Gender Inequality in Eye Care
in
North Western Bangladesh

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LETTER OF ENDORSEMENT

This is to certify that the thesis entitled 'Gender Inequality in Eye Care in North Western Bangladesh' has been submitted to the department of Sociology at the University of Dhaka in Bangladesh, is the original research work of U K M Farhana Sultana, which was conducted under my supervision in partial fulfillment of the requirements for the award of the degree of MPhil.

(Any options, suggestions made in this thesis are entirely that of the author of the thesis. The University does not condone nor reject any of this options or suggestions)

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DECLARATION

The thesis entitled ‘Gender Inequality in Eye Care in North Western Bangladesh’ has been submitted in partial fulfillment of the requirements for the degree of MPhil carried out in the University of Dhaka.

Dated: May 2025
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Abstract

Gender Inequality in Eye Care in North Western Bangladesh

U.K.M. Farhana Sultana

Gender inequality in health care is a well-recognized fact particularly in developing countries; but the determinants of the inequality, both from the provider and consumer perspectives may vary substantially depending on demographic, socioeconomic and cultural background. Studies on gender inequalities are rare all over the world and it is virtually nonexistent in Bangladesh. Exploration of the extent of gender inequality and its determinants are vital for designing evidence based healthcare strategy in any community. In the present study, we aimed to investigate the determinants of gender inequality in eye care in a rural, semi-urban and urban population in north-western Bangladesh. This population was covered by a comprehensive eye care project (named as BADAS-ORBIS Eye care Project) operated by Thakurgaon Swasthoseba Hospital, and managed by the Diabetic Association of Bangladesh (Bangladesh Diabetic Somiti or BADAS, the parent organization of BIRDEM) supported by ORBIS, Dinajpur Govt. hospital and Panchagarh District Hospital. The study population, was selected by a randomization procedure from the total population covered by the project, surveyed by an interviewer administered pretested questionnaire to explore the gender-wise awareness regarding eye diseases as well as regarding the barriers to use of eye care services.

In addition to the Socio-demographic and economic variables the cultural and psychological issues (like traveling alone to health centers, perceived value of surgery, lack of access to information and resources, fear of poor outcome, beliefs and superstitions) were given particular attention. Factors related to provider were also be assessed by the same method. Special focus was given to analyze the inequalities and determinants in terms of ‘sex’ as well as in terms of gender (which transforms the biological variable sex into the social variable ‘gender’). Data was analyzed by univariate analysis using Statistical Package for Social Sciences (SPSS). The data was expected to generate valuable suggestions regarding proper intervention to create gender balance in health care in general.

Research shows that gender discrimination occurs more within the family than among healthcare providers or on the street. Girls are particularly vulnerable to it in the home of their in-laws.

Awareness must be raised nationwide because this prejudice still takes place in families, particularly in the in-laws house, because of outdated superstitions or religious convictions. Religious speakers can free themselves from religious reforms through their speeches. The government could take the most significant step by making hospitals more welcoming to women and allocating a specific budget for women's healthcare.

Chapter- 1

Introduction

Sociology, from a popular perspective, goes through a two-prong way of knowledge practice. One is to make the individual as well as the collectivity of individuals understand individualistic and collective social problems through social investigations. The latter one deals with the appropriate suggestions apprehended as a result of the social investigation/s. This way this social science encompasses utmost all the aspects of humanity as social existence both individually and socially. As an avenue of knowledge, Sociology was termed as Social Physiology due to its prognostic and diagnostic approach to dealing with social problems.

Many of the root causes that we face as collective and individualistic problems; could be found in our behaviors, mentality, and ways of thinking that are indeed issues of sociology. Objective and imperative social researches addressing these issues bring out the natures and statuses of the problems and positively useful ways of solutions. Because of the very useful methods of Sociological investigations; it has been being used to address ranges of cross-departmental issues from its very inception till this day that has extended the peripheral circumference of it and eventually has given birth to newer avenues of knowledge.

Many of the impediments of human developments as understood by the modern globalized notions originate in our personal as well as social practices. The prevalence of a good number of physical diseases has for a very long time been caused due to social practices and could not be made extinct because of socially perceived anomaly. So the prognosis of diseases does not only relate to medical solutions but also to social behavioral practices and changes that are to be found and understood by sociological investigations. A specific branch of Sociology such as Public Health has eventually emerged that later took the shape of a distinctive social science intended to do the above-mentioned kind of studies.

The former colonies of the subcontinent inherited an impoverished population form the British Empire because of the lingering exploitation and suction of wealth from these colonies. After their independence, that lacked technological advancement, especially in the health care sector and suffered much out of the diseases that were easier for the technologically advanced nations

to address. The impoverishment of these nations also covered the spectrum of different branches of modern knowledge. Due to an enduring stagnation of profound knowledge practice and deficiency of openness on discussion of modern solutions of diseases, the long held persistence of older useless and superstitious perceptions towards physical diseases and their treatment continued. Many a times religious superstitions, lack of modern knowledge, socio-psychological barriers etc. are found as the causes.

The results of this backwardness are the irrational continuation of older diseases, gender inequality and discrimination eventually resulting in many unnecessary deaths. A good example of this situation could be given citing the last remaining cases of Polios in the North-Western Frontier Province of Pakistan and the adjacent areas of Afghanistan.

We as a country that falls under the category of the previously said groups of recently independent states of technologically backward and impoverished population inherited country (But it is to be me mentioned that from after the liberation till now, we are an example of a more or less successful initiative to come out of this situation and have a population that is free of diseases possible to be addressed). The lingering presence of superstitious attitude towards disease and lack of confidence on modern ways of treatment have been a problem for long to be addressed in our country. It therefore has been more a social fight than a medical one to confront. The century old discriminatory attitudes towards women as gender have only reinforced the backwardness in successfully addressing diseases that women are prone to be attacked. The vulnerability of women has become more difficult to eradicate due to the obstructions posed by the unfriendly elements of culture.

1.1 Background of the study:

The discrimination against women especially in the health care attitudes starts from the very home they belong to. From general observation, it has been seen that the female offspring are discriminated in having the chance to meet physicians from the period of their very birth. These discriminations cover all aspects of physical ailments are gradually increased overtime. In some cases, these discriminations lead to losses that they bear for the rest of their lives.

From physical elements of infants to the required attentions for juveniles to childbearing and rearing to old age combinations; the social practices and negative attitudes out of that never let them come out of the vicious realm.

1.2 Significance of study

This gender negativity could well be brought out having a study done on the mentioned sector of health care in the hypothesis *i.e.* eye care. Elements of it were observed in large scale in the less educated and ignoring continuity in the North-Western parts of Bangladesh. The necessity of a scientific social investigation has therefore been felt with utmost urgency. This study on the set sample is expected to bring out the root causes of discriminatory cultural and other kinds of attitudes towards women in the sector of eye health care and come out with the suggested solutions to those.

We can describe it in two ways.

Theoretically: After reviewing related literature, it was found that there is very few studies are on this issue. Gender inequality in the health sector is a common phenomenon. Many research or studies are on this. However, studies on gender inequality Particularly on eye care is rare.

Practically: As per observation in practical life, it is seen that there is discrimination in between male and female patients in most of the hospitals. Besides, in family females are not allowed to go hospitals for treatment without any male with her. In that case most of the women must wait for long. By this time their diseases increase.

1.3 Scope of study

The lingering status of existent cultural impediments towards considering women as a class equal to male is one of the biggest obstructions in the path of achieving a society of equity and justice. But before any initiative/s to set off against it the actual status, degree and root causes are to be identified. At the same time the appropriate and useful strategy to combat the problem and wipe it out as a social practice, proper suggestions are a must to be unveiled. There is no alternative of an objective and imperative social research on the issue to do so. Initiative of a research as such is expected to fulfill at least a part of this requirement.

1.4 Operational Definitions

Gender Inequality: Here in the prepared hypothesis, the phrase 'Gender inequality' refers to any unequal or discriminatory attitudes towards the class of women as a gender from any part of society be it the family, the society or the formal or informal, Government or Non-Government health care organism in the specific field of eye care.

Eye Care: The phrase 'Eye Care' is used for treatment and caring of eye either in a formal medical way or an informal one by the state authorized health care system or by any authorized or unauthorized ones in individual or organizational manner.

North-Western Bangladesh: Three administrative districts of the newly formed Rangpur Division; the districts of Panchagarh, Dinajpur and Thakurgaon are referred as North- Western Bangladesh in the study.

1.5 Objectives of the study

The perceived objective of the study is as bellow:

To find out if any gender inequality is existent in the eye care sector within the cases to be studied in the study locate.

Specific objectives are:

1. To bring out the nature, extent and degree of gender inequality in the said field if found.
2. To bring out the root cause/s of gender discrimination in eye care sector.
3. To analyze the status of gender discrimination in eye care sector in Bangladesh in line with the Constitution of the People's Republic of Bangladesh, prevalent political doctrines in contemporary world and the two widespread religious belief systems existent in the population of Bangladeshi society.
4. To analyze the annual national budget of Bangladesh in understanding the status of monetary intervention aiming to develop the scenario of women's health and eye care.
5. To propose appropriate suggestions/recommendations to come out of the possibly found gender inequality in the eye care sector of Bangladesh.
6. To pave the way for new researches on the issue in future.

1.6 Overview of the study:

In this study both primary and secondary data collection were conducted. Objectives were to find the reason of gender inequality, how women are suffering in health issues particularly in eye care sector. This study has an initial chapter where background, rationale, scope, objectives, study locale are mentioned. After that study has a literature review where previous writings or studies related to this subject are highlighted. Chapter three covered the methodology of the study. There

is a chapter where the theory of key terms used in this study is discussed. Next chapter refers to the comparative statement of the health situation in Bangladesh with other developed countries. After that analysis of data collected by survey comes. Reasons for gender discrimination and recommendations come accordingly in next two chapters.

Chapter 2

2.1 Literature Review

The literature review of the study has been decided to be executed keeping the objectives in mind to suffice the apprehended purposes of the study. Both the spectrums of the national and international literatures deemed as necessary with the study will be covered.

It is needless to say that from after the introduction of the internet, a huge number of national and international research have been published online. Not only the studies done from after the introduction of internet, but many previously done research and social investigations are also included in there. A huge number of individual and organizational online web pages provide themselves as the sources of these studies that have made the availability of data much easier. So along with the books available in relation to the study, different online sources of information and data are also considered under the gamut of the literature review for this study.

As an initial sort; the literatures containing the basic rules and methods of a standard social research published both in Bangla and English have been gone through. The study specific/relevant research and articles will be taken as sources to shape the study for good as well. It is also considered to study the feminist epistemology as important for bringing in the feminist approach for a gender study and therefore will be done.

As it was put in the objectives; the Constitution of the People's Republic of Bangladesh will be thoroughly studied to bring out the Articles, paragraphs and Provisions on basic human rights, women rights and health rights as well as the duties of the Government in ensuring those and the chance of supplications the citizens of this country could make in line of those. These Articles, paragraphs and provisions will also be studied and put inside the research to compare the field level scenario for the sake of comparison with the reality.

A brief study of the religious scriptures of the principally practiced two major religious ideologies by the mass populace of this country; Islam and Hinduism will also be included into the arena of the literature review. These two religions are recognized as the very basic sources of social as well as individual practices of the overwhelming mass population of this country. By studying those, the provisions provided by these religious belief systems in relation to rights of women will also be brought out in order to understand the root causes of any discriminatory

attitudes towards women in general and in health care practices practiced in particular; given found in the field.

The most widely observed political as well as economic doctrines in the current world are to be studied and put into the study also. The core concepts of these doctrines *e.g.* Humanism, Communism, Socialism, Democracy, Welfare-states systems etc. will come under scrutiny with their female rights relevant approaches. The field-level scenario from the found data will then be paralleled to those for comparative reasons and bringing out a more appropriate state policy and philosophy for our country.

A study on the most recent budget using the Budget Speech of the Honorable Finance Minister of Bangladesh and the Budget Documents published by the Finance Division of the Ministry of Finance of the Government of Bangladesh will also be done in order to bring the financial intervention/s of the Government in ensuring female health rights in Bangladesh to the surface. It has also been selected for bringing out more appropriate and useful financial involvement from the Government's part for betterment of the current situation. The lessons learned from the financial practices from the study of the widely practiced political and economic doctrines after this budget study will help for a better way of budgetary intervention.

The books studied to fulfill all the objectives and cover the fields of literature review will be specifically mentioned in the Bibliography Section at the end of the study.

Gender Inequality in Eye Care in North Western Bangladesh

Sociology as a science of society, from a popular perspective goes through a two prong way of knowledge practice. One is to make the individual as well as the collectivity understand the individualistic and collective social problems through social investigations. The latter one deals with the appropriate suggestions apprehended as a result of the social investigation/s. This way this social science encompasses almost all the aspects of humanity as social existence both individually and socially. As an avenue of knowledge, Sociology was in its early days termed as Social Physiology due to its prognostic and diagnostic approach to deal with social problems.

Many of the root causes that we face as collective and individualistic problems; could be found in our behaviors, mentality and ways of thinking that are indeed issues of sociology. Objective and imperative social researches addressing these issues bring out the natures and statuses of the

problems and positively useful ways of solutions. Because of the very useful methods of Sociological investigations; it has been being used to address ranges of cross-departmental issues from its very inception till this day that has extended the peripheral circumference of it and eventually has given birth to newer avenues of knowledge.

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The former colonies of the subcontinent inherited an impoverished population form the British Empire as a result of the lingering exploitation and suction of wealth from these colonies. After their independence, these former colonies lacked the technological advancement especially in the health care sector and suffered much out of the diseases that were easier for the technologically advanced nations to address. The impoverishment of these nations also covered the spectrum of different branches of modern knowledge. Due to an enduring stagnation of profound knowledge practice and deficiency of openness on discussion of modern solutions of diseases, the long held persistence of older useless and superstitious perceptions towards physical diseases and their treatment continued. Many a times religious superstitions, lack of modern knowledge, socio-psychological barriers etc. are found as the causes.

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towards women as a gender have only reinforced the backwardness in successfully addressing diseases that women are prone to be attacked. The vulnerability of women has become more difficult to eradicate due to the obstructions posed by the unfriendly elements of culture.

The discrimination against women especially in the health care attitudes starts from the very home that they belong to. From general observation, it has been seen that female offspring are discriminated in having equal chance to meet physicians from the period of their very birth. These discriminations cover all aspects of physical ailments and are gradually increased overtime. In some cases, these discriminations lead to losses that they bear for the rest of their lives. From physical ailments of infants to the required attentions for juveniles to child bearing and rearing to old age complications; the social practices and negative attitudes have never let them come out of this vicious realm.

This gender negativity could well be brought out by having a study done on the mentioned sector of health care in the hypothesis *i.e.* eye care. The necessity of a scientific social investigation has therefore been felt with utmost urgency. Elements of this discrimination were observed in large scale in the less educated and ignoring community in the North-Western parts of Bangladesh. This study on the set sample is broadly undertaken therefore, to bring out the root causes of discriminatory cultural and other kinds of attitudes towards women in the sector of eye health care and come out with the suggested solutions to those.

We have seen earlier that throughout the known history of humankind, women have engaged themselves as active personnel in the healing process. At the same time, it has also been of obvious notice that due to the physically weak nature and the special physical roles that they play as child bearing and rearing and for the physical reaction to the unique pituitary hormones they are subjected to; they go through very unique kind of physical ailments. It has also been a matter of notice that as in other sectors women as a class have also been subjected to lesser importance in the traditional and even in the modern healthcare systems worldwide. The number of studies done on the field referenced here let us have a clearer idea on this.

Of the various aspects of human health, the unique womanly natured health issues have occupied almost all the studies done in terms of bringing out discrimination in the healthcare towards them. **Here in this study however, it was deemed as interesting to research out the general aspects of healthcare attitudinal differences shown by the mainstream social and healthcare system and its different organs for a gender-common disease like eye illness. This indeed helps in showing whether the hitherto existing practice of gender inequality persists in common ailments like eye illnesses or not.** Though there have been a handful

number of studies done in respect to the population of the subcontinent on the scenario of gender attitudes of the health systems; the specific field of eye care has unfortunately been left out so far. So from that respect, **this study could be said as a pioneer gender study in the field of eye care.**

Chapter 3

Research Methodology

3.1 Methodology

A cluster of methods will be used in the execution of the study. A field level survey will be conducted having every single interviews considered as one unit separately. A number of 70 units will be considered as the size of the population. A structured questionnaire will be prepared to make interviews of the units. Both open and close ended questions will be included into the questionnaire.

Interviews of experts on the issue will be taken numbering seven at most. The interviews will be conducted as issue based.

Data and findings of previous sociological and public health studies on the issue found will also be taken help of and mentioned as per necessity as secondary source of information; if felt necessary.

For the convenience of the study; the three targeted districts' Sadar Hospitals will be places where people in need of eye care will be selected as well as other non-government initiatives of the Sadar Thanas and townships of the mentioned districts. Most of the respondents will be taken from Dinajpur as it has got a larger population than the other two districts. To know of the status of the eye care needed both the women and male patients and other members of their family will be interviewed. The size of the population is 70 out of which at least 50% consisted of the women in need of eye care.

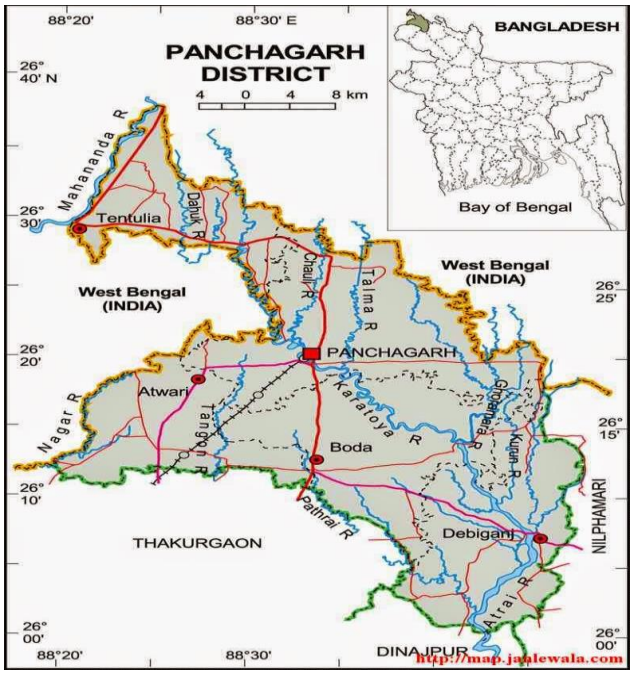
Other than the female patients coming to get eye care treatments the male patients will also be interviewed to know if there exist any female members of their family in need of eye care subjected to gender discrimination in this field as well as their views on the issue.

The major prevalent economic and political doctrines of the contemporary world in relation to the reality of Bangladesh and the predominantly prevalent belief systems as well as the Constitution of Bangladesh will be studied in relation to gender rights. The found data after literary description will then be analogized with these political doctrines, belief systems and the Constitution of this country to evaluate if any contrasts found to be determined as gender discrimination. So along with analyzing data collected through the survey method and from secondary sources; there will analogical analysis done with the prevailing belief systems and

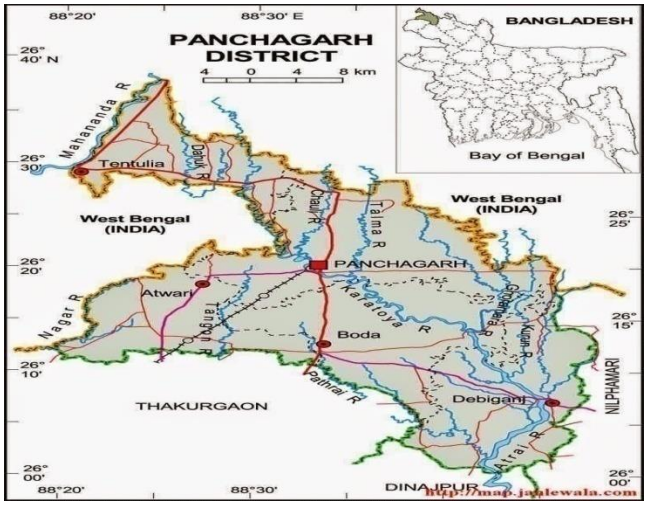
contemporary major political and economic doctrines as well. It is hoped that the suitable form of modus operandi for solutions of the found problems regarding the issue will come out in this way.

3.2 Study Locale

As from general observation of the previous work experiences brought out substantial level of persistent gender inequality in the three districts of Panchagarh, Thakurgaon and Dinajpur; those have been selected as the locale of the study. As it was a perceived intention to study the marginal populace of the country; It was also the geographical proximity that mattered since these places are among the most distant ones from the capital of Bangladesh *i.e.* Dhaka. Additionally, it was known that there is a strong presence of peasant community in the greater Dinajpur area that will help us understanding the status of the most widely practiced way of living in Bangladesh by studying this population. There is also a complexion of indigenous community living alongside the mainstream population in the study locale which could make the resultant outputs of the study more representative.



Map of Panchagarh District



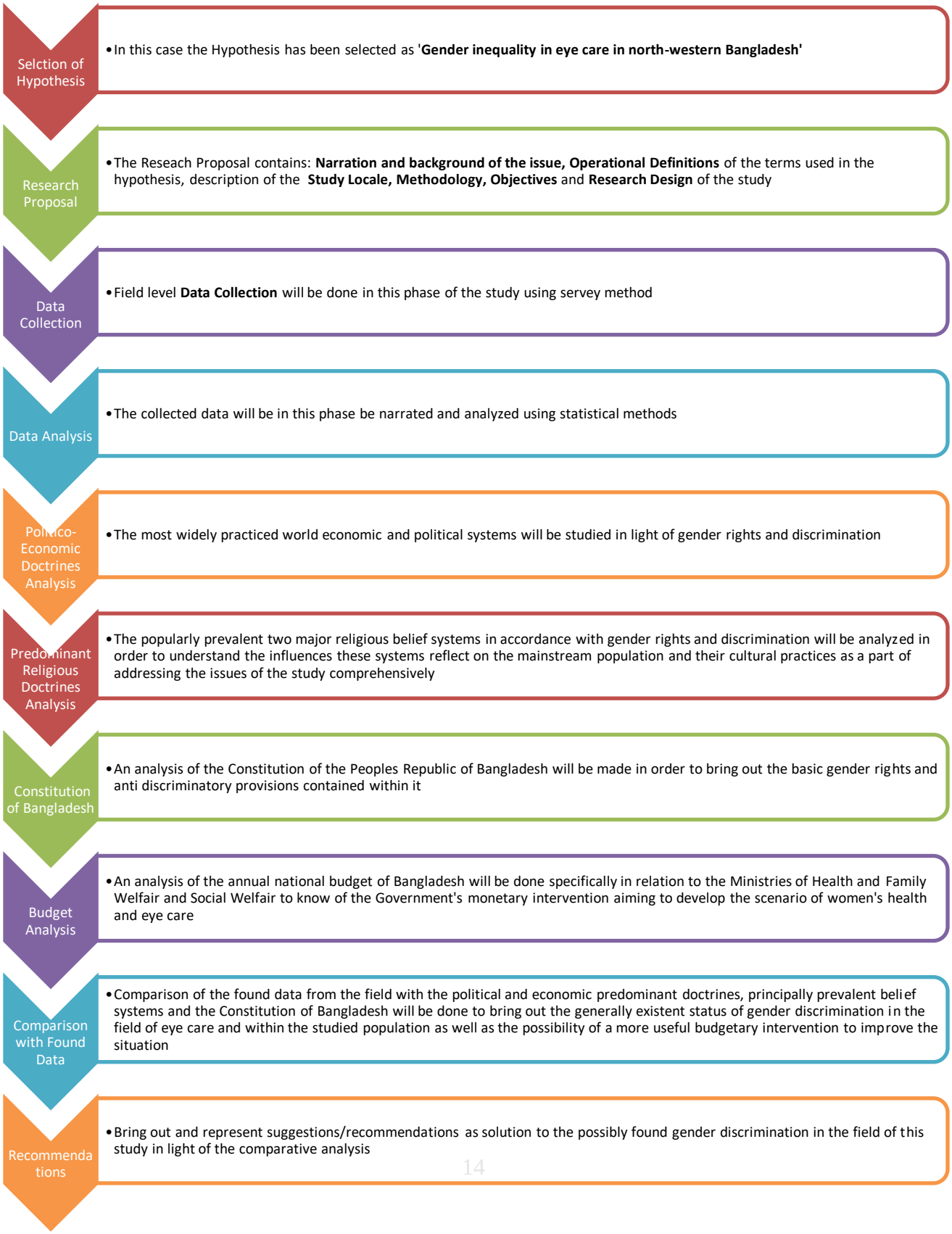
Map of Thakurgaon District



Dinajpur District

Research Design

The design of the study has been drawn as below:



Chapter- 4
Theoretical framework

Most widely practiced economic and political doctrines of the world

It was decided in the objectives of the study to investigate the depths of the most widespread economic and political doctrines of current world. These doctrines have been looked into in the gravity of their core ideas and practices in relation to women and health rights. This has let the study understand the possible positive outputs these doctrines may leave on the practicing population as well as possible shortfalls and draw the bests from among those for ourselves. This also helps us determine the best possible economic approach and political arrangement compatible to our society and country for having the least possible gender discrimination especially in the health care system and more specifically in the field of eye care.

Of the economic and political systems that have been analyzed there are Marxism as a philosophy, the resultant systems of socialism and communism, democracy, capitalism, social democracy and the welfare-state system. The core ideas of these doctrines as well as their relevance to gender rights, health rights and stand point on women's health issues have been discussed in light of theoretical literatures.

Liberal feminism:

Liberal feminism is an individualistic form of feminist theory, which focuses on women's ability to maintain their equality through their own actions and choices. Liberal feminists argue that society holds the false belief that women are, by nature, less intellectually and physically capable than men; thus it tends to discriminate against women in the academy, the forum, and the marketplace. Liberal feminists believe that "female subordination is rooted in a set of customary and legal constraints that blocks women's entrance to and success in the so-called public world". They strive for sexual equality via political and legal reform.

Women in Development (WID):

Women empowerment is the reflection of gender equality which is the precursor to moving the country forward, towards middle income status, towards inclusive and sustainable development. Women in development (WID) is an approach to development projects that emerged in the

1970s, calling for treatment of women's issues in development projects. It is the integration of women into the global economies by improving their status and assisting in total development. Later, the Gender and development(GAD) approach proposed more emphasis on gender relations rather than seeing women's issues in isolation.

Gender and development (GAD)

Gender equality is considered a critical element in achieving Decent Work for All Women and Men, in order to effect social and institutional change that leads to sustainable development with equity and growth. Gender equality refers to equal rights, responsibilities and opportunities that all persons should enjoy, regardless of whether one is born male or female.

In the context of the world of work, equality between women and men includes the following elements:

- Equality of opportunity and treatment in employment
- Equal remuneration for work of equal value
- Equal access to safe and healthy working environments and to social security
- Equality in association and collective bargaining
- Equality in obtaining meaningful career development
- A balance between work and home life that is fair to both women and men
- Equal participation in decision-making at all levels

Marxism

Marxism is defined according to the Dictionary of Sociology of UNWIN HYMAN by David Jary and Julia Jary as, “The total body of mainly theoretical work which aims to develop, amend or revise the original work of Marx by practitioners who identify themselves with the term. The term Marxist can be applied to such work or authors but sometimes has a connotation of political commitments or activity which not all authors may share”.

It is only from 1960s that Marxism has had a significant influence in Western Europe and the US within academic institutions. Before then, and outside of the Soviet law, Marxism’s major

developments come from intellectuals enriched in political organization, and this influence continues alongside contributors in academia.

The mentioned dictionary goes on to depict the main as:

(a) Soviet Marxism, which from the 1930s was dominated by Stalinism and developed a rigid 'scientific' and materialist view, seeing the natural sciences as the basic method of knowledge, but which became more varied after the death of Stalin.

(b) Trotskyism, which developed critical analysis of the nature of the USSR and of the changing nature of 20th century capitalism, and which sees itself as the main heir of the Marxist-Leninist tradition, in terms of continuing to emphasize the importance of a revolutionary VANGUARD PARTY and the revolutionary potential of the working class.

(c) Western Marxism, which has been the main European intellectual current and most widely influential in academic spheres. Leading exponents were Antonio Gramsky, Karl Korsch (1886-1961), George Luracs, Harvard Marcuse and the Frankfurt School 0f Critical Theory. All these were important for opening philosophical debates especially concerning the 'humanistic' or 'scientific' nature of Marxism, re-examining the Hegelian basis of Marxism, being more open to non-Marxist thought and attempting to incorporate it within Marxism.

(d) Third world Marxism concerned especially with exploring the differences between capitalism in the metropolitan and in the colonial and newcolonial countries, relationship between national determination and the achievement of socialism, and the consequences of this question for political action and organization.

The above does not exhaust all the varieties of Marxism. In Eastern Europe in the 1970s important analysis developed countering the official Soviet communism. Everywhere in the growth of academic work has led to intense debate such that in Academia they are now exist many varieties of Marxism. Political believes, philosophical criteria, as well as questions of sociological relevance influenced how these are viewed, but undoubtedly Marxism is now an important dimension of social scientific and sociological thinking, raising many questions not raised in the approaches.

Communism

UNWIN HYMAN DICTIONARY OF SOCIOLOGY - David Jary and Julia Jary (1999) on communism says:

1. A political ideology, deriving from Socialism, and particularly from MARX and subsequent Marxists, which aims at the creation of societies in which private productive property, social CLASSES, and the state are absent.
2. A former society which approximates to the socialist ideal.
3. Any society in the 20th century ruled by a communist party.

The term emerged in the 19th century, and was adapted by Marx to designate the ideal society which socialists should attempt to create. With the revolutionary overthrow of capitalism, Marx established the emergence of 'socialist societies' in which the state would still play a role; only with the transformation of all property relations and the withering away of the state would communism emerge. Foremost of the 19th century, even political parties which ordered in some way to the program still called themselves socialist. In 1981 the Russian Social-Democratic labor party changed its name to the Communist Party of the Soviet Union (Bolshevik Party). From then on the term came to be primarily associated with parties and societies which at some stage were influenced by USSR.

Since the late 1920s, the concept has been decisively influenced by-Stalinism. The international communist movement has been split over whether this represented a continuation or decisive break from Marxist-Leninist development.

Outside of Europe since the 1940s, various communist movements have appeared in the third world. Many of these rose to prominence alongside the national movements for independence. Communist Parties came to power most notably in China, Vietnam, Angola, Mozambique, and Cuba. Most were influenced by the model of party organization, state central planning and one-party policy inspired by Stalinism, even though Maoism in China, with its theoretical view of the primary role of the peasantry, might seem to have offered a theory of revolution more appropriate in the third world.

For non-Marxist observers, the whole experience of 20th century communist societies have supported the argument that communism means a lack of democracy, centralized state controlled

over most aspect of society, rigid economists unable to sustain economic growth, and often tyrannical one-man dictatorship as exemplified by Stalin in the USSR, Mao in China and Castro in Cuba. For some, this led to the development of the concept of Totalitarianism in which both fascists and communist states are contrasted with democratic market based societies.

Socialism

Dictionary of Sociology by UNWIN HYMEN, David and Julia Jary, Second Edition, 1999:

"A political ideology with many variants which emerged in 19th century Britain and France, and which aims for societies in which poverty is eliminated, market forces are not the sole means of the distributions of economic wealth, and where the human ideas of cooperation and altruistic behavior development.

Whilst there were forerunners of this ideology, for example the Diggers in 17th century England, the ideas were developed especially in the 19th century, as theory, e.g. by SAINT SIMON and Robert Owen, and in practice through the development of cooperative societies and the nascent trade unions. Marx and Engels had a decisive influence through their attempts to show that socialism was a 'scientific necessity' rather than merely a preferred form of society. They argued that capitalism and the capital mode of production could not sustain human civilization since it would lead to economic breakdown and chaos. They also argued that since no ruling class in history even gave up its dominating position peacefully, the achievement of socialism could only be possible with revolutionary overthrow of the bourgeoisie and thence capitalism".

From Marx and Engels 'first socialist writings in the mid nineteenth century, differences between socialists have centered around one important issue:

(a) Whether capitalism can be reformed or modified so that most of the ideas can be achieved within its framework, or

(b) Whether it has first to be overthrown

Against that a minority strand of European socialist movements continue to support revolutionary socialism, arguing that reformist measures will be registered by the dominant Bourgeoisie and their capitalism will not provide framework for socialism must be overthrown.

A recent variant of either of this positions exist in modern Euro-communism, That gradual changes in a socialist direction can be defended by the working class within capitalism and there will be a gradual, evolutionary rather than revolutionary, change to capitalism to socialism.

A second main strand of debate concerns the social basis of socialism. Marxist and communists' variants have tended to see the working class as the major social force capable of producing socialism, whereas social democrats have generally rejected a Marxian analysis, of social class and argued that the middle classes are as important, and that even sections of the capitalist class can be one over to socialist ideas.

Humanitarianism and Humanism

The great upheavals of the last century also produced persons who not only had active roles in providing the movements of ideas, programs, organization, leadership, but at least at some cases also offered analysis and assessments of developments in which they were themselves involved. These were intellectuals-activists in the tradition of radicals of France in the 18thcentury, or of the 'intelligentsia' in Russia in the 19th century **(R. Michels, 1932; K. Unwin, 1946; Issiah Berlin, , 1979; S.N. Ray, 1986)**. At the same time there were large group of people among the intellectuals and even the ordinary ones to pursue previously propounded ideas as solutions to the problems newly faced. Both the portions of the earlier and later maneuverers proved to some extents futile in solving the totality of crises in many ways. The results eventually brought ideologies dividing the population of the world in great lines.

Of the tries taking into initiatives there was one that with great dissatisfaction of having seen personal freedom and liberty strangled under the so-called socialism and communism and trends, and programs submitting to the pressure of the so-called absolute free market economy, went for the amalgamation of their thinking and ideas resulting into the formation of the ideology of humanism.

Of the several people that come to mind in this connection one of the most outstanding was M.N. Roy. Who in the diversity and richness of his revolutionary experience had few peers even in his own century; he took an active and leading part in revolutionary movements in India, Mexico, The Soviet Union and China. The vicissitudes of his life were very extra-ordinary.

It might be worthy to mention in Roy's own words his ownership to the concept of humanism that may to some depict the acclaimed innate nature of this notion:

"When, as a school boy of 14, I began my political life, which may end in nothing. I wanted to be tree, independent, complete and absolute, is a newfangled idea. The old fashioned revolutionary thoughts in terms of freedom. In those days, we had no road mark, we did not know about the existence of the proletariat. Still, many spent their lives in jail and went to the gallows. There was no proletariat to propel them. They were not conscious of class struggles. They did not know exactly how those conditions could be changed. But they tried to change them, anyhow **(M.N. Roy, 1982, pp. 121-22).**

The above statement is worthy enough to describe the sense of urge to stand against suppression and oppression and in favor of justice and freedom from the unjust shackles human put against human. The humanists found this urge as the basis of their so-called notion of humanism.

This idea of absolute and total freedom to be given to the individuals marks the admission of having the individual rights attested by the state. There will not be the chances of gender exploitations by one gender as presumed superior to the other in the name of culture and social values. There will not also be prejudices derived out of traditions that goes against any one of those.

The proponents of humanism also tend to think that if the state takes a role of guidance to regulate the population restraining it from violating each other's rights then the concerns over any forms of discrimination could be eradicated.

As a natural consequence it is also perceived from this perspective that women as a class will have no chance of having discrimination over the treatment of their health as a part of this wholesome absence of prejudices.

Humanitarianism however has been described according to **A dictionary of political thoughts, by Roger Scruton, 2nd edition, MacMillan, 1996, London** as:

A term of vague meaning, defined by **Julian Benda** thus: 'I should like to draw a distinction between humanitarianism as I mean it here-a sensitiveness to the abstract quality of what is

human, to Montaigne's "whole form of the human condition"-and the feeling which is usually called humanitarianism, by which is meant the love for human beings existing in the concrete'. Both senses, Benda affirms, are to be distinguished from cosmopolitanism. The 'Love for human beings existing in the concrete' is a vague idea, but presumably correspondent to the warm-hearted and essentially particularized love that is also known as charity. The contrast between the concrete love and abstract virtue of duty to one's neighbor is a familiar theme of moral thoughts, some (**e.g. Kant**) thinking that only the abstract duty can be meritorious, others (**e.g. Dostoyevsky**) arguing that the abstract duty is worthless and that the only thing that matters is love for the individual, here and now, no other love being true to our mortal nature. Both the abstract and concrete love is to be distinguished from another thing known as 'humanitarian sentiment', namely compassion towards humanity as a whole, which **Rousseau called 'Le zélecompatissant'** ('The compassionating zeal'), and **Nietzsche dismissed** as '**slave morality**'. Benda's idea perhaps corresponds to none of the familiar uses but rather to a modern skeptical, and perhaps somewhat anguished version of humanism'.

Totalitarianism

The first half of the previous century was an age of wars and revolutions. The First World War marked the beginning of dissolution of the empires of Europe; the second world war virtually completed the process. The military victory of allied power did not save Britain, France or the Netherlands from losing their far-flung colonies. In Asia and Africa sovereign states arose proclaiming one after another their independence of foreign domination in the decades which followed the Second World War.

Besides the phenomenal collapse of West European empires and the beginning of emergence of new nations and states, these decades also witnessed revolutions in some countries. In the 19th century Karl Marx had anticipated revolution in the most industrially developed societies of the West. However, history did not quite corroborate his anticipations. Instead, the first revolution of the century took place in the backward Russia where the antiquated regime of the tsars was quickly overthrown and under Lenin's leadership, the highly centralized and determinant Bolshevik party captured power from the provisional government and took upon self the task of radically altering Russian society in the shortest possible time. It established a totalitarian dictatorship and used a part of the century's resources in promoting revolutionary movements

abroad which would draw inspiration and guidance from the Bolsheviks and remain under Russian control. China experienced the other major revolution. After decades of civil war and war against the Japanese invaders and the Second World War, this vast and populous country also came under a communist dictatorship which, as in Russian, was committed to revolution.

"Wars upheavals and revolutions involve large masses of people who are moved by forces they rarely understand and almost never can control. **Totalitarianism** which emerged as a political phenomenon in the inter-war decades was a product as much of mass-discontent and upheavals as of mass-manipulation which had been facilitated by newly invented and very powerful instruments and systems of communication and regimentation" (**Karl Jaspens, 1957**).

If break-up of old empires and overthrow of ancient regimes where some of the welcome developments of the first half of the century, then on the other side there would be counted the growing pressures to constrict the scope of individual freedom and responsibility and the trends towards centralization of power and mechanization of human life. **Totalitarianism** however just falls under the latter category.

Democracy

One of the most major notions of socio political systems that has shaped humanity so far in the history is 'democracy'. The concept of democracy to and by some social-political scientists have never been so relevant as it has been in the past hundred year or so. It has with its own ability created and practiced and still going on practicing an extra ordinarily huge influence upon large number of populace mostly in recent times.

Unwin Hymen

The Unwin Hymen Dictionary of Sociology, second edition, 1999, by David and Julia Jaryhas defined **democracy** as:

"Democracy (from the Greek, meaning 'rule by the people') in modern times those forms of government in which all full, adult members of the society or organization *make the policy*-making body".

Democracy, or democratic government has been put in the **Dictionary of social sciences published by Oxford University Press** as, 'rule by the *people* (in ancient Greek, *the demos*), generally at the level of the state, but also including small-scale forms of governance and

decision making. The earliest formal experiment with democracy were in ancient Athens where citizen-rule flourished for an intended period in the 5th century BC. Greek political philosophy laid the basis for much of the practice of democratic thought, although the most influential philosophers Plato and Aristotle were critical of democracy on a number of grounds. Plato believed that an enlightened elite was preferable; Aristotle viewed democracy as rule by the lower orders of society, and therefore as a form of government that needed to be mixed with aristocratic or monarchical elements in order to guarantee that no one group held a permanent monopoly of power other than the monarchy. Both associated democracy with mob-rule, corruption, and tonic instability. Neither thought democracy as feasible in large states, where face-to-face public life were difficult or impossible. The Aristotelian account-especially this small republic thesis-was rediscovered during the renaissance. But what is often missed by the western group of intelligentsia or may be deliberately not mentioned by them is the citing of the accounts of ancient Greek philosophies including democracy by the middle age Muslim philosophers and political scientists such as Ibn Taymiah, Ibn Khaldun, Ibn Rushd, Al-Biruni and the Mu'tazila, community.

Modern democracy draws from a range of developments from the mediaeval era, including the emergence of regimes that guaranteed and granted certain individual rights and made the state authority bound to customary laws *e.g.* **England's Magna Carta (1215)**. Later in Europe the notions of social contract played a major role sprung out of social thoughts. Here as well treaties such as Magna Carta has been the result of a long standing struggle in between the monarchy and mostly the nobler. The writings of medieval Muslim thinkers like **IbnTaymiah** greatly influenced social thinkers of the west like **Thomas Moor**. Another crucial factor was the developing matrix of modern individuality, including new conceptions of the self, new social values and new spaces for collective social processes (such as the market place that together under wrote a shift in sovereignty from monarch to the 'people'). The **social contract of Thomas Hobbs, John Locke and Jean Jacques Rousseau** investigating the meaning of political legitimacy in this changing social order played important basis.

Modern democracy at the state level relies on the content of popular sovereignty: 'ultimate political authority rests with the citizens, but routine decision making is delegated to officials. At the local level direct participation is possible, and in fact traditions of social democratic

governance greatly predate this state-level democratic evaluation of the 18th and 19th centuries. The nature of these arrangements continues to be of interest to democratic theory and activism, especially in the face of the growth of centralized state power and systems of bureaucratic administration. Communications are among the strongest advocates of reinvigorated democratic participations. A variety of counter positions exist, from advocates of technology (or rule by experts) as society grows more complex and the theories of the inevitability of elites. Other long-standing debates within democratic theories and practices continue to play a role of contemporary discussions, including the risk that minority and weaker groups (political, religious, ethnic, racial and gender) will have little power in system that privilege majority role.

Many scholars posit democratization as one of the major axes of modernity. Democratization refers to the transition to democracy from other forms of rules as well as to this process within a democratic society. In this way, the originally narrow-franchise of most western democracies was replaced by **more inclusive forms extended its services towards the poor, social and ethnic minorities, women and young adults**.

Since the late 18th century democratization has been profoundly international process-exported to other countries linked in ways of globalization, development, and domination of western power. The fall of Soviet-communism, some have argued, removed the last major challenge to the progress of global democratization, although again the meaningful content of that process is a subject of much disagreement.

One key debate involves the distinction between economic and political democracies. The principle of one person-one vote implies an equal share of power for each citizen, yet all modern democracies exhibit a highly unequal distribution of economic resources, which correlates with political influence. **Marxists have traditionally argued that political democracy serves to obscure the lack of economic democracy in most societies, while conservatives have argued that the distribution of economic resources equally undermines the principles of personal liberty, meritocracy, and economic efficiency.**

Direct democracy was only proved possible in a meaningful way in city states (e.g. the Greek polies) or similar settings, e.g. modern day Swiss Cantons' Plebiscites and Referenda, in which people are asked to decide an issue. But the timing and content of plebiscites and referenda

usually rests with government. Public opinion polls have sometimes been presented as a new means of direct democracy.

Representative democracy is usually seen as the only forms of democratic government feasible for complex, large-scale modern societies. It is also argued that it is only in modern societies that economic and cultural resources exist to make representative democracy viable *e.g.* the development of participatory political culture, and the capacity to satisfy the demands for social welfare, etc., which representative democracy generates.

According to political scientists **Lary Diamond**, democracy consists of four key elements:

(a) A political system for choosing and replacing the government through free and fair elections.
(b) The active participation of people, as citizen, in politics and civic lives;
(c) Protection of human lives of all citizens, and
(d) A rule of law, in which the laws and procedures apply equally with all citizens.

[**Diamond, L., January 21, 2004: " what is Democracy'**]

One theory holds that democracy requires three fundamental principles:

1. Upward control, i.e. sovereignty residing at the lowest levels of authority,
2. Political equality, and
3. Social norms by which individuals and institutions only consider acceptable acts that reflects the first two principles of upward control and political equity.

[Kimber, September 1989. Wiley 12 (3): 201, 119- 219]

Democracy and Women

According to the **UN website's the journal on Global issue's published online article 'Women and Democracy':**

"Democracy requires the citizens' interest be heard, deliberated and legislated on. Women are half of the world's population, and as such their voice should be heard in the democratic process. Democracy needs women in order to be truly democratic, and women need democracy if they are to change the system and laws that preclude them, and preclude societies as a whole, from attaining equality".

It is through democratic representation that women's interests can be represented and their voices heard. **Article 7 in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)** reiterates the importance of women's representation in the political life of their countries:

"Ensure to women, on equal terms with men the rights:

(a) To vote in on elections and public referenda and to be eligible for elections to all publicly elected bodies;
(b) To participate in the formulation of government policy and implementation thereof and to hold public office and perform all public functions and all levels of government."

The role of women in democratic process is further emphasized in the **2011 general assembly resolution on women political participation (A/RES/133)**, which reaffirms ***'that the active participation of women, on equal form with men, at all levels of decision-making is essential to the achievement of equality, sustainable development, peace and democracy'.***

This same article also makes four key practices for women's' effective political participation:

1. Make both local and national elections free and fair for women.
2. Support women's civil society organization to evidence women's interests.
3. Build accountability women's rights in public institutions.
4. Support women political leaders to expand their influence.[www.un.org/en/globalissues/democracy/women.html]

Democracy and Women Health

The role of democracy and political freedom in population health has been recognized as early as the mid-nineteenth century by the prominent pathologist Rudloph Virchow. He states:

"Do we not always find the diseases of populace traceable to defects in society?" **[Rudolph, 1985]**

"My notion of democracy is that under it the market should have this same opportunity as the strongest." **[Gandhi, 1940]**

Franco et al., 2004 investigated the effect of democracy on same measures of populations health. This study finds longer life expectancies and lower infant and maternal mortality rates in "partially free" and "free" countries compared with "not free" countries. Such categorization of countries is based on the country ranking of democracy by the **Freedom House (2008)**.

In two related studies based on different methodology and data, the role of political freedom and democracy on a number of measure and population health for both men and women across a large sample of developing and developed countries have been published online studied by **Jalil Safaei, 2008, (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3353593/).** The study found that democracy is consistently associated with better health, in terms of lower mortality rates and higher life expectancy.

Congruent with studies on social determinants of health over the past thirty years, research on women's health and well-being has been expanding. Although it is difficult to summarize the evaluation of these researches in this limited apace, some of the key things and areas of focus of this vast literature as related to women health and democracy are identified according to the aforementioned article of **Jalil Safaei**. He stated in this regard:

"Aside from risks and health-threatening exposures common to all human being, women by virtue of their sex are vulnerable by many threats to their health and, as it happens, to their lives some of these threats may be sporadic or situational but most of them are deeply rooted in the persistence of social structures that reproduce and perpetuate stratified societies in which systematic inequalities and discrimination against women are tolerated if not readily condoned,

the following categorization of risks to women's health is by no means complete. Also the categories are not mutually exclusive and at times, they may be confounding to exacerbate women's ill health".

Women's sexuality has been a major risk of health and well-being over the time and space. This major risk has manifested itself in various forms of sexual exploitation.

Poverty and economic inequalities are not unique to women. However, women shoulders are much bigger burden with deprivation and lack of economic opportunities. More than one billion people living poverty around the world, and a great majority of them are women (**UN-INSTRW, 2005**). The annual death toll from poverty–related causes is around 18 million (**WHO, 2004**). The copious literature on development replete with narratives and evidence on women's economic subordination, insecurity and vulnerability. However, such adversity is not necessarily the result of under development. Women face deprivation and inequity even in the most economically developed countries, albeit to a far lesser extent.

Moreover, women have the added responsibility of nursing and feeding their children out of their own share of the food, which further undermines their health in view of their more than proportionate share of burdensome duties within the families.

"Despite a high and growing average income, billions of human beings are still condemned to lifelong sever poverty, with all its attendant, evils of low life expectancy, social exclusion, ill health, illiteracy, dependency and effective enslavement" (**Pogge, 2005**).

Poverty robs people of their very basic necessities of life assaulting their human dignity and minimizing their capacity to sustain life and avoid illness and death. "More importantly, the poor, assailed by life's vicissitude and society's callousness, may learn to accept their fate and sink further into the morass of poverty, disease and deprivation" (**Singh and Singh, 2008**).

However, despite numerous initiatives, legal tools, national and international conference resolutions and conventions; the number of women living in poverty has been steadily increasing (**UN-INSTRAW, 2005**). The world has still a long way to go to address poverty and inequality in any meaningful and effective way.

Although poverty and inequality has been considered as distinct category of women's health risks and vulnerabilities, in light of above discussion, it must be emphasized here that the resultant **women's impoverishment and economic dependence** is the main contributor to the other health vulnerabilities and risks to which women and girls are subjected.

The persistence of unjust socio-economic conditions and their horrendous implications for ill health of the poor has been referred to as structural violence by well-known physician-anthropologist **Paul Farmer (2005)**. This is a fundamental violence that allows and perpetuates all other manifestations of violence towards the weak and the oppressed, as women are in many societies.

If women are to gain their respectful rights to dignity, independence, self- worth, and be able to actualize their selves and live a full, meaningful and healthy life they so deserve, they have to be free from the subjugation of structural violence and their human rights re-installed. This leads us to a discussion of the role of **human rights and democracy in women's health**.

Suffice to say at this point that the extent of those risks as confounded by the lack of adequate services and support available to women are most likely greater in non-democratic countries than in democratic ones. Moreover, lack of freedom of press, widespread censorship and approving social norms in many non-democratic countries lead to systematic underreporting of incidences related to those health risks (**Lievore, 2003**).

With the advent of democracy and representative Government, human rights have been expletively identified and recognized. Such rights were popularized with the adoption and proclamation of the **Universal Declaration of Human Rights** by the **United Nations in 1948** in recognition of the inherent dignity and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world (**United Nations, 1948**). They have been refined and extended with subsequent interventional, regional, and national covenants and conversions.

The rights to health, as human rights, has been distinctly recognized by WHO. Ensure access to effective health care for all, especially for **women and children**, is definitely a giant step

forward. However, these fundamental steps have to be taken by the authorities in many developing countries, especially the more impoverished ones (**Singh & Singh, 2004**).

The right to health even in its restricted sense, would call for resources and policies to provide adequate and accessible services and support for women facing various health risk with a great promise to improve their health and well-being. A major portion of those resources would be best spent in female education with a focus on health-improving and health-pressuring practices.

More importantly, however, in light of the recent recognition of the role of socio-economy and political factors in population health, the right to health must be understood as the right to all economic, social, and political enlightenments, that so fundamentally defines and shapes our health and well-being. Women, and the poor majority would far greatly benefit from **policy aimed eradication of poverty, income redistribution to social security systems, recognition of their reproductive rights, abolition of all discriminatory social barriers to ownership and education and effective participation in social as well as political domains**, that those policies directed solely at increased access to correlative health care.

Social Democracy-Welfare State System

Other than the principally most practiced theories mentioned that are also the principally influenced ones across the globe there has been conscious try from among the intellectuals of political and social science backgrounds for socio-political ideologies which could neither be stated as fully left or rightly leaned for a more applicable socio-economic system to overcome the shortfalls of the mainly of absolute free market as well as over controlled systems. These tries have attempted for an alternative solution than purely profit-driven capitalist mode of socio-economic systems or closed door or semi-closed door systems. They have to some degree amalgamated different properties of the two said systems as well as invented some pro-people and welfare oriented ways for socio-politically arrangement that could mitigate the needs of the ordinary people with preference. Nevertheless, the system of multi-party contending democracy and open market economy to a large extent has not been avoided and deliberately kept in place.

In doing so as the outcome of gradual development of these tries, the system of social democracy has come out as a fruit that has enormously been enriched more recently after the Asian financial

crises of the late 90's and economic recession of the west starting from 2008; that has got a 'made in America' seal. The victims of the crises in Europe, most notably Spain, Portugal, Iceland, Ireland, Italy and Greece has helped the thinking process of social democrats to re-shape. In order to get into the detail of public welfare centric programs that social democracy could provide, one has to have an idea of what these phrase means in the first hand.

Today, those who advocate social democracy argue that capitalism is possible to reform (the position of most European Social Democratic Parties, including the British Labour Party). They argue that some combination of state supervision of the market and state ownership or regulation of selected sectors of the economy, combined with welfare measures and socialization into altruistic rather than selfish motivation, will achieve the aims of socialism. This form of society will be more democratic than forms of state socialist societies, in that, political power will not be so centralized and people will gain more central in more areas of their lives. They argue that this can be achieved within the framework of the electoral politics and parliamentary and legislative procedures established in western democracies, which socialists have played a major part in creating.

Though social democracy started showing its existence more profoundly from the late 1970; it still is in the process of constant evolvement. It is to be noted that the term itself has got different meanings to different intellectual schools. Nevertheless, there is more or less a consensus around the principles by most of the proponents. The main philosophy of social democracy however contents the notion of liberty; many a times interpreted as equity and unity. The United Nation's charter on basic humanitarian civic rights of 1966, gives recognition to political, economic, social and cultural rights that were ratified by almost all the member states that form a basis. This basis started to become real life institutional laws in turn.

In the discussion on Social Democracy, we shall rely on the theory of Thomas Meyer since the rationality presented by him are more systematic:

"According to the contemporary usage 'Social Democracy' is simultaneously a basic concept of democratic theology as well as the name of a political program. Although the application of these two is interrelated in various ways they indicate to different activities with different justifications. The theory of social democracy, the ideological basis of it or the role of its

interpreter, eventually the comparative discussion of the different ways of its application is not related to any specific political player though in every of its step it needs the help of the political activists who take the programs out of its resultant pragmatic programs. On the other hand, the activities of different political actors use the concept of social democracy as a program, given that they feel it will hold their interest. Whether it is relevant to the social theories or not or whether it has got any connection with it or not is not something that is dependent" **(Meyer, 2005, p. 12)**.

So it is understandable that as a theoretical model social democracy and political party or trends relevant to social democracy get head to head. They are not one or some might argue they are never one.

It however is understandable that in the basic concept of social democracy opposition to injustice is an integral part and unity go in line with the idea of eradicating any kind of injustices and discrimination on the basis of gender. To find out the impacts of social democracy in practice we may take the chance looking into the countries who claim to have implemented social democracy wholly or in part.

Sweden

In case of Sweden, the parity of contribution of taxes paid by the people and contribution of the state as welfare measures, tops as one of the highest in the world. In case of unemployment, the government pays up to 80% from the last salary obtained by the receiver's last employment and the low income elderly people are ensured of pensions in addition to general earning benefits that gives them additional financial security. **All these benefits reach the female members of the society for a sure status of financial equality with the men counterparts from being subjected to any economic discrimination for gender.**

The Swedish model of social democracy has given way to the term of 'Swedish welfare state' concept that has become popularized worldwide.

The economic situation of Sweden worsened after second world war, hence the labor unions active strongly pursued for the establishment of the 'Uniform salary policy'. It had a twofold objective to be achieved: firstly, it wanted the 'same amount of salary for similar kind of works'

policy that encouraged for the increase average predictability and secondly it was deemed to decrease the differences between monetary benefits of different kinds of works. **The question of differentiation in between genders in terms of salary vaporized with the implementation with this policy**.

It was thoroughly understood that rapid enhancement of government services in line with the full scale employment throughout the year could only be achieved through getting the female class of the society been anticipated. During the period from 1960-1990 the rate of employment of economically active women in Sweden reached a massive 83% with comparison to the European average of 50%.

So here it is observed that these facilities were provided not on the basis of amount of taxes paid by individuals rather on the basis of the need of the individuals. That is why **Meidner/ Hedberg, 1984, p. 56)** said that, "the facilities were given not on the benefits of market situations but by political decisions".

The basic factors of services provided by this welfare system such as pension, unemployment benefits, **income intensive subsidized health system**, subsidized education system all helped extinguishing the previously existent backwardness of women in general. The following **statistics** could help describe the **Swedish gender situation**:

Rate of employment	74.30%	The employment ratio of the age group of 15 to 64 (for women). **Source: Euro Stat, 2009**
Income of women with comparison to men	67%	The rate of women earning compared to men. **Source: Human Development Index, 2009, p: 186**

Germany

In lieu of the devastated political, economic and social situation of Germany immediately after the Second World War the practice of social democracy could be termed as very successful (referred to West Germany till 1990 and the unified one from then). Germany has brought major changes in their basic laws taking lessons from the failure of the Weimmer Federation. Though these laws do not speak of any distinctive economic system, it contains substantial number of

security measures both against uncontrolled market capitalism as well as super planned socialist economy. For example, the 14th paragraph of its basic law the rights to property and inheritance has been ensured, but at the same time its usage has to be welfare centric for the bundes (people). The paragraph has taken a political shape through social market economy.

German Welfare State

Germany is a heavily discussed very good example of conservative welfare state that is many a times known as "Christian Democratic" or the "**Bismark**" system.

The German welfare state system's principle project includes various social insurance systems that are financed by the evaluation based obligatory contribution of the workers. The necessary subsidies are continually allocated from the central budget with this. Of the provided facilities under the welfare system, there comes pension, unemployment insurance, education subsidies, health services subsidies etc.

With comparison to the international standard advantages of the health insurance system it is better and at the same time costlier. Children and unemployed spouses and the guardians' economically active mates collectively come under insurance and those who receive the social benefits automatically come under the benefits of health insurance system. However, the self-employed, government service holders and highly paid workers are not obligated to pay the insurance taxes that are mandatory and can have better insurance policies under better conditions. **This whole system at the end of the day helps women as a class of vulnerability and in general put themselves in a far better scenario**. The precariousness of women's economic status that exists in many societies is largely taken away by this strong interference of the state. The **Human Development Index of 2009 in page** 186 shows the earning of women in Germany as 59% from that of the men.

On application of Welfare-State Systems

How the system of this Welfare-State system works in reality will certainly help us have the advantage of its practical fruitfulness in the countries where this is practiced most. Their experiences will certainly help the policy organism of Bangladesh in taking the suitable decisions for our country in practice given we decide to follow it as a model for having a more just and gender biased free women's health arrangement in practice.

Health Care

In Europe, different health care models have developed over time in the acclaimed welfare-state spectrums. The basic difference concerns state-run, tax-finance systems such as the UK National Health Service (NHS), and systems based on social insurance, such as those of Germany and Netherlands. In some European countries, we can also find mixed system, for example, involving financing from both taxes and social security contribution or subsidy.

Form of organization and characteristics of health care models in European welfare-state economies-

National health service	• **Access of free of charge for the whole population to state controlled medical establishments** • **Largely financed from taxes** • **Mainly public service provider**
Social insurance model	• **Comprehensive compulsory insurance** • **Predominantly financed from the earnings-related contributions of employers and employees** • **Private or public health insurers** • **Public and private service providers**

German Health Care System:

The German Health Care model dates from 1883. The Law on workers' health care insurance introduced uniformed compulsory health care insurance for workers up to a certain level of

income. All those subject to compulsory insurance became members of the statutory health insurance scheme set up for their profession.

The current system of social health care insurance is decentralized and federal. It is characterized by the fact that various non-state (corporatist) institutions are in a strong position. For example, **on the side of the service providers; the doctors' and dentists' associations and on the purchasers' side; the health insurance funds and their associations are the main actors in the health care insurance systems.**

Outpatient medical care is the sector in which the corporatist institutions have the greatest influence (**Busse/ Riesberg 2005**). The doctors' associations negotiate a compensation package with the funds operating in their land, which they distribute among their members in accordance with the rational revolutions adapted to regional circumstances. Basically, the remunerations of general practitioners and specialists is based on the health services provided. There is a remuneration ceiling on services provided.

Inpatient care is characterized by duel financing. Investments are planned by the federal states and subsequently co-financed with federal government, while the health insurance funds are responsible for recurrent expenditure and maintenance costs. Since the Australian diagnosis-related groups (DRG) system was adopted in Germany in 2004, recurrent hospital expenditure has mainly been accounted for under this system (**WHO 2006**).

Statutory Health Insurance:

The German health insurance system is divided into statutory and private health insurance funds. Statutory health insurance (GKV) is financed predominantly from insurance contributions. Until 2005, contributions were collected from employers and employees on an equal basis. In that year, however, an additional contribution of 0.9% was introduced for employees and pensioners. **Children and spouses with no income from employment are co-insured, free of charge.**

Around 86% of the population is covered by statutory health insurance (GKV). Membership of a **health insurance fund is compulsory for blue-collar workers** and employees whose annual income exceeds a certain amount (compulsory insurance threshold). In 2009, the threshold was a monthly gross income of 4050 Euros.

At present, there are around 145 statutory health insurance funds (March 2012). Since 1996, virtually all people under insurances have been able to choose their own fund. The memberships structures of particular health insurance funds is extremely varied, depending on differences in contributions received and morbidity structured.

In order to balance out such differences, after various preliminary stages, morbidity-based restructured compensation (Morbi-RSA) was introduced. On this basis, the health insurance funds receive a basic flat rate for each ensured person in the amount of average per capita expenditure. **This flat rate rises or falls in accordance with age and gender via increases or reductions.** On top of this there are increases for insured persons with certain chronic or serious illnesses that give rise to above average costs.

Morbidity-based risks structure compensation is intended to even things up for those health insurance funds that have an especially high number of insured persons with costs-intensive illnesses. 'Morbidity' comes from the Latin 'morbidus' and means sick. The old form of compensation (up to 2002) between the health insurance funds **took into account age, gender and work incapacity.** Since 2002, participation in special programs for the chronically ill have also been taken into account. The new restructure compensation now takes in to consideration 80 selected cost-intensive chronic and serious illnesses, for which the funds receive supplements.

Private Health Insurance (PKV)

Around 11% of the population is covered by this (November 2011). In the case of private health insurance (PKV) and insurance premium is calculated in accordance with the agreed scope of services, a person's **general state of health, gender and age** at entry. On this basis, PKV rates is set in accordance with individual insurance risk.

In contrast to the GKV, which operates in accordance with the pay-as-you-go principle (in other words, insurance services are financed from the contribution revenue of the same year), private health insurance funds are oblige to accumulate old-age reserves (capital funded) by which, since 2009, insurance receivers have been able to take with them to a new provider, up to the level of basic tariff, if they switch to PKV.

Since private health policies predominantly have above-average incomes and a low health risk the PKV, in effect, siphons off higher revenue and good risks from the solidarity financed health insurance scheme. For the private insurance receivers; civil servants, self-employed and higher earners, this is so profitable that they cannot only provide medical services at normal price, but also make reimbursements. This creates an incentive for service providers to treat private patients on a preferential basis (**Walendzik, 2009**).

Since 2009, private insurers have been obliged to offer a basic tariff which, with regard to its range of services, corresponds to the GKV provision and costs no more than the average GKB contribution (around 599 Euros a month in 2014). PKV and voluntary GKV insurance receivers can, however, switch to the basic tariff only under certain circumstances. The entry contribution depends on the insurance receiver's age and gender.

Health Care System in the Netherlands

The Dutch health care system is similar to that of Germany's. Both are social insurance systems with mainly earnings-dependent contribution, free choice of the insurance receiver, largely privately organized insurance providers and extensive-albeit not always clearly defined package of services. The similarity between the two systems can be explained easily: the Dutch health care system introduced in 1941 was basically inspired by the German system (**Greb et al. 2006**). It was last fundamentally reformed in 2006.

The Dutch health insurance system consists of three pillars. The first pillar (care and long- term insurance) and the third pillar (private additional insurance) were left generally untouched by the fundamental health insurance reform in 2006. The reform concerns the second pillar almost exclusively. Before the reform the second pillar comprised (statutory) compulsory social insurance and private comprehensive insurance. Employees and self-employed above a certain income threshold had to need the compulsory social insurance scheme and take up private comprehensive insurance.

Since the reform there has been a uniform health insurance system. Previously social and public health insurers now complete in the uniform insurance system.

The same conditions apply to all health insurance funds. They are subject to an obligation to contract and thus cannot turn away applicants, may not levy risk-dependent premiums and are integrated in a morbidity-oriented risk structure compensation scheme. The health insurance funds can offer insurance receiver' different tariffs and there is a general insurance obligation.

United Kingdom

Health care provision in the United Kingdom is traditionally the province of a state. Most of the tasks of **health care system are planned, directed and regulated by National Health Service (NHS)**, which was founded in 1948. **The NHS is largely tax-financed and state-run. All citizens are statutorily covered by the NHS.**

All residents are entitled to health care services, regardless of nationality or income. Basic provision, accessible to all, consists of general and specialists, outpatient and inpatient treatment, as well as placement in care institutions.

The health care system is largely financed from tax revenues, but also from private copayments- predominantly for medicine and dentistry services- as well as from national (social) insurance contributions paid by self-employed and dependent employees and employers. Patient treatment is, as a rule, free of charge.

The so-called Primary Care Trusts (PCT) play a central role in the organization of services. **There are 151 networks of general practices responsible for the care often average of 340000 people**. **PCTs are responsible for requirement planning with regard to health services in their region and for insuring the corresponding provision. They receive more than 75% of the budgets** for health services and conclude supply contracts with municipal care institution, the NHS Trust, and also with institutions in neighboring districts as well as private or charitable providers.

Basic provision is given by **GPs. These mainly self-employed family doctors play a key role as gate keepers for further specialist services in the health care system**. Hospitals receive funding both in relation to services provided and on a contractual basis. **The overall budgets are kept and subject to central control by Ministerial bureaucrats and health Ministries of England, Wells, Scotland and Northern Ireland**.

Patients' choices are limited. Free choice of doctors to some extent possible within the framework of residents in a particular district. For example, patients, prior arrangement with their GP, can opt for treatment at a number of listed hospitals. This option to choose between hospitals is also aimed at reducing waiting times.

One problem with the UK health system is **inadequate funding and the resulting long waiting times.** Comparing to GDP, UK health care spending is comparatively low in 2010, while Germany spent around 11.6% of GDP on health care, The United Kingdom spent 9.6%, just above the OECD average of 9.5% (OECD 2012). As a consequence of budget austerity and regulation of access to services inpatient treatment is subject to bottleneck.

In 2012, the liberal-conservative Government in the UK approved a reformed aim that reducing spending and introducing more competition between state and private providers. In future, **patients will be able to choose their GP freely. GPs are no longer bound to households in their regional neighborhood**. Administration is to be restructured. **PCTs and the ten strategic health authorities are to be abolished. General practitioners must join together to form so-called consortiums**. These consortiums will be allotted funds based on the quality of treatment provider. GPs are to seek the best treatment for their patients and have to pay relevant providers. **Hospitals will in future be free to accept private patients and will have to compete with private providers for GP treatment contracts**.

Chapter- 5
Health situation in Bangladesh comparing with other countries

5.1 Health situation in Bangladesh:

Annual National Budget of Bangladesh on Women Health and Welfare

The Budget Speech (Financial Year of 2015-16)

In the last budget speech of the Financial Year (FY) of 2015-16, the honorable Finance Minister of Bangladesh gave the following statistics citing the sources of those information as the **Finance Division, Bangladesh Bank and Bangladesh Bureau of Statistics**:

- **The foreign exchange (forex) reserve reached to 23.7 billion USD as of May 27, 2015**. The amount of reserve is experiencing hike for the last 15 years or so. This has eased the financial status of the Government to take decisions according to its liking and necessity.
- **The total amount of budget has reached 2,39,668 (Crore Tk.)** as revised for the last FY before this budget that shows a very rapid increase of volume of money being involved in the annual national budget. Some may argue the rapid expansion of the size of the economy citing this statistics.
- **The per capita income of the individuals of Bangladesh has been estimated as 1314 USD as provisional in the 2014-15 FY**. There has been large scale controversies around the argument of being judgmental on the basis of per capita income of any country's citizens, since this is calculated as the average income which could be misleading in judging the reality of the situation of the poor and the marginalized people. Nevertheless, in successful implementation of a trickledown economy, might make it possible to get some benefits out of the increase of income by any quarter of the population.
- The Finance Minister on the basis of his sources stated that **the average life expectancy of Bangladeshis has reached 70.7** years that according to him has increased by more than four percent from 10 years before.
- **The rate of poverty in Bangladesh has decreased to 24.30%** during the period of 2009-14 with comparison to 40.0% from the end of 2006. The projected position of this rate after the end of the 2014-15 FY has been estimated as 22.40%.

- **The percentage of extreme poor people who live under the extreme poverty rate has reduced to 9.95%**. The projected percentage of this rate after the end of 2015-16 FY has been shown as 7.92. However the statistics regarding poverty and extreme poverty rate has been a producer of large scale controversy by many budget and Financial Analysts.

In the budget speech, in paragraph 22 under the topic of Social Protection, the honorable Minister for Finance stated, "We have started a nationwide survey to identify the types and extent of disability prevalent in disabled community in order to formulate need-based action plan for their welfare. Till March 2015, a total of 18 Lac 3 Thousand 456 disable people have been brought under the census and the type and extent of disability of 14 Lac 55 Thousand people have been identified. In order to preserve all data relating to the disabled, data of 2 Lac 27 Thousand people have so far been entered in the Disability Information System. We hope to finish the data entry by June 2015". Here it could be expected **since eye ailments are considered as a kind of disability by the experts; the Government therefore will enlist all the people with eye ailments included into the list of disabled people. After doing so, any kind of social protection extended towards disables will cover the people with eye illnesses**.

Under the topic of Women and Children Development; the Finance Minister in his said **Budget Speech** talked about "... **formulating gender sensitive laws and regulations, development planning and budget etc**." This statement could be the basis of having special regulations of treating women patients of eye ailments with special care having special budget allocated for them and need specific development planning for them.

In paragraph 26 of his last **Budget Speech** under the topic of Health the Minister further reiterated, "I have already mentioned that **12 Thousand 979 community clinics have gone into operation and another 882 are under construction. These clinics are catering to the health and the nutritional needs of the poor destitute and pregnant women and children while conducting population control activities**". The intention and pledge of the Government focused under the **given statement has created the chance to expand the said services to cover eye illnesses** and untie the potential radical positive change that could be done by this coverage. Given that the community clinics facilitate special medical care personnel (not necessarily there has to be full doctors but paramedics could play the role) within the arena of its function in line with special needs of women, a revolutionary change could be done covering an unbelievably

huge number of women getting them into the umbrella of the services facilitating their special needs. The vows of the Government to ensure **telemedicine services to ordinary rural people may have special provisions for women suffering from problems with eye health**. This will certainly make a positive change in the field.

The rate of inflation of the economy by the end of April 2015 was cited as 6.6% by the Finance Minister in his last **Budget Speech**. This percentage however will let the analysts help understand the purchasing power of the citizens that will indicate how values of the previously allocated money for different sectors and sub sectors of the Health ministry including eye care have been lessen compared to the last FY and the amounts needed to be added for maintaining the same standard as before or improvement. **It is an argument on behalf of the study not only to increase the amount of monetary allocation in the budget but also to increase the percentagewise allocation from the Ministry of Health to the specific sector of addressing eye ailment with consideration to the special needs for women**.

As the remittance flow as well as the Forex reserve both have increased dramatically showing a sharp upward trend, it will surely be easy for the Government to facilitate more inflow of money in to the said field without creating any hindrance to any other quarter/s financially.

The initiatives of the Government of creating **National Skills Development Authority (NSDA) to coordinate the Skills Development activities of various Ministries and National Human Resource Development Fund (NHRDF)** to ensure continuous funding for these activities have been mentioned by the honorable Minister for Finance in his speech. An amount of tk. 100 crore was also proposed by him for formulating the proposed NHRDF for FY 2015-16. Through the NSDA and NHRDF, special groups of engendered paramedics could be trained to work in the earlier mentioned community clinics throughout the country that will be helpful to the female eye patients with special care.

In **paragraph 117 of the budget speech**, the Finance Minister under the title of **Social Safety** said, "... we are going to implement a project titled 'Strengthening Public Financial Management for Social Protection' shortly to increase the effectiveness and accountability of the social safety net programs. Under this project a Social Protection Unit will be established in the Finance Division. In order to widen the coverage of social safety net, I proposed enhance the number of beneficiaries for old age allowance to 30 Lakh from 27 Lakh 23 Thousand, for widow, abundant

and destitute women allowance to 11 Lakh 13 Thousand from 10 Lakh 12 Thousand, and for insolvent disable people allowance to 6 Lakh from 4 Lakh. The number of disable students receiving stipends will be increased to 60 Thousand from earlier 50 Thousand". The good **intention of the running authority of the state *i.e.*, the Government to help the disable could also be shown in including the female eye patients in the group of the beneficiaries covered by social safety net**.

The Finance Minister talked about a plan to provide identity cards by using the national disability database and also to revise the existing development programs and take up new initiatives by taking the nature of disability in to account. He also talked of a process of reforming the existing laws and rules that is underway. He further stated, "I have already mentioned about the allocations made for expanding activities for improvement of living standard of Hijra, Dalit, Horizon and Bede communities, providing emergency food assistance to tea laborers, and extending financial assistance to the poor patients suffering from cancer, kidney diseases and liver cirrhosis. This year amount of budget allocation for these activities has doubled".

Here it is notable to see that the **pledge of the Government to "take up new initiatives by taking up the nature of disability into account"**, has been expressed by the Finance Minister. This might be referred to as an **opportunity opened for the female eye patients for having special treatment facilities according to their special needs. The financial assistance provided for poor patients might also include female eye patients that will substantiate the special needs of the poor female eye care patients** for sure.

The Budget

A closer look at the budget reveals that the Finance Minister proposed in front of the Parliament a total of **12, 725, 63,00,000 Tk. as the annual budget for the Ministry of Health and Family Welfare for the FY of 2015-16. This total amount has increased from 11, 568, 37, 92, 000 Tk., 99, 79, 09,81,000 Tk. and 91, 51, 79, 87,000 Tk. for the FY of 2014-15, 2013-14 and 2012-13 respectively**. These figures of course show a gradual increase in total budgetary amount but again this increase may not reflect the actual increase in the availability if the services to common people since the purchase power parity may differ from the previous years on the basis of inflation and other economic factors and the overall economic situation of the state. An

analysis into the government policies both in micro and macro levels of the health system and the spending patterns depending on those will help us understand how much the government spending is coming into the benefit of health for the common people specifically the female eye patients and in which ways.

In the budget documents published by the **Finance Division of the Ministry of Finance, Government of Bangladesh, the principle functions of the Ministry of Health and Family Welfare has been cited as bellow:**

- To formulate and implement contemporarily necessary strategies relevant to health and family welfare.
- To provide the services of health, nutrition and family planning and enhance the scopes of the services according to the **expectation of the people**.
- To improve the state of public health with the improvement of health and **treatment facilities and cure various non-contagious diseases**.
- To produce, distribute and import good quality drugs and ensure the quality of the drugs that are exportable.
- To conduct the functions of population control, medical education, nursing education and the works of research and training on national population and health.
- To build infrastructure related to health and family welfare, service institutes and colleges and their maintenance and expansion.
- To ensure child and maternity health service, extended immunization program alternative treatment systems and nutritional improvements and
- Connecting with all the local and international agencies on health.

The Ministry of Health and Family Welfare has also produced documents such as the **'National Health Policy of 2011', 'The Bangladesh Population Policy of 2012' and 'Strategy of Budgeting on Health Services of 2012'.**

In the **National Health Policy of 2011**; the things that have been mentioned in relation to women's health according to the '**Gender Budget Report 2015-16'**, published by the **Finance Division, Ministry of Finance of Government of Bangladesh** are as bellow:

- To reach the basic materials of treatment to the people of all walks of life of the society **as per the Constitution of the country and the International Declarations** about improvement of the status of public health and nutritional progress.

- To reduce the rates of child and maternal mortality, having the specific goal in mind to reduce those by a rational proportion within 2021, the year of golden jubilee of gaining of the independence.
- To strengthen and reinforce family planning, reproductive and health services to achieve replacement level of fertility within 2021.
- To take satisfactory measures for improvement of maternal and child health and ensure maternity service to each and every village so far as possible.
- **To ensure gender parity in health services.**
- **To ensure rights of women on better physical and mental health in every spheres of life cycle for establishing gender parity.**
- To reach reproductive health service to the marginalized people of both villages and cities in huge extent for reducing maternal mortality and reproductive rate.

In the Demographic Policy of 2012 the followings have been said on women:

- To reduce maternal and child mortality rates and take steps to improve maternal and child health by ensuring safe maternity.
- **To ensure women's empowerment and gender equity** and strengthen programs to eradicate gender discrimination in family planning, maternal and child health activities.
- To skill the rural women by providing loan facilities and vocational training and generate employment for the unmarried rural women.
- **To pursue for gender sensitive work strategy for all the government and non-government program.**
- To encourage the organizations/agencies engaged in women's development in family planning and reproductive health service activities.
- To eradicate **all kinds of sexual abuse and all kinds of violence against women** and child trafficking.
- To take up awareness building programs for making men more sincere on the importance of family planning and reproductive health service needs for women.
- **To create equal opportunities in health service gaining nutrition, education and employment for both boys and girls.**

The Gender Budget Report of 2015-16 has demarcated the directions related to the Ministry of Health in the Nation of Policy Papers for Development of women. The Policy for Development of Women of 2011 asserts the following pledges:

- **To establish equal rights in all spheres of the state and public life in line with the Constitution of Bangladesh.**
- **To ensure safety for women on all aspects of the state, social and family life.**
- To ensure equal participation of women in the mainstream of socio-economic development activities.
- **To eradicate the prevalent male-female discriminations.**
- **To ensure proper steps to secure good quality health and proper nutrition for women.**

The pledges made in the **6th Five Years Plan for women's development** according to the same Document are as bellow:

- **The efforts taken so far to eradicate all kinds of discrimination in the fields of education and health in the 6th Five Years plan will be continued. The sector wise goals and programs will be fixed on the basis of those efforts.**
- **Any rules, acts or laws, organizational approach, Policy, projects or programs that are not gender-sensitive will be amended. The institutional process to coordinate and examine the issues of gender parity will be strengthened.**

The strategic objectives and activities taken for development of women in the budget chapter of the Ministries are as bellow:

SI	**Mid-term strategic objectives**	**Activities**
1	2	3
	To ensure good quality health care for mothers and children	• To continue the Maternity Health Voucher Scheme and expand Jurisdiction • To expand pre-delivery services, emergency delivery services and post-delivery activities; continue the midwifery and community-based

SI	Mid-term strategic objectives	Activities
		skilled midwifery service. • To distribute iron tablets among pregnant women and vitamin A capsules and anti-worm tablets among children. • To pursue for building awareness campaign along with creating encouragement for breast feeding.
2	Population control and expansion of good quality reproductive health	• To reach the family planning service seekers through field workers • To operate awareness raising programs on taking short mid and permanent birth control methods among the couples worthy of accepting those. • To take comprehensive approach in the areas of lower rate of adoption of family planning method. • To conduct awareness activities on reproductive health suitable for adolescent and young males and females.
3	**Control contagious, non-contagious and new diseases evolved due to climate change**	• To operate targeted activities among the high risk population to control HIV/AIDS along with executing the national programs on AIDS/STD. • To operate programs to control arsenic, tuberculosis (TB), Malaria, filarial, Dengue, leprosy, Kalazar and newly evolved diseases and provide services. • To formulate and implement strategy papers for controlling smoking and use of other

SI	Mid-term strategic objectives	Activities
		tobacco related products.
4	Enhance consumption of nutritional food	• Expand the jurisdiction of providing supplementary food for pregnant ladies, delivery patients and children.
5	**Create skilled manpower in the fields of health, population and nutrition**	• To provide education and training to the nurses, midwifes, skills to community midwifes, **paramedics**, **field workers and other female health workers**.

The Gender Budget Report of 2015-16 themselves provided us with the solutions to some gender discrimination prevalent in the works of the Ministry of Health and Family Welfare (MoHFW) that are very interesting.

The proportion of women working in the MoHFW and the Departments under it and in the different health service providing centers is very poor with comparison to their male counterparts. The statistics cited in the **Gender Budget Report (GBR) of 2015-16** shows that the proportion of female officers and employees are only **28.93% and 38.8%** respectively working in the MoHFW and the various Departments under it. The discrimination pointed out in the Document are given bellow:

- **The women are facing impediment due to lack of female doctors and other service providers in necessary proportions.**
- **The female patients are facing problems or discriminations since most of the health service centers are not women-friendly.**
- **The working environment of the MoHFW and the Departments under it and the health service centers are not women-friendly overall. As a consequence; women are facing many problems in these work places.**
- The women victimized to violence also are facing various discriminations/problems in the health service providing centers along with many social and familial impediments.
- Women are also discriminated for the lack of necessary facilities in the reproductive health services.

- **Though there exists a 'Gender Equity Strategy' in the MoHFW; there is lack in success in its implementation.**

The Document also provides us with the work strategies against the understood gender discriminations in the activities of **MoHFW** those are as bellow:

- **Under HPNSDP; the MoHFW has taken initiative to employ female officers, doctors and workers in different organizations and health service centers in line with increasing manpower and related facilities in the health sector.**
- A new operation plan is underway under the department of health to give greater emphasis on mothers, infants and increasing child mortality.
- The places prone to higher maternal mortality rate and with people isolated due to geographical and social reasons are given greater emphasis in providing services.
- **The Ministry has taken initiative to gradually make all the hospitals of the country women-friendly.**
- Through the regular activities of Department of health and Department of family welfare the nutrition program is being extended throughout the country by integrating nutrition services within the mainstream.
- There already are eight **One Stop Crisis Centers (OCC)** in the Divisional Headquarters and the other one being in Faridpur. Moreover, with the assistance of Ministry of Women and Children Affairs (MoWCA) another 40 **One Stop Crisis Cells** have been established in the district and 20 in the Upazilla level hospitals.

As a determinant of women's participation and share in the overall budget; we got the following percentages of women employees in different Agencies/Departments and the secretariats of the Ministry from the **Gender Budget Report of 2015-16**:

Sectors	**Officers**				**Employees**			
	2013-14		2014-15		2013-14		2014-15	
	Male	Female	Male	Female	Male	Female	Male	Female
Administration Secretariat	79	21	52	48	84	16	71	29

Sectors	Officers				Employees			
	2013-14		2014-15		2013-14		2014-15	
	Male	Female	Male	Female	Male	Female	Male	Female
Health Institute Health Dept.	97	3	76	4	89	11	87	13
Divisional institutions Upazila Health complexes	91	9	74	26	96	4	66	34
Service Department	19	81	0	100	58	42	24	76
Medical Science education Medical Colleges	75	25	75	25	79	21	77	33
Paramedical Institutions	72	28	85	15	44	56	82	18
Medical Assistant Training school	90	10	90	10	86	14	81	19
Nursing Colleges	5	95	7	93	72	28	70	30
Centre for Medical Education	71	29	63	33	43	57	82	58

Sectors	Officers				Employees			
	2013-14		2014-15		2013-14		2014-15	
	Male	Female	Male	Female	Male	Female	Male	Female
Hospitals Medical College Hospitals	71	29	78	22	79	31	49	51
Districts Hospitals	44	56	84	16	54	64	36	64
Other District Hospitals	78	22	73	27	74	26	54	46
Upazila Health complexes and village Health centers	79	21	74	26	90	10	66	34
Specialized hospitals and institutes	56	24	76	24	73	27	44	56
Clinics and Health centers School health centers	77	23	53	47	79	21	68	32
Other Facilities	40	60	59	41	68	32	63	37

The mentioned Document goes on to give some detailed statistics and programs with relevance to the issue:

- '**Maternal Health Voucher**' is on to give health services to the poor, distressed and pregnant women in 53 Upazilas and will be commenced in another 20 Upazilas. In the Financial year of 2013-14, 175000 pregnant women benefited out of this scheme.
- In addition to the extension of jurisdiction of the delivery and post-delivery services, 15,15,000 pregnant ladies received the services of community based midwives.

The couples are being encouraged on a door to door basis to take permanent methods of family planning. During the period of July 2013 to January 2015, 16.89 crore cycles of birth control pills and 23.28 crore pieces of condom have been distributed and 2.18 crore vials of injections have been injected.

Women's share in the budget of Ministry of Health and Family Welfare:

Description	**Budget 2015-16**			**Corrected 2014-15**			**Budget 2014-15**		
	Women's share			**Women's share**			**Women's share**		
	Budget	Female	Percentage	Corrected	Female	Percentage	Budget	Female	Percentage
Total budget	295100	79,087	26.8	239668	68087	26.74	250497	66739	26.68
Budget of Ministry	12, 726	4684	36.81	11568	4972	42.98	11176	4823	43.15
Development Budget	5331	2025	37.99	4562	2441	53.51	4349	2415	55.53
Non-development budget	7394	2659	35.96	7006	2531	36.13	6827	2408	35.27

Source: RCGP Database

Scenario of women's development in line with the suggestions of the previous years:

S.I.	Suggested activities of the previous years	Scenario of development
1	**Making enhance effort on creating increased awareness of all quarters about the importance of women-friendly and women centric health services.**	Initiative has been taken to create honorable and unbothered environment of health service delivery for women through **Women Friendly Hospital Initiatives (WFHI)**. This initiative will ensure expected service delivery to women of all ages to make the existing government hospitals more responsible in women's health service delivery programs that is underway in phases. Already 10 district hospitals (Manikgonj, Jaypurhat, Cox'sbazar, Rajbari, Nilphamari, Thakurgaon, Moulovibazar, Narail, Jamalpur and Gaibandha) under this program have been declared as women-friendly. Further works are going on to declare six more district hospitals (Madaripur, Kishorgonj, Kurigram, Gopalgonj, Magura and Lalmonirhat) and four Upozilla hospitals (Borolekha, Fatikchhari, Chougachha and Bhairab) as women friendly hospitals. A target has been fixed transform 30 government hospitals as women friendly within 2016 and the rest of the hospitals will also be made as such, phase-wise.
2	**To gradually increase number of women in different layers of health service providers.**	The rank status of nurses has been uplifted from third to second class. A number of 6,950 female workers have been employed in the village level from among the community health care providers.
3	**To make the environment encouraging in receiving**	In general health service, rich nutrition and population activities in the grassroots and to ensure

S.I.	Suggested activities of the previous years	Scenario of development
	women's health services by providing necessary medicine and other facilities to the community clinics.	the participation of the communities in the operation of health services, an initiative of establishing a total of 13861 community clinics has been taken of which 12,979 have already started operation. Of the service receivers from these clinics about 80% are women. In 759 community clinics throughout the country, normal delivery service is being offered. From January 2011 to October 2014 a number of 13214 normal deliveries have taken place in those clinics and this number is rising.

As per the **budget documents of MoF, GoB** the significant activities or projects/programs to be implemented in the 2015-16 FY are as bellow:

a) To ensure by the operation of the primary health, nutrition and population activities, child and maternity health and primary health service along with nutrition of the rural population through the 13861 community clinics.
b) To establish 487 community clinics.
c) To operate activities to increase the number of both short and long term modern family planning methods receivers.
d) To operate campaigns throughout the country for enhanced immunization program, vitamin A campaign, Polio campaign, MR campaign and to extend EPI cold storages in the central and district levels.
e) To strengthen hospital services in the Upazilla, district and tertiary levels.
f) To take special activities for the prevention and cure of both contagious and non-contagious diseases.
g) To operate **Maternity Health Voucher Scheme** in 73 Upazillas and emergency delivery service (24/7, C-EOC) activities in the Upazilla Health complexes in 132 Upazillas.

h) To build new medical colleges in Kishorgonj, Shatkhira, Kushtia, Faridpur, Gopalgonj, Noakhali, Cox'sbazar, pabna, Jessore, Rangamati, Shirajgonj, Manikgonj, Jamalpur, Gazipur, Patuakhali and Tangail and increase number of beds in eight older medical colleges.

i) To transform 20 hospitals from 100 to 250 beds, 40 hospitals from 50 ton100 beds and 265 Upazilla health complexes from 31 to 50 beds.

j) To establish five new nursing colleges (two in Dhaka, one in Khulna, One in Lalmonirhat and one in Manikgonj) and to transform five nursing institutes (Pabna, Jessore, Kushtia, Comilla and Chadpur) to nursing colleges.

k) To train a number of 700 students in four years B.Sc. in **Nursing (basic) Course**, 375 students in two years B.Sc. in Nursing (post basic) Course, 1570 students in three years long Diploma in Nursing Course and 525 students in three years long Diploma and Midwifery Course.

l) To build health infrastructures in the Union, Upazila, District, Division and national levels and

m) To build a 20 storied health complex in Mohakhali, Dhaka.

Special programs taken for development of women according to the same Document:

a) Under the gender centric reproductive health development activities, increase various services, for example: family planning, adolescent care, maternity health, pre-delivery service to the pregnant women, emergency delivery service and post-delivery service and Maternity Health Voucher Scheme.

The two widely practiced religious belief systems in Bangladesh:

After discussing the different political doctrines mostly practiced around the world; now we come to the point to talk about the religious canons that have the most amount of influence up on the general mass of our country. According to the latest population census of Bangladesh the most followed religion in this country is Islam having about 90.2% of the population as its adherents. The second most religion in this country that constitutes 8.2% of the population is Hinduism.

It is profoundly evidential that the religious beliefs have most amount of influence up on the moral, culture and every other aspects of the life of the population of this country. Women rights even an agreed in the religious creeds do unquestionably influence the practice of the population in its vey core. It surely is undoubtedly the most influential factor regarding the customs, values, norms and cultures and practices regarding this issue are a day to day life as well as even the legal status of the population of a state.

Therefore, it is deemed as of upmost importance to converse on the issues of the mostly practiced religious creeds by the population of this country.

Islam

There has recently been a very widespread propaganda against the religion of Islam mainly in the western media to illustrate it has a religion that oppresses women and has very little sympathy towards the issues of rights of women quite contrary to this propagandist movement a careful look into the creed depicts situation quite contrary than what is being said by the propagandists.

The very basic source of the creed of Islam is the last and final revelation to human kind by the Almighty Creator to Mohammed (PBUH). The source that comes right afterwards Sunnah or the sayings and practices of the messenger i.e. Mohammed (PBUH). It is therefore an indispensable necessity that we go into the details of the very verses of the Holy Quran concerning the issue of the rights of women.

Professor AbdurRahman I. Doi, says “in Islam there is absolutely no difference between men and women as far as their relationship to Allah Ta’alah his concerned, as both are promised the same reward for good conduct and the same punishment for evil conduct.

We would be able to find many verses in the Holy Quran concerning women. In fact, there is a whole chapter revealed in the Quran named as ‘An-Nisa’ meaning ‘The Women’. The Holy Quran says:

“And for women are rights over men similar to those are men over women”. (Sura 2, Ayah: 228).

The Quran, addressing the believers often loses the expression, ‘believing men and women’ to emphasize the equality of men and women in regard to their respective duties, rights, virtues and merits. It says:

“Who so does that which is rights and believes, whether male or female, him or her will I verily quicken to happy life”, (Sura 16, Ayah 97).

The Quran admonishes these men who oppress or ill-treat women:

“O you who believe! You are forbidden to inherit women against their will. Nor should you treat them with harshness, that you may take away part of the dowry you have given them-except when they have become guilty of open lewdness. On the contrary live with them on a footing of kindness and equity. If you take a dislike to them, it may be that you dislike something and Allah will bring about through it a great deal of good.” (Sura 4, Ayah 19).

Considering the fact that before the advent of Islam the pagan Arabs used to bury their female children alive, make women dance naked in the vicinity of Ka’abah during their annual fairs, and treat women as mere chattels and objects of sexual pleasure possessing no rights or position whatsoever, this teachings of the Noble Quran where revolutionary. Unlike other religions, which regarded women as being possessed of inherent sin and wickedness and men regards men and women being possessed of inherent virtual and nobility, Islam as the same essence created from a single soul. The Quran declares: “O mankind! Reverence your guardian- Lord, who created you from a single person, created, of like nature, his male, and from this pair scattered (seeds) countless men and women. Reverence Allah, though Whom you demand your mutual

(rights), and reverence the wombs (that bore you); for Allah ever watches over you." (Sura 4, Ayah 1).

The Prophet of humankind Mohammed (PBUH) said "women are the twin halves of men"

The Quran emphasize the essential unity of men and women in a most beautiful simile:

"They (your wives) are your garment and you are a garment for them". (Sura 2, Ayah 187).

Just as a garment hides our nakedness, so do husband and wife, by entering into the relationship of marriage, secured each other's chastity. The garment gives comfort to the body; so does the husband find comforts in his wife's company and she is in his.

"The garment is the grace, the beauty, the embellishment of the body, so too are wives to their husbands as their husbands are to them". Islam does not consider woman" an instrument of the devil", but rather at Holy Quran calls her Muhhsina. Muhhsina means fortress against Satan because a good woman, by marrying a man, helps him keep to the path of rectitude in his life.

It is for this reason that marriage was considered by the Prophet Mohammed (PBUH) as a most virtuous act. He said: "When a man marries, he has completed one half of his religion". He enjoined matrimony on Muslims by saying: "Marriage is part of my way and whoever keeps away from my way he is not from me (i.e. is not my follower)". The Holy Quran has given raison d'être of marriage in the following words:

"And among His signs is this that He has created you mates from among yourselves, that you may dwell in tranquility with them; and He has put love and mercy between you. Verity in that are signs for those who reflect" (Sura 30, Ayah 21).

Prophet Mohammed (PBUH) was full of praise for virtuous and chaste women. He said:

"The world and all things in the world are precious but the most precious thing in the world is a virtuous woman". He once told the future Khalifah, 'Umar: "Shall I not inform you about the best treasure a man can hoard? It is a virtuous wife who pleases him whenever he looks towards her, and who guards herself when he is absent from her".

Before the advent of Islam women were often treated worse than animals. The Prophet (PBUH) wanted to put a stop to all cruelties to women. He preached kindness towards them. He told the Muslims: “Fear Allah in respect of women”. And: “The best of you are they who behave best to their wives”. And: “A Muslim must not hate his wife, and if he be displeased with one that quality in her, let him be pleased with one that is good”. And: “The more civil and kind a Muslim is to his wife, the more perfect in faith he is”.

The Prophet (PBUH) was most emphatic in enjoining upon Muslims to be kind to their women when he delivered his famous Khutbah on their Mount of Mercy at ‘Aarafah in the presence of thousands of his Companion who had gathered there for the Hajj al- Wada (Farewell Pilgrimage). In it He ordered those present, and through them all those Muslims who were to come later, to be respectful and kind towards women. He said:

“Fear Allah, regarding women. Verily you have married them with the trust of Allah, and made their bodies lawful with the word of Allah. You have got (rights) over them and they have got (rights) over you in respect of their food and clothing according to your means”.

In Islam is women completely independent personality. She can make any contract or bequest in her own name. She is entitled to inherit in her position as mother, as wife, as sister and as daughter. She has perfect liberty to choose her husband. The pagan society of pre-Islamic ‘Aarabiah had an irrational prejudice against their female children whom they used to bury alive. The Messenger of Allah (PBUH) was totally opposed to this practice. He should them that supporting their female children would act as a screen for them against the fire of Hell:

It is narrated by the Prophet’s (PBUH) wife, ‘Ayshah (R), that a woman entered her house with two of her daughters. She asked for charity but ‘Ayshah (R) could not find anything except a date, which was given to her. Woman divided in between her two daughters and did eat any herself. Then she got up and left. When the Prophet (PBUH) came to the house, ‘Ayshsh (R.) told him about what had happened and He (PBUH) declared that when the woman was brought to account (on the day of judgment) about her two daughters they would act as a screen for her from the fires of hell.

The worst calamity for a woman is when her husband passes away and, as a widow, the responsibility of maintaining children falls upon her. In the Eastern World, where a woman does not always go out to earn her living, the problems of widowhood are indescribable. Prophet Mohammed (PBUH) upheld the cause of widows. Most of his wives were widows. In an age when widows were rarely permitted to remarry, Prophet (PBUH) encouraged his followers to marry them. He was always ready to help widows and exhorted his followers to do the same. Abu Hurayrah (R.) reported that the Prophet (PBUH) said: "one who makes efforts (to help) widow or a poor person is like a Mujahed (warrior) in the part of Allah Ta'alah, or like one who stands up for prayers in the night and fasts in the day".

Woman as mother comments great respect in Islam. The Noble Quran speaks of the rights of the mother in a number of verses. It enjoins Muslims to show respects to their mother and serve them well even if they are still unbelievers. Prophet (PBUH) states emphatically that the rights of the mothers are paramount. Abu Hurayrah (R.) reported that a man came to the Messenger (PBUH) of AllahTa'alah and asked: "O Messenger of Allah (PBUH), who is the person who has the greatest right on me with regards to kindness and attention? He (PBUH) replied, 'Your mother', then who? He (PBUH) replied, 'Your mother', then who? He (PBUH) replied, 'Your mother'. Then who?He (PBUH) 'Your father'.

In another tradition, the Prophet (PBUH) advised a believer not to join the war against the Quraish in defense of Islam, but to look after his mother, saying that this service to his mother would be a cause of his salvation. Mu'awiyah (R.), the son of Jahimah, reported that, Jahimah came to the Prophet (PBUH) and said, "Messenger of Allah! I want to join the fighting (in the path of Allah Ta'alah) and I have come to seek your advice". He (PBUH) said, then remain in your mother's service, because Paradise is under her feet".

Prophet's (PBUH) followers accepted his teachings and brought about the revolution in their social attitude towards women. They no longer considered women as mere chattels, but as an integral part of society. For the first time women were given the rights to have share in heritance. In a new social climate, women rediscover themselves and became highly active that members of society rendering useful service during the wars which the pagan A'arabs forced on the emerging Muslim Ummah. They carried provisions for the soldiers, nursed them and even fought

alongside them if it was necessary. It became a common sight to see women helping their husbands in the field, carrying on trade and business independent, in going out of their homes to satisfied their needs. Ayshah (R.) reported that SaudahBintZem'ah went out one night. 'Umar saw her and recognized her and said, "By Allah, O Saudah why do you not hide yourself from us?" She went back to the Prophet (PBUH) and told him about it why He (PBUH) was having suffered in her room and He (PBUH) said, "It is permitted by Allah for you to go out for your needs". The predominant idea in the teachings of Islam with regard to men and women is that a husband and wife should be full- fledged partners in making their home a happy and prosperousplace, that they should be loyal and faithful to one another, and genuinely interested in each other's welfare of their children. A woman is expected to exercise a humanizing influence over her husband and soften the sternness inherent in his nature.A man is enjoined to educate the women in his care so that they cultivate the qualities in which they, by their very nature, excel.

These aspects where much emphasize by the Prophet (PBUH). He exhorted men to marry women of piety and women to be faithful to their husband and kind to their children. He said:

"Among my followers the best of men are those who are best to their wives, and the women are those who are best to their husband.

Once Muawiyah (R.) asked the Prophet (PBUH), "What are the rights that a wife has over her husband?" Prophet (PBUH) replied, "Feed her when you take your food, give her clothes to wear when you wear cloths, refrain from giving her a slap on the face or abusing her, and do not separate from your wife, except within the house".

Once a woman came to the Prophet (PBUH) with a complaint against her husband. He (PBUH) told her: "There is no woman who removes something to replace it in its proper place, with a view to tidying her husband's house, but that Allah Ta'ala' sets it down as a virtue for her. None is there a man who wants with his wife hand in hand that Allah Ta'alah sets it down as a virtue for him; and if he puts his arm round her shoulder in love, his virtue is increased tenfold".

Once He (PBUH) was heard praising the women of the tribal Quraish, "…because they are the kindest to their children while they are infants and because they keep a careful watch over the belongings of their husbands".

The Shariah regards women as the spiritual and intellectual equals of men. The main distinction it makes between them in the physical realm based on the equitable principles of fair division of labor. It allots the more strenuous work to the men and makes him responsible for the maintenance of the family. It allots the work of the managing the home and the upbringing and training of children to the women, work which has the greatest importance in the task of building a healthy and prosperous society.

It is a fact, however, that sound administration within the domestic field is impossible without a unified policy. For this reason, the Shariah requires a man, as head of the family, to final say in decisions concerning it. In doing so he must not abuse his prerogative to cause any injury to his wife. Any transgression of this principle involves for him the risk of losing the favor of Allah Ta'alah, because his wife is not his subordinate but she is to use the words of the Prophet (PBUH), 'the queen of her house', and this is the position a true believer is expected to give his wife. In contrast to his enlightened teaching of Islam in respect of women, western talk of women's liberation or emancipation is actually a disguised form of exploitation of her body, deprivation of her honor, and degradation of her soul.

As a reaction to the atrocious work of burying female children by the pagan custom of the A 'Arabs, the revolution of the Ayahs of the Holy Quran came as:

"In the name of Allah the most beneficent and most meaningful.

When the sun will be wrapped up in darkness.

And when the stars fall, disappearing,

And when the mountains are removed,

And when full-term she-camels are neglected,

And when the wild beasts are gathered.

And when the seas are filled with flame,

And when the souls are paired,

And when the girls buried alive will ask.

For what sin was I killed?

And then the pages will be made live public."

Hinduism:

In the question of the religion of Hinduism according to scripture legends and other sources that emulate the creeds, if obviously is a matter of grave disturbance to observe the far more negativity towards the notion of rights of women both in the material world and the projected afterworld. There has for the last 200 years or so much criticism of this stands of Hinduism both in the literate parts of Hindu and non-Hindu societies. A good number of laws had to be passed (Civil as well as Criminal) to overcome the negative and pessimistic prejudices this belief system possesses and as a consequence influences the followers of it. However, some parts of the creeds could be mentioned as having positivity towards women as a class.

Hindu texts present diverse and conflicting views on the position of women, ranging from feminine leadership as the highest Goddess to limiting her role to an obedient daughter, housewife and mother. The Devi Sukta hymn of Rig Beda, a scripture of essence of the Universe, the one who creates all matter and consciousness, the eternal and infinite, the so-called metaphysical and empirical reality (Brahmin), the soul (supreme self) of everything.

As it has already been said this religious doctrine has positioned women either as in supreme positions such as Deities or in limiting their positions as low as subservient to the of main counterparts inside the home. The religious scriptures of Hinduism have been made divided into two broad divisions; the Smriti and the Shruti. In Smriti's such as the ManuSmrit, the position of women in Hinduism is mixed and contradictory. Manusmriti asserts that "as a girl, she should obey and seek attention of her father, as a young woman her husband, and as a widow her son [Patrick Olivlle (2005), Manu's code of Law, Oxford University Press, pages 98, 146- 147]. In other sections the same text asserts that "women must be honored and adorned" and "where women are revered, there the Gods rejoice; but where there not, no secret rite bears any fruit" [Patrick Olivlle (2005), Manu's code of Law, Oxford University Press, page 111]. However,

Scholars have questioned the authenticity and corruption at the text over time, given the numerous inconsistent versions of the Smriti's manuscript have been discovered [Patrick Olivlle (2005), Manu's code of Law, Oxford University Press, pages 353-354, 356-82].

Ancient and medieval era Hindu texts present a diverse picture of duty and right of women inn Hinduism. The texts recognize eight kinds of marriage, ranging from father finding a marriage partner for his daughter and seeking her consent (Brahma marriage), to the bride and groom finding each other without parental participation (Gandharba marriage) [RajbaliPandey (1969), Hindu Shamskaras: Socio-religious study of the Hindu sacrament pages 158-170 and chapter viii], [The illustrated Encyclopedia of Hinduism: A-M. James G. Lochtefeld (2001), page 427]. Scholars state that Vedic era Hindu text, and records left by travelers to ancient and medieval India, suggests ancient and medieval Hindu society did not practice dowry or sati [Michael Witzel (1996), "Little Dowry, No Sati: The Lot of Human in Vedic Period". Journal of South Asia Women Studies 2, no. 4 (1996)]. These practices likely became widespread sometime in the second millennium CE from socio-political development in the Indian subcontinent [Sashi, S. S. (1996), encyclopedia Indica: India, Pakistan, Bangladesh 100. Anmol Publications, page 115.]. But these arguments could vehemently be opposed as both the widespread practices of the systems of dowry and Sati were conspicuously mentioned as a practice of a very long time by the famous Muslim Scholar and historian who wrote exclusively on ancient Indian Philosophies and histories 'AbūRayḥānMuḥammadibnAḥmad Al-Bīrūnī(4/5 September 973 – 13 December 1048), known as Al-Biruni.

Hinduism, state Bryant, has the strongest presents of the divine feminine among major all religions, from ancient times to the present [Bryant, Edwin (2007) Krishna: A source book, Oxford University Press, page 441]. The Goddess is viewed as central in Shakti and Saiva Hindu tradition [Flood, Gavin, Ed. (2003), The Blackwell Companion to Hinduism, Blackwell Publishers Ltd., pages 200- 203]. It is very negatively peculiar and surely is a matter of unacceptability from the senses of women rights as well as human rights that the so-called divine Goddesses of the doctrine are highly revered whereas the human the women in flesh in the earthy world are not so and rather are without many basic rights.

Some basic points on the rights on women given in the general civil law with comparison to the Hindu scriptures are asserted in the following.

Divorce

The Hindu text declares that a marriage cannot be dissolved by a woman [Robert Lingat (1973), The Classical Law of India, University of California Press, page 84]. The website named as hinduwebsite.com with regard to divorce says that 'in ancient times, women in Hindu society had limited freedom. Women were bought and sold, abducted, forcibly married and forced into slavery or prostitution. There was nothing like the modern concept of a divorce or a legal separation in Hindu society. Once a woman left her parent's home, she was completely at the mercy of her husband or his parents and if he found her incompatible or unattractive and abundant her, there was little that she could do. She has no right to divorce, no right to remarry and no right to live the house and approach anyone without her husband's permission. Part of the problem was that Manu, the famous Law Maker, viewed women with suspicion and would not trust them with freedom. He believed that they needed to be kept under the protection and watch of men all the time, so that they would not have the opportunity to cause the confusion of casts' [("she must not seek to separate herself from her father, husband, or sons; by leaving them she would make both contemptible", Manusmrity, chapter 5, Verse 149), hinduwebsite.com//hinduism//h_divorce.asp].

Varna

Hinduism opposes a woman marrying someone outside her own cast [see the last reference]. Hinduism in general forbids mixture of casts as the foundation of the continuation of four different divisions within the populace determined as per birth. This regulation, very rigorously applied and practiced however, made to ensure a permanent supremacy of the people of certain casts over others and stop's social mobility.

The manusmriti in this regards states in the book of Manu verse 5 "a Brahmin who marriage a Shudra woman, degrades himself and his family, becomes morally degenerated, looses Brahmin status and his children to attain status of shudra". The same book further states in the verse of KanyamBhajanti: "in case women enjoy sex with a man, higher cast the act is not punishable. But on the contrary, if women enjoy sex with a lower class men she is to be punished and kept in

isolation". The following verse says "in case a man from a lower cast enjoys sex with a woman from higher class, the person in question is to be awarded the death sentence. and if a person satisfies his carnal desire with a woman of his own cast, he should be asked for compensation to the women's faith".

There have however been a number of tries initiated by different contemporary theologians for example Patrick Olivelle, Robert Lingattetc defending rights of women in this respect in Hinduism by altering some meanings of Hindu laws.

Property rights

The texts of the belief system forbid women from having any property from the sides of either her paternal or her in laws. But on later dates further newly interpreted versions by western Theologians such as Patrick Olivelle talks of six types of property lady could have those include the things that she received at her marriage, or as gift when she eloped or when she was taken away, or as token of love before marriage, or as gifts from her biological family, or as received from her husband subsequent to marriage, and also from inheritance from deceits relatives. Though he could not mention of any direct verse from any scripts of Hinduism stating the rights of inheritance. Furthermore, any gift/s or property can in no way be termed as rights.

Self-dependency

In manusmriti, it is said, "girls are supposed to be in the custody of their father when they are children, women under the custody of their husband when married and under the custody of her son as widows. In no circumstances she is allowed to assert herself independently" (Verse 13). In verse 15 of the same book goes on to say "women have no divine right to perform any religious ritual, make vows to observe a fast. Her only duty is to obey and please her husband...". The stated verses clearly project the helplessness provided by the Hindu scriptures for women. There have however been deviations from these codes at and in every period of history. Many a times these deviations were dealt with by the Hindu clergy and theocracy and many a times the deviations could escape the reaction of the clergy.

It is clearly evident that women, if followed the Hindu scriptures would certainly be in a status of helplessness and even disgrace. Therefore, there have been conscious social efforts to alter laws

of Hinduism that regulate the lives of the Hindu populace and modern civil and criminal laws have replaced those out-rightly. It is for these reasons have become more compelling for Hindu population to seek the refuge of the state provided modern civil and criminal laws instead of their religious code in terms of getting something in favor of rights of Hindu women.

5.2 Comparing Health care system in Bangladesh in relation to other countries of the world

Comparison of Health Care Systems

The strengths and weaknesses of different systems are often assessed with reference of the health care policy objectives. Besides the general capabilities and high quality of care of a health care system **it should be oriented primarily towards equal opportunities with regard to access to health services and needs-based justice**. **This has long been regarded as one of the main social policy objectives of the 20th century: health care profession regardless of income or social quality.**

Thanks to progress medical technology, far more illness can be treated successfully today than a few decades ago. This goes hand in hand with rising costs, however. The question of the efficiency and affordability of the health care system thus inevitably arise.

Euro Health Consumer Index

An annual comparison of European health care systems- the **Euro Health Consumer Index (EHCI) - which is taken particularly seriously at the political level**, has been undertaken by the consultancy Health Consumer Power House (HCP) since 2005. **The aim of the index, compiled on the basis of publicly available statistics (national, WHO and OECD), legal texts, documents, interviews, service and expert panels, is to depict the health care system's user-friendliness: in other words, the views of consumers are the focus of investigation**.

European Health Care System was classified on the basis of the ESCI in 2012, in five key areas: patients' rights and information; treatment waiting times; medical outcomes, prevention, extent and scope of health care system services, medicines. These encompass, in turn, 42 performance indicators.

Issue	Germany	Netherlands	United Kingdom
Patients' rights and patient's information	117	170	160

Issue	Germany	Netherlands	United Kingdom
Waiting times for treatment	200	200	133
Medical outcomes	200	263	133
Extent and range of health services	111	163	146
Drugs	76	76	81
Total points	740	872	721
Ranking	14	1	12

(OECD statistics, 2012)

According to the ESCI 2012, **Germany** ranks 14th out of 34 health care systems investigated in Europe. This marks a significant downward trend, from 6 place in 2009, 5th place in 2007 and 3rd place in 2005.

In 2008, HCP rated as a major plus in Germany the virtual absence of waiting times, problem-free access to specialist care and the extent of services. It rated of positive the fact that in Germany patients can get a second-opinion at any time. Germany also came out comparatively well with regard to the quality of medical outcomes. This includes child mortality, five-year cancer survival rate and the mortality rate after a heart attack.

With regards to patients' rights' and patient information, by contrast, Germany was doing relatively poorly as early as 2008. The lack of a **patient protection law** also led to a loss of points, as did the fact that German doctors and clinics are not subjective transparent quality comparison.

The significant decline in the ranking of the Euro Health Consumer Index in 2012 was partly the introduction of nine new indicators. It is nevertheless clear that while Germany still had a top

class health care system in 2009, the EHCI for 2012, points to a mediocre health care system, Germany thus finds itself below the UK for the first time. Germany does surprisingly badly with regard to cardiac care and hospital infections. As a possible explanation the HCP mentions the large number of small, unspecialized hospitals. The system also seems to be becoming less generous (scope and existence of health services). E-health (the use of ICT in the health care system) is being introduced very slowly. There is also a need to catch up in the area of health prevention. **The issue is closely linked to the idea of a preventive welfare state and health care infrastructure, but also to education issues**.

The Netherlands consistently comes out one of the most consumer-friendly health care systems in the EHCI. In 2006 and 2007, the country ranked second and in 2009, first. In 2012 the Netherlands are again heading the rankings, followed by Denmark, Iceland, Luxemburg and Belgium. The Dutch health care system, **characterized by a number of insurers, in competition with one another and a strong role for patient organizations in decision-making** appears to have no weak points. There is still room for improvement only with regard to waiting times. However, these good results have been achieved by means of the **highest per capita health spending in the EU**.

The UK still ranks somewhere in the middle, but it is showing a rising trend and in 2012 for the first time ranks above Germany. In 2006 it was in 15th place, 17th in 2007, 13th in 2008, 14th in 2009 and 12th in 2012. It ranks 3rd after Denmark and Norway in the area of **patients' rights and information, including e-health**. Based on major investment progress is discernible in the extent and scope of health services. There has been some success with regard to access to health care services, although waiting times are still characteristics problem of the health care system. Medical outcomes are still unsatisfactory for a highly developed country. Undoubtedly, it can be debated whether the spectrum of chosen indicator is 'representative' for an overall evaluation and the comparison of health care systems.

Health care spending comparison:

Issue	Germany	Netherlands	United Kingdom
Health care	11.6	12	9.6

Issue	Germany	Netherlands	United Kingdom
spending as a percentage of GDP			
Per capita health care spending*	4338	5066	3443

*In US dollars, adjusted for the influence of various price levels (PPP) // source: OECD (2011).

If health services are to be accessible to all citizens to an equal extent also in the future, **the broadcast possible approach to funding, based on solidarity**, must be adopted. In theory, this can be **achieved both by means of an increase in tax-based funding, as under the health care premium model, or by means of citizens' insurance**. The real redistribution effect, in both models, **ultimately depends on the design of tax subsidy system or of the level of the contribution assessment threshold**. Since the subsidy system affects only those on lower incomes, however, under the health care premium model a heavier burden falls on middle-income households in contrast to citizens' insurance, to the benefit of higher income household.

Sick people, regardless of background, age or gender, have the same entitlement to provision and to benefit equally from medical advances. We do not want two-tier medical system. We therefore want everyone to be included in solidarity-based citizens' insurance (**Hamburg Program 2007: 58**).

The example of the Netherlands shows that **building together "social" and private health insurance can enhance competition to the benefits of insurance receivers. The basis for sensible reform would be funding that is as broadly-as possible and compulsory insurance for all citizens within the framework of a uniform health insurance market, characterized by an obligation to contract on the part of the health insurance funds, contribution rates independent risk and the morbidity-oriented risk structure compensation.**

For social democrats this means:

- The guiding principles for social democracy with the health care domain are efficiency,

need-based justice and solidarity (solidarity of risk and income)

- higher tax subsidies or the introduction of citizens' insurance make possible more broadly-based and fairer funding of the health care system
- fair complication between the health insurance funds (statutory and private) requires reconciling the various risks, the abolition of compulsory insurance threshold and an obligation to contract on the part of health insurance funds
- preventive provisions and measures must be extended

Performance-based justice

For most people the most appropriate principle of justice in accordance with which differences of distribution can be justified is performance-based justice. Performance-based justice –or the performance principle – demands that equal achievements and unequal achievements should be treated unequally. A typical example of this maxim of justice is the demand for equal wages or equal work.

Social democracy- to refute a prejudice that keeps on being leveled against it-has always regarded differences in the distribution of goods and resources as legitimate, as long as this is based on a specific need or performance or on perceptible, recognizable and assessable differences in attainment (**Thierse 2005:14**)

However, it is often not so easy to say how performance or merit can be assessed. Is it the same as the outcome of a particular activity? Or with the effort- that is, the trouble taken and the exertion-that accompanied the activity? Furthermore, what role does talent play in the assessment of performance? Should particular gifts–given to one at birth and thus not achieved-be awarded or not?

'Only God, who knows what secrets dwell in the hearts of men, would be able to make the necessary distributions. If human being had to do the work, the distributive mechanism would be seized early on by some band of aristocrats (so they would call themselves) with a fixed conception of what is best and most deserving, and incentive to the diverse excellences of their fellow citizens' (**Walzer 2006**).

Individual talent, in contrast, is considered by most people to be relevant to the evaluation of performance only in combination with effort. The level of exertion, effort and religions in particular cannot be easily judged from outside, however.

Clearly, it is not easy to apply the performance principle consistently. The least complex solution is to leave it to the market to define performance. This has consequences of its own, however. The market does not necessarily reward performance in terms of individual efforts and enthusiasm.

Instant, it is oriented primarily towards outcome. As a result of this, by the way, the income differences that people consider to be justified by individual performance are much lower than actually existing differences (**Miller 2008: 112**).

There is an even more fundamental problem: many activities- **in particular within the family- are unpaid (care, child raising, nursing), because such activities are still disproportionately carried out by women there is a twofold injustice:**

1. **The activities of many people are not remunerated.**
2. **It is above all women who are affected by injustice**

Need-based justice

Need-based justice was what Karl Marx called for in his quarrel with the Gotha program: 'From each according to his abilities, to each according to his needs'. However, he did not consider this to be a political task. He took the view that this principle would be realized of its own effort in the later stages of the communist society, as a result of which the concept of justice would become superfluous.

What kind of understanding of need or want would be suitable serve as a basis for the allocation of goods in a modern society? Perhaps they would be taken to be synonymous with individual desires. Many people might feel the need for a villa with an enormous park around it. However, the minutes of its applicability rapidly be reached due to scarcity of resources.

The alternative is to understand as needs conditions necessary for a decent life in a given society. Adams Smith's conception of necessary items (what he called 'necessaries') was along his lines:

“By necessaries I understand not only commodities which are indispensable necessary for the support of life, but whatever the customs of the country render it indecent for creditable people, even the lowest order, to be without” (**Smith 1978 [1766]: 747**).

The goal of needs-based justice therefore is predominantly directed, average or minimum coverage on basic needs. But even it’s such a definition means that the above mentioned villa cannot be considered a basic need, there is no hard and past dividing line. What exactly are the goods required by a decent life? Clearly, this depends entirely on the circumstances on each particular society. Today, telephone, television and internet would be considered basic goods, while up in to the 1960s none of them were.

Obviously, the basic ides of needs-based justice, with reference to a decent life, is in keeping with the thinking that net to the inclusion of the welfare state principle. It is thus easy to see that yet too it is not always simple to apply it in practice. (**Soziale Demokratie**)

Equality of Opportunity

Equal opportunities as the fourth of the principles of justice dealt with here is distinct from the other three in one essential point: equality of outcome. Contribution or performance-based justice and needs-based justice in many situations contradict one another. Equality of opportunity, by contrast, not only recognized contribution or performance-based justice with equality of outcome, but in a way it is a necessary condition for application of the two principles. But first things first.

The first notable thing about equality of opportunity is that, in contrast to the other concepts, it refers to the certain kind of moral. This principle does not concern the distribution of goods and resources in general, but expressly concerns the equal distribution of opportunities. In other words, **the level playing field.**

If this equality is ensured, then subsequent inequality in the distribution of income, status and other things is fair. The performance principle can be applied because the initial conditions are the same for all. What are the starting conditions for a self-determined life, which initially are very unequally distributed both between people and at the different points of a person’s life? Inequality of opportunities arises, for example, as a result of differences of innate abilities,

different opportunities enjoyed by parents, gender-specific role allocation and different education and training paths.

In the case of equal opportunities, however, one faces the problem that even when situations characterized by equal opportunities have been established **they can rapidly become unequal once again**. **Modern theories of equal opportunities are therefore geared towards 'equality of life chances'**. **In this conception, justice demands not only one of interventions by the states but continuous correction in order to establish and maintain justice**.

But here too the question arises of what exactly has to be equally distributed in order to bring about equal opportunities. **One proposal is to link this to the causes of inequality**. Unequal life situations based on individual purposes do not justify state intervention.
Inequalities that, in contrast are the result of talents and abilities that cannot be affected- nature's lottery- should entail state action to compensate. This distinction sounds plausible, but in practice clear-cut distinctions between fair and unfair causes or inequality are seldom possible.

> On the one hand, we must, on paying of violating equality, allow the distribution of resources at any particular moment to be [...] ambition-sensitive. [...] but, on the other hand, we must not allow the distribution of resources at any moment to be endowment-sensitive, that is, to be effected by differences in ability of the sort that produce income differences in a laissez-faire economy among people with the same ambitions (**Dworkin 1981: 311**).

Others have therefore, **proposed focusing on the distribution of capabilities**. Everyone should be provided with competences that put them into a position to be able to pursue their life plans. In order to ensure the life chances of an individual person, social policy should not seek to reduce inequality subsequently. Rather **it is one of the key tasks of the welfare state to provide people with the means to avoid involuntary and permanent social disadvantage or even exclusion**.

Given that under this principle of justice fair initial conditions are so central, it grows without saying that education/training policy will be one of the key areas of application. **Public provision, in many countriies ranging from day-care centers for children whose parents are**

in full-time environment to vocational training, show clearly that the state considers it to be its task to provide access to education/training for all.

Summarizing the four above points

Erhard Eppler formulates the matter clearly: "politically, it makes no sense to agonize about absolute social justice. There is no such thing" (**Excorsus: Erhard Eppler all the concept of justice**).

Perusing a single concept of justice in accordance with which to organize every area of politics and society is not only illusory but also profoundly undemocratic. The fact is that people's views on what is fair often diverge.

Debate on the different principles has shown that different degrees of importance are attached to particular maxims of justice in different policy areas. Nevertheless, **politics needs a compass it can call on when making decision.**

What does that mean for social democracy?

- Equal dignity and equal opportunities with regard to a self-determined life and political participation require fair distribution of society's resources.
- The question of fair distribution can be discussed on the basis of the four principles of equality, contribution-or performance-based justice, needs-based justice and equal opportunities.
- These principles must be weighted differently in different areas. Equality, contribution or performance-based justice and need-based justice limit one another. Equality of opportunity is an overarching principle. It is the condition for the application of the other principles, especially contribution-or performance-based justice.

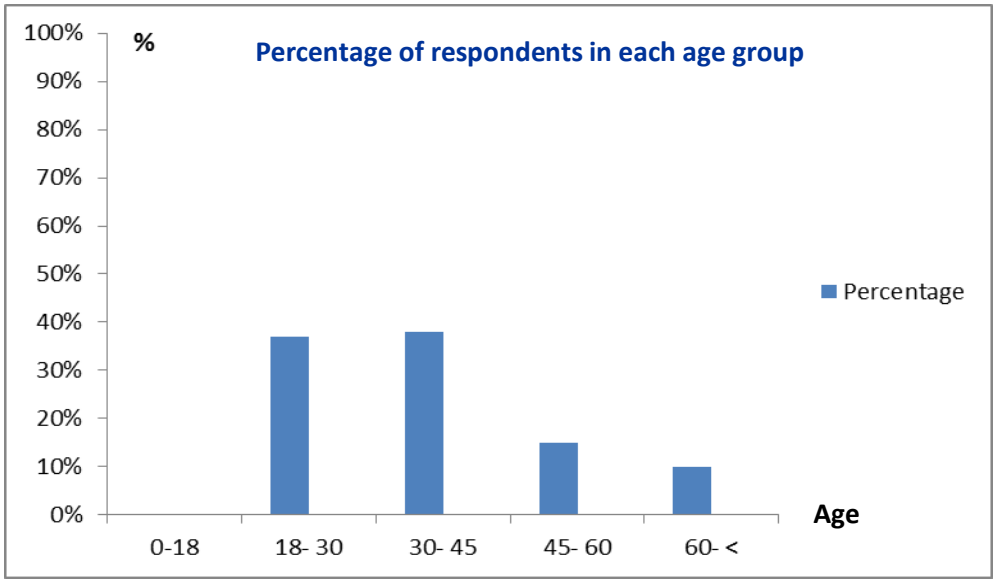
Chapter - 6

Findings of the study for gender discrimination in the eye care field

1.0: Personal Information

1.1: Age

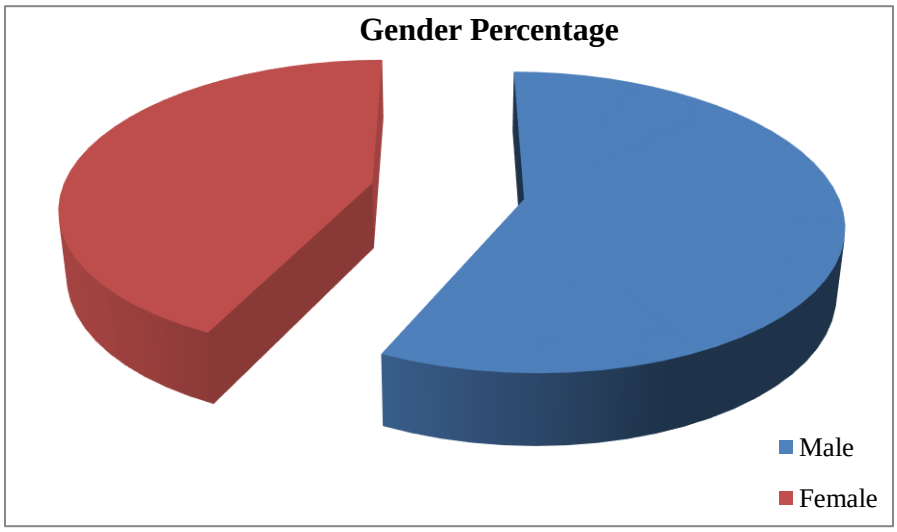
As the collection of data started, among the first collected were the respondents' personal information including his/her age, sex, marital status and educational details. It was found enquiring the age data that most of the respondents numbering 26 fell under the age group of 30-45 years the percentage of which is 38, followed by 37% just short to the most populous age group by 1% numbering 25. These figures may help the reader have an idea of the overwhelming number of participation of the young people combined in the study that is principal work force. It is also interesting to note that this comes in compliance of the much-cited statistical assumption that data tend to have a concentration towards the middle that is called as the Central Tendency. However, the work of data collection was carried out randomly and in an unbiased manner concentrating the focus on the people having relevance with the people with eye ailments; this central tendency quite evident nevertheless. The top two percentages are followed by 15% of the respondents or 10 in numbers falling under the age group of 45-60 and only 10% or seven people falling in the age group of more than 60. This is shown in a column chart as below:



Graph: *Percentage of respondents in each age group*

1.2: Sex

One may find it peculiar to see more male than female respondents taken as interviewees but that also comes around the operational necessity of the study and may help the reader understand of the view of the opposite sex on the issue of discrepancy comparing the provision eye care between the genders.



Graph: *Percentage of respondents based on gender*

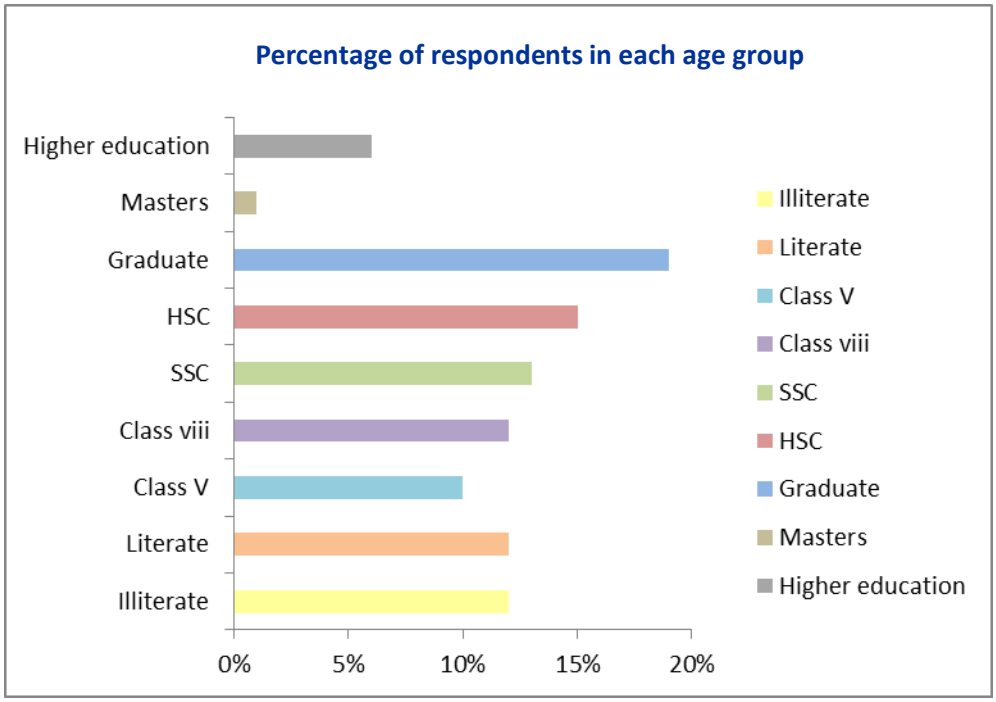
1.3 Marital status

The status of marriage was also considered as important to have an idea on differing views of the respondents in line with this factor. The overwhelming majority of the respondents of the study were married having a percentage of 81 and numbering 55. 18% or 12 of the respondents were single. Only one respondent that is less one percent of the total was identified as divorced.

1.4 Educational qualification

It often is propositioned that more educated people acquire the ability to examine an issue more accurately and consequentially can come to closer to the right decision. The data of education shows out of 68 respondents; the number of graduates are 13 or 19%, followed by 10 or 15% having passed HSC and 9 or 13% having passed SSC. Both the people having only literacy and the illiterate are 13% each of the respondent population numbering 8 each. The people having post Masters Education consisted 4% and having Master's Degree completed consisted less than

1% numbering four and one respectively. This distribution of educational variety represents the diversity of educational backgrounds the respondents are from and help analyzing weights of differing opinions of the respondents' making analogy with their differing educational qualifications.



Graph: *Percentage of respondents based on educational qualification*

1.5: Profession:

Since social phenomena such as social status and dignity are closely related to that of a person's occupation and the amount of money earned; it was deemed necessary to get information on this issue of the respondents. The answers of the question on this issue of whether the respondents were engaged to an occupation or not gave a mixed reaction. Most of the respondents that is 68% of them or 46 respondents responded positively that means they engaged in some kind of occupation and thinks that they earn, while a lesser number i.e. 22 of them or 32% denied the fact of being engaged in any kind of occupation.

1.6: Amount of Monthly Income

The income table made on the basis of collected data shows the most number of respondents falling under the category of a low income group ranging from a monthly earning of 5000 to 10000 taka, numbering 22 having a percentage of 32. As the lower income group of the economic strata was preconceived as more vulnerable and prone to for being subjected to and practice or show unequal attitudes themselves; people of this group was encouraged to be interviewed for sake of knowing the precarious situation of the most vulnerable part of the society. The two groups that follow having second number of respondents in terms amount of earning per month are who earn in between 10000-15000 taka and 15000-20000 taka respectively. Both of these groups have a percentage of 12 each and 8 respondents included into their factions. In the class of the higher income group 9% i.e. 6 of the respondents fall. 4% of the respondents told that they earn in between 20000-25000 taka per month and only 3% or two of the respondents earned within the range of 0-5000 taka per month according what they said.

Meanwhile it might be considered as important to be noted that 16% or 11 eleven of the responded declined to talk about the amount money they earn per month. This inertia of responding to the question that reveals a person's amount of earning a person does per month may be a result of thinking that the answer as too confidential to be revealed and out of the generally practiced unwillingness of uncovering a financial account in front of a newly met person.

1.7: Monthly Expenses

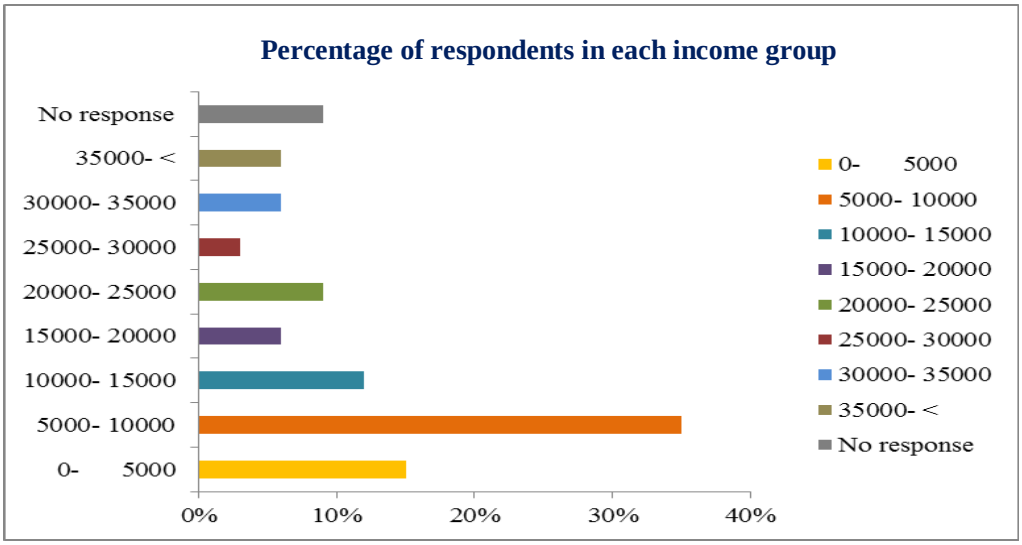
Information on amount of monthly expense of the respondents were made for bringing out the data on whether they could make any savings at the end of the month or not or whether they were put in the state of deficit. This information was deemed as necessary because the attitude of people towards having medical care on eye ailments taken may be a subjected to their economic status. However, it was seen that most of the people interviewed i.e. 35% 24 of them identified them of spending in between the range of 5000-10000 taka that goes quite hand to hand with that of having most number of people interviewed were of low income group. The second most number of people that is 10 or 15% of the respondents spent of 0-5000 taka followed by 12% spending in between 10-15 thousand taka. The other groups followed were 9%, 6%, 6% and 3% spending 20-25, 30-35, 35 and more and 25-30 thousand taka per month respectively totaling

24% who might be considered to be among the middle-income group while 9% declined to answer this question.

2.0: Knowledge of the respondents about eye ailments

2.1: Status of knowledge of the respondents on eye ailments

In order to know about the minimal level of consciousness on eye ailments; this question was asked to the respondents. It was a matter of delight to see that 97% of the respondents responded positively indicating that there remains a good proportion of consciousness on the specialty on eye related ailments among the mass given this sample of population is considered as a



Graph:*Percentage of respondents based on income group*

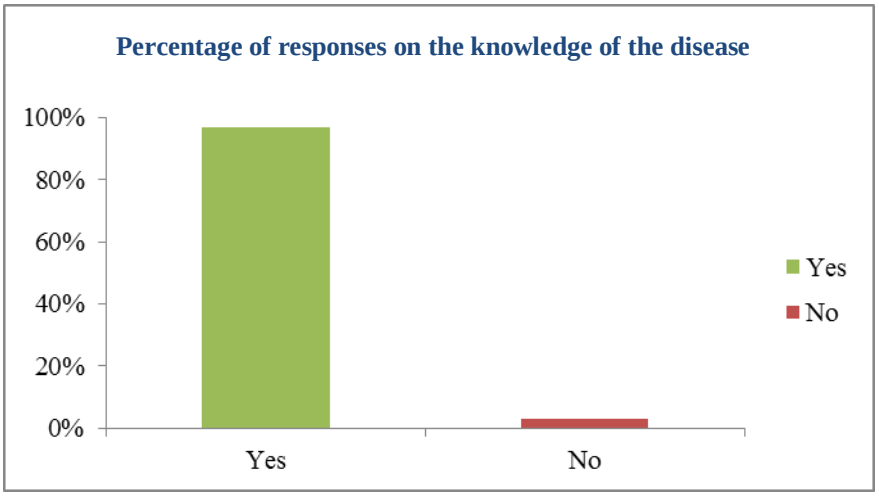
representative sample. Only 3% however did not know of the specialty of eye ailments that may add point to the failure of the concerned initiatives with the task of informing everybody of such a vital field of health care and its distinctiveness.

2.2: Source of the respondents' knowledge

This very important part of the study deals with the level of success of intervention of different sources ranging from purely government to semi or non-government and very private sources personalized sources such as family and friends, social connections etc. it was discovered that most of the people that is 59% responding to the question answered that they came to about the issue from more than one sources. This categorically implies of the many elements working on

the issue of creating social awareness on the mass of the issue and its uniqueness. The second most percentage of people i.e. 18% came to know about it through family and friends followed by 12% who knew from the family. Other anonymous sources had 4% and non-government eye camps accounted 3% of the population as the sources from which they firstly came to know of it. It was ironic to see that none of the respondents considered government employed health workers or any other government sponsored programs as their primary source of information on the issue. **The absence of effective programs from the part of the government is palpable in this field. This may be said as a failure from part of the government machinery. Introducing useful government sponsored awareness program and inclusion of topics on eye health related issues in the primary school curriculum may be ways forward to overcome the problem.**

It was also noticed that no one answered that they came to know about this problem through private medical doctors. Someone may feel the business oriented attitudes of the physicians while they engage in private practice and there they do not feel bound by the ethics of necessity of helping the humanity and creating awareness among them of the possible diseases they should be made aware. It was a mystery however why 4% of the respondents denied to respond to the question. An area chart therefore has been given below to try to give the reader an idea of how much influence which factor has in informing people of the issue.



Graph:*Percentage of responses on the knowledge of the disease*

2.3: Status of Gender Inequality in getting informatin about eye ailment

The presence of gender inequality in the very source from where the respondents came to know firstly of the issue may very likely influence their knowledge about it. It may even sway them based on the presence of gender inequality and its various degrees of reacting to eye ailments in their future years. In order to have a clear idea of existent gender inequalities (if any) in the various sources from where the respondents came to know of eye ailments firstly, a number of questions were asked.

It is a matter of contentment that only 6 of the respondents thought that there was some kind of gender biasness in disfavor of the women in the sources from where they came to know about eye ailments for the first time and 56 of them did not think of any presence of such thing in there. Even the number who thought they witnessed such events is very small; five of the six persons of them did not seek refuge for any help to any person/s against it shows the mental subjugation suffered by the children from their early age to speak out against any biasness they perceive.

3.0: Information of eye ailments of the respondents

3.1: Information on whether the respondents suffered from the ailment or not

For the sake understanding whether the respondents in study themselves had firsthand knowledge of the situations faced a person suffering from eye ailment/s; the question on whether they themselves suffered from it was asked. Most or 56% of the respondents answered positively that means a little more than half suffered from it and the remaining 44% did not suffer from it. This experience of suffering or not suffering from the disease may be a factor contributing to difference of opinion of them on matters relating to the existing scenario relating to the disease.

3.2: Kind of eye ailments the respondents suffered from

Of the 56% or 38 people who went through eye ailments at moment of their life 9 identified their disease of eye as pain, 6 for short sightedness, 5 each for both blurred sight and cataract, 4 as headache due to eye related complications, 3 told their eye sight were severed as rice husk entered their eyes, 2 for each identified problems such as watering from eye, eye allergy, itching and eye swelling and 1 one as having blood clot in eye, pain around eye and dried eye vein. This gives an idea of the variety of eye related problems prevalent in the lives of this land and therefore the need of specialized eye-care treatment facilities for this particular ailment.

3.3: Types of treatment the respondents pursued

It was presumed that based on the academic and economic statuses of the respondents the cultural standards will vary and consequently to that their persuasion towards determining the way/s of accepting means of measures in resolving eye related ailments would also vary. This selection from different forms of medications and measures are of also greatly influenced by the level of awareness achieved through acquiring knowledge from different awareness raising programs.

To know of the situation in the field, when the question of the kind of treatment the respondents chose as a reaction to the eye ailments, the answers varied little. The most number of respondents i.e. 28 responded NGO provided Eye Hospitals or Support Centers as the places to get treatment while the second most numbers i.e. 18 referred to private doctors as the primary source of their treatment. Four referred to Community Clinics to be the answer Government Upazila Health Complexes and Government District Hospitals were mentioned by only one respondents for each. This scenario however may put us in a state of ease that in the case of this disease people are not motivated to be allured by the traditional superstitious methods of unscientific ways of the past such as village shamans or kavirajs. **On the other the failure of the part of the government in providing a essential treatment as this as popular has also come out. Further researches could take place in order to know of this failure and to find out the ways forward to resolve that.**

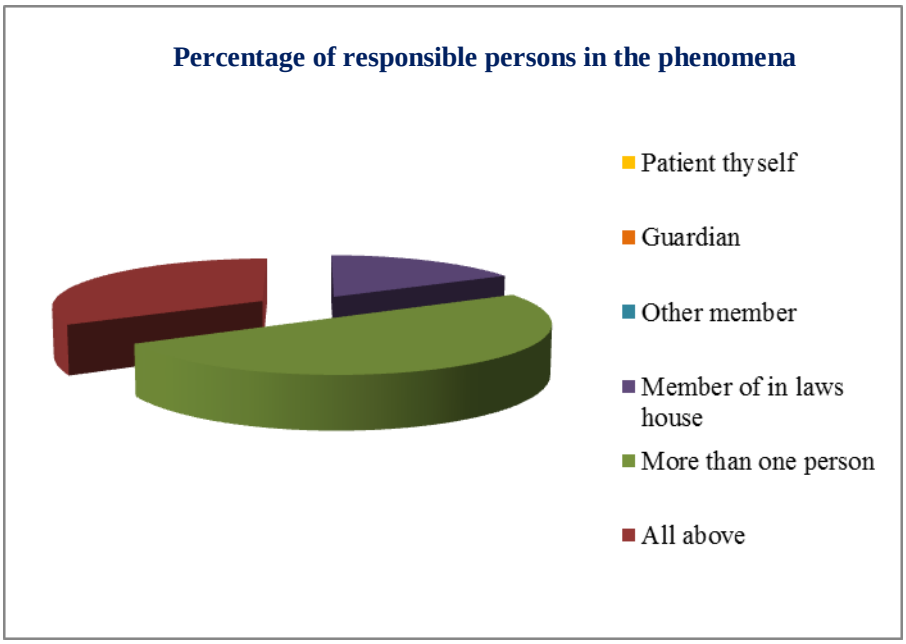
4.0: Gender inequality in patient selection for treatment

4.1: Whether Gender inequality in patient selection persist

When asked the question if the respondent feels that any kind of gender discrimination prevails when the question of selection of people to be considered as worthy to be treated in case of eye ailments or not, overwhelming majority of the respondents or 87% of them answered in negative. Only 9% felt that there in fact was. About 4% declined to comment on the issue. This actually gives us the picture that **though most of the people who answered were not of the feeling that selection of patients was not an issue of gender; some people thought so and according to the mass perception, gender discrimination though in a minor form has yet not been totally eradicated and remains.**

4.2: Who is responsible if the phenomena exist?

Of the six persons with the thinking that there remained gender discrimination in selection of patients, 3 felt it is done by more than one group of people from the given options. While 2 persons made all the groups of people that are direct guardians, members of the family of the in laws, the patient's self, with influences of the neighbors are all responsible for the said kind of discrimination. One respondent held the members of the in laws family particularly responsible for this.



Graph:*Percentage of responsible persons in the phenomena*

4.3: People who are Responsible If Gender Discrimination persists in patients' selection in the respondents own family

When asked who the respondent thinks as responsible in case of any gender discrimination in the above mentioned field, 'parents' was the answer of the most that is 20 of the respondents. 12 made all the members of the family responsible for such things while 3 thought that the elderly ones are the people to blame for it. Only one felt mother as the one as responsible while 1 person each felt the responsibility goes to the grandfathers and grandmothers and the other one responded that this responsibility of discrimination may vary according to the situations.

* Rest of the respondents thinks that they did not notice any inequality.

4.4: Seeking help to anyone against this form of Gender Discrimination in the Family

When asked, in the presence of gender discrimination inside the family, whether the person subjected to that seek help of anybody against it or not, 32% of the respondent admitted of having no knowledge of such movements at all. While 22% categorically answered in negative and only two felt that in some cases reaction as such happens. The rest of the respondents restrained from answering this question. This gives us the idea that even if women get subjected to discrimination inside the family on the issue, they usually do not speak out against it or do not try oppose it. A state of psychological subjugation can be smelt here.

4.5: Reaction to asking for help

Of the two persons that felt like in some cases women show enough courage to seek the help of someone against discrimination inside the family on the issue, one answered that they do not get the necessary help regarding resolving it and the other one admitted of having no knowledge of what happens as the help is asked. So it seems like even if someone tries to bring out the said issue into light and try to get help against it, her effort dies without getting any help from anyone. This response that did not differ among the respondents that if a lady fails to get any help in spite of seeking that from any person she immediately stops there and does not take any more step/s regarding the issue.

4.6: The scenario of Gender Discrimination in the in laws house on matters relating to eye care

When posed the question that if a married lady is subjected to gender discrimination in matters relating to eye care diseases in the house of the in laws, who could be termed as responsible for that, the answers came holding husbands principally responsible. 47 respondents had this view while a significant portion of them, 10 named the mother in laws as the person responsible. Thinking of other members of the in laws house were insignificant though about 13% were with the view that all the members in the laws house could said as responsible in such incidents. 12 did not have a view on the question.

5.0: Information on Distance of the Eye Care Centers

5.1: Distance between the Eye Care Centers and the Respondents' Staying Places

It is understandable that the convenience of the patients to reach the medical centers providing eye care is important to know since it surely has an impact on the possibility as well as frequency for them to visit those places. The found frequency for them to the medical facilities without considering the said factor may bring out results that are misleading. Moreover, it also is associated with the greater holistic responsibility of the state running authority to ensure their convenience along with improvements of other factors.

In order to fulfill this need of information, the respondents were asked about the distance in between their staying places and the nearest eye care centers. A vast number of them accounting for 52% said that the nearest eye care center from their staying place was more than 30 kilometers away. This brings out the fact (given the data is representative) that the efforts to reach out all the members of the state within close vicinity of the centers providing eye care is yet a challenge for us and for most of the people getting proper eye care is still a problem considering the distance they have to cover to reach the centers.

On the contrary, 26% of them told that the proximity from where they lived to the centers are a mere walking one but not to be forgotten the fact these respondents were all living inside the city centers and this helped them have this advantage. **The disparity of enjoying this medical amenity in between the city and village dwellers is quite evident and very clear.** Further information added to this enquiry only reinforces the findings as we see the 10% of respondents who said the centers are about 20-25 kilometers away from their home actually lived within the same amount of distance from the city centers and the reason of the other 6%, 1% and 1% saying the distances were 5-10, 10-20 and 25-30 kilometers away are also likewise. As the problem is found, the need for resolving it by reaching out the most distant part of the population establishing more and more eye care centers in the remote areas could also be considered.

Way to reach the eye care centers

Most of the people or 79%, have to use more than one vehicle in order to reach to the centers. While 6% could reach by CNG/auto, 6% by rickshaw/van and only 3% on foot. It is interesting that even for a good number of city dwellers, there do not exist a single uninterrupted transportation system let alone people coming from the village areas. **Considering the cultural**

and social norms and practices of the society that we live in, it is easy to say from general observation that these obstructions in the way to reach the eye care centers affect the class of female more than the male.

6.0: Gender Discrimination in the Transports to the Eye Care Centers

6.1: Information on Gender Discrimination in the Transports

A generalized question was asked to the respondents on whether women generally get discriminated in the transport or not. Of all the respondents 88% answered that they do not 12% gave their view that they do. However, it may seem satisfactory looking at the percentage but with comparison to the goal of totally eradicating gender disparity, this is unsatisfactory.

6.2 Impediments created due to gender discrimination in the transportation

People who agreed that gender discrimination is prevalent in the way to whatever extent that may be, did not generally agreed their decision of taking eye care treatment as a result of this way related obstructions are impeded except for one respondent. It may have resulted from the increased awareness that increased awareness on this issue. However, the person who thought the problems of the way are preventing some ladies from taking eye care treatment was also of the view that 25% of the ladies may have restrained because of obstructions of the said kind.

6.3 Conditions of road to the eye care centers

When asked to tell about the condition of the path the respondents would follow to reach to the eye care centers from their staying places, 54% or the majority described that as easy. About 32% thought of the way as not so bad whereas 14% felt that as very bad.

6.4 Containment of female patients due to severity of the path

Here, when asked whether women restrain from going to the centers due to the severity of the path to the hospital, only 7 people agreed and the rest did not. Of the seven, two felt the percentage of this abstention to be 20%-40% and one person thought it to be 40%-70%. The rest of the four respondents did not have view on the question.

6.5 Gender discrimination in transport

The view of 75% of the respondents was that the transport sector related people do not subject women to gender discrimination. On the other hand, 16% of them thought they do while 9% did not have any view on the question. When asked of what kind discrimination they face by the said group, the latter group of respondents answered exemplifying the following ones:

- Sometimes male passengers do not leave their seat for any standing woman. However, it is very difficult for a woman to stand in a moving vehicle.
- Ticket checkers stand very closely beside any woman while checking tickets and that is very uncomfortable.

None of the respondents though, felt that any woman restrains from taking treatment on eye care nonetheless, discrimination from the transport related personnel persisted was thinking of some.

7.0: Gender situation of the Hospitals

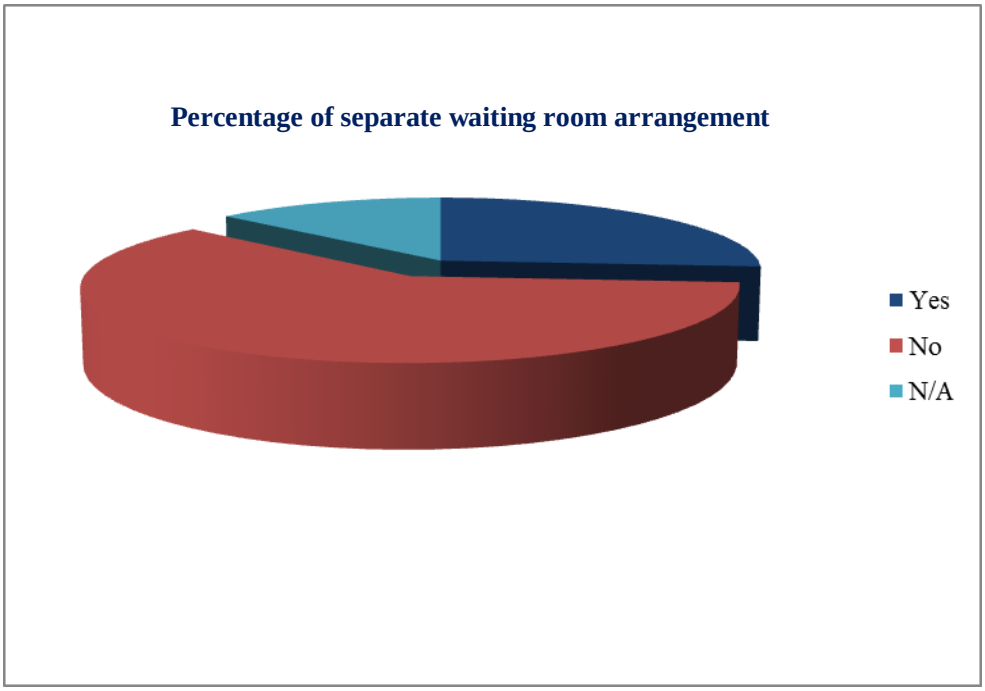
7.1: Security for Women in the hospitals

It was perceived that the situation of the hospitals as one of the core areas with relevance to eye care treatment. The situation of these places in relation to gender attitudes is indispensable to know in order to understand whether gender discrimination in this sector prevails at all or not. As attempts to gather information in this regard, a number of questions were posed before the respondents.

The very first question of part of the enquiry was what the respondents feel for the state of security for women in the eye care hospitals. About 94% of the respondents felt that security situation for women in the eye care centers were satisfactory whereas only six percent answered negatively. People who did not feel the security situation as good enough all mentioned of cases of pick pocketing from inside the area of the hospitals. It might be of worth to mention that no kind of threat/s due to gender came out in the answers that could be perceived as a good thing.

7.2: Provision of separate Waiting rooms for Women

When asked of the presence of separate waiting rooms for the women in the hospitals, 67% of the responses came as negative. This may be a small hint of the callousness of the concerned authority of the special needs for women.



Graph:*Percentage of separate waiting room arrangement*

7.3: Provision of Special Toilets for Women

One may feel a sense of great accomplishment that according to the answers of the respondents, all the eye care medical facilities they knew about, women had special facilities of separate toilets.

7.4: Information on other things that are not Women friendly in the Hospitals

To know of the existence of any women unfriendly things in the centers, the respondents were asked to notify about them. They identified the following ones:

- Scarcity of lady doctors for women
- Absence of separated prayer rooms for women
- No canteen in the centers that is an overall problem but women are the principal sufferers

8.0: Gender Discrimination by the Hospital Management

8.1: Existence of this Desrimination

Another question was asked to know if any management people of the hospitals show any gender discriminatory attitudes or not. About 78% of the respondents did not feel that any discriminated by the hospital management personnel exist while 22% feels on the contrary. The latter also felt that this discrimination actually happens from all strata of the hospital administration.

8.2: Kinds of Discriminations

The people who were with the view that there remained discrimination in the attitude of the hospital management people were further requested to state the kind of discrimination they think exist. Of the 22% from the total respondents who fall under this group, 15% told of discrimination in the case of name entry for visiting the physician or getting admission in the hospital. Women were less prioritized with comparison to men in these cases was there allegation. The 7% even mentioned different kinds of teasing towards women by the management people that may if properly enquired fall under the Criminal Law as Penal Offence.

It was additionally asked to them if women abstain from going to the hospitals/s on the face of the said discriminations or not all of them answered negatively. This is they think because of the mildness of the discriminations.

9.0: Gender Discrimination by the Physicians

9.1: Existence of Gender Discrimination by the Physicians

Answering the question that if the female patients be discriminated by the doctors because of their gender, all the respondents answered negatively denying the presence of any discrimination by the doctors for the reason of gender. The respondents also did not find any discrimination according to gender in case/s of surgery. None of them accounted of any discrimination of female patients for gender reasons in visiting the physicians afterwards either.

10.0: Any other kind of gender discrimination:

It was finally asked to the respondents whether they could think of any other kind of gender discrimination in eye care treatment or not and they could not find one.

Principal gender discriminations found in the findings

Analyzing the found data from the field; the gender discriminations were principally found in the population of the study locale:

S.I.	Question		Positive (%)	Negative (%)	No Answer
1	Gender discrimination in patient selection		√ 9	X 87	= 4
	1.1	The responsibility of this discrimination goes to	Parents	20	
			Every members of the family	12	
			The elderly ones (unspecified)	3	
			Grandfathers	1	
			Grandmothers	1	
			Mothers	1	
			Varies according to situations	1	
	1.2	If the discriminated seek help	They do not	22%	
			They do	2.94%	
			No knowledge	32%	
			Unanswered	43.06%	
	1.3	The result of seeking help	Did not get it	1	
			Do not know	1	
2	Existence of gender		Exist	100%	

S.I.	Question		Positive (%)	Negative (%)	No Answer
	discrimination in eye care in the in laws house		Do not exist	0%	
	2.1	Responsibility of gender discrimination in the in laws house	Husbands	47	
			Mother-in-laws	10	
			Other members	13	
3					
	3.1	Distance of eye care centers from the patients' staying places	More than 30 km.	52%	
			25-30 km.	1%	
			20-25 km.	10%	
			10-20 km.	1%	
			5-10	6%	
			Walking distance	26%	
	3.2	Means of reaching the eye care centers	More than one vehicles	79%	
			CNG/Auto van	6%	
			Rickshaw/manual van	6%	
			On foot	3%	
4	4.1	Gender discrimination in the transport systems	Exist	88%	
			Do not exist	12%	
	4.2	Whether going for eye care treatment for this	Impeded	>1% (about 25% of the female	

S.I.	Question		Positive (%)	Negative (%)		No Answer
		reason is impeded or not		patients are impeded)		
			Not impeded	<99%		
	4.3	Condition of roads to the eye care centers	Easy	54%		
			Not so bad	32%		
			Very bad	13%		
	4.4	Containment of female patients from reaching eye care centers due to severity of the path	They do restrain	7	2 felt it to be 20%-40%	
					The other 5 felt it to be 40%-70%	
	4.5	Gender discrimination by transport people	Exist	16%		
			Do not exist	75%		
			Do not have any view	9%		
			Types of discrimination in the transports	Women have to stand if the seats are occupied even by men		
				The ticket checkers stand		

S.I.	Question		Positive (%)	Negative (%)	No Answer
				indecently close to the ladies	
	4.6	Restrain of female patients from going to eye care centers due to gender discrimination in this field	They do restrain	0%	
			They do not restrain	100%	
5	5.1	Security situation for women inside the hospitals	Satisfactory	94%	
			Not satisfactory	6%	
	5.2	Separate waiting rooms for women	There are	67%	
			There are not	33%	
	5.3	Separate toilet for women	There are	100%	
			There are not	0%	
	5.4	Other problems faced by the female patients	▪ Scarcity of lady doctors for women ▪ Absence of separated prayer rooms for women ▪ No canteen in the centers that is an overall problem but women are the principal sufferers		
6	6.1	Gender discrimination by the hospital management	There exist	22%	
			There exist not	78%	

S.I.	Question		Positive (%)	Negative (%)	No Answer
	6.2	Kinds of discrimination faced from the hospital management	▪ Women are given less priority during name entry ▪ Women get subjected to teasing by some hospital employees		
	6.3	Abstinence from going to the eye care centers due to this discrimination	0%		
7	7.1	Gender discrimination by the physicians	0%		
	7.2	Gender discrimination in surgery	0%		
8		Gender discrimination of any other kind in the field of eye care	0%		

Reasons Specified by the respondents for gender discrimination in the eye care field

The respondents mentioned the following ones as reasons for gender discrimination in the eye care field:

a) **Lack of education:** People often misguided by their illiteracy. Lack of education is cause of gender inequality. Illiterate people have many kind of wrong belief that oppresses women.

b) **Superstitious Social customs:** Most of the women in Bangladesh believe in erotic social value and superstition. In this condition women are always dependent on men. From the early childhood female child is neglected. The birth of male child is welcome on the other hand that of female child is considered as a curse. When the female child is growing up, she realize that she is born to serve the female, she is a curse for the society or family and the social environment enhances her idea and for this men use social superstition, religious sentiment, ignorance's and weakness and helplessness of women.

c) **Wrong explanation of religion:** there are two major religions in Bangladesh. But as most of the people of our country are not educated, they explain religion wrongly thus caused gender inequality.

d) **Lack of consciousness:** Women are not conscious about their health. They do not think regular eye checkup is important unless their eyes get troubled.

e) Personal points of view: there are many people who think that women health is not that important like men's health as women do not work outside and earn money

f) **Lack of implementation of laws for woman:** Bangladeshi laws are good and women friendly. But there is a lacking of implementation of laws. This is the reason of gender inequality.

g) **Financial problem:** Most of the people of Bangladesh are below poverty line. One family consist only one earning member and most of the times that is male. As they do not have enough money to live, when the question of health comes, they prioritize male than a woman.

h) Lack of knowledge: Lack of knowledge is another cause for gender inequality.

i) **Family problem:** Sometimes family problems can be the reason for gender inequality. Every family is not same. Most of the families in Bangladesh are superstitious. So they create inequality in gender.

j) **In some case, women themselves are responsible:** Women themselves are very careless about their health. They hide their problems.

k) **Husband's negligence:** Bangladesh society is male dominant. Husband's rule is everything for women here. So if husband does not want, wife cannot go for treatment.

l) **Considering women as disable:** Society of Bangladesh think that women are disabling. They do not need to be cared.

Data comparison between principal findings and theoretical inputs

The theoretical discussion put here are to be discussed with the reality of Bangladesh and then taken the good things out of those to formulate a solution for are that is practical for us and usable in terms of having a national state philosophy and in-field practice to ensure an eye care sector free of any gender discernment. There is no scope to ignore social structure. Therefore patriarchal value still dominating the society. As a result women are socialized such a way where they did not learn to value their own opinion. They even do not give value to their eyes which are most important organ in our body. SO we can say that women themselves are responsible to be discriminated in every field.we can give an example of a case story.

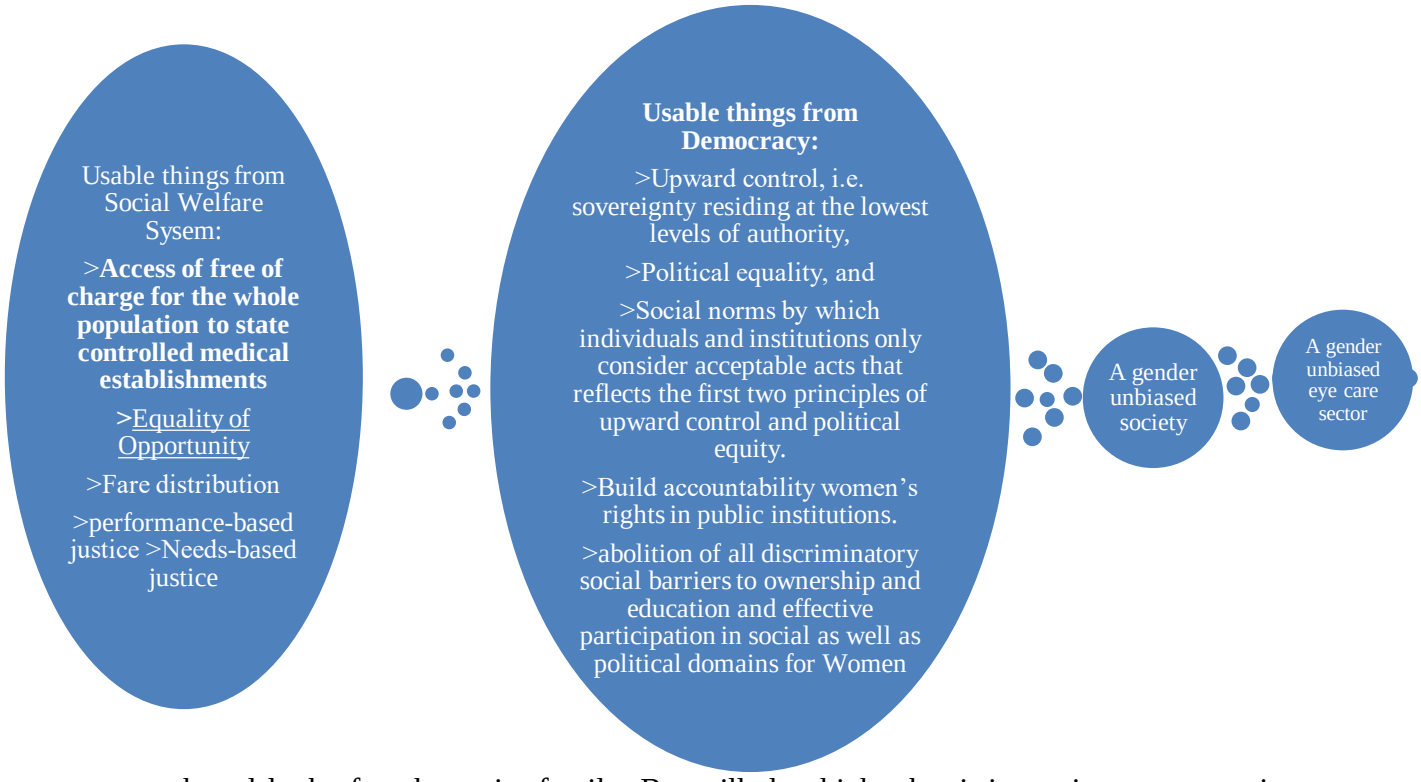
Case story-1.

Name: NasimaBanu

Age- 45

Adress- dinajpur.

she came for his 12 years old son who is a patient of eye. while taking her interview, it revealed that she has been suffering from eye problem since long. But neither had she told any of her family member, nor any member given attention on her problem. in reply of the question why did she do it, she told that, as she is not earning money, eyes are not that important for her. But when we asked if she does any household chores or not, she replied that she had to do each and



every work and look after the entire family. But still she thinks that it is not important to give importance on her health.

In a nutshell, this given in the following chart:

Chapter-7

Recommendations/suggestions

Considering the gathered data and comparisons with those to the suitable state system that has come out after analyzing the principally practiced state systems philosophies of current world, principally practiced religious doctrines of our population and the Constitution and Budget of Bangladesh; the recommendations for having a state and society free of gender discrimination especially in the field of eye care could be drawn as below:

- Any superstitious practice/s discriminatory to women in the field of eye care must be dealt with an eradicated using the method of mass awareness, campaign and social motivation.
- The religions have no issues using which discriminations could be practiced in this field; however misinterpretations of religions could be tackled using the friendly interpretations of religions. The religious Leaders and Scholars could be a very useful tool in doing so.
- There should be a comprehensive state philosophy accommodating equality, equity, performance-based justice, needs-based justice and knowledge basis amalgamating the good factors of the religious and principally practiced state philosophies appropriate for our society. Social Democracy in this regard could be a good way to practice.
- The Constitutional Directional as well as Obligatory Articles and Clauses upholding the rights of women must be ensured in practice in the field of eye care treatment.
- The annual national budget (ANB) of the country in the field of eye care for women should be specified in the budget documents which is currently absent.
- The ANB for female eye patients is highly recommended to be formulated in a bottom-up approach instead of a top-down approach that is being followed currently.
- There should be special eye care units and facilities in all the 13000+ community clinics coming into operation as well as special facilities for the female eye patients in those. A revolutionary change could be done if this is implemented.
- Not only the amount but the proportion of budget should also be increased I the field of eye care in the budget of the Ministry of Health and Family Welfare and the proportion specified for female patients should also be increased.

- The eye care patients should be considered as disabled and included into the social services provided by the government for the disabled.
- The proportion of female doctors, nurses and other eye care related personnel as well as hospital people must come to the point of satisfaction and therefore more women are to taken in these fields.
- The legal provisions for crimes against women such as teasing must be practiced for any incidents relevant to such crimes in the eye care centers.
- There could be provisions for mobile eye care centers built specifically for rural women to supplement the huge need in the rural areas until all the suggested community clinics have provisions for eye care treatment.

Conclusion

It can be seen that gender inequality does exist in eye care in North western Bangladesh. It is not more in service, but women themselves are responsible for that. They look after the entire family, but when it comes to their health, they often ignore. Thus, discrimination in eye care service happens. In summary, our society would be healthier if more women take part more and take care of them.

In Northwestern zone of Bangladesh eye disease exists. In that context, selected NGOs are working. For example, Grameen Eye hospital is conducting their operations for several years. Besides this many other NGOs are also working. It's widely seen that both male and females are affected by eye diseases. But females are more affected due to the regular job as smoke and ashes created from cooking fuel affect their eyes as comparing to their male counterpart. Therefore, infection of eyes among women is seen more in number. In addition, there is a tendency of not getting treatment due to various factors.

Further, case study conducted, indicates that women are less eager to come forward to go for treatment. Besides, due to patriarchal values they are one step behind like other women of the different parts of the country. Data shows that patriarchal values in the socialization process deeply influences not to take equal part with man but rather to lag. Women are responsible particularly regarding health care issue they are seen to be reluctant in health care system especially at their home. Regarding these dimension women may be partially responsible regarding discrimination in their unconscious level due to the socialization process.

Annex- 1
Bibliography

The books and other pieces of literature gone through during this study are stated below:

Andersen K., Lawner LJ., Dewey M E, Letenneur L., Copland J. R. M., Dartigues J. F., Kragh-Sorensin P., Baldereschi M., Brayne C., Lobo A., Martinez-Lage J. M., Stijnen T., HofmanA., (1999) *Gender Differences in the Incidence of AD and vascular Dementia by and the EURODEM incidence research group*, Journal of Neurology, Vol. 53, No. 91992.

Bairey Merz CN, Shaw LJ, Reis SE, Bittner V, Kelsey SF, Olson M, Johnson BD, Pepine CJ, Mankad S, Sharaf BL, Rogers WJ, Pohost GM, Lerman A, Quyyumi AA, Sopko G; WISE Investigators, (2006), *Insights from the NHLBI-Sponsored Women's Ischemia Syndrome Evaluation (WISE) Study*, Part II: Gender Differences in Presentations Diagnosis, and Outcome

Baron-Cohen S., F. J. Scott, C. Allisol, J. Williams, (2009) "*Prevalence of Autism- Spectrum Conditions: UK School-based population study*",https://www.ncbi.nlm.nih.gov/pubmed/19478287

Beletsky, L. (1996). *The red-winged blackbird : the biology of a strongly polygenous songbird*. Academic press, London.314 pp.

Berlin I, (1979), '*Russian thinkers',* Penguin,; Ray S.N., (1986), *The Intellectuals*, Calcutta.

Calhoun C, (2002), *Dictionary of social sciences, Oxford University Press*, ISNBN 9780195123715, DOI: 10.1093/acref/9780195123715.001.0001

Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (1979), Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979,https://www.ohchr.org/Documents/ Professional Interest/cedaw.pdf

Cooper-Patrick, Gallo JJ, Gonzales JJ, Vu HT, Powe NR (1999),Race, Gender and Partnership in the Patient-Physician Relationship by Lisa MD, MPH, MBA; Christine Welson, RN; Danielle E. Fort, MD, MPH; published in The journal of The American Medical Association (JAMA), Vol. 282 No. 6.

Diamond, L., (2004), *Lecture at Hilla University for Humanistic Studies,: "What is Democracy*', https://diamond-democracy.stanford.edu/speaking/lectures/what-democracy.

Dunkle KL, Jewkes RK, Brown HC, Yoshihama M, Gray GE, McIntryre J, and Harlow SD (2004), *Prevalence and Patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa*, American Journal of EPIDEMIOLOGY, Vol. 160, Issue 3, Pages 230-239.

General Assembly Resolution of UN on Women Political Participation, (2011), (A/RES/133).

Holdcroft A, (2007), *Gender-bias in Research: How does It Affect Evidence Based medicine*? Journal of The Royal Society of Medicine (JRSM), Vol. 100, No. 1, 2, 3.

Holy Quran Majid, Surah 30, Ayath 21 (Meaning).

Jary D and Jary J, (1999), *Dictionary of Sociology*, 2nd Edition.https://www.amazon.co.uk/Dictionary-Sociology-David-Jary/dp/0261671995

Jewkes RK, Watts C, Abrahams N, PennkekanaL, Garcia-Moreno C, (2000), *Ethical and Methodological issues in conducting research on gender-based violence in southern Africa, Reproductive Health Matters*' Issue 15, Vol. 8, Pages 93-103.

Julia Kim, MmatshiloMotsey (2002), *Women Enjoy Punishment: Attitudes and Experiences of Gender-based Violence among PHC nurses, in rural South Africa, Social Science & Medicine*, Vol. 54, Issue 8, April, P 1243-1254.

Karl Jaspens, (1957), '*Man in the modern age*', New York, **ASIN:** B004C2X49Q, https://www.amazon.com/Man-Modern-Age-byKarl-Jasper/dp/B004C2X49Q

K Lokuge, M Verputten, M Ajakali, B Tolboom, G Joshy… - PloS one, (2016) *Sexual and Gender-based violence, Médecins sans frontiers/ Doctors without Borders (MSF),*www.journals.plos.org

Kimber and Richard, (1989)."*Democracy". Scandinavian Political Studies* (Wiley) 12 (3): 201, 119- 219, https://www.pssurvival.com/PS/Cooperatives/Democracy-2016.pdf

Kristin, Jewkes RK, Brown HC, Gray GE, McIntryre AJ, Harlow SD, (2004), *Gender based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in south Africa*, 'THE LANCET', Vol. 363, Issue 94119, p 1415-21.

LeonerdSyne S., Amaro H, Emory E, Kellermall AL, Kiecolt-Glaser J, McCormick M, Machanic D, Shekelle P, Sorensen G, SterkC, Swets JA, (2001), *Promoting Health: Intervention Strategies from Social and Behavioral Research; Promotion and Allen Press Publishing Services*, American Journal of Health, Vol. 15, Issue 3.

Lievore D, (2003), *Non-reporting and Hidden Recording of Sexual Assault:An International Literature Review*, ISBN 1-877042-41-2, non-reporting-and-hidden-recording-of-sexual-assault-an-international-literature-review%20(1).pdf.

Meyer L, (2015), Gender-based Medicine: The path to better health for women, Science Page of the Huffington Post.

Michels, R. (1932) '*intellectuals', Encyclopedia of Social Sciences*, *Vol. 8*, New York.

Mumtaz Z, Salway S, Waseem M and Umer N, (2003) "*Gender-based barriers to primary healthcare provisions in Pakistan: The experience of female providers*" Oxford Journal- Medicine And Health - Health Policy and Planning, *Vol. 18*, Issue 3, pages 261-269.

Nasreen HE, Kabir ZN, Forsell Y and Edinborgh M, (2011), *Prevalence and Associated factors of Depressive and Anxiety Symptoms During Pregnancy: A Population Based Study in Rural Bangladesh*, BMC Women's health Journal.

Roy M.N., (1982), '*New Orientation'*, Calcutta, pp.121-22

Roger Scruton, (1996), '*A dictionary of political thoughts*', by, 2nd edition, MacMillan, London

SafaeiJalil, PhD of Economic Programme '*Democracy and Women*', University of Northern British Columbia, received in July 02, 2008, revised in July 19, 2008, accepted in July 19, 2008 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3353593/).

SahihBukhari, Muslim and Ibnemajahsharifs.

Schuler SR, Hashemi SM, and Jenkins AH, (1995), *Bangladesh's Family Marriage Success Story: A Gender Perspective, International Family Planning Perspective, Vol. 21*, No. 4, Pages 132-37, 166.

The Constitution of the People's Republic of Bangladesh

Truant, R., Fridell, R.A., Benson, E.R., Herold, A. and Cullen, B.R. (1998), *Nucleocytoplasmic shuttling by protein nuclear import factors*. Eur. J. Cell Biol. 77: 269-275)

The Medical Research Gender Gap: How excluding women from clinical trials is hurting our health. The guardian magazine, (Apr 30, 2015), UK.

The Journal on Global issue, ISSN # 1544-5399, UN website.

Universal Declaration of Human Rights byUnited Nations in 1948.

Unwin, K.(1946) '*A Century from Freedom*', London,

UN-INSTRW, (2005)

Weiss M. G., Somma D., Karim F., Abouihia A., (2008) C.*Cultural Epidemiology of TB with reference to gender in Bangladesh, India and Malawi,* International Journal of Tuberculosis and Lung Disease (IJTLD);12(7):837-47

Wennerás C and Wond A, (1997), *Nepotism and Sexism in Peer-review; Women, Science, and Technology,* Reader in Feminist Science Studies.*Vol.387/22,* Macmillan Publishers Ltd.

With Regards to Gender-based Pathophysiology of Atherosclerosis, and Macro-vascular and Micro-vascular Coronary Disease,Journal of the American College of Cardiology (JACC), Vol. 47, Issue 3S21-9.

Annex 2

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