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Gender Responsive Budgeting at Union Parishad: Current Status, Potentials and Challenges

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Abstract: ***While the idea of gender-responsive budgeting has piqued the imagination of individuals all around the world, it is a relatively new phenomenon in Bangladesh. This budgeting technique has been stressed in Bangladesh's previous four National Budget speeches. The government is prioritizing it in order to distribute government funding to all parts of society, especially women. The goal of this research is to establish the level of gender-responsive budgeting at the Union Parishad (UP) and its impact on the responsiveness of UP services, with a focus on health care. Furthermore, it strives to highlight at the union level the opportunities and challenges of gender-responsive budgeting in the health industry. Timeliness in service delivery and level of satisfaction of the service recipients were measured. The impact of gender responsive budgeting, and local political control on budget for UP health services is analyzed. 'The study considers the amount of allocation, flow of fund, continuity of budgetary allocation, responsiveness in service delivery, level of satisfaction of women and level of local autonomy as independent variables to know what services are being provided along with their impacts. The study has opted for a mixed method for data collection and analysis including survey, interview from primary sources along with secondary literature. The study found that most of the local people don't avail health service from Union Parishad and their expectation is not reflected in service delivery or the UP Plan and budget. Timeliness of service delivery and access to information were also major issues. All UP members were not aware of the allocation amount for women's health issue despite 50% UP members saying consultation with women happens before preparing budget. Overall, the study finds that the budgets are not gender sensitive and there is no priority setting of the budget in health sector It recommends training for the UP officials and government initiatives 10 adopt and implement gender responsive budgeting at the union level.***

Keywords: Budgeting, gender, local governance, union parishad, upazila parishad,

I. INTRODUCTION

Gender-responsive budgeting (GRB) is more than just creating separate budgets for women or boosting expenditure on women's initiatives. It rather "seeks to guarantee that the collection and allocation of public resources are carried out in ways that are successful and contribute to the advancement of gender equality and women's empowerment." [1] Gender-responsive budgeting can be traced back to the concept of macroeconomic policy, which contributes to either shrinking or growing the gender gap in sectors such as education, health, and sanitation, among others (Elson, 2002) [2]. In this light, gender-responsive budgeting is a crucial tool for achieving not only gender parity but also equitable distribution of development resources. The Medium-Term Budgetary Framework (MTBF) was implemented in four-line ministries in fiscal year 2005/2006. During the fiscal year 2011/2012, all ministries and divisions were subjected to this process. [3] Government of Bangladesh is now emphasizing public investment for achieving economic growth, equality and development as well. Besides, gender budgetary report is published every year in the budget. [4] The Minister for Finance stated in his budget speech for 2007/08, "MTBF [5] allows evaluating poverty and gender sensitivity inherent in each of the medium-term strategic plan targets." As a result, there would be greater visibility of initiatives linked to gender parity and poverty sensitivity as a guide to financial allocation. In his budget speech for 2008/09, he noted that Gender expenditure accounted for 23.5% of the entire budget. "There have been requests from women activists that there should be an examination of actual allocations and expenditures versus the gender budget allocations," according to the government of Bangladesh's report for fiscal year 2011/12, which included twenty ministries for gender-responsive budgeting. The administration, however, contended that given the current financial data management methods, this was not feasible. Actual expenditure data must be sex-disaggregated in order to track and monitor expenditures for men and women'. [6] Many issues concerning men's and women's health require addressing at the rural level, i.e., union parishad, in order to meet the Gender-responsiveness standards. The government emphasizes 'local governance legal framework, building capacity of local government bodies, expanding the role of citizens' committees, strengthening participation of citizens from various groups, including women and the poor, increasing citizens' role in planning, budgeting, and monitoring' in the seventh five-year plan. [7] As a result, it is critical to analyze the current situation, potentials, and barriers of gender-responsive budgeting at the union level, especially in the health sector.

II. METHODS AND DATA ANALYSIS

A. Method

Data for the current study were gathered from both primary and secondary sources. The study's primary data was gathered through interviews, questionnaires, and focus group discussions (FGD).

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Secondary data was gathered from books, journals, and research studies commissioned by international donor agencies and other organizations. Primary data has been collected from 4 Union Parishads namely, Purba Pagla, & Durgapasha from Dakshin Sunamganj Upazila and Tahirpur Sadar & Badhaghat union from Tahirpur Upazila, Sunamganj District through conducting questionnaire surveys, interviews and focus group discussions. Secondary data was gathered from a variety of sources, including books, scholarly publications, journals, newspapers, and pertinent documents.

B. Data collection instruments

The below table describes the type of instruments used for data collection for this research-

Table 1: Instruments for data collection

No.	Data Collection Methods	Instruments
1.	Questionnaire Survey	Question paper, Questionnaire
2.	Interview	Personal Interview, Using Recorder
3.	Focus Group Discussion	Open Setting FGD

C. Sampling method

The study employed random sampling, stratified sampling, and multi-stage sampling. To conduct the study, 100 respondents were recruited at random from four unions in the Sylhet District, and the respondents in each union were stratified at random based on gender, economic position, and age.

Table 2: Sample Size and Method

Sl. No	Mode of Data Collection	Respondents	Number of respondents
1	Questionnaire survey	Citizens (25 respondents from each of the 4 UPs)	100
2	Interview	UP Chairman- 1x4=4 UP members- 1x4=4 Staff from Health Ministry - 3x4=12	20
3	Focus Group Discussion (04)	Citizens (5 Females for each FGD)	20
	Total		**140**

III. LITERATURE REVIEW

Parveen (2010) investigated gender-responsive budgeting in the health sector in order to achieve gender equality, as well as the function of the national budget and its contribution to GRB. [8] Another study stressed the significance of gender budgeting in the Medium-Term Budgetary Framework in dealing with present constraints and challenges. [9] Akter (2015) investigated how the government continues to spend money for women's progress via the actions of all ministries, divisions, departments, and agencies. [10] Islam, Ahsan, and Biswas (2015) stated in their study that the revenue budget allocation for health services in Bangladesh at the district and sub-district levels is fixed considering the number of staff and beds for food and drugs, whereas other factors such as epidemiological measures, health system including social and other forms of insurance, and Universal Health Care (UHC) are key indicators in health system financing, resulting in the promotion of health facilities. [11] Siddique (2008) noted in the study 'Budget Response of Financial Year 08-09: Gender Lens' that "the ministry has a huge impact on achieving health-related MDGs and for the welfare of the nation." However, continuing disregard of the ministry's budget has done nothing to help achieve the strategic objectives and targets specified in NSAPR-1.' [12] 'of the 54 ministries and divisions, 39 have no direct expenditure for women,' he continued. In three ministries/divisions, there is no gender distribution. CPD (2003) stated in its Report No.53 "Health Sector Programme in Bangladesh: Promoting Participation and Gender Equity" the interaction between primary stakeholders who receive health services and other stakeholders who provide service (government, NGOs, etc.) in order to make health programs pro-poor, gender-sensitive, and participatory while emphasizing gender inequities in health sectors. [13]

In its Second Urban Primary Health Care Project (2015), the Asian Development Bank focused on gender equality, identifying key health issues and approaches to promote health sector development such as reproductive health care, immunization, management of common and minor diseases and injuries, control of endemic diseases, health education and behavior change communication, services related to violence against women, normal delivery and Cesarean section delivery, and primary eye centers. [14]

Nazneen, Sultan, and Mohammad (2018) developed their case study as part of a gender-responsive and socially inclusive budgeting learning process. They investigated and highlighted what works in terms of effectively incorporating gender-responsive budgeting methods into the local government process, notably on the spending side of public finance management. Bangladesh and Kirghizstan were chosen as nation case studies for their field of study. [15]

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Huq (2016) stated in his article that he believes the state of women's participation at the Union Parishad level is critical and deserves special attention in order to empower them, as participation and empowerment are necessary for sustainable as well as participatory development, although there are tremendous gaps in gender balancing in terms of government policy both at the local and national levels. [16]

IV. DATA & ANALYSIS

Union Parishad has budgeted allocations for particular services. The current study analyses the UP health budget in order to get insight into the degree of gender-responsiveness in budgetary allocation. To ensure need-based services, the government is increasingly stressing GRB in local budgets. This chapter will evaluate budgetary allocation for health services of the UPs for three consecutive years, areas of allocation, pre-budgetary allocation, and the reflection of people' expectations in the UP budget to understand the current situation of GRB at the local level. Government has specific allocation to provide health services at union level. The following table shows information about the amount of budget allocation in selected UPs for 3 consecutive years-

Table 3: Information about the Amount of Allocation for health services in three consecutive fiscal years

Name of the Union	2016-17	2017-18	2018-19
Purba Pagla	26,82,033/	13,14,817/=	11,50,000/=
Tahirpur	1,98,620=	1,70,970/=	7,50,000/=
Dorgapasha	18,00,000/=	21,00,000/=	17,00,000/=*
Badhaghat	6,00,000/=	7,00,000/= [1]	8,00,000/=

Budgetary allocation of the Union Parishad is almost same and increases marginally every year. However, the allocation was mostly in the following areas:

1. Vitamins
2. Pregnancy allowance
3. Post-delivery gifts
4. Safe drinking water
5. Saline and basic medicines
6. Medicine cost
7. Pregnancy care and test
8. Hospital infrastructure
9. Stair in community clinic
10. Fever
11. Cold

Specific areas of allocation for women:

1. Pregnancy allowance
2. Post-delivery gifts
3. Pregnancy care and test

In the FGD we found out that the UP members are completely unaware of the amount of allocation for women health issues. It means proper communication regarding budget on health issues isn't taking place. As the UP members were unaware of the amount of allocation for women's health issues, they could not specifically mention the areas where the fund has been spent in the particular fiscal year. In a member's word, "We do not have any idea about the amount of allocation because we only take part in the pre-budgetary discussion but we are not informed about the areas of allocation after the budget gets approved." Regarding budgetary information, one of the UP chairmen shared his experience in this way: "We prepare budget following the previous budgetary framework and increase the amount slightly. We have no idea about gender-based allocation. Even, there has not been any enforcement to implement gender-based budgeting. We spend the budget mostly for roads, logistics, sanitation in Community Clinic etc."

1. Pre-budgetary discussion and reflection of citizen's expectations in the up plan/ budget

Citizens have the platform to communicate with their elected representatives about their service-related needs. Respondents are taking health services from facilities such as Union Health & Family Welfare Center, Union Sub-center and Community Clinic which are coordinated by the UP. So, they should have the opportunity to share their views and feedback with the UP chairman and members. 94% of respondents had never contacted UP officials about their need for help. According to them, there is no way for them to complain to UP officials that they are not receiving proper health care from the union parishad. One of the respondents shared his opinion in this way, "UP Chairman and Members hardly give any attention to our response. So, it is very difficult to place it before UP officials through UP chairman and members". In contrast, 6% of beneficiaries have talked with UP officials (i.e. chairman, member) about their service-related requirements since they have or are receiving those services as a result of their strong relationship with UP authorities.

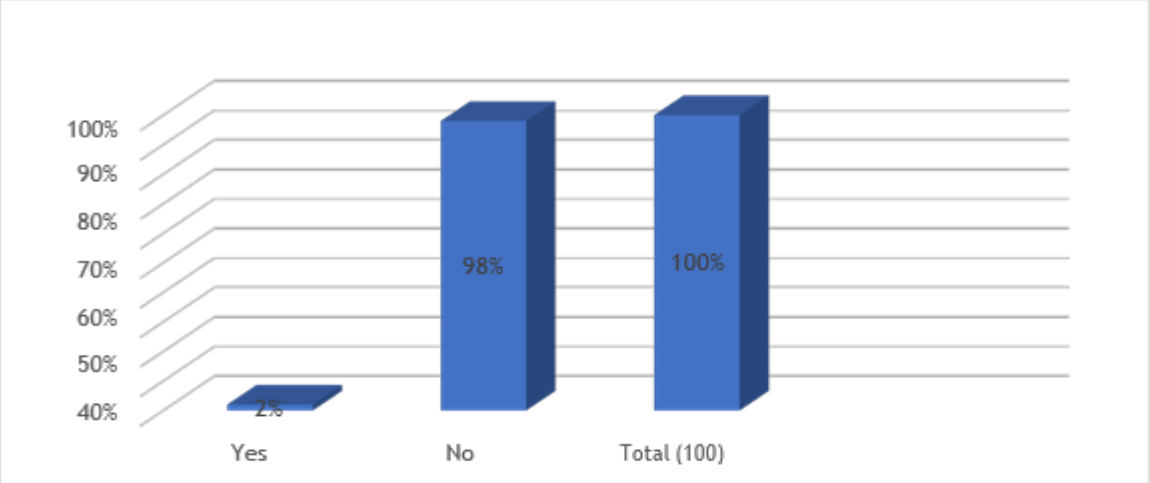
Table 4: Consultation with the community women by UP members

No	Consultation with community women prior to preparing budget	Purba Pagla	Dorgapasha	Tahirpur	Badhaghat	%age
1.	Yes	--	05	--	04	09
2.	No	06	--	03	--	09
	Total	06	05	03	04	18

According to Table 4, 50% UP members opined that they had consulted with women before preparing budget at Ward Shava and UP Budget meetings. According to them, discussion regarding the following takes place:

- Ward Shava
- General UP Budget Meeting
- Only Presence of community women

In contrast, 50% of UP members believe that women are not consulted before budget preparation. Ward shava provides a venue where locals may express their requirements through financial conversation and have them considered for inclusion in the local budget. Local people were asked whether their expectations for health services have been reflected in the UP budget or not.



Graph 1: Reflection of Citizen's Expectations in the UP budget

From Graph 1 we see that, 98% of the study's respondents said that the UP plan or budget did not meet local people's expectations for health care, while just 2% said that their expectations had been reflected. In reality, UP members do not know the specific health services and are unconcerned about them. As a result, the UP plan or budget reflects very little of the local people's expectations for health care.

2. Impact of GRB in UP

Citizens are entitled to receive health services from Union-level Health Facilities. So, it is a matter of concern as to whether they are receiving health services or not. Also, it comes to concern whether the union parishad is adequately providing health services to local people within their budgetary allocation. To understand the impact of GRB on UP health services, the study has focused on the ratio of local people receiving services versus the people not receiving them, timeliness in service delivery and level of satisfaction of the respondents based on the health service availed from Union Health and Family Welfare Center and Community Clinic.

i.Profile of recipient vs non-recipient of health service

Locals have the right to certain health services provided by the union parishad. According to the questionnaire surveys, only 40% of respondents got health care from Union Health and Family Welfare Center and Community Clinic. Because of the absence of GRB, most of the local people are not availing health services from Union Health and Family Welfare Center, Union Sub-center and Community Clinic. Their respective Union Parishad is supposed to ensure the provision of health services through these entities.

Table 5: Health Services availed from 4 unions

No	Name of the union	Total Respondents	Service availed recipients
1.	Purba Pagla	25	12 (12%)
2.	Dorgapasha	25	18 (18%)
3.	Tahirpur Sadar	25	00 (0%)
4.	Badhaghat	25	10 (10%)
5.	Total	100	40 (40% out of 100)

Table 5 shows that 18% of local people of Dorgapasha received health services from Union Health & Family Welfare Center and Community Clinic and 12% of local people of Purba Pagla received health services from Union Health & Family Welfare Center. In Badhaghat, however, service delivery is severely lacking, with only 10% of the local population receiving health care from the institutions. The Union Health and Family Welfare Center, Sub-center, or Community Clinic provided no health services to Tahirpur Sadar Union survey respondents. Unfortunately, many residents are ignorant of the health services provided by Community Clinics in their community. One respondent claim, "We hardly heard about health service provided by the Union Health & Family Welfare Center and Community Clinic. As far as I know, no one has any experience of receiving health service."

ii.Timeliness in service delivery

Citizens had to wait much too long to acquire health care. As a result, both male and female respondents were asked how frequently they visit Union Health & Family Welfare Centre, Union Sub-center, and Community Clinic for health services. As seen in Table 4, only 40% of respondents use health services.

Table 6: Frequency of going to get Health Services

No.	Frequency of receiving service	Number of recipients
1.	Monthly (At least Once/Twice)	9%
2.	Sometimes (Once/Twice in 6 months)	9%
3.	Yearly	5%
4.	**Rarely (Once/Twice in 2-3 Years)**	**17%**
	Total	**40%**
	Never taken	**25%**
5.	**Not known about the service**	**35%**
6.	**Total**	**60%**

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Because service beneficiaries are not involved in the budgeting or planning processes, the UP is unaware of their health requirements, resulting in the present budget being gender insensitive. Furthermore, male beneficiaries do not receive health care at Union-level facilities. It paints an image of services that are insufficient within the present budgetary allocation because individuals are denied access to such services. If the budget is Gender-responsive, it indicates that the requirements of the local population in terms of health have been represented in the budget and money has been distributed accordingly. That is why we attempted to investigate how long locals have to wait for health care. According to Table 6, we know that 40% of respondents have received health services at union-level health facilities, and their experiences with waiting times for service delivery vary from monthly to yearly. Respondents have been asked about how long it took to get a particular service.

Table 7: Waiting time for service delivery

No	Unit of Time to receive services	Respondents
1	15-30 days	16 (40%)
2	4-7 days	09 (22.5%)
3	1-2 office days	09 (22.5%)
	Total	34 (85%)

The aforementioned table 7 shows that 40% of respondents got very delayed service i.e. within 15-30 days whereas only 22.5% got on-time health service meaning within 1-2 official days. Rest 22.5% of the respondents had to wait a minimum of 4-7 days to get health services. Here, it is to be mentioned that another 15% (6 respondents) did not get any kind of health services from the designated places. Rather they were only provided with prescriptions and were asked to get services from private places. That is why it has not been mentioned in the above table.

Table 8: Timeframe of Specific Service Delivery

Specific health Services	1-2 Official Days	4-7 Days	15-30 Days	Total
Cold	1	6	5	12
Fever	1	2	3	06
Headache in head, chest etc.	0	0	5	05
Pregnancy	3	1	0	04
BP	3	0	2	05
Others (male and female related service)	1	0	1	--
Total	**09 (22.5%)**	**09 (22.5%)**	**16 (40%)**	**34 (out of 100)**

Because citizens' aspirations are not represented in the UP budget, financial allocation is not gender-based. The timeframe to provide basic health care is shown in Table 8 above. Looking attentively at the data, we can find that, with very few exceptions (pregnancy, BP), most of the services took far too long (4-7 or 15-30 days) to be supplied to the recipients because of the lack of GRB. The Table 9 below depicts a Union-specific picture of the state of health services based on data collected from FGD of community women, with Tahirpur Sadar performing very poorly in terms of health service delivery and Badhaghat performing somewhat better than other unions, because locals obtained services within 1-2 official days.

Table 9: Timeliness in receiving health services by the Community Women

Name of the Union	Services received within 1-2 official days	Services received within 4-7 days	Services received within 10-15 days	Services received 15-30 days	Total
Badhaghat	05	--	--	--	05
Tahirpur Sadar	--	--	--	05	05
Purba Pagla	--	05	--	--	05
Dorgapasha	--	--	05	--	05
Total	05	05	05	05	20

According to evidence acquired from many sources, unions do not prioritize gender-based budgeting, causing service to be delayed. In terms of timeliness in providing health care, Badhaghat and Purba Pagla have GRB statuses that are significantly higher.

iii.Level of satisfaction

Male and female patients have different demands when it comes to health care, and GRB helps them be heard. Because GRB mandates budgets to be created based on gender requirements, when users want health services from UP institutions, they will find them easily available, maintaining their level of satisfaction. Because individuals are not receiving the necessary health treatments because of the absence of GRB, their degree of satisfaction is low.

Table 10: Expected and availed health services

No	Expected health services	Number of recipients	Services availed by respondents	
1	**Emergency or male-related service**	**16%**	**4%**	
2	**Emergency or women related service**	**24%**	**4%**	
3	**Primary service (fever, gastric, body ache, allergy, diabetes, headache, cold and cough etc.)**	**43%**	**23%**	
4	BP measure	1%	5%	
5	Better medicine	2%	---	
6	Child health	1%	---	
7	Availability of medicine	2%	---	
8	Availability of doctor	2%	---	
9	**Pregnancy-related service**	**7%**	**4%**	
10	**No expectation**	**2%**	---	
			Total availed	**40%**
			Not availed	**60%**
		Total 100%	**Total 100%**	

From Table 10 we can depict that, 43% of respondents anticipate Union Health & Family Welfare Center and Community Clinic to provide primary health care (fever, stomach, body ache, allergies, diabetes, headache, cold and cough, etc.), while only 23% have gotten those services. As a result, the expectations do not match the services provided. According to the study, 24% of respondents expected emergency or women-related services from Union Health & Family Welfare Center and Community Clinic, but only 4% received such services; similarly, 16% of male respondents expected emergency or male-related services, but only 4% received such services. Aside from that, 7% of female respondents expect pregnancy-related assistance, while only 4% have gotten them. As a result, it clearly demonstrates the disparity between the respondents' expected services and the ones they actually received. 20 Community women were specifically asked in the FGD about the expected services and the services availed. The following table 10 shows similar results about the expected and required services of 4 union parishad under Dakhsin Sunamganj Upazila and Tahirpur Upazila.

Table 11: Union Specific Expected and Availed health services

No	Name of the union	Expected services	Service availed
1	Purba Pagla	Pregnancy-related service	Pregnancy-related service
2	Dorgapasha	Fever, headache, pregnancy-related service	Fever, headache
3	Badhaghat	Pregnancy, child-related and basic health	Pregnancy, child-related and basic health
4	Tahirpur Sadar	No expectation due to unavailability of information about the services	No services availed

From Table 11, we see that except for Tahirpur Sadar, the 3 other UP community women had some basic services including pregnancy-related services as their expectation. But their expectations were somewhat met only in 2 of the unions i.e., Purba Pagla and Badhaghat. The other union i.e. Dorgapasha was unable to provide the mentioned services. Just 40% of respondents could get health care.

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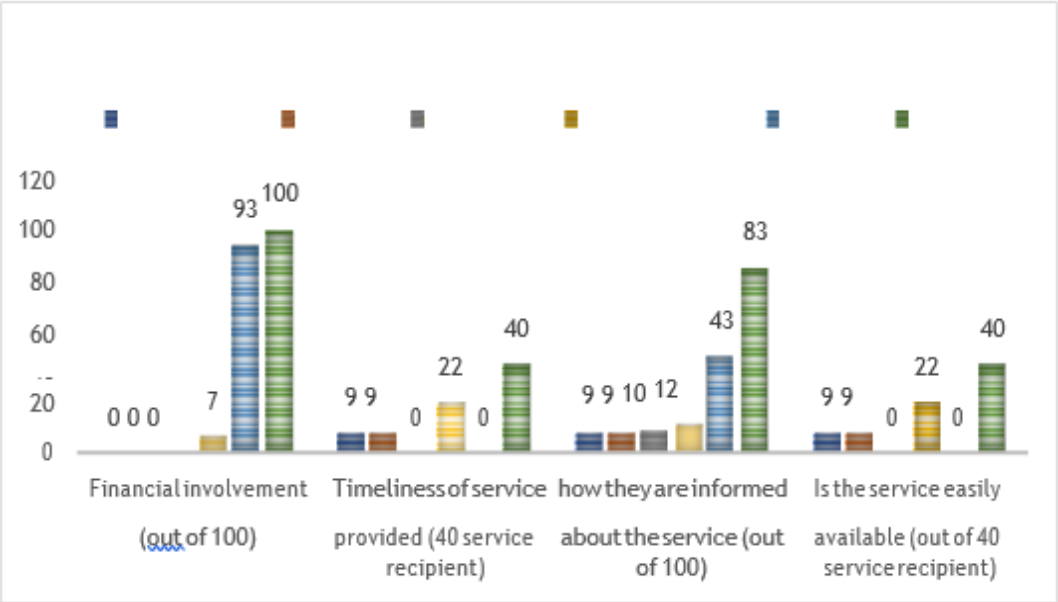
We next questioned that 40% of locals how happy they were with the services provided. People's happiness has been assessed by a variety of factors such as financial engagement, timeliness of service delivery, how they are educated about the specific health care, service availability, and so on. People's happiness may be assessed by a variety of factors such as financial engagement, timeliness of service delivery, how they are educated about specific health care, service availability, and so on.



Graph 2: Level of Satisfaction

From Graph 2, we'll be able to see that, 93% are unsure if they have any participation issues with health care. 7% said they are extremely dissatisfied with their level of engagement in financial decisions. In terms of the timeliness of service delivered, 22% of respondents are extremely dissatisfied. Only 9% are extremely happy with the particular health care. Furthermore, 43% of respondents are uninformed about the specific service, whilst 9% are highly happy and knowledgeable about the service. Service should be freely accessible to the local population, however, only 40% of respondents had used health services, with 22% extremely dissatisfied, 9% very happy, and another 9% satisfied. It paints a picture of four unions' existing budgets that are not gender sensitive. Citizens are seldom involved in the budget-making process. As a result, present financial allocations do not match residents' needs. In brief, the extent of GRB is very trivial which has a broader impact on service delivery as follows:

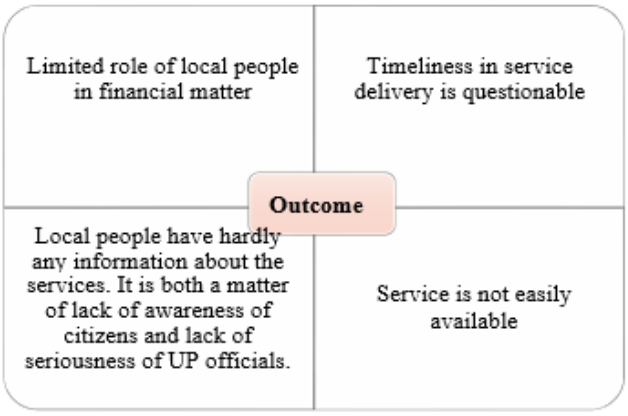


Figure 1: Reasons for Low-level of Satisfaction of the Local People

Figure 1 Beside shows the specific reasons for lower level of satisfaction in each of the Union Parishad namely Purba Pagla, Dorgapasha, Badhaghat and Tahirpur Sadar.

V. RESULTS AND OUTCOME

Potentials of gender responsive budgeting:

a) Eagerness of the citizens

It was shocking to observe that the locals had no notion how to participate in the budget-making process. They were concerned and eager whether or not they would be heard if they spoke to the UP bodies about their concerns. Harnessing this excitement, implementing GRB in these areas will be easy.

b) Willingness of the officials

Due to lack of conception or proper orientation to the concept of what Gender-responsive Budgeting really is, most of the officials did not know how to make it work. But they loved the idea that the people of their area will get better service and as a result seemed more than willing to implement GRB in their respective unions. This is a great potentiality when it comes to implementing the GRB at Union Level.

c) Adequate budgetary allocation for UPs

Since UPs do not have inefficient financial allocation, gender-responsive budgeting will be easier to implement with the assessment of gender needs for health care.

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Challenges of gender responsive budgeting

a) Creating awareness about GRB among up officials

Before implementing gender-responsive budgeting, it is critical to ensure that government officials and local representatives are properly educated on the concept of gender-responsive budgeting. According to the findings of the study, policymakers have little knowledge of gender-responsive budgeting. They prepare the budget by following the budget script from the previous year. As a result, men's and women's health services are never given top priority during planning. One of the members of Tahirpur Union shared his understanding-

"As a member of the Union Parishad, I do not have any idea regarding gender budgeting. Generally, we listen to the opinion of the common people and then suggest UP Secretary take necessary actions. After getting the approval, we are notified about the allocation in various sectors."

b) Administrative barrier

Before implementing gender-responsive budgeting, it is critical to ensure that government officials and local representatives are properly educated on the concept of gender-responsive budgeting. According to the findings of the study, policymakers have little knowledge of gender-responsive budgeting. They prepare the budget by following the budget script from the previous year. As a result, men's and women's health services are never given top priority during planning.

c) Inefficient service delivery

Locals are continuously confronted with challenges while receiving services. For example, respondents claimed that UP officials have never discussed the money or the services they are supposed to receive from Union level health institutions, demonstrating that GRB is non-existent in these Unions. One of the most serious issues raised by virtually all of the people polled in the area is the scarcity of medicine whenever they seek medical attention, which makes service delivery inefficient and difficult to reach out to consumers. Because GRB ensures that people participate in the budget-making process and that their needs are acknowledged, it aids in the delivery of effective services. Since the budget is allocated according to the needs of the people, service delivery becomes more efficient if the other barriers such as administrative barriers are taken away.

d) Union specific challenges

Based on our research, we observed that each union faces unique challenges. Along with gender-specific financial challenges, there are also very union-specific issues described in see Figure 2 that generate difficulty with providing efficient services to the people, according to the community women's in-depth discussion of the existing obstacles through the FGDs. -

a) Institutional Inefficiency
b) Lack of information about the services
c) Making the existing services better

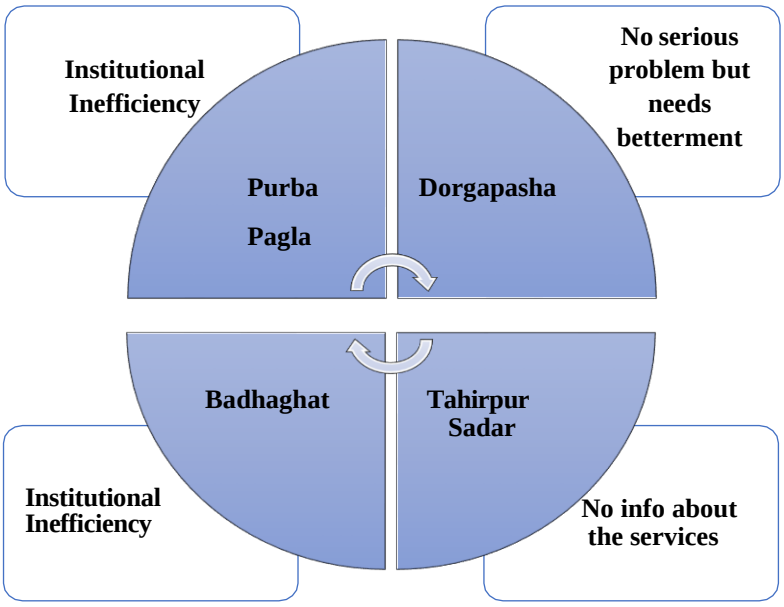

Figure 2: Union specific nature of the problem

e) Priority of females (less priority of males)

By logically attempting to give the female population priority when it comes to handing out drugs or providing care or services, union-level health institutions unintentionally create a picture in which the male population of the area is discriminated against while receiving the same services-

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Table 12: Number of Male and Female Service Receiver from Each Union

Number of People who Received Services in each Union	Male	Female
Purba Pagla- 12	02	10
Dorgapasha- 18	07	11
Tahirpur- 00	00	00
Badhaghat- 10	02	08
Total- 40	**11 (27.5%)**	**29 (72.5%)**

According to Table 12, of the 40% of people who received services, only 11 (27.5 %) of the males received services, however nearly three times as many women (29 women or 72.5 %) received services from union level health institutions. Males have been denied care in cases where there was no female present, because only females are given precedence for services. It also paints a different picture: 60 percent of the surveyed population, regardless of gender, did not obtain any service at all. As a result, it can be stated that the service offered is not gender specific.

VI. CONCLUSION

Gender-responsive budgeting is the method through which the government attempts to ensure that the budget is dispersed for the equal development of society, particularly in the country's rural areas. The analysis demonstrates that the majority of budgets in the selected Union Parishads are not truly gender sensitive. Rather, it is general budgeting with a female focus. In the health sector, there is hardly any budgetary prioritization. In most circumstances, residents do not receive their constitutionally mandated primary health care from the union parishad. The government should provide orientation training for Union Parishad officials, as well as steps to adopt and execute Gender-responsive Budgeting at the Union Parishad level, with effective monitoring.

RECOMMENDATIONS

a) Proper enforcement of GRB

There is no clause or legal documents that make GRB mandatory to be followed at the Local Level, where it is made mandatory at the National Level. Therefore, there should be proper enforcement of GRB at Local Level by the DC office along with National Level.

b) Information gap

While gathering data from the locals, it was discovered that there is a significant gap between the locals and the union authority about the gender-based requirements of the locals. The authorities' and the locals' perspectives were diametrically opposed. The authority must ensure that the opinions of their stakeholders are documented and can be utilized in the future.

c) Gender-based allocation

Because there is a large disparity between what the local people want and what they get, the authority fails to design a budget that addresses the local people's gender-specific demands. As a result, the authorities must concentrate on developing a budget in which monies can be allocated based on the gender needs of the local population.

d) Improve service delivery process

To improve service delivery, there must be enough medicine available and emergency examination possibilities for both male and female populations, as well as information dissemination to the local people. There have been cases where males have been denied medicine because they do not have any female members with them.

e) Professionalism in service delivery

Professionalism in service delivery is extremely poor in all of the unions from which we have received data. The persons in charge of providing services must ensure that they are provided on time, which means that emergency services are provided immediately, and other services are provided according to the period specified in the Citizen Charter. To deliver better services, the Health Officer must have a greater awareness of the population and their problems. The health officer must also be held accountable for providing services when they are required.

f) Changing perception of the society

The majority of people who live in a Union Parishad have no understanding what services they are expected to receive from the authorities. As a result, when they are deprived of those things, they are unable to raise their voices. As a result, they should be informed about their rights so that if they are violated, they can hold the authority accountable.

These are some of the most critical requirements for implementing GRB. If done right, the gender budgeting in the local level such as Union Parishad would result in well implemented policy decisions to bring about tremendous level of positive change in the sector.

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AUTHOR PROFILE

Mostafa Ferdous Hassan is working as the Research and Knowledge Management Officer in The Asia Foundation. He has the primary responsibility for overall Research and Knowledge Management, of his project Collective Impact on Future of Work in Bangladesh funded by the H&M Foundation. He ensures creation and development of research and knowledge products. Mr. Mostafa identify topics and important issues that require more focus from a research perspective. That way he is be able to deep dive into those specific matters to understand the deeper reasoning and to forecast and predict the upcoming internal needs of the project. His reports inform the project to proactively identify issues that are necessary to be looked into as well as provide suggestions and recommendations based on research as to how that issue can be addressed. Mr. Mostafa has 2 years of experience in research and knowledge management especially in qualitative research in the social science and governance arena. He has completed his own research project on Local Governance as the leader of his team in UNDP. The project required him to inherit and showcase comprehensive abilities to finish complete research with all its components including field level data collection, questionnaire making, writing research reports and overall managing a team. Besides that, his simultaneous experience of working with high level researchers in short-term project-based research work has given him experience in quick and agile studies. This experience along with the past year experience in the H&MF project provides him with the right set of expertise to understand the needs of the project and contribute to it from a research perspective. He not only creates research and knowledge products for the internal projects but also produce reports and other writing pieces for communicating them externally to different upstream partners, high level industry and outside stakeholders and public in general. He also serves as the focal for communication and coordination for external consultants related to research and knowledge management. His role in that arena includes coordination of activities of the external consultants, the Foundation and H&MF; ensuring the deliverables; ensuring the proper quality of the deliverables etc. Mr. Mostafa has completed his Bachelor's and Master's Degree from Department of Public Administration from the University of Dhaka as the top of the class.

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