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What Money Can't Buy: Getting Implementation Right for MDG3 in South Asia

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The preceding chapter estimated the financial requirements for achieving the third Millennium Development Goal (MDG3). Adequate funding is necessary but not sufficient: policies must also be appropriate, and execution of these policies must be reasonably efficient. This chapter argues that inordinate focus on financing can detract from urgent institutional and policy reform issues. One key argument is that, while financing is important, institutional and implementation-related impediments constitute the real constraints to achieving MDG3 in South Asia and perhaps other low-income countries as well. Often, institutional change does not require large amounts of funding, but rather, strong commitment to implementation and monitoring based on political will.

The issue of financing is at best complex and at worst confounding. This chapter documents the fact that financing can have some rather unexpected correlates and impacts. In particular, the chapter has three main points:

- Funds allocated toward achieving MDG3 frequently remain unspent because of low capacity of implementation agencies and poor attention to bottlenecks.
- There are serious inefficiencies in expenditures and allocations related to mistargeting, corruption, and lack of monitoring, among other factors.
- Outcomes can vary considerably, and good outcomes do not necessarily result in countries with a high level of financing and vice versa. There are cases, as in Nepal most recently, where health and education outcomes have improved despite low and unchanged expenditures.

The chapter also points out that the level of economic development seems to have little relationship to progress in gender equality. Economies with low growth and low per capita income, such as the state of Kerala in

India, and Sri Lanka, succeeded in reducing infant mortality, furthering education for all, and charting the course of rapid fertility decline. This did not happen in other countries. The issue of policy reform, to start with, is difficult because of issues of design and political will, but even when good policies are in place, poor implementation can thwart positive impacts.

The major theme underpinning this chapter is that accountability to citizens and to women in particular is missing from the discourse on MDG3 and in countries where outcomes are poorest. The chapter suggests that such lack of accountability to women and to gender issues, accompanied by women's poor voice in decision-making processes, is at the core of the poor implementation of MDG3. The key pathways to change are to enhance women's voice through such measures as enforcement of property rights, physical security of women, and incentives that will change norms and behavior.

One of the greatest impediments to assessing the impact of public spending and, hence, of financing MDG3, is the fact that literature on the differential impact of financing, or indeed, of weak implementation, on males and females is not easy to find. Conversely, recent public expenditure reviews and other studies on the impact of spending on outcomes have measured the differential impacts of public spending on the poor and nonpoor. An unusual benefit incidence analysis of public expenditures conducted for the Pakistan Gender Assessment showed that the marginal impact of an increase in total expenditures was higher for boys' enrollment than for girls', indicating that boys tend to benefit more from public expenditure on education than girls at both the primary and secondary levels (World Bank 2003).

Conversely, it is difficult to say whether additional allocations in these sectors would positively affect women unless specific efforts are made at targeting and key demand-side issues are taken into account. For the most part, all the countries in question have policies that expressly address the needs of women and girls, at least on paper. Education enrollment, for instance, specifically addresses the problem of lower enrollment among girls, and health policies also take into account the culture of discrimination that leaves girls behind in access to basic health care. But as this chapter will show later, even allocations that are made remain unspent, and neither allocations nor the policy focus on women and girls in the health and education sectors have led to much progress (except in Bangladesh recently). What will change the focus away from the rhetoric contained in policy documents and the attendant allocations made in these sectors and toward implementation and innovations in enhancing demand where it is currently low? This chapter discusses some of the pathways to change.

The Human Development MDGs

This section is based on the argument that meeting MDG3 in health and education is a subset of general outcomes in these sectors. When health and educational systems perform badly, both females and males are affected. For the most part, the poorest women and girls tend to bear the disproportionate burden of poor public services because of their different needs and abilities to access systems. Therefore, reform of dysfunctional and inefficient education and health systems will positively affect all populations, and within them, women and girls.

Health

The MDGs use issues of child and maternal mortality as key indicators of gender equality in health, but in most countries in South Asia, primary health care is seriously constrained for everyone, especially for rural populations and those from the poorest families. Within these constraints, women tend to fare worse because of their special needs during their reproductive years and their differential ability to access services. This section shows that while public health expenditures in the region are low as a proportion of GDP, even the allocated funds are poorly used and outcomes vary substantially across the region, often showing no connection with allocations or expenditures.

Health expenditures per capita vary across the region. India, with historically large public health programs that address everything from immunization and communicable diseases to reproductive and child health, spends about \$27 on health per capita per year, while Bangladesh, Nepal, and Pakistan each spend less than half that—between \$12 and \$13 (table 6.1). However, most of these expenditures are private; public health expenditures count for no more than 1 percent of GDP in any of these countries. Bangladesh has the highest share of public expenditures as a proportion of total health expenditures.

There are Large-scale Inefficiencies in Health Spending

Filmer and Pritchett (1997) found that cross-national higher public spending on health as a share of GDP was only tenuously related to improved child health status. The observed efficacy of public spending was several orders of magnitude lower than the apparent potential. This lack of efficacy was seen to be linked to three possible reform options—increasing the cost effectiveness of public spending, increasing the net impact of additional public supply, and enhancing public sector efficacy—none of them easy and

TABLE 6.1
South Asia: Expenditures on Health, 2003

| Country | Health expenditure per capita (current \$) | Health expenditure, total (% of GDP) | Health expenditure, public (% of GDP) | Health expenditure, public (% of total health expenditure) |
|------------|--|--------------------------------------|---------------------------------------|--|
| Bangladesh | 13 | 3 | 1 | 28 |
| India | 27 | 5 | 1 | 17 |
| Nepal | 13 | 6 | 1 | 24 |
| Pakistan | 12 | 2 | 0 | 18 |

Source: World Bank Development Indicators Database 2007.

each politically intractable. However, only countries that have taken a tough stand on these issues have succeeded in lowering their mortality levels. Other public expenditure reviews across the region show similar inefficiencies, especially with regard to the mistargeting of subsidies and benefits of the public health system flowing to the nonpoor rather than the poor. Thus, Mahal et al. (2001) show that while in general public health care is skewed toward the rich in India, some states do manage to make their spending more pro-poor, pointing again to the importance of institutional change and policy focus. This chapter draws on these studies as examples of analyses that show the inefficiency of public health spending but, unfortunately, have little information on the impact of spending by gender.

While public health expenditures are low, institutions do not seem to absorb these limited public sector allocations and money often remains unspent. "Surrender" of funds—a commonly used administrative term—by districts to subnational treasuries toward the end of fiscal years is common in India. In particular, funds earmarked for the "soft" side of health, for instance, capacity-building initiatives, awareness drives, and demand creation initiatives, such as setting up mothers' groups, are poorly used. In some areas even allocations made for buildings and hardware are not spent.

These low levels of utilization are not just true of India. In most of the years in the period 1999–2004, Nepal spent only about three-fourths of its allocations in health. Table 6.2 shows that the relatively high expenditure of more than 86 percent during 2003–04 was driven largely by high "regular" expenditure, which is a term used for salaries and other recurrent costs. "Development" expenditures (which indicates investments other

TABLE 6.2
Nepal: Proportion of Health Allocations by Expenditure Category

| <i>Fiscal year</i> | <i>Regular expenditure as a proportion of allocation (primarily salaries and other recurrent costs)</i> % | <i>Development expenditure as a proportion of allocation (including donor funds)</i> % | <i>Spending as a proportion of total allocations (regular + development)</i> % |
|--------------------|--|---|---|
| 1999–2000 | 85.79 | 72.32 | 77.18 |
| 2000–01 | 93.10 | 65.40 | 75.48 |
| 2001–02 | 88.86 | 66.48 | 76.16 |
| 2002–03 | 94.18 | 57.79 | 74.00 |
| 2003–04 | 97.40 | 62.38 | 86.45 |

Source: HMGN, Ministry of Health 2004.

than salaries and overhead) as a proportion of allocations are relatively smaller, at about 62 percent of allocations. In fact, the gap between regular and development expenditures as a proportion of allocation widened over the five-year period from 1999–2000 to 2003–04.

Low spending as a proportion of allocation results from a combination of poor program design, rigidity of spending norms, low public awareness that restrains demand for services, capacity constraints of implementation agencies, and low levels of accountability of service providers. Indian states with the poorest health indicators also have the weakest institutional capacity and are unable to spend the allocated funds.

A recent performance audit of a sample of 12 districts in Uttar Pradesh by the highest office of the Comptroller and Auditor General of India (CAG) found that only 64 to 78 percent of the funds allocated for the Reproductive and Child Health Program had been used during 2000–05. In absolute terms, the unspent balance actually increased in the five-year period under review. The report also identifies a number of institutional and implementation constraints that led to the poor use of funds (CAG 2006). Similar reports from the Planning Commission indicate that funds in the lowest performing states remain unspent despite hefty allocations in recent years. Corruption is another major issue in all sectors and this, too, becomes a particular problem in areas with the weakest governance and transparency levels and where state and service-provider accountability are poor.

Outcomes Vary Considerably, Seemingly Having Little Connection with Allocations or Expenditures

Although India spends twice as much per capita as Bangladesh on health care, it has worse outcomes in every health indicator except maternal mortality. Infant mortality rates range from 61 per 1,000 in Bangladesh to 75 per 1,000 in Pakistan. The decline in infant mortality in Bangladesh has been more dramatic than in any of the other countries. Both Nepal and Bangladesh had high infant mortality rates in the 1950s but have brought their infant mortality rates equal to (Nepal) or below (Bangladesh) those of India (table 6.3). Gender differences in infant mortality are similarly uneven. Bangladesh's infant mortality rate for girls is now lower than that for boys, while India continues to have higher mortality for infant girls. Sex ratios in India are declining, favoring boys, while Bangladesh is close to reaching parity in sex ratios. Pakistan has fared most poorly in bringing down its infant mortality rate for both boys and girls.

Immunization rates are similarly puzzling. On the one hand, despite large donor and nationally funded programs for immunization, Indian immunization rates are the lowest in the region and in some states, seem to actually be declining as the Reproductive and Child Health Surveys show (Government of India 2005). On the other hand, Nepal enhanced its immunization coverage despite the Maoist insurgency in the early years of the present millennium. This led to an immunization-driven decline in infant mortality in Nepal. Bangladesh lowered early childhood mortality from vaccine-preventable diseases through the dogged implementation of its national immunization program. These facts point to the salience of factors other than financing.

TABLE 6.3
Pace of Decline in Infant Mortality over Half a Century

| | <i>Male</i> | | <i>Female</i> | |
|------------|----------------|----------------|----------------|----------------|
| | <i>1950–55</i> | <i>2000–05</i> | <i>1950–55</i> | <i>2000–05</i> |
| Bangladesh | 199.6 | 63.0 | 201.4 | 59.5 |
| India | 166.1 | 60.9 | 165.2 | 64.2 |
| Nepal | 211.7 | 64.5 | 210.0 | 64.4 |
| Pakistan | 168.1 | 73.4 | 169.1 | 77.5 |

Source: United Nations 2007.

Note: Infant deaths per 1,000 live births based on medium variant 1950–2005.

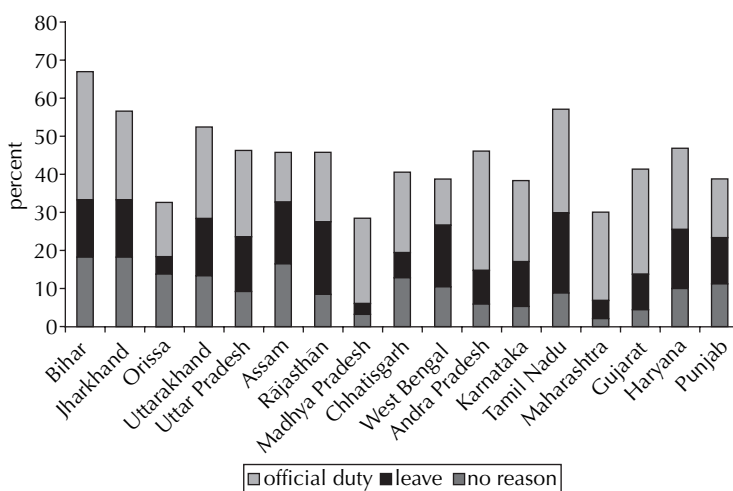
Often Even Well-Intended and Well-Funded Interventions Do Not Work

One intervention, India's Reproductive and Child Health (RCH) Program, serves as an instructive example. The objective of this large national program was to enhance reproductive and child health. The program has been a challenge to implement and maternal mortality remains stubbornly high. Phase I of the program identified the lack of money for transportation as one of the bottlenecks to getting pregnant women to health facilities. The program's response was to set aside money for transportation to be administered by the *panchayat*, the local government with the *sarpanch* at its head. However, when the program was reviewed, evaluators found that most of this money was left untouched partly because the *panchayat* did not know that the funds should be used for this purpose. Moreover, getting pregnant women to hospitals or centers for safe delivery is not a community priority, so the head of the local government never considered spending the money to be a priority, either. Absenteeism among medical personnel is so common that the auxiliary nurse midwife often does not live in the village and, hence, is not available to coordinate the transportation of a pregnant woman to a health center for delivery.

Even when money is available and accessible, frequently no transportation is available to take a woman to the health center. In still other cases the health center is so far and road conditions so difficult that women make local arrangements for birthing, however unsatisfactory these are. Even in the few cases where both the allowance and the transportation are available, there is no guarantee that a doctor would be available at the health center (see figure 6.1).

Setting aside money for transportation was a laudable intervention, but it just did not work well. This example serves to illustrate how well-intended and well-funded interventions are not implemented because of either lack of flexibility and information, or poor demand for and supply of services. The next phase of the program (RCH II) tried to address some of these difficulties by creating greater flexibility and increasing awareness. However, the program is still struggling in many states with low institutional capacity and poor implementation and monitoring systems. A recent audit of RCH II in Uttar Pradesh found that none of the money released for this referral transport was accounted for through "utilization certificates," thus stymieing the release of the next tranche (CAG 2006). The CAG's report also highlights the importance of human resources management and the availability of medical personnel in remote areas.

FIGURE 6.1
India: Doctor Absence at Public Health Facilities by State and Reason, 2003



Source: Hammer, Samji, and Aiyar 2006.

Education

As with health, the relationship between spending and outcomes in education does not yield the expected results. Annex table 6A.1 shows that a country's income level has little bearing on girls' education outcomes. Also, table 6.4 shows that even spending on education overall does not seem to matter much. Per capita spending on education in Bangladesh is much lower than that in India, or even in Nepal for primary education, but progression to secondary school for girls in Bangladesh is much higher. Bangladesh also spends a lower proportion of its GDP on education than India. Income level similarly has little correlation with girls' schooling. Compared with other low-income countries, Bangladesh stands out as a success story in female secondary education, along with some ex-socialist countries and Vietnam. In Bangladesh, moreover, targeted expenditures to girls have succeeded in improving outcomes at the secondary level. Therefore, quality of spending as well as design of programs is important, in addition to implementation.

Bangladesh, Sri Lanka, and Kerala state in India demonstrate what policy and its tenacious implementation could do for girls' education. Though not as dramatic as Bangladesh, Nepal shows that despite the Maoist insurgency

TABLE 6.4
South Asia: Select Education Expenditures and Outcomes, 2003

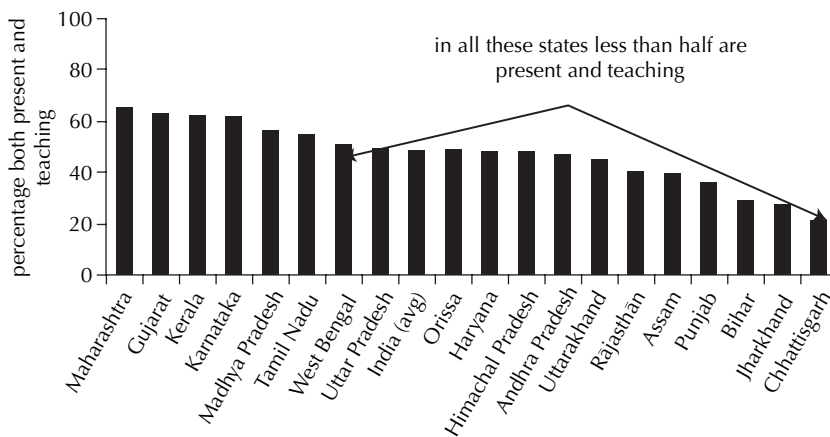
| | Public spending on education, total (% of GDP) | Public spending on education, government expenditure | Public spending on education, total (% of government expenditure) | Expenditure per student, primary (% of GDP per capita) | Expenditure per student, secondary (% of GDP per capita) | Progression to secondary school, female (%) | Progression to secondary school, male (%) |
|------------|--|---|---|---|---|--|---|
| Bangladesh | 2 | 15 | 8 | 13 | 92 | 86 | |
| India | 4 | 11 | 11 | 20 | 82 | 87 | |
| Nepal | 3 | 15 | 12 | 10 | 74 | 79 | |
| Pakistan | 2 | 9 | 6 | 11 | 74 | 74 | |

Source: World Bank Development Indicators Database 2007.

and continuing low expenditures in education, it is rapidly catching up with India in girls' secondary school enrollment. Both supply and demand for girls' schooling rose dramatically in the late 1990s and early 2000s. In India, learning outcomes are improving very slowly despite higher expenditures and larger education programs. Improvements in education outcomes have been stymied by serious implementation constraints and imperfect setting of priorities. For instance, governments tend to be preoccupied with enrollment targets without addressing quality of education and dropout rates. Teacher absenteeism, poor teaching quality, and lack of accountability are other issues that are not addressed that lead to poor outcomes.

Figure 6.2 is based on a nationwide survey using unannounced visits to schools in India, and indicates that fewer than half of teachers were both present and engaged in classroom activities at the time of the visit. Another recent analysis for India found that the correlation between public spending on elementary education and enrollment rates was not strong. However, when efficiency and demand-side factors were controlled for, public spending was positively correlated with enrollment and with quality of education as measured by teacher-pupil ratio (Pradhan and Singh 2000). Fixing control factors, such as efficiency, and enhancing demand for services are at the heart of institutional reform and building trust between providers and their clients.

FIGURE 6.2
India: Teacher Engagement by State



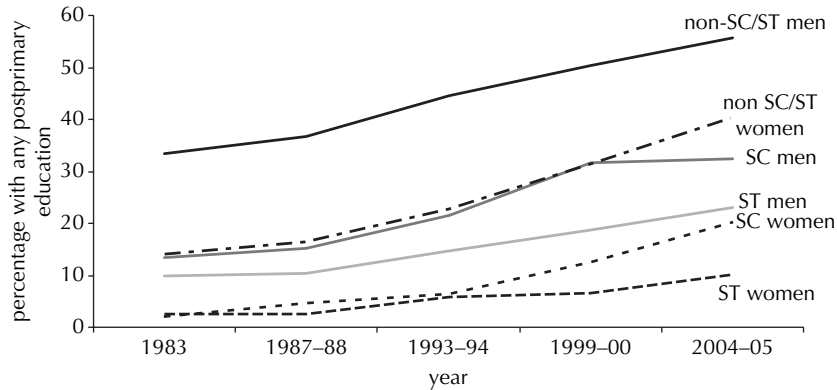
Source: World Bank (2006) based on Kremer et al. (2005).

Some groups and areas are more disadvantaged than others and face the brunt of a poorly functioning public education system. Overall enrollment rates in India are driven down by extremely low educational enrollment for girls from the Scheduled Castes and, more so, the Scheduled Tribes. In Orissa, one of India's poorest states, the overall literacy rate (denoted by ability to write one's name) in the 2001 census was 63 percent, but for Scheduled Tribes it was 37.3 percent. This was an increase from 22.3 percent in 1991, but it is scant comfort that even today the literacy rate for Scheduled Tribe women is only slightly higher than 23 percent (for men it is 51.5 percent); fewer than 10 percent of working age women from the Scheduled Tribes have postprimary education according to estimates based on the National Sample Survey 2004–05 (Das 2006b). Central government allocations to Orissa are high and special programs for Scheduled Tribes exist, funded by both the state and central governments.

The greatest institutional constraints are also in states like Orissa, which find it very difficult to implement policy. Allotted positions remain vacant for years because health and education professionals are even less willing to live in tribal areas where social infrastructure, such as roads, transport, and schools for the children are unavailable. Higher levels of government also find it difficult to monitor these areas for similar reasons. Perhaps at the heart of the problem is the fact that the tribal areas do not have the same priority as coastal areas, home to the majority of the political elite who exercise the greatest voice over political and administrative decision makers. Tribal disempowerment is not merely a result of low levels of infrastructure and services but also the ambivalent rights over the forests in which the tribes live. This situation is not peculiar to Orissa—most of India's tribal populations living in so-called Scheduled Areas have identical issues. As figure 6.3 shows, tribal women in Orissa fare the worst in educational outcomes. This is also true of their health and livelihood outcomes.

In many areas cultural practices combined with structural impediments constitute real barriers to progress. The Pakistan Gender Assessment points out that the practice of restricted female mobility plays a large role in perpetuating gender gaps in school enrollment (World Bank 2005). In Pakistan, school attendance for girls is very sensitive to school proximity, and girls are much less likely to attend school if one is not available within the settlement. This sensitivity to school proximity worsens as girls grow into adolescence. Qualitative studies suggest that concerns over safety and norms of female seclusion are the primary factors behind the precipitous drop in enrollment beyond age 12. This concern is also evident in the rising expenditure on transportation to school reported for older girls.

FIGURE 6.3
Orissa: Change in Postprimary Education by Caste and Gender, 1983–2004/05



Source: Author's calculation based on National Sample Survey for working-age population.

Note: SC = Scheduled Caste; ST = Scheduled Tribe.

Decreasing the physical cost of attending school for girls is thus likely to pay big dividends. How can this be achieved? Because large parts of rural Pakistan are underserved or lack schools for girls, school construction will continue to be important. Where feasible, construction of schools is likely to face another important constraint: there simply are not enough educated women in many Pakistani (or Afghani) villages to staff schools for girls. Government schools and most private schools for girls require female teachers, but insecurity and significant barriers to female mobility prevent educated women from relocating or commuting to areas with teaching jobs. Hiring and retaining female teachers will continue to be a problem, and this problem will be worse in precisely those areas that are poorly served at present (World Bank 2005).

Bangladesh shows that with national vision, the right policy mix, dogged implementation, and high demand, outcomes can change dramatically. Bangladesh's success in female secondary school enrollment is especially commendable because this growth took place within a democratic regime and started from a low base. A clearly articulated national vision for girls' education, and implementation of deliberate policy, propelled Bangladesh's success. In the 1980s, primary school enrollment rose rapidly after the introduction of a food-for-education program for poor children. Following the introduction

of a national scholarship program for secondary schools in 1994, female enrollment exceeded male enrollment in rural areas, and urban-rural differences in girls' education diminished and even reversed. Nongovernmental organizations (NGOs) have also played a large part in improving access to education. For instance, the Bangladesh Rural Advancement Committee initiated a nonformal education program that grew to 35,000 schools covering material for the first three years of primary school. However, there is still work to be done, as indicated in box 6.1.

Institutions have an important role in education and health outcomes. Areas in South Asia with strong implementation mechanisms, discretion at the local level to spend money according to need, strong civil society movements, and efficient administrations have fared the best in education and health outcomes. While Bangladesh, Kerala state in India, and Sri Lanka are the best known cases, others include the states of Tamil Nadu, Karnataka, and Maharashtra. Conversely, poorly administered areas with a high degree of social fragmentation, weak movements to demand accountability, opaque state systems, and poor implementation machinery have fared the worst. Mahal et al. (2001) showed that although the majority of Indian states indicate little difference in the share of inpatient bed days between men and women, this was not the case in Bihar, the North East states,

Box 6.1

Bangladesh through the Eyes of Youth: Improving Educational Outcomes Further

While Bangladesh is a success story in girls' education, challenges relating to boys' enrollment, urban enrollment, education for the poorest children, and overall quality of education remain. The World Bank study "Whispers to Voices" conducted detailed focus group discussions in 2006 with adolescent boys and girls to identify gaps in the education system. Almost every focus group lamented the quality of their teachers. Young women, particularly those still in school and aspiring to higher education, outlined the need for gender-segregated facilities. For instance, schoolgirls in Satkhira said, "There is no college in our area—we want a college to be established here." In Sunamgonj, an area known for its conservatism and yet with very high demand for education among adolescent girls, schoolgirls aspiring to higher education said, "We would like a separate library for girls and more girls' hostels." If appropriate facilities and opportunities are provided, the gap between girls and boys at the higher secondary and college levels can be bridged.

Source: World Bank 2008.

and Uttar Pradesh. In Bihar, for example, the share of men and women below the poverty line is similar (53 percent of women and 52 percent of men), but a smaller share of inpatient bed days was used by poor women (12 percent compared to the 20 percent used by men). All of these states have weak institutions to hold the state accountable and poor implementation of several development programs.

Some ethnic groups seem to fare worse. Women are a heterogeneous category and those belonging to minority ethnic groups and living in remote areas fare worse than men and other women. Figure 6.3 shows the change in secondary school education over time in Orissa for different groups of men and women. A clear hierarchy of who benefits seems to emerge with upper caste (or non-Scheduled Caste and non-Scheduled Tribe) men at the top, followed by upper caste (non-Scheduled Caste and non-Scheduled Tribe) women, and then Scheduled Caste men. Scheduled Tribe women are the bottom of the heap in access to education and this pattern is replicated in access to health.

Similarly, in Nepal, access to and use of a range of health and family planning services for rural women is lowest among the Dalit (lowest caste) and Tarai Middle Caste women. Knowledge levels of Dalit women are also very low compared with the dominant caste Newar, Brahman, and Chhetri and also the Hill Janajati. Contraceptive use among married rural women is lowest for Dalits and Muslims (World Bank and DFID 2006).

Employment and Labor Force Participation

While one of the MDG3 indicators is the share of women in wage employment in the nonagricultural sector, the fact is that nonfarm wage employment is a very small proportion of all employment in many countries, whether for men or for women. In India, for instance, only 15 percent of women and 42 percent of men were in any type of wage work in the late 1990s; of this, the major part was casual agricultural work. In Bangladesh, only 10 percent of employed women and 22 percent of men ages 20–55 received any cash wages in 2003/2004¹ (Das 2006a; World Bank 2008). Most low-income countries are predominantly agricultural and enhancing nonfarm employment is a development goal in itself, so to speak about women's participation in this arena as a marker of gender inequality seems unrealistic and detracts from issues as such barriers to entry into the labor force, unequal wages, and work conditions.

Nevertheless, many countries set up large public employment or safety-net programs for the poor; these programs are typically public works

programs in the nonagricultural sector. India's new National Employment Guarantee Scheme (NREGS), with its rights-based approach to livelihood and its avowed objective of "guaranteeing" women avenues for wage employment and "empowerment," is a very recent example, although it has precursors in earlier similar programs. However, despite its focus on enhancing the participation of women, the results are uneven across Indian states. Table 6.5 shows that whereas the uptake of the employment guarantee is high in Rājasthān, Assam, Madhya Pradesh, and the North Eastern states, women's participation in the program exceeds 50 percent only in Rājasthān. Only Tamil Nadu ranks higher than Rājasthān in women's participation, but the overall uptake of work through NREGS (table 6.5, column 1) is so low that the absolute impact of the program for women is limited.

Voice and public action can change outcomes. Why is the participation of women in NREGS in the top-performing states lower than in Rājasthān, a state otherwise known for its poor indicators of gender equality, its feudal culture, and restrictions on the mobility of women? States like Madhya Pradesh and Gujarat, where rural poverty and tribal populations are high—both factors that would pull women into the scheme—do not do as well as Rājasthān. It can be argued that Rājasthān's performance is a function of voice and public action. The state has had a long history of struggle against irregular payment of wages in public employment programs. In fact, the movement for equal wages for women workers has its origins in the Women's Development Program (WDP) in the 1980s. The WDP took up the issue of wages to women in public employment programs, where contractors would take thumb-impressions of uneducated women on receipts but pay them lower wages than were due (see Das [1992]). Subsequent movements and programs built upon the WDP's momentum. The Mazdoor Kisan Shakti Sangathan (MKSS), for example, is perhaps the most vocal and influential network today, and has taken it upon itself to ensure that the NREGS succeeds in Rājasthān. The MKSS voluntarily and tenaciously monitors the program, demanding government accountability. As a result of its efforts, public officials and government institutions in Rājasthān are much more responsive and alert to problems in NREGS.

In many cases women are "discouraged workers" because of hiring practices or wage discrimination. Oaxaca-Blinder decompositions conducted for wages of male and female casual workers in India and Bangladesh found that unobserved factors accounted for more than 70 percent of the difference in wages (Das 2006a; World Bank 2008). Of these unobserved factors, a large proportion is likely to be discrimination. In Nepal as well, both agricultural wages and unskilled nonagricultural wages for women are lower than for men.

TABLE 6.5
India: Performance of the National Rural Employment Guarantee Scheme, 2007

| | <i>Person-days of NREGS employment per rural household</i> | <i>Share of women in NREGS employment (%)</i> |
|-------------------|--|---|
| Rājasthān | 77 | 67 |
| Assam | 70 | 32 |
| Madhya Pradesh | 56 | 43 |
| North East | 45 | 49 |
| Chhattisgarh | 34 | 40 |
| Orissa | 21 | 36 |
| Himachal Pradesh | 20 | 12 |
| Uttarakhand | 20 | 30 |
| Karnataka | 17 | 51 |
| Jharkhand | 14 | 28 |
| Jammu and Kashmir | 13 | 4 |
| Uttar Pradesh | 11 | 17 |
| Andra Pradesh | 10 | 55 |
| Haryana | 9 | 31 |
| Tamil Nadu | 9 | 81 |
| Bihar | 8 | 17 |
| Gujarat | 7 | 50 |
| Punjab | 7 | 38 |
| West Bengal | 6 | 18 |
| Maharashtra | 4 | 37 |
| Kerala | 3 | 66 |
| INDIA | 17 | 40 |

Source: Drèze and Oldiges 2007 Table 2.

Note: Unskilled labor only. North East states excludes Assam (approximate figures, based on incomplete data). All figures pertain to the districts where NREGA came into force on February 2, 2006. This table is based on figures up to and including February 2007.

Even if equal wages are mandated by law, enforcement is weak. A social audit conducted by an NGO working with the NREGS in a village in Orissa showed that women were actually paid a lower wage, despite equal wages being set for both men and women under the program. This was because the prevailing agricultural wages for men were higher than the wages set under NREGS and men refused to work on NREGS unless their wages were

raised. Instead of allowing men to leave the program, their wages were raised and women ended up being paid wages lower than the mandated wage (AID Rural Technology Center 2007). However, when governments are serious about ensuring equal pay for equal work by putting in place enforcement mechanisms, it is worthwhile for women to enter the labor force, as happens in Organisation for Economic Co-operation and Development (OECD) countries.

The issue of wage employment for women with some skills and better human capital endowments is not in the policy discourse. South Asia ranks second only to Middle Eastern and North African countries in having the lowest women's labor force participation rates. Evidence from India and Pakistan shows that education lowers the probability of women participating in the labor force (Das and Desai 2003; Das 2006a; Sathar and Desai 2000) and that returns to education are low for women in India (Kingdon and Unni 1997). With increasing levels of education across South Asia, women with even low levels of education will not accept manual work and will stay out of the labor market if there is another earning household member (see Das 2006a). Both cultural and structural factors have been implicated in these patterns.

Increases in female labor force participation can result from policy changes, although this may not be the expressed policy goal. Most countries in the region have had policies in place to "protect" women and guard their "morality," and it is often difficult to overturn these policies unless the right opportunities appear. The Indian Shops and Establishments Act 1953 is one example, in that it prevented night work for women in a paternalistic bid to protect women and safeguard public morality. Amending the act so that the information technology (IT) industry was exempt from restrictive provisions regarding night work for women led to the large-scale entry of young educated women into this growing sector. Amendments enabled IT companies to employ women between 8 p.m. and 6 a.m., provided the companies make special arrangements for security, employ women in groups with a minimum of 10 female employees, ensure toilet and rest facilities, and have at least 50 employees in a given shift. Although the amendments to the act were prompted more by the need to tap into a larger supply of skilled labor for the burgeoning IT industry, it opened up that job market for women. While women employed in the IT sector represent a small proportion of all women workers, there is widespread recognition that the visibility of young women in the IT workforce is changing social mores about what is acceptable female employment. Thus, a small amendment can lead to a transformation of cultural norms that are perceived to be restrictive.

Growth in specific sectors resulted in a dramatic increase in female labor force participation rates in Bangladesh. Female labor force participation rates increased from 9 to 26 percent from the early 1990s to 2003 (World Bank [2008], based on Bangladesh Labor Force Survey). Two factors explain the increase in female labor force participation. The first is growth in the garment sector resulting from Bangladesh's advantage through the Multi-Fiber Trade Agreement. The second is growth in the teaching and health care sectors. These two factors meant that women entered the manufacturing and the social services sectors in larger numbers. West Bengal, similar to Bangladesh in cultural norms governing women's work and mobility, actually has lower female labor force participation rates than Bangladesh and this has changed little over time (World Bank [2008] based on Indian National Sample Survey 1999–2000).

Policies that control migration of women similarly show that policy can have unexpected consequences. In a bid to eliminate cross-border trafficking and exploitation of women, several countries have age restrictions and other safeguards in place that require women to produce documentation to show that they will be legitimately employed and their interests in the receiving country will be protected. However, migration policies that seek to protect women have been double-edged swords—responding to genuine threats, but also preventing women from responding to demand for female labor in other countries in the process. The Indian Emigration Act was amended to prevent women under age 30 from migrating as housemaids and caregivers. NGOs are concerned that this will lead to illegal and undocumented migration of younger women and prevent them from accessing any benefits they may be entitled to in the receiving country. Other countries also have age limits for women migrants, but whether this contributes to women's welfare or increases vulnerability is unclear (Manchanda 2007).

Cross-Cutting Issues and Ways Forward

The discussion in the previous section shows that institutional failures, and women's lack of voice and limited decision-making powers are at the heart of poor progress toward MDG3 in most countries in South Asia. This section will examine cross-cutting issues and focus on what is needed to advance the achievement of MDG3.

Women's Poor Voice and Lack of Decision-Making Power

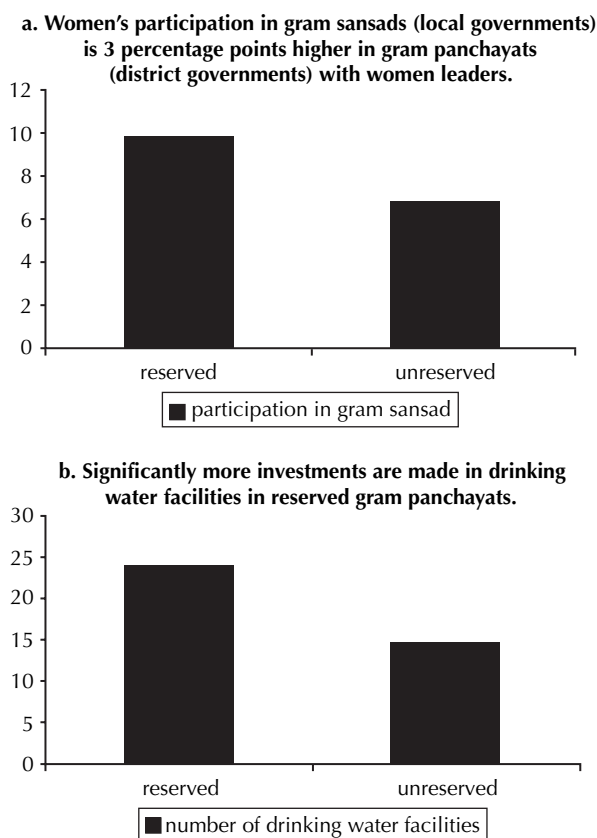
The MDG indicator "proportion of women in national parliaments" is viewed as an indicator of women's voice in decision making. As noted in chapter 3,

this indicator has several weaknesses. It ignores not only women's roles in local-level decision making, but also the fact that national parliaments have only limited power in seeing how policies are implemented. What appears to be more important in the achievement of the MDGs for gender equality is the fact that women lack voice and power at the local level to hold service providers and governments accountable. They are, moreover, not perceived as clients in their own right or decision makers for themselves, either in the public or the private domains. Central to the ability to exercise voice are issues of information, institutions, groups, and rules that place the onus on providers to be accountable to all, and to women in particular. Issues linked to accountability and decision-making power will be discussed in this section.

Many countries have reserved seats in local governments for women. Bangladesh, Pakistan, and India have reserved one-third of the seats in local governments for women. However, no comprehensive evaluation has been made of the impact this has had on women and women's issues, especially on the progress toward achieving MDG3. There are two levels at which such impacts are important. At the level of developing women's leadership, the demonstration effect of having more women in the public domain is instructive for society as a whole and can change perceptions about women's voice. At another level is the question of whether women's presence as decision makers changes outcomes for other women and for gender equality. So, do women take up issues that are important to women? The evidence is thin and it is mixed. Some studies find that women leaders tend to invest more in areas that are a priority for women (figure 6.4). For instance, women leaders in West Bengal are shown to invest more in water and road projects and less in nonformal education, while in Rājasthān women leaders invest more in water and less in roads (Duflo and Topalova 2004 and Bardhan et al. 2005 cited in Ban and Rao 2007). Others find that reservation of government seats for women does not increase accountability to women.

Microcredit groups also have huge empowerment potential. Women's ability to form successful groups is an indication of their voice. Women's solidarity groups have been shown to have a salutary effect on women's ability to seek and access services and markets. In South Asia the impact of microcredit groups on poverty reduction and employment generation is contested, but it is fairly well established that microcredit groups empower women in many different ways. In addition, the general welfare benefits to the household are undeniable (improved child nutrition, immunization coverage, and higher contraceptive use) and the individual benefits for poor women are widely acknowledged. These include a greater role in household

FIGURE 6.4
India: Elected Women Members in Local Governments Enhance Women's Voice



Source: World Bank 2006 based on Chattopadhyaya and Duflo 2004.

Note: *Reserved* indicates those constituencies where the position of the head of the local government was reserved for women.

decision making, mobility, access to services, enhanced self-esteem, and greater public participation (World Bank 2008).

In Bangladesh, the delivery of microcredit through informal groups has helped to nurture a functional space in an institutional environment in which not only formal rules and regulations were very exclusionary for the poor but more specifically exclusionary for women (Rahman 2006). Thus, the informal microcredit group emerged as a separate space for poor women

that allowed them to recognize their weaknesses and consolidate their own strengths, and provided the launching pad for women to enter the public space of entrepreneurship. Within this space they were able to learn the “rules of the game,” how to handle household-based microenterprises while negotiating intrahousehold power dynamics, and to effectively operate larger group enterprises (land lease, water selling, and pond fishery, for example) within broader societal power dynamics (Rahman 2006; World Bank 2008).

A similar debate is under way in India with the massive number of self-help groups that were initially formed with state backing and that also draw on traditional women’s groups, or *mahila mandals*. A recent study on moving out of poverty finds that the existence of women’s self-help groups enhances the overall development performance of a village and the welfare of individual members. Perhaps what these groups succeed in doing most effectively is to provide collective voice for women’s issues (Narayan, Prennushi, and Kapoor 2007). The role of these groups as an antialcohol lobby in Andhra Pradesh is legendary. These groups serve also as training grounds for women leaders. Newspaper reports have pointed to large numbers of women who belonged to self-help groups and contested the recent local elections in Bihar and won.

Policy and government programs, such as India’s Development of Women and Children in Rural Areas (DWCRA) in the 1980s (which was the precursor of other policies that built upon it), as well as nongovernmental initiatives, such as Bangladesh’s Grameen Bank, have aided the formation of these groups. DWCRA started as a component to a standard integrated rural development program but later received central bank backing. Public sector banks, which constituted in the late 1980s and early 1990s the majority of the banking sector, were mandated to lend a certain share to self-help groups. This was monitored most effectively by the National Bank for Agriculture and Rural Development. Simultaneously, state governments put in place their own programs to develop self-help groups.

Therefore, while many microcredit or savings and thrift groups may start out as state-sponsored and supply-driven groups, over time they appear to evolve into viable solidarity groups, provided some conditions exist (Sanyal 2007). However, there are also areas where such movements have not taken off; for instance, in remote tribal areas in India and Bangladesh these groups are either very weak or nonexistent. Other factors may impede their strength—in Bangladesh microcredit does not reach the poorest because women who access microcredit need some collateral.

Access to Assets and Property

That ownership of property, especially of land, matters greatly has long been recognized. This fact has been established empirically through a study of domestic violence in India that finds that ownership of land more than any other factor protects women against violence, thus enhancing their esteem and worth in the household and the community (Panda and Agarwal 2005). Ownership, of course, is not the same as control, but it is a starting point to enhance voice. Although formal property rights in South Asia do not exclude women and some legislation even emphasizes women's rights of inheritance, cultural pressures often force women to give up their inheritance.

Unfortunately, information on ownership of assets by women and men is not collected in regular surveys. Special surveys and tabulations from censuses show, however, that women tend not to be owners of assets. Less than one-fourth of women in Pakistan in a recent survey managed to inherit and retain their parental property (World Bank 2006). In Bangladesh, while the practice of giving up parental property is declining, approximately 25 percent of women who were eligible to inherit property gave it up, and less than 20 percent of older women (who have greater say in household decisions) had their names on rental agreements or title deeds. According to the Bangladesh agricultural census of 1996, out of 17.8 million agricultural holdings only 3.5 percent were female owned (World Bank 2008). In Nepal, according to the 2001 census, only 17 percent of households had at least one female member who owned land, housing, or livestock, and less than 1 percent of households reported female ownership of all three types of assets. Although 84 percent of all households in Nepal own land, just 11 percent of women do so, and whereas more than 90 percent of Nepali households own their home, just 6 percent of women do so (World Bank and DFID 2006).

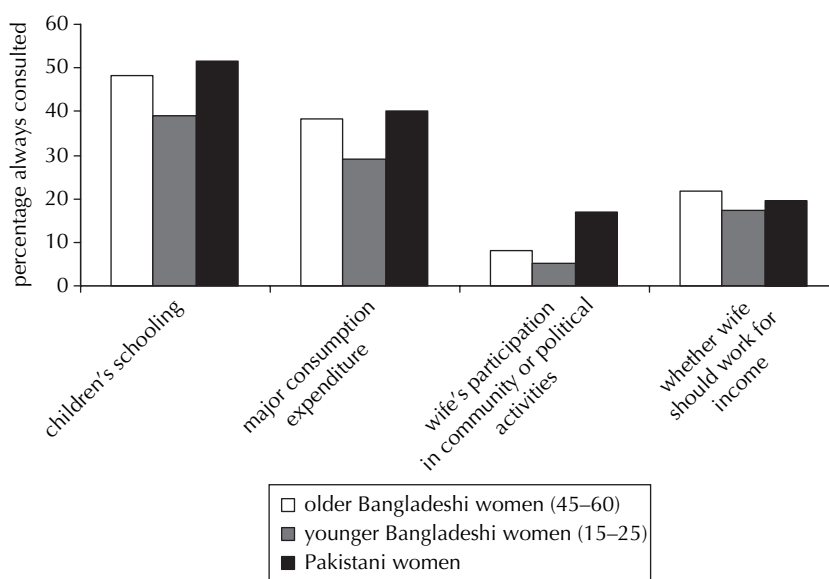
Demand and Ability to Access Markets and Services

Related to women's voice and accountability of service providers, elected representatives, and government functionaries to women is the issue of whether women are able to access services and markets. Intrinsic to women's access to education, health, and labor markets is their ability to leave the home and seek these services and markets. Ability refers to both the absence of restrictions and the financial wherewithal to seek these

opportunities. These have been written about at length, usually based on the questions from the Demographic and Health Surveys (DHS). While much is made of constraints on mobility, the DHS show that the main reason women did not seek antenatal care in Bangladesh was because they did not find it necessary to do so. Thus, demand for maternal health care is severely constrained even if the supply is good. But issues of demand and supply are too mutually intertwined to be easily separated. For example, maternal care facilities may be available, but if women do not like the quality of service, they would suppress demand for the service. Lack of awareness and information come through as key constraints to demand (see World Bank [2008] for Bangladesh).

Women's limited voice in the household and community restricts their access to services. Women's influence in household decision making is typically confined to aspects of household functioning (figure 6.5). In particular,

FIGURE 6.5
Bangladeshi and Pakistani Women Are Usually Consulted in Matters Related to the Home but Not Necessarily in Decisions about Their Own Lives



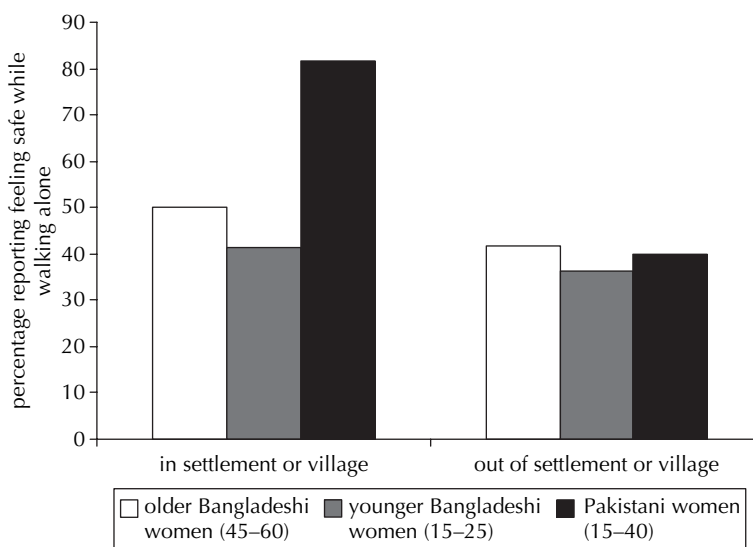
Sources: World Bank 2006, 2008.

women are consulted in areas that have to do with children. Even so, only half of all women surveyed in Bangladesh were regularly consulted in such matters as discipline of children, decisions regarding a sick child's treatment, and children's schooling (World Bank 2008). In addition, in areas dealing with their own relationship with their external environment, women's influence shrinks considerably. This lack of influence has ramifications on their voice in the community as well. In Bangladesh, for instance, women are usually not invited to be mediators in alternative dispute resolution systems (*shalish*), and only some of them can even approach these informal conflict resolution systems (World Bank 2008). In the wake of low access to the formal judiciary for all Bangladeshis in rural areas, such mechanisms are the primary channels through which community-level influence is exercised.

Lack of safety in public spaces can seriously hamper demand for markets and services. Even when demand for services, such as education, exists, factors other than the supply of that service play a major role in constraining access. One such factor is safety and security in public spaces. Figure 6.6 indicates that fewer than half of married women surveyed in Pakistan or Bangladesh feel safe moving alone outside their village or settlement, even during the day (World Bank 2006, 2008). This is a strong reflection of the state of public safety for women. Even the perception of lack of safety can have seriously deleterious consequences on their ability to access markets and services.

Cultural norms are also correlated with perceptions of insecurity by families of girls and women. Permission to leave the home, which is measured in many surveys like the DHS, may actually be a reflection of more than a cultural norm of seclusion or control being exercised by elders. It may also reflect the hazards to personal security in public spaces that women face. This is where policy can make a huge difference. Making public spaces safe for women is a major step forward in enhancing women's access to these spaces. Anecdotal evidence about the pressure on local administrations in such cities as Bangalore, Hyderabad, and Pune (India), where the new outsourcing industry employs young women working shifts, indicates that governmental response to such pressure is important. Moreover, issues of security in general and women's security in particular have been taken up by India's National Association of Software and Service Companies. Backing by such influential lobbies is important in ensuring that security concerns are addressed, but in rural areas, women seldom have lobbies that articulate this demand.

FIGURE 6.6
Perceptions of Safety among Pakistani and Bangladeshi Women



Sources: World Bank 2006, 2008.

Policy and Gender-Equality Outcomes

Policy and national vision have clear roles in achieving gender equality and meeting MDG3. Although women's empowerment is often not central to the design of key policies, in some instances it has been an unintended consequence. Not every good outcome for women needs to necessarily be the result of a formal policy, but the recognition that many policies have different impacts on men and women is an important step and draws from the overarching national framework.

Integrating women's empowerment and gender-equality goals into the design of national policy yields good results. Outcomes for women toward gender equality have usually resulted from a central policy directive, attendant rules, and good monitoring based on a national or subnational vision. The experiences in Bangladesh and Sri Lanka show that a clear national vision that includes women's education and health as priorities has helped shape all policies, not just those that target women. In OECD countries, tax laws that reward employed women while also encouraging fertility have been

central in high levels of women's labor force participation. In India, central bank guidelines that mandate public sector banks to lend to women's credit groups or self-help groups have helped to catalyze a movement of savings and credit groups across the country by placing the onus equally on banks and state governments.

Each of these initiatives first defined an objective of gender equality or women's empowerment, in these cases, facilitating women's entry into the labor force or fostering women's credit groups, and then looked at which macro-level policy needed to be "gendered." These initiatives give the term "mainstreaming gender into macroeconomic policy" a different meaning. Rather than trying to include a gender flag in every policy, which sometimes leads to a "checking the box" approach, this strategy makes gender equality a key national goal. The Bangladesh Poverty Reduction Strategy Paper, for instance, has one of the most forward-looking chapters on gender and sees progress on gender equality as a key remaining national development issue (Government of Bangladesh 2005).

Policy pronouncements by themselves often do not lead to a real impact on processes and outcomes. Most countries have constitutional provisions, gender-equality policies, and laws that forbid discrimination. The policy and legal landscape sometimes seems littered with well-meaning pronouncements. These seldom translate into good enforcement. In extreme cases, seemingly retrogressive policies may be announced, but even these may not have the intended consequence. Bangladesh's progressive National Policy for the Advancement of Women was overturned in 2004 because of political considerations, and several conservative clauses were introduced surreptitiously. This generated widespread criticism and protests from activists in the women's movement and other members of civil society. From 2004 to 2007, there have been no indications that these changes have spearheaded more conservative policies in other areas. Therefore, the mere enactment of policies or laws is not enough. Unless marked by implementation and monitoring within a clear national goal, the effects will at best be patchy.

A strong civil society movement that safeguards women's rights and progress toward gender equality is indispensable for good outcomes. This chapter has reviewed several examples of citizen monitoring and public action as the propellant for good outcomes. Pressure from grassroots movements and increased awareness about gender inequalities in the public domain help to pressure policy makers and implementing agencies. The role of NGOs in Bangladesh not only in direct provision of services, but also in carrying

out innovations and in representing the interests of poor rural women has been well documented. In India, NGOs take up specific issues, as examples from NREGS in this chapter have shown. The women's movement in South Asian countries is typically an amorphous entity comprising both men and women from academia, NGOs, governments, and political parties. In some countries, its voice and influence is larger than in others. Efforts that can enable these organizations to network successfully to create "movements out of initiatives" are one of the ways in which external aid can help. Governments can help by creating the enabling environment for such organizations to thrive and by building components of third-party monitoring into their programs.

Conclusion

This chapter argues that to achieve MDG3 in South Asia, and perhaps in other low-income countries, we have to think beyond resources and funding. In fact, this chapter shows that pushing money at the problem will not make it go away. As it points out, the issue of financing is at best complex and at worst confounding. Policy reform is difficult because of issues of design and political will; even when good policies are in place, poor implementation can thwart positive impacts. The major theme underpinning this chapter is that despite similar levels of allocation as a proportion of overall spending, outcomes vary considerably across countries. Moreover, even funds allocated to specific programs that should benefit the MDG3 indicators often remain unspent. Finally, the quality of the spending is often poor.

The missing element is accountability to citizens and particularly to women. This issue is even more intractable in areas with poor institutions to start with—not only are outcomes for women worse in such areas, but women have lower voice than in other places. Minority women and women residing in geographically far-flung and inaccessible locales are at even greater risk of not benefiting from policies implemented to meet MDG3. Strengthening the voice of women requires strong social movements and public action, as well as strong national vision that puts in place conditions for women to participate effectively. These include enforcement of property rights, equal wages, child care arrangements, physical security, and incentives that will change norms and behavior.

Annex 6A

TABLE 6A.1
Female Secondary Education in Low-Income Countries, 2000

| <i>Country</i> | <i>Female gross secondary school enrollment (%)</i> | <i>Per capita GDP at constant prices (\$)</i> |
|------------------|---|---|
| Angola | 15 | 715 |
| Bangladesh | 47 | 360 |
| Benin | 15 | 362 |
| Burkina Faso | 8 | 231 |
| Cambodia | 13 | 282 |
| Chad | 5 | 177 |
| Congo, Rep. of | 28 | 934 |
| Eritrea | 22 | 155 |
| Ethiopia | 14 | 102 |
| Gambia, The | 28 | 321 |
| Ghana | 32 | 254 |
| India | 40 | 450 |
| Kenya | 29 | 347 |
| Kyrgyz Republic | 87 | 279 |
| Lao PDR | 31 | 324 |
| Lesotho | 36 | 493 |
| Malawi | 28 | 166 |
| Mauritania | 19 | 355 |
| Moldova | 72 | 301 |
| Mongolia | 77 | 395 |
| Mozambique | 9 | 208 |
| Nepal | 33 | 238 |
| Nicaragua | 58 | 779 |
| Niger | 5 | 167 |
| Pakistan | 19 | 531 |
| Papua New Guinea | 20 | 695 |
| Rwanda | 14 | 235 |
| Senegal | 14 | 459 |
| Sierra Leone | 22 | 126 |
| Sudan | 30 | 388 |

(continued)

TABLE 6A.1
Female Secondary Education in Low-Income Countries, 2000 (continued)

| Country | Female gross secondary school enrollment (%) | Per capita GDP at constant prices (\$) |
|----------------|--|--|
| Tajikistan | 71 | 160 |
| Uganda | 7 | 253 |
| Vietnam | 64 | 397 |
| Yemen, Rep. of | 27 | 538 |
| Zambia | 21 | 328 |
| Zimbabwe | 40 | 570 |

Source: World Bank Development Indicators Database.

Notes

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1. Current weekly status for those not attending school.

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Equality
for
Women

Where Do We Stand
on Millennium
Development
Goal 3?

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