Rahman, 2010). It ranges from 32 deaths per 1,000 live births of children whose mothers have completed secondary or higher education to 93 deaths per 1,000 live births of children whose mothers have no education (BDHS, 2007). Birth spacing is another variable associated with under-five mortality. As the birth interval becomes shorter, infant mortality chances rise sharply. Poverty has accelerated both the infant and child mortality as well. It is apparent that, both infant and child mortality rates are lower for those who are in the highest wealth quintile (BDHS, 2011).

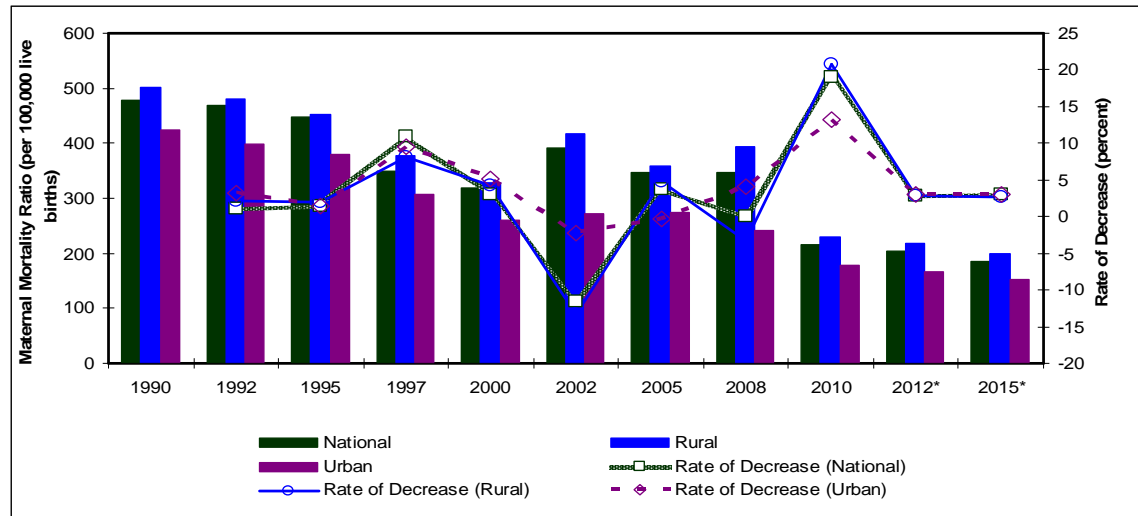
Malnutrition is also a vital cause of concern in case of infant and child mortality. After the first month of birth, malnutrition becomes an important factor for the infant and child mortality. One in every nineteen children born in Bangladesh dies before reaching the fifth birthday (BDHS, 2011). In Bangladesh, however, it often occurs early because of improper feeding practices which play a pivotal role in determining the optimal development of infant. Poor breastfeeding and infant feeding practices have adverse consequences for the health and nutritional status of children. Only two-thirds among the infants, less than 2 months old (64 per cent) are exclusively breastfed. The remainders are given water, other milk and liquids in addition to breast milk, and 6 per cent of them even receive complementary foods. From about six months of age, the introduction of complementary foods is critical for meeting the protein, energy and micronutrient needs of the children. Among children of age 6-9 months, only three in four children receive complementary food (BDHS, 2007). Malnutrition passes from one generation to the next as malnourished mothers give birth to malnourished infant. If the children are girls, they often become malnourished mothers themselves and the vicious cycle continues.

## **5. MATERNAL MORTALITY RATIO**

Maternal mortality ratio (MMR) is a very important mortality index of the mother who is exposed to the risk of death during child birth (WHO, 1977). It is generally expressed as the ratio of maternal death in a period to live birth during the same period expressed per 1000 live births. Maternal mortality ratio in Bangladesh has reduced from 478 per 100,000 live births in 1990 to 216 live births per 100,000 live births in 2010 with an annual rate of 2.7 per cent. According to the historical track record, if this rate continues, the maternal mortality ratio might stand at 186 per 100,000 live births by 2015. This indicates that the achievement of the MDG targeted at 143 per 100,000 live births might not possible by the time limit of 2015. Maternal mortality ratio is comparatively higher in the rural area than that of the urban area. The maternal mortality ratio in the rural area has reduced from 502 per 100,000 live births in 1990 to 230 per 100,000 live births in 2010 at a rate of 2.7 per cent per year. Continuation of this rate signifies that maternal mortality ratio would be 199 per 100,000 live births by 2015. In the case of urban areas, maternal mortality was 178 per 100,000 live births in 2010 which has reduced from 425 per 100,000 live births in 1990 and the rate of reduction between 1990 and 2010 was 2.9 per cent. If this rate of reduction remains the same, the maternal mortality ratio in the urban area might stand at 152 per 100,000 live births by 2015 (Figure 3).

Socio-economic development, effective applications of modern medical care, women empowerment etc. have combined effects on such reductions in maternal mortality ratio. It, however, remains still high and the desired targets are further yet to be achieved.

**Figure 3: Current situation and future projection of maternal mortality ratio (per 100,000 live births)**



Source: Author's calculation based on the Report on Sample Vital Registration System, 2010, Bangladesh Bureau of Statistics, 2011

## 6. CAUSES OF MATERNAL MORTALITY

Most maternal deaths occur due to haemorrhage, unsafe abortion and natal problems. Over half of all the pregnant women do not receive any institutional health service during childbirth, whereas significantly few of them received institutional post-natal health care (BDHS, 2011). About four in every ten women receive no antenatal care. Seventy one per cent of the deliveries still take place at home. The percentage of deliveries with assistance from qualified professionals is also very low; 32 per cent deliveries are attended by medically trained personnel while 11 per cent births are attained by trained birth attendants. Only 29 per cent births are taken place with health facility (BDHS, 2011). Malnutrition, particularly chronic energy deficiency (CED) and anaemia results in poor maternal health and bad pregnancy outcomes for both the mother and her children. Severe anaemia increases the risk of maternal mortality, which accounts for over one-thirds of the maternal deaths. Recent data indicates that 40 per cent of adolescent girls, 46 per cent of non-pregnant and 39 per cent of pregnant women are chronically malnourished (BDHS, 2007). Moreover, there has been a substantial increase in women experiencing obstetric complications seeking treatment. This includes home based treatment, purchasing medicine from pharmacies and seeking treatment outside the home (BMMS, 2010).

## 7. NUTRITIONAL STATUS OF WOMEN

The nutritional status of a population is a key indicator of poverty, hunger, health, education and social inequality. In other words, good health, cognitive development and productivity cannot be achieved in the absence of good nutrition. The prevalence of malnutrition in Bangladesh is one of the highest in the world. Millions of women are suffering from one or more forms of malnutrition. Today, malnutrition not only affects the women but its effects also pass from one generation to the next as malnourished mothers give births such infant who struggle to grow and thrive (Titumir and Rahman, 2011). There have been some modest improvements in the past decades, but the nutritional status of women in Bangladesh

remains alarming. Almost one-third of women of the reproductive age have a body mass index less than 18.5; this means they are so underweight. Even among the wealthiest quintile of the society, 13 per cent of the women are underweight. Girls are also more likely to be stunted and underweight for their age, compared to boys of the same age<sup>1</sup>.

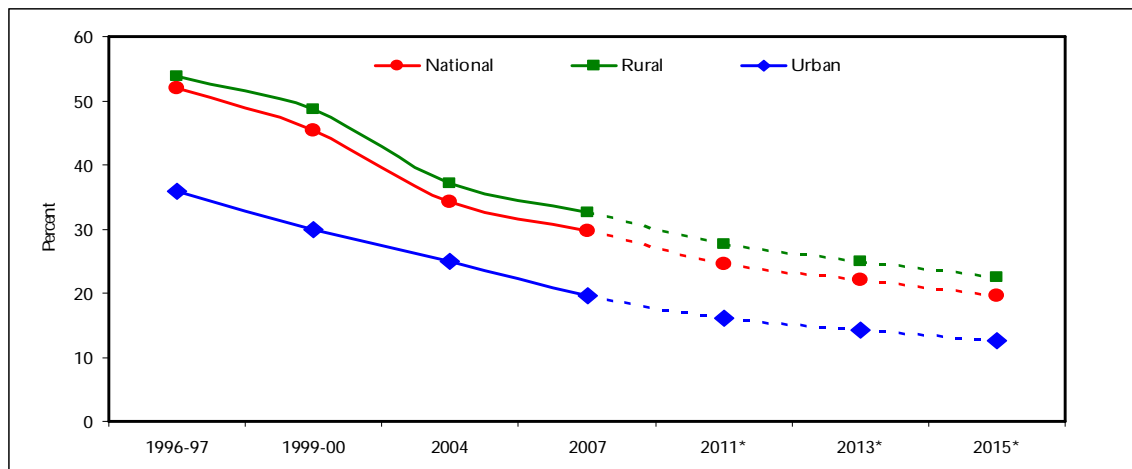
The nutritional status of children largely depends on the nutritional status of their mothers. The nutritional status of women is commonly measured by Body Mass Index (BMI). It is defined as weight in kilograms divided by height in meters squared (kg/m<sup>2</sup>). The main advantage of the BMI is that it does not require a reference table from a well-nourished population. A cut-off point of less than 18.5 is used to define thinness or acute under nutrition.

### 7.1 Nutritional Status of Women by Locality

The target of the MDGs related to the nutritional status of women is to reduce the percentage of thin or malnourished (BMI < 18.5) to less than 20 by 2015. The percentage of malnourished women has decreased from 52 in 1996-97 to 29.7 in 2007 at a rate of 4.3 per cent per annum. Continuation of this rate indicates that, Bangladesh is well on track to achieve the targets of the MDGs of less than 20 per cent, which might stand at 19.5 per cent by 2015.

The nutritional status of women is not equally distributed throughout the country. It largely varies in terms of locality. The percentage of thin or malnourished women in rural area has reduced to 32.6 in 2007 from 53.8 in 1996-97 with an annual rate of 3.9 per cent. According to the historical track record, if this rate remains the same the percentage of malnourished women in the rural area might be reduced to 22.4 by 2015. On the hand, the percentage of the malnourished women in the urban has decreased at an accelerated pace than that of the rural area during the same period (i.e. from 1996-97 to 2007), that was 4.5 per cent per annum. As a result, there exists an inequality in the percentage of malnourished women between the rural and urban area, i.e. rural area might have more malnourished women than that of urban area (Figure 4).

**Figure 4: Current situation and future projection of the nutritional status (BMI < 18.5) of ever married women by locality**



Note: \*Estimated data

Source: Authors' calculation based on the data of Bangladesh Demographic Health Survey (BDHS), 1996-97, 1999-00, 2004, 2007

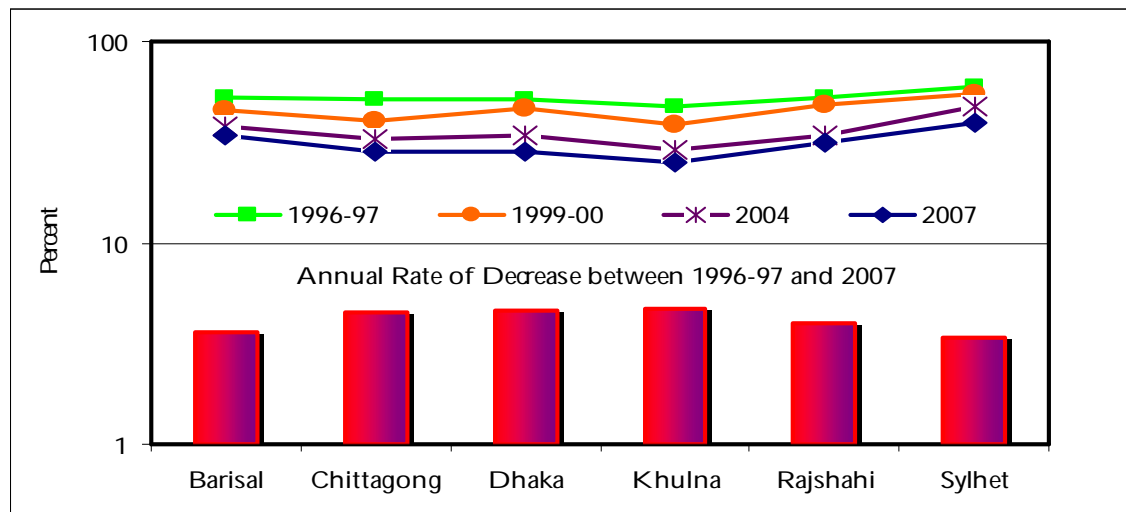
<sup>1</sup> National Institute of Population Research and Training (NIPORT), *Bangladesh Demographic and Health Survey 2007*, March 2009



## 7.2 Nutritional Status of Women by Division

Nutritional status of women varies in the different divisions of the country. In 1996-1997, the highest percentage (59.6 per cent) of the malnourished women has been found in Sylhet division while the lowest percentage (47.6 per cent) has been found in Khulna division compared to the other divisions. Similar results have been found in 2007 as well. The rate of decrease in the percentage of malnourished women also varies in the different divisions. In Khulna division, this rate has decreased at a more accelerated pace (4.7 per cent) among the other divisions. It is followed by Dhaka (4.6 per cent), Chittagong (4.5 per cent), Rajshahi (4.0 per cent), Barisal (3.6 per cent) and Sylhet (3.4 per cent) between 1996-97 and 2007 (Figure 5).

**Figure 5: Nutritional status of women by division**



Source: Authors' calculation based on the data of Bangladesh Demographic Health Survey (BDHS), 1996-97, 1999-00, 2004, 2007

## 7.3 Nutritional Status of Women by their Education

Education, especially of girls and women, can improve nutritional status in various ways. A higher level of education of women empowers them to make better decisions and seek more information on child care, health, food and nutrition (Titumir and Rahman, 2011). The percentage of the malnourished women largely varies according to their educational status. The percentage of malnourished women, who have no education, has decreased from 57.7 in 1996-97 to 37.6 in 2007 at a rate of 3.5 per cent per annum. On the other hand, this rate of reduction was 4.5 per cent and 5.7 per cent for those who have completed primary education as well as secondary and higher education respectively during the same period. Continuation of these rates indicate that the percentage of malnourished women might stand at 27.1, 18.2 and 8.8 by 2015 for those who have no education, completed primary education as well as secondary and higher education respectively (Table 1). Therefore, the target of the MDGs of reducing malnourished women to less than 20 per cent by 2015 may be met for those women who have completed primary education, secondary and higher education but those who have no education may remain far away from the target.

**Table 1: Current situation and future projection of the nutritional status (BMI<18.5) of ever married women by education**

Year	No Education	Rate of Decrease	Primary Complete	Rate of Decrease	Secondary and Higher	Rate of Decrease
1996-97	57.7	-	51.4	-	37.7	-
1999-00	52.1	3.24	48.3	2.00	30.1	6.7
2004	40.1	5.76	31.7	8.60	17.3	10.6
2007	37.6	2.10	28.4	3.5	16.2	2.1
2011*	32.3	3.50	23.3	4.5	12.5	5.7
2015*	27.1	4.00	18.2	5.5	8.8	7.4

Note: \*Estimated data

Source: Authors' calculation based on the data of Bangladesh Demographic Health Survey (BDHS), 1996-97, 1999-00, 2004, 2007

#### 7.4 Nutritional Status of Women by Wealth Quintile

Nutritional Status of women is largely varies according to their wealth quintile. Women, who are poor, are much more malnourished than their rich counterparts. There is a huge difference in the percentage of malnourished women between the lowest and the highest wealth quintile groups. The percentage of malnourished women of the lowest wealth quintile groups has reduced to 43.4 in 2007 from 47.1 in 2004 at a rate of 2.62 per cent per year. The rate of reduction, however, was 2.72 and 7.36 per cent for middle and the highest wealth quintile group respectively during the same time period (i.e. 2004-2007). This current rate of reduction suggests that, it is difficult to achieve the target set in the MDGs of less than 20 per cent by 2015 for the lowest and middle wealth quintile group which has already been achieved by the women of the highest wealth quintile group (Table 2). More specifically, the percentage of malnourished women might be reached to 34.3, 25.6 and 5.5 by 2015 for those in the lowest, middle and highest quintile group respectively.

**Table 2: Current situation and future projection of the nutritional status (BMI<18.5) of ever married women by wealth quintile**

Year	Wealth Quintile					
	Lowest	Rate of Decrease	Middle	Rate of Decrease	Highest	Rate of Decrease
1996-97	NA	NA	NA	NA	NA	NA
1999-00	NA	NA	NA	NA	NA	NA
2004	47.1	-	35.6	-	17.2	-
2007	43.4	2.62	32.7	2.72	13.4	7.36
2011*	38.9	2.59	29.1	2.75	9.5	7.28
2015*	34.3	2.96	25.6	3.01	5.5	10.53

Notes: NA= Not Applicable; \*Estimated data

Source: Authors' calculation based on the data of Bangladesh Demographic Health Survey (BDHS) 1996-97, 1999-00, 2004, 2007

## **8. WHY MALNUTRITION PERSISTS**

Though some initiatives have been taken by the government to address the problems of malnutrition, the improvement in nutritional status is not satisfactory for several reasons.

Women are socially discriminated from the beginning of their lives within the family. Social structure of a patriarchal society like in Bangladesh deprives women and girl children in improving their nutritional status. They are given less nutrition than their male counterparts and remain malnourished. In Bangladesh, like other developing countries, poverty, ignorance and social taboos play strong negative effects on food intake of women; they have to eat last and the least in a family. The prevalent norms, existing values and traditions have been passed from generation to generation, resulting in malnourished mothers giving birth to malnourished children.

The successive governments, including the current one, have always claimed of having enough food in reserve. This claim has been questioned because of the failure in ensuring the required amount of food for the marginalized portion of the society. The situation has been further aggravated due to lack of effective public food distribution system, which has been undermined through structural adjustment programmes. The policy of leaving the market to determine the prices of food in some cases has resulted in a predatory fixing of prices whereas the open market sales programmes or the supply through safety net programmes remain limited. These market manipulations and the inadequacy of public food distribution system have a negative implication on the nutritional status.

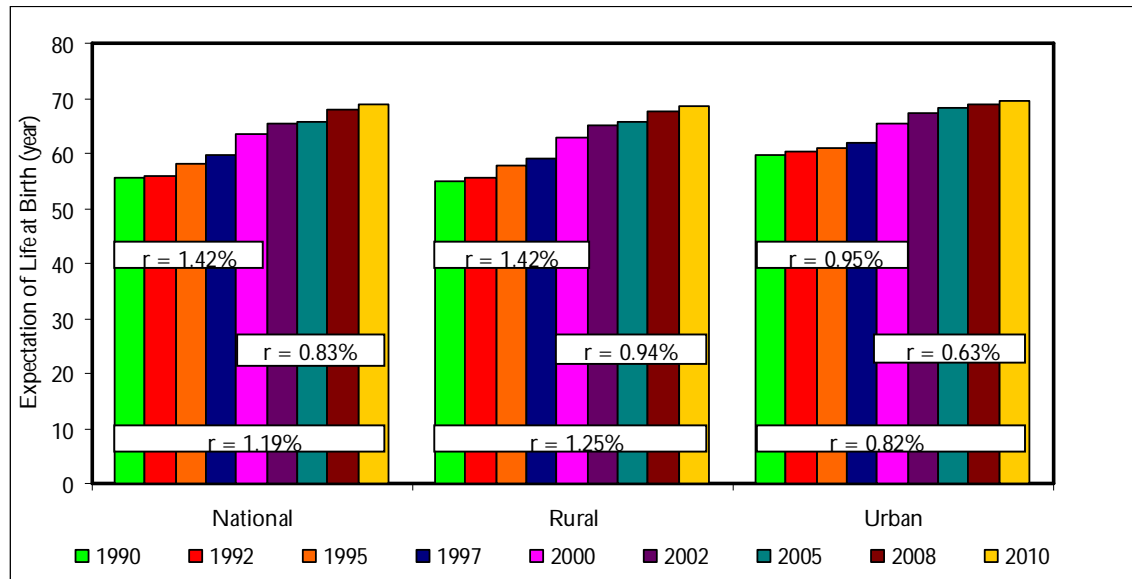
The proposed budgetary allocation of the government is lower than their committed amount in the National Health Policy (NHP). The proposed budgetary allocation in health sector is BDT 93,330 million in the fiscal year 2012-13, as a percentage which is 0.18 per cent lower than that of the revised budget of the FY 2011-12. This budgetary allocation for a population of 152.3 million is insufficient to cope with the problem of malnutrition of its population especially for women. Besides, widespread poverty is always one of the stumbling barriers to achieving proper nutrition for a population in a developing country like Bangladesh.

## **9. EXPECTATION OF LIFE AT BIRTH FOR WOMEN**

Life expectancy at birth (the number of years a new-born infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life) for females has increased over the years. The latest data indicates that the expectation of life at birth for females was 68.8 years while for male it was 66.6 years (BBS, 2011). However, women's living longer than the men does not necessarily mean that they enjoy better health. A possibility could be there that women live with their diseases whereas men die from them. Indeed, there is a difference between the sexes regarding disease patterns i.e. women having more chronic nonfatal conditions - such as arthritis, osteoporosis and autoimmune disorders and men having more fatal conditions, such as heart disease and cancer (Perls and Fretts, 1998). The expectation of life at birth for females has increased from 55.6 years in 1990 to 68.8 years in 2010 at a rate of 1.19 per cent per year at a national level. On the other hand, this rate of increase was 1.25 per cent and 0.82 per cent for the rural and urban area respectively. Moreover, it is apparent that the improvement in the expectation of life at birth for women in the last ten years (2000-2010) has occurred at a slower rate than that of the previous ten years (1990-2000) at national, rural and urban levels (Figure 6). The reasons for such decrease in the rate of increase are still under debate. Some researchers however, feel that women are close to the natural limits of human life span and so, their gains in life

expectancy must inevitably diminish. Again, some sociologists have discounted this reason, pointing out the changing roles of women in the society instead. Now-a-days, women have been suffering from different behaviours and stresses that were formerly confined to men and consequently, they have to suffer more likely from diseases which are traditionally considered as "masculine."

**Figure 6: Expectation of life at birth for women**



Source: Authors' calculation based on the Report on Sample Vital Registration System, (2010), Bangladesh Bureau of Statistics, 2011

## 10. CONCLUSION

Despite considerable progress over the last two decades in health sectors, women are still facing a lot of barriers in accessing health facilities. These failures are the most acute in poor countries like Bangladesh where about one third of its population are living below the poverty line (HIES, 2010). The women here are the poorest among all the countries. Every woman has not benefited equally from the recent progress and many of them are still unable to reach their full potential because of persistent health, social and gender inequalities and inadequacies in health care.

The results of this study indicate not only the degree of various health related indicators for women but also its pattern, which should be considered in formulating health policies. This independent assessment, however, casts doubt about the prospect of achieving the MDGs in its totality in the country. The projections provided in this report indicate that the country is well on the track to achieve some of the targets of the MDGs related to health and nutritional status of women within the stipulated time, but many of the targets might remain far behind from their expected levels. It will be difficult to reach the targets unless radical efforts are undertaken from the government.

It is relevant to mention that theoretically, many of the strategic documents and policy papers are sound as well as seems to be implementable. In reality, however, it fails to do so due to lack of the establishment of an effective referral system, access to quality care of Government of Bangladesh (GoB) or implementation of nutrition programme as safeguard to improve the health situation. This report is not intended to propose a definite solution

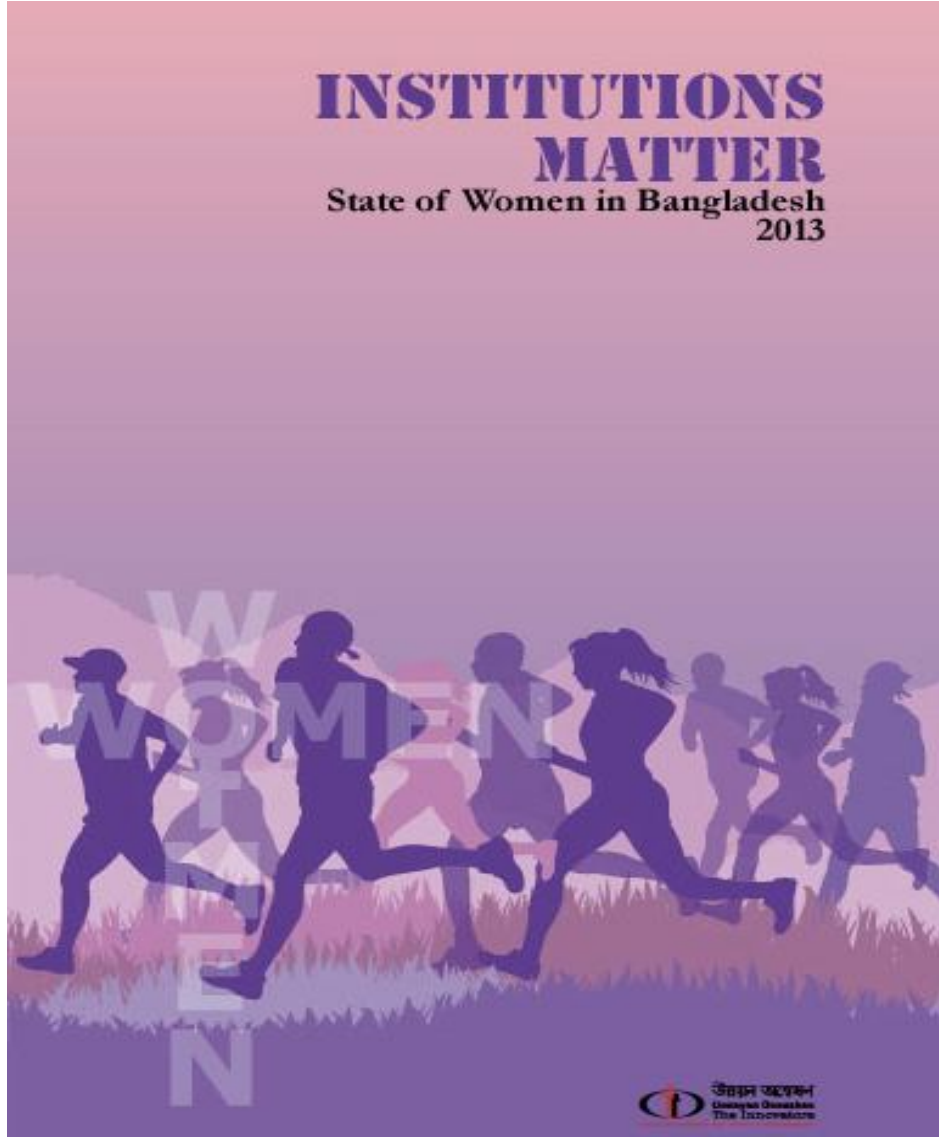
rather to present with possible decision making policy options, their viability and their expected outcome. Reviewing the evidence and setting an agenda for the future, this report points out the way towards the actions which are needed to improve women's health facilities. Health service providers have to be sensitive towards the requirements of women across the course of their lives, including older women, women with disabilities, adolescent girls, and most-at-risk groups of women. The point is to be noted that sound political, social and economic reasons are there to invest in the health care of a woman over the course of her life, i.e. the girl child, the adolescent girl, the adult woman and the older woman.

Bangladesh has a commitment to primary health care, but health provision remains woefully inadequate, particularly in the rural areas. Health provision remains urban biased but a general bias against the poor is also there in both the rural and urban areas. Medical personnel are in the lack of skills relevant to preventive primary health care rather than curative approaches. Problems of recruitment in rural health facilities are widespread, at least, in this part because of constraints on the local budgets. Moreover, poverty is an important barrier to positive health outcomes for both men and women. The challenges in reducing income inequality and the low economic participation of women also remain as major concern (GoB, 2012). Poverty tends to yield a higher burden on women and girls' health, for example, feeding practices (malnutrition).

Nutritional programmes are needed to be incorporated into homestead food production. Moreover, a poverty reduction component for households and communities to increase their resources and hence, access to food for better nutritional quality should be ensured to have a sound health status. Poor households especially in the rural areas should be provided with access to skilled training for homestead gardening, income generating activities and credit which will allow them to purchase or grow more food. Greater efforts should be made to increase the female participation in higher education. Balanced development should be undertaken both for the rural and urban areas. Policies should be targeted towards the rural and poor women. The government should address the issues of inequality on a priority basis. In addition, policymaking requires both theoretical knowledge and practical judgment for the implementation.

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