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Social Development in Bangladesh: Pathways, Surprises and Challenges

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Bangladesh in recent times has achieved rapid progress in many social development indicators despite still widespread poverty and the poor quality of public service delivery. Underlying this 'development surprise', the article argues, there is a remarkable process of social transformation involving changes in social norms and attitudes such as towards female schooling or contraceptive adoption. Much of the progress has resulted from the increased public awareness created by effective social mobilization campaigns and from the adoption of low-cost solutions, like the use of oral saline for diarrhoea treatment, leading to a decline in child mortality. This was helped by a strong presence of non-governmental organizations (NGOs) and public support in the form of many innovative interventions. The article draws a contrast between the NGO-led process in Bangladesh with other possible pathways to social development such as through strong local governance. While Bangladesh has transformed itself from being a laggard to an over-performer in respect of social development indicators, continued progress may become increasingly difficult without larger public social spending and an improvement in service delivery along with a more rapid reduction in poverty.

INTRODUCTION

Bangladesh emerged from its war of independence desperately poor and over-populated, and reeling from overwhelming war damage to its institutional and physical capital. The country was ravaged by acute food shortages and famines during the early years of its independence. Its income per head was among the lowest in the world along with dismally low levels of various social development indicators. According to some authors, Bangladesh was designated as a 'test case' for development while Henry Kissinger called it 'an international basket case'.[1]

More than 30 years later, those doubts have largely been proven wrong. With sustained growth in food production and a good record of disaster management, famines have become a phenomenon of the past in the country. Bangladesh's per capita GDP has more than doubled since 1975. Life expectancy has risen from 50 to 63 years, population growth rates of 3 per cent a year have been halved, child mortality rates of 240 per 1,000 births have been cut by 70 per cent, literacy has more than

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doubled, and remarkable progress has been made in providing universal basic education.

Most of these gains have taken place since the early 1990s, with accelerated growth in per capita GDP.[2] The progress in social development indicators has, however, clearly outpaced the growth in per capita GDP. As a result, Bangladesh is now an over-performer in most social development indicators in relation to its per capita GDP, while two decades or so ago, it was in fact a laggard among countries with similar per capita income levels (World Bank, 2003a; Ahluwalia and Hussain, 2004).[3] Bangladesh ranked among the top performing countries in the 1990s in the extent of improvement in the UNDP Human Development Index and it is among the few developing countries that are on target for achieving most of the Millennium Development Goals (World Bank, 2005; Government of Bangladesh, 2007).[4] The decline achieved in infant and child mortality rates in the country since the early 1990s, for example, is among the fastest in the developing world. Bangladesh has already eliminated gender disparity in primary and secondary school enrolment. Its success in reducing the population growth rate through the adoption of modern birth control methods is also unique among countries at similar per capita income levels. Bangladesh belongs to a regional belt, stretching across northern Africa, the Middle East, Pakistan, and northern India, that is characterized by patriarchal family structures along with female seclusion and deprivation. This makes its achievements all the more noteworthy.

Bangladesh's above achievements in improving its social development indicators may appear as a 'development surprise', with the country's desperate initial conditions and allegedly poor record in governance adversely affecting the quality of public service delivery (Devarajan, 2005; Mahmud, *et al*., 2008). While Bangladesh has overcome its initial image of a famine-prone country, it is now rated extremely poorly according to most global indicators of political and economic governance. Although considerable progress has been made in poverty reduction, a large proportion of the population—estimated to be nearly 40 per cent in 2005—still lives below the national poverty line.[5] A number of questions have therefore been raised: How could the improvements in social development indicators achieved thus far have been possible under conditions of still widespread poverty and an allegedly poor institutional and governance environment? Is this progress sustainable and what are the risks and challenges ahead? How far can one identify the factors behind such achievements in light of the various pathways of social development as experienced in other countries and regions? This article attempts to answer these questions.

SOCIAL TRANSFORMATION: THE UNDERLYING FACTORS

The improvement in Bangladesh's standing within South Asia in respect of some of the social development indicators is evident from Table 1. During the 1990s, Bangladesh is seen to have improved its indicators beyond the South Asian average. This has happened in spite of the fact that Bangladesh remains the second poorest

country in the region, ahead of only Nepal, with a per capita income that is 30 per cent lower than that of South Asia as a whole (in terms of the US dollar adjusted for purchasing power parity; see World Bank, 2005a). Global comparisons show that Bangladesh's ranking has, in fact, improved considerably among low-income countries generally in respect of a number of social development indicators over the last two decades or so (Ahluwalia and Hussain, 2004).

Table 1

Improvements in Some Human Development Indicators since 1990, Bangladesh and South Asia

		1990	*2002-2004*
Gross primary enrolment rate (%)	Bangladesh	80	109
	South Asia	*95*	*103*
Ratio of girls to boys in primary and secondary education (%)	Bangladesh	77	107
	South Asia	*71*	*89*
Under-5 mortality rate (per 1,000 live births)	Bangladesh	144	69
	South Asia	*130*	*86*
Population with access to improved sanitation (%)	Bangladesh	23	48
	South Asia	*20*	*37*

Source: Estimates of access to sanitation are from UNDP's Human Development Report 2005; all other estimates are compiled from the World Bank's *World Development Indicators* as reported in World Bank (2005a) and World Bank (2006).

The figures in Table 1, in fact, reflect a process of social transformation in Bangladesh that is of a much broader scale and dates back to even earlier decades. It is noteworthy that the changes in the different socio-economic indicators occurred simultaneously, though at a varying pace. Primary school enrolment rose gradually and unevenly until the 1980s, then rapidly and consistently, particularly for girls (Hossain and Kabeer, 2004). The fertility rate declined from 6.3 births per woman in the mid-1970s to about 3.0 currently, with the most rapid decline being witnessed between the mid-1980s to the mid-1990s, and only a modest decline occurring since then. The rate of adoption of modern contraceptives, which gathered momentum from the early 1980s onwards, increased from 5 per cent of the eligible couples in 1975 to 47 per cent in 2004. As a result, Bangladesh now leads all other South Asian countries except Sri Lanka in the prevalence rate of modern contraceptives (MHHDC, 2007, p. 203; UNDP, 2007, p. 249). Meanwhile, there has been a rapid increase in the rate of women's labour force participation—from 8 per cent in 1983-84 to 18 per cent in 1995-96, and 23 per cent in 2000-01, according to the official Labour Force Survey.[6] There has also been a very rapid increase since the early 1990s in the group-based micro-credit programmes, which currently have about 15 million borrowers, who are overwhelmingly female and represent more than half of the rural households.[7]

There are well-known synergies among these various aspects of socio-economic developments involving changes in incentives for household decision-making as well

as in social attitudes and behavioural norms. Attempts to explain changes in any one of the social development indicators separately may fail to capture the mutually reinforcing nature of the changes. For example, there is a large literature pioneered by Gary Becker regarding the interlinks among female employment, fertility behaviour and investments in children's health and education leading to a change of preference for 'quality' over the 'quantity' of children (Becker, 1981). The Beckerian approach has often been criticized for narrowly focusing on household economic costs and benefits, thus lacking a broader perspective of social transformation, but the interacting and reinforcing nature of the changes is generally well recognized. What is, however, striking in Bangladesh's case is that such a transition seems to have taken place at much lower standards of living than is usually expected in the literature. The demographic transition, in particular, is remarkable not only for having taken place at such low levels of income but also for the relatively short duration of the different phases of the transition (Caldwell, *et al*., 1999).[8] Similarly, Bangladesh's experience in social transformation such as regarding female employment or girl's schooling shows that the time-scale for the associated changes in social attitudes and norms can be much shorter than is assumed in the literature on institutional economics *a la* Douglass North (North, 1990).

It is not easy to identify the causal mechanisms or 'triggers' behind the kind of social transformation that has taken place. For example, micro-credit programmes may have been a contributing factor by promoting social interactions and mobility for rural women in a traditional society characterized by female seclusion. Besides the economic impact of micro-credit on poverty, the mobilization and functioning of women's credit groups can lead to non-economic gains through enhanced agency, empowerment, mutual support, etc., thus creating the social environment for other development interventions to work better. But, as mentioned earlier, changes in many of the social development indicators preceded the period of rapid expansion of the micro-credit programmes in the 1990s. A plausible assumption is that social transformation that had started earlier was helped and extended by micro-credit, which itself benefited from female membership.

An increase in employment and income-earning opportunities for women is likely to have a positive impact in a number of areas such as fertility behaviour, expenditure on children's welfare and demand for girls' education. Ironically, it was the widespread destitution caused by the 1974 famine, along with the post-famine rehabilitation work of the government and the non-governmental organizations (NGOs), which proved to be a turning point in women's seeking employment outside the home in large numbers. Since the early 1990s, the stimulus to women's employment has come largely from the dynamism of the rural non-farm sector and the phenomenal growth of the export-oriented garment industry (Mahmud, 2007). The garment industry currently employs more than 2 million workers, mostly women having some formal education and many of them recent migrants from rural areas (Kabeer and Mahmud, 2004).

Recent analyses of poverty dynamics in Bangladesh suggest that, as compared to many other developing countries, upward economic mobility in Bangladesh is less constrained by class, ethnicity or other socio-economic barriers. Access to markets with extensive rural transport networks, increasing participation of women in work outside the home, and a very rapid spread of micro-credit have contributed towards the expanding economic opportunities for the poor. Thus, everyone, even the poorest, see a chance of escaping poverty.[9] Such inclusiveness may contribute to social cohesion, while also making people pro-active to economic opportunities, which may explain why even the poor families are increasingly sending their children to school.

There is another unique aspect of Bangladesh's progress in social development. Much of the progress has been due to the adoption of low-cost solutions like the use of oral rehydration saline (ORS) for diarrhoea treatment, leading to a decrease in child mortality, and due to increased awareness created by effective social mobilization campaigns such as those for child immunization or contraceptive use or school enrolment. The scaling up of programmes through the spread of new ideas is helped in Bangladesh by a strong presence of development NGOs and also by the density of settlements and their lack of remoteness. For example, the initial spread of the use of oral saline for diarrhoea treatment was largely due to the work of BRAC, the largest development NGO in Bangladesh (Zohir, 2004). Diarrhoea used to be the single major cause of under-five mortality in Bangladesh; but deaths from diarrhoea have now been greatly reduced by the widespread adoption of the ORS technology, including the use of home-made saline. Similarly, under-five mortality due to communicable diseases like measles has also been largely reduced through successful child immunization campaigns by the government and NGOs. In fact, Bangladesh is now a leader among developing countries in the rates of child immunization. For example, the percentage of one-year-olds immunized against measles in 2005 is estimated to be 81 in Bangladesh as compared to 58 in India and 74 for the developing countries as a whole (UNDP, 2007, pp. 248-50).

The connectedness of rural communities has been facilitated by the fact that the government has made increasing budgetary allocations for developing extensive networks of rural roads (Mahmud, 2002). Bangladesh ranks among the countries with very high road density (i.e., road length per unit of area) and such dense transport links have helped in many ways. Besides generally promoting rural development, this has helped in making services more accessible to the rural communities, specially to women, and in scaling up social development campaigns as mentioned above.[10]

The government's commitment, supported by innovative programmes and increased budgetary allocations for public social spending, has also been a contributing factor. The family planning programme of the government was taken up in earnest, particularly since the early 1980s, with an extensive network of domiciliary services along with the 'social marketing' of contraceptive devices. Efforts to integrate children from poor rural households into the formal school system were geared up since the early 1990s with the introduction of the so-called 'food for

education' programme, while female school enrolment was promoted by the introduction of a universal stipend programme for female students attending secondary schools.[11] The female stipend programme has been described as the world's vanguard programme of this type having a profound impact on parental attitudes and social norms regarding the sending of adolescent girls to schools. All these programmes have been effective on both the supply side and the demand side, i.e., in provisioning services at affordable costs as well as in creating demand for such services through increased awareness and various incentives. However, their impact over a relatively short time needs to be viewed in the context of the broader socio-economic change.

The trends in the government's budgetary allocations show that the shares of expenditure on both health and education out of the total budget expenditure have increased steadily from the early 1980s to the late 1990s (Table 2). This was a period when fiscal restructuring was undertaken as part of the so-called structural adjustment reforms. This restructuring of public expenditure also resulted in a rising proportion of GDP being allocated to these two sectors.

Table 2

Government Expenditure on Health and Education (as Shares of the Budget and as Percentage of GDP; Five Year Averages)

	1980/81-1984/85	*1985/86-1989/90*	*1990/91-1994/95*	*1995/96-1999/2000*
Percentage of Total Budget Expenditure				
Education	8.16	11.24	13.62	15.51
Health & Population Planning	5.40	5.88	6.77	7.13
Percentage of GDP at Market Prices				
Education	1.00	1.33	1.81	2.11
Health & Population Planning	0.66	0.70	0.90	0.97

Source: Based on the official Revised Budget figures.

The analysis of benefit incidence shows that the distribution of benefit from public spending on both health and education among households is weakly pro-poor, i.e., the distribution is more equal than the overall income distribution in the economy, though it favours the relatively rich. However, expenditure on mother and child health and on primary education is strongly pro-poor, so that the poor get more absolute benefit than the rich (Osmani, *et al*., 2003; World Bank, 2003). A high proportion of public education expenditure goes to primary education (about 45 per cent), while a high proportion of the government's health budget is also allocated for primary healthcare covering both mother and child health (about 65 per cent). Overall, it must be acknowledged that the public expenditure policy of Bangladesh deserves credit for raising the share of the social sectors in the total budget, as also for implementing a pro-poor stance in the allocations of public social spending.

FUTURE RISKS AND CHALLENGES

If the foregoing analyses of factors underlying the progress in social development in Bangladesh are true, they also point to the future risks and challenges.

The improvements in social development indicators achieved so far represent, in part, a "catching up", since two decades or so ago, Bangladesh was in fact a laggard in respect of these indicators among countries with similar per capita income levels. As the situation has now clearly been reversed, maintaining recent rates of progress for Bangladesh will become increasingly difficult without concomitant rapid income growth and poverty reduction. There is ample evidence that, in spite of the progress made in terms of the overall indicators, large disparities persist in health and educational achievements among households of different income groups, and that poverty and deficiencies in human development perpetuate each other. The available evidence shows that the children still remaining outside schools belong almost entirely to the poorest households and that there is a health divide among the rich and the poor, such as in respect of child immunization or maternal mortality (Hossain and Kabeer, 2004; NIPORT, *et al.*, 2005). Another manifestation of poverty is the prevalence of child malnutrition, which is among the highest in the world and is an impediment to further progress in reducing child mortality.[12]

Moreover, as the gains from low-cost solutions are reaped, further progress may increasingly depend on increased public social spending and an improvement in service delivery systems. As discussed earlier, the declines from the very high initial child mortality have been largely driven by relatively inexpensive interventions such as child immunization and oral saline treatment for diarrhoea. As the overall child mortality has declined, the ratio of neo-natal mortality to under-five mortality has rapidly increased (World Bank, 2005, p. 27). Further reductions in child mortality will thus require more expensive child survival interventions, such as hospital-based care to avert neo-natal mortality resulting from birth-related complications including underweight births. Similarly, lowering the currently high maternal mortality rate will also require the provision of relatively costly health services. Again, while remarkable progress has been made in school enrolment, especially for girls, there are serious concerns now about the quality of education. Although the gross primary enrolment rate in Bangladesh is higher than the South Asian average, the school completion rate (i.e., the percentage of grade 1 students completing grade 5) is relatively low—73 per cent as compared to the regional average of 80 per cent during the period 2000-2004 (World Bank, 2005a, pp. 202-03). Clearly, Bangladesh needs to improve the quality of service delivery in order to consolidate the gains made thus far and to make further improvements.

The problem of governance resulting in poor service delivery is widespread in the social sectors in Bangladesh. Service delivery systems are highly centralized with there being very few mechanisms for accountability through community participation. The rural healthcare system is plagued by poor utilization of services and widespread absenteeism of doctors—estimated to be as high as 75 per cent

according to a nationwide survey (Chaudhury and Hammer, 2003). Similarly, the quality of schooling suffers from widespread teacher absenteeism and lack of accountability. Clearly, ensuring adequate access of the poor to education and health services of sufficient quantity and quality requires much more than allocating more budgetary resources to these sectors.

Mobilizing enough resources for public social spending is also a formidable challenge. In spite of favourable budgetary allocations, the per capita public expenditure on health and education in Bangladesh in absolute terms is quite low even by South Asian standards—about US$ 11.5 annually as compared to US$ 18 in India, US$ 35 in Sri Lanka and US$ 13 in Pakistan (the estimated average for the period 1997–2002 based on the data reported in World Bank, 2005, p. 7). It should also be noted that the structural shift in the budget towards larger social spending in Bangladesh has come about from a redefinition of the role of the government and is, therefore, of a once-and-for-all nature (Mahmud, 2002). In future, higher allocations to social sectors will require more difficult reforms for public resource mobilization. Because of the prevalence of large-scale tax evasion, Bangladesh has an extremely low rate of revenue collection, with a revenue-GDP ratio of only about 10 per cent. A steady decline in foreign aid has made the task of public resource management even more difficult.[13]

A challenge for Bangladesh is to fully exploit any remaining scope for improving its social development indicators by creating awareness about low-cost solutions, since this is one approach wherein the country seems to do very well. For example, survey results show that there is ample scope for creating awareness about pre-natal care as a means of screening potentially complicated deliveries, thereby reducing the maternal mortality rate.[14] Bangladesh is currently lagging behind in respect of the MDG target of reducing maternal mortality, even though the rate has been falling significantly over the years. It is noteworthy that, as compared to India and Pakistan, Bangladesh has a lower maternal mortality rate in spite of having a much lower rate of medically-attended births.[15] This is perhaps another evidence of Bangladesh's edge in benefiting from improved health awareness despite meagre health facilities. Again, survey results suggest that there may be scope for reducing the prevailing high child malnutrition rates in Bangladesh through food-healthcare educational interventions. Although child malnutrition rates in Bangladesh are among the highest in the world, impressive gains have been made over the last decade or so, with a rate of decline in the prevalence of child malnutrition that is superior to that of India (World Bank, 2005, pp. 32-35).[16]

International donor agencies, while supporting many social development projects in Bangladesh, have often ignored low-cost and locally relevant solutions.[17] These agencies have a tendency to go by the globally accepted template, ignoring more cost-effective technologies that are more readily adopted by local communities. For example, as a means of improving rural sanitation in Bangladesh, the Public Health Engineering Department was supported by the UNICEF to promote water-sealed fully sanitary latrines. However, a lower-cost but usable technology of ring-

slab latrines promoted by local entrepreneurs, combined with the creation of awareness about the value of better hygiene, has proved to be a much more effective means of improving sanitation in the initial stage.

Another case of policy failure has been a programme supported by the UN agencies in Bangladesh to train young women as skilled birth attendants (SBAs). This programme was designed to bypass the task of technically upgrading the more culturally experienced traditional birth attendants (TBAs) located within the communities. The result of this emphasis on SBAs rather than on TBAs was that the newly trained inexperienced younger women found very little demand for their services. In contrast, one successful home-grown programme for reducing maternal mortality is that of Gonoshasthya Kendra (GK)—Bangladesh's world-renowned healthcare NGO; the programme uses the services of trained TBAs along with referral to public health clinics.

One challenge for Bangladesh is to prevent reversals of the gains made thus far. Continued deterioration in the quality of schooling, for example, may discourage parents from sending their children to school. The increasing trends towards private tutoring, even in rural areas, may raise the costs of education, thereby offsetting the incentives provided by government programmes. Again, while a large part of the gains in social development indicators were achieved through successful social mobilization campaigns—such as for immunization or contraceptive adoption—it remains to be seen whether the positive outcomes are habit-forming and can be sustained on their own, or may falter in the absence of continued campaigns.

VARYING PATHWAYS: LESSONS FROM EXPERIENCES

Experience across countries and regions shows the possibilities and limitations of various pathways to social and human development. Amartya Sen for example, distinguishes between 'income-mediated' and 'support-led' human development (Sen,1999; Chapter 2),. The former works through rapid and broad-based economic growth, which facilitates better standards of living and better provision of social services (South Korea is a favourite example), while the latter works primarily through effective welfare programmes that support health, education and social security (Sri Lanka, pre-reform China, Costa Rica and the Indian state of Kerala are the oft-cited examples).

Bangladesh's achievements thus far do not exactly fit into either of the above typical pathways to social development. Although its social development indicators are higher than what one would expect at comparable levels of per capita income, it does not represent a typical case of support-led human development achieved through high levels of public social spending. In terms of social development indicators, Bangladesh compares favourably with some of the socially progressive states of India, though it lags far behind those states in both per capita income levels and per capita public social spending in absolute terms (Mahmud and Chowdhury, 2008).

One possible explanation provided by Dreze (2004) regarding the relatively more rapid progress made by Bangladesh as compared to India has to do with the fact that public health expenditure as a proportion of the GDP in Bangladesh is higher than in India. This may be true for some recent years, but not for the earlier years. In 1990, Bangladesh spent only 0.8 per cent of its GDP on health— less than what India spent (1.3 per cent) (UNDP, 2007, p. 286).[18] Dreze also does not take into account the fact that India's public spending on education (4.1 per cent of the GDP) is considerably higher than that of Bangladesh (2.4 per cent of the GDP) (UNDP 2007, p. 286). Given the differences in per capita incomes of the two countries, the gap in absolute expendiure per capita will be even higher.

An important factor that has characterized the pathways to social development followed by Bangladesh is the role of its development NGOs. Bangladesh may well be the world's leader in using NGOs as vehicles of development. NGOs are involved in virtually every developmental activity in the country—relief and rehabilitation, poverty alleviation, health, education, social and environmental protection, to name a few.[19] One advantage of this NGO-led approach has been that social development has been broad-based, since NGOs primarily work with the poor and are effective in motivating them through social campaigns. This, along with the fact that most of the gains have come from low-cost solutions, probably explain why there are less inequalities in social development indicators in Bangladesh than, say, in India. Thus, according to the UNDP's Human Development Report 2007/2008, while the overall under-five mortality rate among the poorest 20 per cent households is lower in Bangladesh than in India (121 as compared to 131 per 100,000 live births), the reverse is true for the richest 20 per cent households (72 in Bangladesh as compared to 46 in India; see UNDP, 2007, p. 255). Another evidence of the broad-based nature of social development in Bangladesh is that the female advantage in primary and secondary school enrolment can be seen across all income groups.

The NGOs in Bangladesh, however, have their limitations. They are mostly effective in promoting self-interested behaviour for promoting individual welfare, even if the benefits accruing to the targeted households have elements of 'public good' (for example, immunization, birth control, sanitation, etc.). They have been far less effective in promoting civic activism, such as for demanding better service delivery by government agencies. While many NGOs are indeed engaged in promoting human rights and good governance, the scaling up of their programmes have proved difficult. The beneficiaries of NGOs are on the receiving side, often not conscious of what they ought to have as a matter of right. In the absence of effective local government, the NGOs in Bangladesh work almost at a parallel level with the highly centralized public service delivery systems. Moreover, they feel constrained to engage in campaigns with political overtones, since it may place them in a confrontational position with the government and jeopardize their foreign funding. It is not surprising, therefore, that in spite of the many achievements in social development, Bangladesh performs poorly in ensuring civic and human rights, including the prevention of violence against women.

In contrast to Bangladesh's experience, some progressive states in India like Kerala provide examples of a different pathway to social development, namely, through decentralization and effective local governance. While the NGO-based interventions in Bangladesh largely use the agency of women to affect household behaviour, local governance and the supporting community-based organizations use what Sen and Dreze call 'the agency of the public' (Sen and Dreze, 1995, pp.190-91). Kerala's story regarding the role of social movements in breaking the old inequalities of class, caste and gender is well known. The experience of Uttar Pradesh (UP) in India represents the opposite example of being caught in the vicious circle of government apathy towards the needs of the citizens and public inability to challenge that apathy. Again, the state of West Bengal provides an example wherein grassroots political development has had success in addressing issues of local democracy and land reform with relatively good effect, but public policies dealing with health, education and other related matters of social development seem to have been largely neglected so far.

While well-functioning local democracy can facilitate a 'support-led' approach to social development, there is also a risk of the elite capture of local government. This was the case in Bangladesh when the *upazila* system of elected local government was introduced for a brief period during the semi-autocratic regime of General Ershad in the 1980s. It is also noteworthy that non-democratic China's performance in terms of the provision of primary education and health services at the local level may have been better than in democratic India; local communist officials in China have been responsive to local needs as long as there is no conflict with party directives. The experience of Sri Lanka in decentralizing service delivery has been largely disappointing (Kelegama, 2007, p. 152). Clearly, while there are many pathways to social development, there is no unique blueprint for success.

To sum up, Bangladesh has yet to meet the challenge of finding an appropriate institutional basis for improving its public service delivery systems. The problem of poor service delivery in social sectors is symptomatic of the overall governance problem that poses a serious risk to the country's prospects for continued economic and social progress. Nevertheless, Bangladesh's experience has shown that it is possible to achieve rapid progress in many social development indicators amid widespread poverty, and that social attitudes and behavioural norms can change over a much shorter period than is usually assumed in the literature. It has also been shown that it is possible to achieve near-universalization of some aspects of social protection simply by creating awareness and using low-cost affordable solutions.

NOTES

1. See, for example, Faaland and Parkinson (1976).

2. The growth of per capita GDP, at an annual average rate of 1.1 per cent a year, had been slow in the 1980s, but it accelerated to 3 per cent in the 1990s, and to about 4 per cent in the more recent period. The acceleration resulted partly from a slowdown in population growth but also from a sustained increase in GDP growth, which averaged at 3.7 per cent annually during the 1980s, 4.8 per cent during the 1990s and nearly 6 per cent since then.

3. Regressions with cross-country data show that the current values of most social development indicators for Bangladesh are distinctly superior to the predicted values at the given level of per capita income; see Government of Bangladesh (2005), Table 1, p. 9.

4. The absolute increase in the value of the Human Development Index for Bangladesh between 1990 and 2001 is surpassed notably only by China among all the countries for which such estimates are available (see UNDP, 2003, pp. 241-44).

5. This estimate refers to the official 'upper poverty line'.

6. This increase has taken place in both urban and rural areas. The estimates are based on the so-called 'traditional' definition of labour force, rather than the more liberal 'extended' definition.

7. There is some uncertainty regarding the estimates of the coverage of micro-credit because of multiple memberships leading to considerable overlaps.

8. Bangladesh's demographic transition can be seen to have three distinct phases: very low growth until the 1930s with high fertility and high mortality levels, rising growth between the 1930s and the 1980s with falling mortality but unchanging fertility levels, and declining growth thereafter with fertility levels falling faster than the mortality levels.

9. For a longitudinal study on the movements of households into and out of poverty in rural Bangladesh, see Sen (2003).

10. The road density in Bangladesh is approximately the same as that in the UK and is higher than in many other OECD countries; see World Bank (2005b), p. 37.

11. Under the 'food for education' programme, children from poor rural families were given wheat rations (later monetized) in return for regular school attendance.

12. The child malnutrition rates are, however, equally high in India as well; see MHHDC (2007), p. 204.

13. The financing of the budget through foreign aid has secularly declined—from the equivalent of 6 per cent of the GDP in the early 1980s to less than 2 per cent currently; see Mahmud, *et al.* (2008), Table 1.

14. The results from the *Bangladesh Demographic and Health Survey 2004* show that lack of awareness, and not the existence of any social barriers, is the main cause for women not accessing antenatal care. According to the survey, 63 per cent of the women do not know about the benefit of antenatal care and another 13 per cent are not aware of the existence of the service; see NIPORT, *et al.* (2005).

15. According to the World Bank's estimates for 2000-03, the maternal mortality rate in Bangladesh is 380 per 100,000 live births as compared to 540 in India and 500 in Pakistan, while the percentage of births attended by trained health personnel is 14 in Bangladesh as compared to 43 in India and 23 in Pakistan; see World Bank (2005a), pp. 294-95.

16. The child malnutrition rate (weight for age of under-fives) is estimated to be 48 per cent in India and 47 per cent in Bangladesh, which are among the highest in the world; see UNDP (2007), pp. 252-53.

17. For a detailed discussion on this, see Mahmud (2006).

18. There are difficulties in comparing public expenditure on health as a proportion of the GDP because of significant discrepancies among the figures quoted by different sources. According to one source, for example, this proportion was about the same in India and Bangladesh in 2003, i.e. 1.2 per cent and 1.1 per cent, respectively; see MHHDC (2007), p. 208.

19. For a comprehensive account of the NGO sector in Bangladesh, see World Bank (2007).

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