REPRODUCTIVE HEALTH BEHAVIOUR: AN ANTHROPOLOGICAL STUDY AMONG THE SLUM DWELLING COUPLES OF CHITTAGONG CITY

MOHAMMAD MAHBUB ALAM TALUKDER

IN PARTIAL FULLFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PHILOSOPHY IN ANTHROPOLOGY UNIVERSITY OF DHAKA

JULY-2002

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SUBMITTED BY:

MOHAMMAD MAHBUB ALAM TALUKDER
M.PHIL (THESIS PART)
SESSION-1996-1997
ROLL/REG. NO.-223
DEPARTMENT OF ANTHROPOLOGY
UNIVERSITY OF DHAKA

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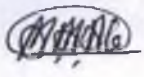
SUPERVISOR

MRS. SHAHEEN AHMED
PROFESSOR & CHAIRPERSON
DEPARTMENT OF ANTHROPOLOGY
UNIVERSITY OF DHAKA

DECLARATION

I would like to declare and confirm that, no part or the material offered in this dissertation has not been previously submitted by me for any degree or diploma in the any other university or institutions.



(Mohammad Mahbub Alam Talukder).

M. Phil Researcher

UNIVERSITY OF DHAKA

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF ANTHROPOLOGY

CERTIFICATE

THIS IS TO CERTIFY THAT, THE WORK IS INCORPORATED IN TO THE DISSERTATION ENTITLED "REPRODUCTIVE HEALTH BEHAVIOUR: AN ANTHROPOLOGICAL STUDY AMONG THE SLUM DWELLING COUPLES OF CHITTAGONG CITY"WAS CARRIED OUT BY MOHAMMAD MAHBUB ALAM TALUKDER UNDER MY SUPERVISION.

THIS DISSERTATION IS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PHILOSOPHY (M.PHIL) IN ANTHROPOLOGY, THE UNIVERSITY OF DHAKA, DURING THE SESSION 1997-1998.

SUPERVISOR

Shaheen Ahmed

(PROF. SHAHEEN AHMED)
CHAIRPERSON
DEPARTMENT OF ANTHROPOLOGY
UNIVERSITY OF DHAKA

IN MEMORY

TO

MY

FATHER

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ACKNOWLEDGEMENTS

I acknowledge with gratitude the financial support provided by the United Nations Population Fund (UNFPA) through the Bangladesh Medical Research Council (BMRC) for this research.

With great pleasure and respect I express my profound gratitude to my supervisor Prof. Shaheen Ahmed, chairperson, Department of Anthropology, University of Dhaka, who added new ideas to my thinking in this area, helped me to put the materials collection into a meaningful order. Without her critical but constructive suggestions it would have not been possible on my part to complete this work. In spite of her heavy workload, I am fortunate in having her active cooperation and guidance throughout the period of this study. Her scholarly instructions and affection shall remain preserved in my mind.

I would like to express my sincere thanks to the Director of the Bangladesh Medical Research Council (BMRC) for approving my dissertation entitled "Reproductive Health Behaviour: An Anthropological Study among the Slum Dwelling Couples of Chittagong City".

I avail myself of the opportunity to pay my sincere tribute to Professor Dr. Ahmed Fazle Hasan Chowdhury, Founder Chairman, Department of Anthropology, University of Chittagong, who from the very beginning of this research, carefully lead me, forwarded valuable techniques and his suggestions, keen interest on the progress of my research. His philosophy of work will inspire me from times to come.

I am ever grateful to Md. Nurul Islam and his family members, Residence of Shantinagor slum who offered to share their home, their food, their family with me. Their warmth, their intelligence, their dignity made me appreciates their hospitality and respect their traditions. Without his active support and cooperation it would not be possible on my part to carry out such a research at Shantinagor slum. I also express my thanks to Rowshan Ara,Hoshne Ara Ripa,Lipi, Munni, Ruma,Joshna, Faroque, who helped me giving the data collection from the respondents.

I express my heartiest thanks and gratefulness to the all respondents of Shantinagor who were the sources of information for this research and without their cooperation this study would have not been possible to carry out.

I am also thankful to the librarians and their associates at the libraries of NIPSOM, ICDDR,B, BIRPERHT, BRAC as well as those of the National Health library for their active help. I also thank Mrs. Zamida Ahmed, Project Officer and Mr. Shazahan and Khairul Alam, Scientific officer of BMRC for their honest inspiration and cooperation during the period of this study. I must thank Mr. Rajesh for SPSS Mr. Nipu for formatting and Mr. Nasir, Mr. Sohel and Mr. Moin for providing me with computer services timely and efficiently.

July, 2002

Md. Mahbub Alam Talukder
M. Phil Researcher
Department of Anthropology
University of Dhaka
Dhaka, Bangladesh.

Reproductive Health Behaviour : An Anthropological Study Among the Slum Dwelling Couples of Chittagong City

ABSTRACT

For a long time, the study of disease and health issues was conceived to be the principal domain of research exclusively within the medical science depending on the biologistic approach. The locale of focus was the human organism itself any physioloque disorder was examined strictly in functioning organs. The causality was examined in biological terms and the emphasis was placed on the cure of the malfunctioning organs within the body. Such an approach though could solve the disorder only, but hardly could explain the broader socio-cultural and environmental context in which disease occurs. Such inherent weaknesses of the bio-medical perspective brought about a major paradigmatic shift in the analysis of not only disease pattern but also health status of a population as a field of inquiry. Epidemiological, Ethno-medical, Ecological as well as social science perspectives -- emerged as new competing theoretical frameworks and increasingly began to dominate in health sciences today.

The pervasive prevalence of high maternal and child mortality that was identified as a critical problem in the traditional rural environments attracted the attention of the health professionals both in the national and international arenas. Major thrust of interventions called for vigorous investigations in cross-cultural settings including Bangladesh in order to find out the clues for such maladies, even at a time when the diagnostic methodologies in medical sciences advanced to a miracle stage. With growing sophistication of research methodologies in medical anthropology and other public health sciences, fresh and holistic studies accumulated evidences of the causality of high morbidity and mortality in the behavioral patterns of adolescent married women in particular. Women of reproductive age both in rural and urban slums tend to share a number of common but typical behavioral characteristics to make them delicately vulnerable to increased morbidity and mortality.

The present research explored into the life-ways of slum dwelling married couples in Chittagong City from medical anthropological perspective. The combined execution of survey and anthropological methodologies disclosed the cultural and environmental context of high morbidity produced primarily by non-compliance of fertility regulation at early stage of marriage, lack of adequate information about the new set of rules to be followed during pregnancy (increased food intake, essential antenatal check ups, avoidance of heavy work load, etc), selection of home setting as a place of child birth and the preference of traditional birth attendant for delivery), non- and under utilization postnatal heath care, non-immunization of new born child within prescribed period, faulty child feeding practices and so on.

Findings of this nature bear implications for urgent health interventions in the slum areas in order to meet the health needs of the currently married women in particular. Given the fact that slums population has increased to an alarming population in recent years, the policy makers and health planners need to turn their attention to the disadvantaged women living under the impoverished conditions. The future plans should also address the issue of proper rehabilitation of the slum dwellers, who have been victims of natural calamities, river erosion, and landlessness at their ancestral rural home. National and International Organizations should take the share of burden towards the elimination of causes that jeopardize the risks of the life of the slum women in their future agenda on development.

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LIST OF ABBREVIATION

ANC- Antenatal Care.

AHI- Assistant Health Inspector.

AIDS- Acquired Immune Deficiency Syndrome.

BRAC- Bangladesh Rural Advancement Committee.

BBS- Bangladesh Bureau of Statistics.

BDHS- Bangladesh Demographic and Health Survey.

BIRPERHT- Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies

CDR- Crude Death Rate.

CPR- Contraceptive prevalence Rate.

EPI- Expanded Programme on Immunization.

FWV- Family Welfare Visitor.

FPMCH- Family Planning Maternal and Child Health.

GDP- Gross Domestic Product.

HIDV- Human Immune Deficiency Virus.

ICPD- International Conference on Population and Development.

IPPF- International Planned Parenthood Federation.

MR- Menstruation Regulation.

NRR - Net Reproductive Rate.

NGO- Non Government Organization.

TFR- Total Fertility Rate.

TBA- Traditional Birth Attendant.

WHO- World Health Organization..

FHI- Family Health International.

GO- Government Organization.

HPSP- Health and Population Sector Program.

IEC- Information, Education and Communication.

RTI- Reproductive Tract Infection.

STDs- Sexually Transmitted Diseases.

UN- United Nations.

IUD- Intrauterine Devices.

UNFPA- United Nation Population Fund.

UNICEF- United Nation Children Fund.

US AID- United Nation Agency for International Development.

PNC Postnatal Care

Key: Study area (Chittagong City)

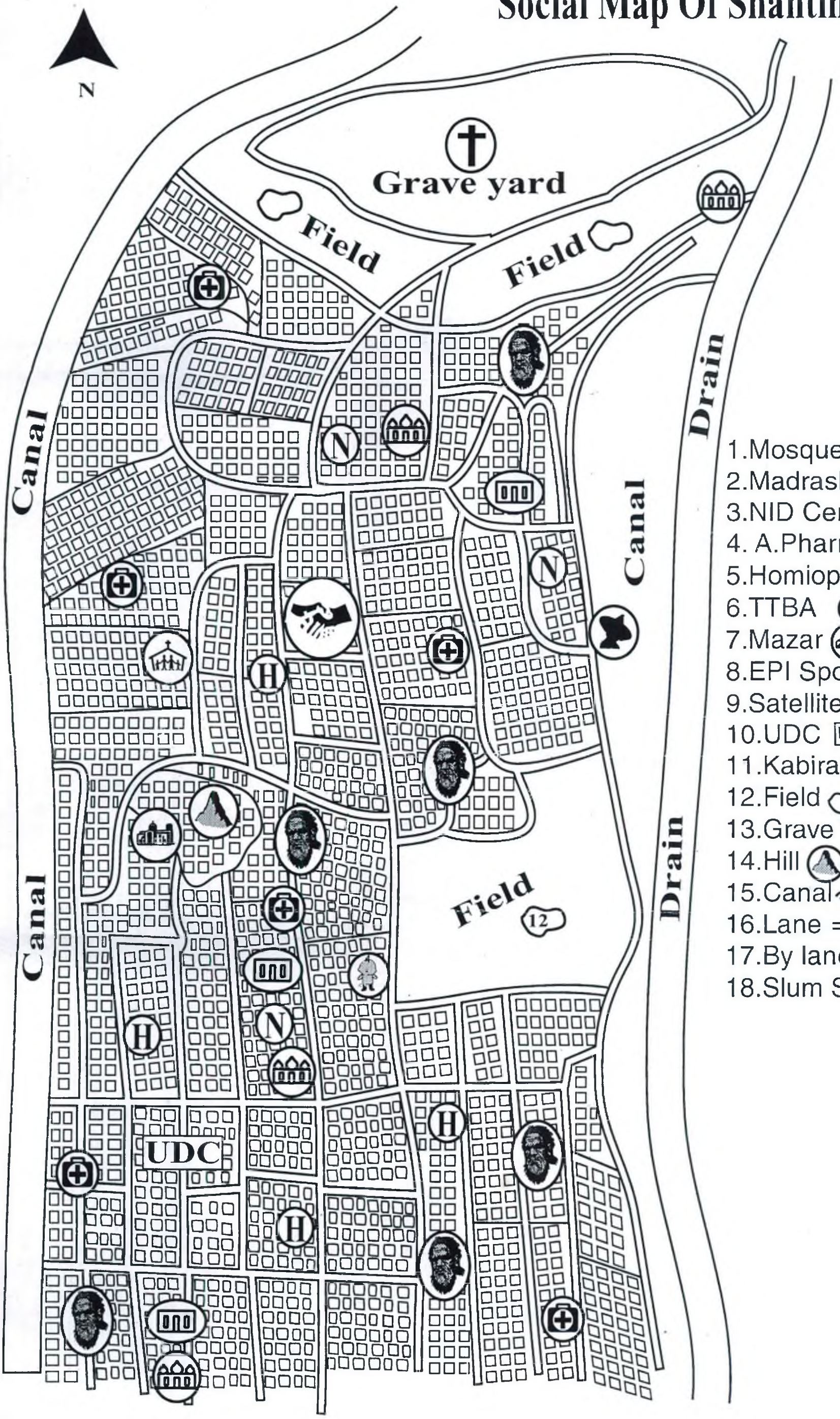
Map of Bangladesh showing the study area (Chittagong City)

CHITTAGONG CITY MAP

Key ● Study area (Shantinagor slum)

Map of Chittagong City showing the study area (Shantinagor slum)

Social Map Of Shantinagaor Slum



CHAPTER - 1
INTRODUCTION

For a long period of time, health professionals in general, demographers and Public Health Specialists as well as Medical anthropologists in particular were absorbed in their research concerns with the problem of regulation of high fertility, and maternal as well as child mortality using conventional demographic parameters. An inherent weakness of such investigations was the ignorance of the complex dynamics that lied at the crucial time point of the women's reproductive health that made them highly vulnerable to alarming health risks in the developing countries, including Bangladesh. This called for search of new perspective both in terms of methodology and theorization, which could address the issue, in question in appropriate direction. The present research is an attempt to investigate the complexities of issues of the reproductive health behaviour of slum dwelling couples in Chittagong City, situated at eastern Bangladesh.

The slum dwellers, which are out-migrants from rural environments trend to share many traditional health values and practices during their reproductive life cycle. They further live is congested unhygienic conditions, predominated by violence, rape, drug trafficking and sex-crimes. These factors put extra risks on the life of the slum dwelling women. They lack of access to primary health care, and thus, their conditions are no less precarious than those residing in rural areas. The health need of such vulnerable group requires to be addressed urgently. No anthropological study has been done on this sub-culture to date.

It is pertinent at this point to briefly provide a rounded picture of the general health related information of women of reproductive age of Bangladesh as a background of the magnitude of the problem under investigation. Bangladesh from the past inherited a high fertility and low mortality demographic feature, a phase normally designated as a "stage of demographic explosion" showing a gradual trend of mortality reduction due to internationally sponsored health intervention programs against deadly tropical and infectious diseases. The present population of Bangladesh is about 120 million, the 9th most densely populated countries of the world at present (BBS 1997). According to a more recent estimate of Bangladesh Demographic and Health Survey (1999-2000),"The population growth rate peaked in early 1970s at about 2.5percent per annum, followed by a decline to 2.2 during the 1981-1991 periods. The relatively young age structure of the population indicates continued rapid

population growth in the future." (NIPORT 20001). From the above data, it is quite evident that Bangladesh has been experiencing a gradual fertility decline over the last two decades. The total fertility rate has declined from about 6.3 in the early 1970s (MOHPC, 1978:73) to 3.4 in the early 1990s (Mitra et. al. 1994:27). The crude death rate has also fallen dramatically, from about 19 per 1,000 populations in 1975 to 8 in 1995 (GOB, 1994:4;BBs, 1997 a; 144). Although infant and under-five mortality rates are declining, they are still high. The infant mortality rate approached 150 deaths per 1,000 live births in 1975 and fell to 87 in 1989-93 (GOB, 1994:5 Mitra et. al., 1994:92).

Despite a considerable decline in the population's general mortality rate, a typical pre-modern health pattern exists pervasively in two demographic segments: mother and child, which continue to show a pattern of high casualty until today. This problem has received increased attention from the health planners and researchers. "The magnitude of the magnitude of reproductive health problem of Bangladesh women", as described by Halida Hanum Akhtar and Taslima H. Khan," is reflected in the high maternal mortality ratio of nearly 5 per 1000 live births" (1997). The problem of high health risk for the adolescent women at their reproductive age in both rural and urban slum sub-cultures is all the more alarming.

Various medical anthropological and epidemiological studies conducted in rural Bangladesh indicate clearly that during the entire span of the reproductive life cycle of a woman, the pregnancy in the early (15-20 years age) and the late stage before reaching menopause (40-45 years age), is equally high risk periods which often results in maternal mortality because of biological predisposition's. The prevalence of high maternal mortality that is encountered in rural environment as well as poor and culturally impoverished slum settings in Bangladesh occurs in the upper age grade of women (adolescent stage) than in subsequent years. One needs to bear in mind that pregnancy is a normal condition of women's life cycle, if it occurs at the proper age of conception, i.e., 23-35 years. This is considered as an ideal and safe period of safe motherhood.

1.1 Reproductive Health as an Issue of Anthropological Research: During the past decades the world has witnessed a significant change in the way population and reproductive health related issues have been discussed and addressed. Initially in the seventies a special programme was undertaken by the World Health Organization (WHO)

to address the issues of 'Human Reproduction'. At that time its objectives were limited to the research and development of safe, acceptable, and effective methods for fertility regulation and thus population control. Later the scope of the programme was gradually broadened to include infertility, sexually transmitted diseases, HIV/AIDS and maternal and child health issues. Still later, it was realized that human reproduction problems could not be addressed as a separated entity.

As a consequence, a stimulus was generated for giving a new look in to the previously unexplored domain of women's reproductive health, particularly of those who constitute the high-risk group (married adolescents). As the policy- oriented research progressed, the analysis unveiled complexities soft high prevalence of maternal and child morbidity and mortality, arising from the arena of cultural and behavioral domains. The crux of the problem appears to be integrally related to the life cycle of reproduction of women in the critical phase of the reproductive life.

In dealing with the issue of reproductive health, a number of competing approaches and methodological techniques are presently being employed. For long the dominant perspectives have been the biomedical, ecological, socio-cultural and epidemiological frameworks that attempted plain to the problem of reproductive health. Recent emphasis has shifted to the need for reproduction related health care to groups of women and men the new approach allows to deal with problems and health care needs of special groups-not only of those who are pregnant but also for those who want to become pregnant and those who do not. Women today are concerned to cater their health needs, not only as newly mothers, but also as women. Ironically, the successful implementation of the intervention programmes in a traditional society like Bangladesh could not yet reach the full potentials, as the plans promised.

An anthropological investigation essentially entails a holistic approach to the research problem, underlying meaning of, which refers to the recognition that for any particular outcome or phenomenon to be explained, great many interrelated factors are at work. This holistic perspective often leads to be highly critical of other disciplines when they appear to adopt single factor explanations or seemingly simple explanations of illness conditions The application of anthropological know-how in developmental problems, be it health,

nutrition promotion or income generation have shown greater potentials of success because of the fact that an anthropological designed investigation places more emphasis on model building using the local indigenous knowledge as it a base for planning. This is, in short, designated as the IKS approach (Indigenous Knowledge System approach) which takes the ingredients of change from etic categories. As Ahmed Chowdhury puts it "This essentially requires more concentration on the one hand between cultural content and indigenous practices on the other and examinees health problems emanating from local behavioral patterning on the other'" (1988:132). In other words, the nature of cultural practices , geographical setting (rural, slum etc) and habitual behavior of the people call for a holistic, multi-level orientation in a study seeking behavioral change.

The difference of anthropological framework with other branches of social science or health discipline lies in that the latter often indiscriminately employ 'etic orientation' (analyst's own viewpoints instead of actor's orientation). The present research has been theoretical designed after such an anthropological conception of health problem.

1.2 Conceptualization of 'Reproductive Health'

An important and operationally measurable definition of the concept an important and operationally measurable definition of the concept Reproductive health offered by WHO, presented here " Reproductive Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating top reproductive system and its functions and processes,,

To quote from Akhter & Khan: "Reproductive health research is no longer a domain of biomedical or medical research but embraces all social scientists and a wide range of methodologies including qualitative methods to allow in-depth look into health needs, causes and problems of reproductive health" (1997). In realization of this fact, recent investigations stressed on the incorporation of the socio-cultural and anthropological theoretical as well as methodological approaches in the study of the issues involved with the reproductive health particularly of the disadvantaged segments of female population. This concomitantly demands an operationally measurable definition of what conceptually falls under the notion of 'reproductive health'. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the freedom to

decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of family planning as well as other methods of their choice for regulation of fertility which are not against the law, and the couples with the best chance of having healthy infant" (WHO definition adopted at ICPD Programme of Action, A/CONF.171/13,Paragraph 7.2).

Major Reproductive Life Events: The major events of reproductive life described below:

Pre-conception:

It includes adolescents and women, married or unmarried, who are or are about to become sexually active. In many communities where early marriage is prevalent and women are prematurely exposed to sexual activities and thus leading to adolescent pregnancies increasing health risks of both mother and the newborn

Conception/Pregnancy:

In developing countries majority of the women has to pass through this stage several times in their lives, exposing herself to the risks and hazards of pregnancy each time.

Childbirth:

It includes the process of labour and childbirth itself. Many factors are involved in a safe child delivery both in terms of achieving favorable outcome for both the mother and the infant.

Post-natal:

It includes the time period when the mother gradually recovers from the injuries of childbirth and regains her normal health, while nursing and taking care of her newborn at the same time.

Interconception:

It is the period of spacing between two consecutive pregnancies.

Perimenopausal:

This stage extends from the time when a woman nears menopause up to some years after reaching menopause, and corresponds age of the women approximately from 45-55 years.

At this time women experience irregular periods and bleeding. After menopause she may experience flushing, irritation, insomnia etc. for some years until her system becomes adjusted to the new physiological environment of her body.

Infertility:

Some women may not have to pass through the above-mentioned stages at all when her condition is termed primary infertility. In some women after conceiving once or twice no more conception occurs, usually due to some pathology, which in most of the cases is curable and preventable also. This condition is known as secondary infertility.

The basic elements of reproductive health in main include the following components:

- Family Planning
- Safe Motherhood
- Safe abortion facilities
- Infant and childcare
- Male participation and responsible behaviour
- Adolescent reproductive health
- Infertility
- Reproductive tract infections (RTI)
- Sexually transmitted diseases (STDs)
- HIV/AIDS
- Cancers of reproductive tract
- Reproductive health needs of disables

Against the backdrop of these vital reproductive events, the health problems faced by married women of Bangladesh as brought forth in cross-cultural studies will be reviewed below:

1.3 Reproductive Health Problems; Bangladesh Context:

The special requirement to deal with this whole domain of women's reproductive health in research and intervention has emerged only in the recent years. The problems of maternal morbidity and mortality as child survival are integrally related to the life cycle of reproduction of women and their behavior in specific stages of this cycle.

Recent epidemiological and Public Health studies conducted in rural Bangladesh indicate clearly that during the entire span of the reproductive life cycle of a woman, the pregnancy in the early (15-20 years age) and the late stage before reaching menopause (40-45 years age), is equally high risk periods which often results in maternal mortality because of biological predisposition's. The prevalence of high maternal mortality that is encountered in rural environment as well as poor and culturally impoverished slum settings in Bangladesh occurs in the upper age grade of women (adolescent stage) than in subsequent years. One needs to bear in mind that pregnancy is a normal condition of women's life cycle, if it occurs at the proper age of conception, i.e., 23-35 years. This is considered as a period of safe motherhood.

Many investigations conducted in such settings documented a pattern of high morbidity and mortality in the married females, which is suspected to be associated with inappropriate cultural behaviour, ingrained in the life ways of both rural and slum sub-cultures. Such investigation also indicate that pregnancy-related complications, inadequate utilization of health care facilities, timely immunization, antenatal check ups, proper nutrition intake, avoidance of heavy work load with the progression of pregnancy, cultural stigma associated with exposing health complications to male doctors in the community or clinics, delivery through untrained birth attendant (TBA) at home setting in the absence of safe delivery kits, negligence of their husbands to meet the special care of the pregnant wife at critical life experience - all concomitantly produce a condition for high maternal mortality. The forthcoming section will deal at length on the problems faced by pregnant mothers, as revealed by various research studies. Before so doing, it is essential to identify the crucial phases of pregnancy and the problems that jeopardize their health.

Until now, women have been the primary focus of reproductive health programmes. The emphasis on fertility reduction as female phenomenon has led to a dismissal of the importance of male attitudes toward responsible parenthood (Ontiz O A 1994). The reasons for female centered family planning activities are pragmatic, "they are the one who become pregnant, most modern contraceptive methods are females and consequently reproduction .The International Conference on Population and Development held in Cairo in 1994 recommendations address necessary changes in both men's and women's

knowledge, attitudes and behavior and other conditions for achieving the harmonious partnership of men and women (1997).

For a long time women have been the primary focus of reproductive health programmes in matters of fertility on the emphasis on fertility reduction as female phenomenon has led to a dismissal of the importance of male attitudes toward responsible parenthood (Ontiz O A 1994). The reasons for female centered family planning activities are pragmatic, "they are the one who become pregnant, most modern contraceptive methods are females and consequently reproductive health services have been offered on MCH/FP outlets" (Green et al 1995). With increasing awareness and concern about the role men play in the transmission of STDs/HIV and AIDS, marginalizing men in family planning and reproductive health services is not appropriate. Ignoring men's needs greatly increases their health risks, as well as those of their partners (Heise LL 1994).

1.4: Research Objectives

1.4.1 General objectives:

The major focus of this research on the identification of various critical determinants, which are associated with depleted child bearing mother reproductive health in the urban slum. The present research examines the health behaviour, belief and practices of married women living in 'Santinagar' a slum situated in Chittagong city.

1.4.2 Specific objectives:

The specific objectives of this study are outlined below:

1. Evaluation of the belief, attitudes, concepts of urban slum house hold members related to women reproductive Health.
2. Determination of the health care seeking behavior pattern related to pregnancy, childbirth and complication during pregnancy and labor in slum life.
3. Exploration of the beliefs, views, ideas, about conception, menarche, fertility control, family parity size.
4. Information on dietary behavior, food feds and taboos during pregnancy and motherhood.
5. Assessment of work load and antenatal care during pregnancy
6. Determination of the mode of health care options for child delivery
7. Identification of Complication during pregnancy and child delivery.

8. Nature of postnatal care among mothers
9. Assessment of child feeding practices and child immunization
10. Knowledge of sexually transmitted Diseases

Variables under examination

1. Age
2. Educational Status
3. Occupational status
4. Migrational status
5. Monthly income
6. Type of dwelling house
7. Type of latrine
8. Type of drinking water
9. Overall hygienic management
10. Perception on biological conception
11. Concept of pregnancy
12. Cognition of conception
13. Rituals and restriction during menarche
14. Age at menarche
15. Age at marriage
16. Duration of conjugal life
17. Age of women at first childbirth
18. Age of the last child
19. Birth interval
20. Total number of children
21. Contraceptive Prevalence
22. Current status of contraception use
23. Reasons for not using contraception
24. Future use of contraception
25. Decision making with husband about FP
26. Decision making process about pregnancy
27. Discussion about pregnancy related issues

28. Dietary behavior during pregnancy.
29. Food restriction during pregnancy.
30. Work load and rest during Pregnancy.
31. Sharing of husband the household activities at wife pregnancy.
32. Pattern of ritual performed at the time of pregnancy.
33. Pregnancy-related Complications.
34. Antenatal Care.
35. Pregnancy-related complications.
36. First took antenatal care.
37. Number of antenatal check-up.
38. Last antenatal check-up.
39. Immunization status of women during pregnancy.
40. Reasons for vaccination during pregnancy.
41. Reasons for not taking vaccine.
42. Husband accompanied wife at ANC check-up.
43. Reasons for not accompanying wife at ANC check-up.
45. Total number of vaccine received.
46. Place of stay during first Childbirth.
47. Reasons for staying at women father house at first childbirth
48. Perception about labour pain
49. Place of child delivery
49. Delivery attendants
50. Reasons for delivery conducted by untrained TBA
51. The remuneration against the services offered by the TBAs
52. Rituals performed after childbirth
53. Postnatal Care
54. Post partum rest
55. Child-feeding
56. Colostrums feeding practices
57. Age of child at birth
58. Perception about birth weight of last child
59. Child immunization
60. Sickness of child
61. Knowledge on HIV/AIDS

CHAPTER- 2
REVIEW OF LITERATURE

The present chapter provides a comprehensive assessment of reproductive health related problems encountered by rural women and slum dwellers of Bangladesh, revealed in published reports, journals and literatures. Given the paucity of research in this field, particularly of those done with anthropological methodologies, the author has to depend largely on epidemiological investigations that provided more quantitative analysis than qualitative interpretations.

Reproductive Health Knowledge:

Kane TT et al discussed key issues in reproductive health that pose a continuing challenge involve contraception, abortion, fertility, sexually transmitted diseases (STDs), maternal mortality and morbidity, and invent and child mortality. Research done by the Extension Project in Bangladesh following the 1994 Cairo population and development conference produced a monograph on reproductive health in rural Bangladesh using data from the project sites in Abhoynagar, Sirajganj, and Mirsarai thanas in addition to other thanas. Data sources included information from the longitudinal sample registration system for the 1983-96 period and several population-based sample surveys. The papers in the monograph covered five thematic areas: (1) reproductive health knowledge and behavior (awareness and knowledge of reproductive tract infections (RTIs) and STDs was low among rural women; one-third of women reported that their husbands had a genital problem; the abortion rate was on the rise and 15% of women had multiple induced abortions; over 90% of deliveries occurred at home assisted by untrained attendants); (2) contraceptive use dynamics (contraceptive use was the lowest among adolescent married women; half of injectable users discontinued during the first year; use of fixed-site services was very low; (3) demand, cost, and utilization of maternal-child health and family planning (MCHFP) services (prices of contraceptives did not adversely affect contraceptives use; contraceptive prevalence was maintained where cluster service delivery was introduced; increasing the number of satellite clinics and combining them with EPI spots was more cost-effective); (4) determinants of fertility decline in rural Bangladesh (women's education, employment, and access to the media had a significant and negative effect on fertility); and (5) determinants of infant and child malnutrition and

mortality and consequences of adult mortality (child spacing of less than 2 years, larger number of siblings, female gender, and mother's low educational level increased malnutrition (Kane TT et. al 1997).

Gender Inequality: Culturally structured position of women in Bangladesh

In rural Bangladesh women's lives are encapsulated within patriarchal households, which are primary units of production and consumption. Men, in their position as fathers, husbands and even sons, generally own and manage the land, control income and women's labor. (T.Blanchet 1988). Traditionally, the roles of women in Bangladesh are domestic in nature and they have relegated primarily to play the role of a docile daughter, a compliant wife and a dependent mother. The women are inferior by nature and that motherhood, with it are domestic role in the family, and are their natural place is upheld by strong cultural, mythological and religious beliefs. These beliefs are very strong in Bangladesh (Jahan Roungq 1975) Purdah, literally meaning the curtain, refers to the system of seclusion of women prevalent in the Middle East and South Asia. In the strictest sense purdah involves keeping women confined within the four walls of the home and putting them in veil when moving out of the home. The strict practice of purdah is a social and religious ideal in rural Bangladesh. She is never seen by any but close family males. (T. Abdullah & S. Zeidenstein 1979).

Omidyi documented that a sexual division of labour, which favours men and the general belief that men are the heads of the wives, are just a part the gender inequality existing in Yorubaland, as is the case with Bangladesh. High fertility levels are most significantly influenced by inherent cultural beliefs regarding marriage and child bearing, childlessness, sex preference, the number of children a couple should have, child death and replacement and contraception (Zakia Sultana 1987).

Purdah or seclusion from the outside world is a time-bound ritual in the cultural system of Bangladesh. One of the most significant effects of purdah in Bangladesh is reluctance to talk about future pregnancies, contraceptives, and acceptance of family planning methods (Maloney et al 1981). As purdah of seclusion of women is related to religion in this country, obviously causes women's dependence on male section, their status is inferior, less autonomy both on their body or rights, health and illness. The very existing socio

cultural norms about women's status, role in the family, poor access to modern health care facility, family size, and contraceptive use certainly have implications on reproductive health.

Women's seclusion has great implications of female reproductive health. Seclusion of 'Purdah' has long been viewed as implying a much inferior status for women. This may perhaps a simplistic, western bias. It is true that seclusion automatically reduces a woman's freedom of movement and above all her opportunities for economical independence by means of paid work. Undoubtedly, the social status of women is low in communities practicing purdah. In broad sense, the purdah system is related to status, since the poor cannot afford to forego income of pay for the extra service required. It is related also to social distance and the maintenance of moral standards, expressed as 'separate worlds' and symbolic shelter' (Papanek, 1971). " In a culture where male pride is a very significant -and very fragile-element of identity and status, the seclusion of women is an important aspect of male control" (1971).

Female -centered family planning:

Ever since the population control programme was launched in Bangladesh. it was not the male but the female segment of the population which was targeted as the main focus of fertility regulation. This, in part, arose from the male-bias cultural values that placed women in the disadvantaged socio- economic and demographic conditions. This is well reflected in the female centered family planning programmes in proportionate degree.

A relatively wide range of contraceptive choices is available to women in Bangladesh ranging from short acting to medium - term, long acting and permanent methods. Despite widespread availability of these methods, the on maternal lives result in 8000 maternal deaths every year. Majority of abortion cases admitted into hospital fore treatment of complication are older, multigravida women with little or no education, who don't desire additional children for social / economical reasons (1993:15).

Berngart et. al mentioned their study one frequently cited barrier to more widespread adoption of family planning in Muslem countries is religious opposition. To examine the depth and extent of such opposition in Bangladesh, 106 men who had been identified by their wives as religiously opposed to family planning were interviewed. Unexpectedly, 26

percent of the "opposing" husbands reported that they were current users of a contraceptive and an additional 50 percent, although not practicing said they were in favor of family planning on religious grounds. One-fourth of this last group was able to cite specific Islamic injunctions against family planning. It appears on the basis of these data, which were collected in the religiously conservative area of Lakshimipur, that the perception of widespread Islamic-based resistance to contraception in Bangladesh is not founded in fact (Berngart.MH et. al. 1990).

An important recommendation of the International conference on Population and Development held in 1994 was the identification of the need to shift from family planning to a more holistic reproductive health approach. Many scientists and professionals advocated for increased stress on male involvement in family planning programmes and men's responsibility for contraception equity in gender relations in family planning and in other reproductive health services of any community. (Ashford LS. 1995, JOICFP, 1994, Sabbir AA. et. al 1996). Ironically until today, there has been a little success in removing the gender disparity in the practice of family planning.

A relatively wide range of contraceptive choices is available to women in Bangladesh ranging from short acting to medium - term, long acting and permanent methods. Despite widespread availability of these methods, the adoption rates of pills among others seem to be a dominant choice. Now a days, a strong sentiment is developing about the side effects of the use of pills which are said to create the problem of uterus damage in the long run.1PPF stressed the male involvement in reproductive health programme for fostering a better relationship between men and women through the practice of family planing as a joint and equal responsibility. This is infect, the underlying theme of 1PPFs overall concern in this particular area (1PPF 1984).

Briend et al mentioned in their study the association between contraceptive use and Breast- feeding duration was investigated in 2380 women in rural Bangladesh where women usually stop breast-feeding once pregnant. Life table analysis showed that women receiving regular injections of depo medroxy progesterone acetate (DMPA) and those using non-hormonal contraception breast-fed significantly longer than women using no contraception. In contrast, women are using oral contraception. In contrast, women using

oral contraceptives (combination of 0.5-mg norgestrel and 0.05 mg ethinyl oestradiol) did not breast-feed longer than women using no contraception. It is suspected that prolongation of breast-feeding obtained by delaying the next pregnancy with this oral contraceptive was offset by the depressing effect of oestradiol on lactation. Thus, in communities where prolonged breast-feeding is associated with improved child survival, non-hormonal contraceptive methods, or injectable DMPA should be preferred for lactating women to oestrogen-containing oral contraceptives (Briend-A et. al. 1991).

Menarche:

William Burr II Hunt discussed about age at menarche and it's effect o n child bearing age, sexual activity, pregnancy and consequences of teenage pregnancies all our the world in his writings in population Report, 1996. He pointed out that the trend toward earlier menarche appears to b e universal although it seems to have leveled off in a few developed countries. Today girls everywhere are sexually mature at an earlier age than previous generations. In Europe the mean age at menarche has decreased by about 10 months each generation 50 percent of the girls in 1845 were menstruating by age 15, while 50 percent in 1962 were menstruating by age 12, Genetic, health and socio economic factors influence the wide variations in age at menarche among different cultures. Attainment of a certain body size and the accumulation of a certain proportion of body fat are necessary to trigger menarche. Better nutrition in childhood also appears to be a major cause of early menstruation (William Bur Therese Blanchet and Clarence Maloney described the rituals and proscriptions during menstruation and also at menarche in Bangladesh in their studies. The beliefs and practices at menarche and menstruation reflect the traditional lifestyle of Bengali Muslim society where cultural constructions are one of the factors. Religious affiliation is also a remarkable feature in the performance of rituals and proscriptions during menstruation.

Age at marriage:

The contemporary health scientists assert that two groups of population in every society are identified to be worthy of receiving particular attention, women during the period of their pregnancies and children particularly during their infancy. Although remarkable progress has been made in the care of mothers and children in the developed countries since the beginning of organized public health efforts in this field, much remains to be achieved in the

developing countries in this regard. Childbearing in Bangladesh begins early with the large majority of women becoming mothers before they reach the age of twenty. The median age at first birth is around 18. However the median age at first birth (DHS1993-94) has increased slightly from around 17 for older women to around 18 for women in their forties report having had their first birth before age 15, compared to only 5% of women age 15-19.

Gandhi reported in a conference on 'Women's perspective on population and reproductive Health' that in Sri Lanka literacy rate was nearly 90% among women in 1991, which had contributed to an increase in the marriage age. In spite of the modern methods, 45% of the women in Sri Lanka preferred the traditional rhythm method. (Gandhe R. 1993) It gives evidence to the fact that education bears relationship with marital age. Lower literacy rate, as observed among the rural women in Bangladesh can be attributed to the marriage of girls at the their early adolescence age.

It finding should be carefully taken into future planning since the number of women entering the reproductive ages in Bangladesh, by and large, is increasingly rapidly and that will continue well into the future. The average increase in the number of women in the reproductive ages 15-49 will be more than three percent per year during the period 1991-2006. Age at marriage is rising slowly from 13.9 in 1961 to 18 in 1989. The number of married women is likely to increase from about 20.4 million in 1991 to at least 30.8 million in 2006(1995).

Abortion:

Sultana Jahan conducted a study on 125 cases of women about the reasons for adopting non-scientific methods in termination of pregnancy. All the cases were attending the three major hospital of Dhaka City like DMCH, MCHTI, and IPGMR. Major findings indicate that all of them induced indigenously and the mean gestation age of abortion was 9.3 weeks. About 66.4 percent self induced, 17.6% by indigenous abortion practitioners. 5.6% by pharmacist and FWA/FWV respectively. Other providers were 4 percent homeo doctors and 0.8% pallichikitsak. About 42.4% stated termination as initiated by oral pill, 12.8% by quinine, 4% by Ketrax and herb tablet respectively, 18.2% by homeo-medicine, 13.6% gave history of introducing local foreign body like stick, herb etc., and remain 4.8% by injection. As the reason for adopting non-scientific method 44.8% stated they

were afraid of surgery, 23.2% refusal by clinic, 19.2% could not afford the high cost scientific method and a small percentage (13.6%) was not actually aware about the scientific method (Sultana Jahan 1993).

Begum Sabiha showed in her study on relationship of pregnancy wastage with gravid, pregnancy order and age of mother that abortions were more common while stillbirths and early neonatal deaths were almost equal. Majority of the mothers had history of only one type of pregnancy wastage viz. Abortion, stillbirth or early neonatal death. Among the abortions, spontaneous abortions were reported by 75% and MR by 23.8% pregnancy wastage was more among those with more than 6 gravidity, mothers aged over 40 and in birth order (Begum Sabiha 1993).

Nutritional Deficiency during Pregnancy period:

Nutritional Deficiency at Pregnancy seems to be a major cause for both poor lactational performance and low birth weight baby. H. Pelto mentioned in his study that in developing countries several sources of evidence low average weight gain in the pregnancy, low birth weight and high rates of neonatal and maternal mortality point to nutrition problems during pregnancy. Dietary studies rarely show increased food consumption during pregnancy or lactation. There are several sociocultural dimensions which to seek the sources of dietary and behavioral mechanisms that affect adjustments during pregnancy and lactation, among them; cultural beliefs about appropriate food intake during pregnancy and lactation; beliefs about appropriate energy expenditure activities of pregnant women: activity patterns and changes from the non pregnant condition and relationship of these to household and community characteristics (H. Pelto 1987: 553-559).

Complications, antenatal care and mode of delivery:

The major types of morbidities with the progression of pregnancy lead to hemorrhage, abortion, eclampsia, puerperal sepsis and obstructed labour, which are preventable, yet cause great deal of sufferings to mothers and often lead to death (Lee E. 1994). It is estimated that quarters of all pregnancies are high risk. Mostly untrained relatives, neighbors, conduct only 10 percent of the deliveries in rural areas; attend trained persons while the rest. Dais etc. institutional deliveries take place only in 4.4% cases in these areas. In Africa and rural India, and estimated 80 percent of women are assisted during

birth by TBAs. World wide, the WHO estimates that about 60-80% of women are attended by TBAs. (WHO: 1979). In Bangladesh, according to available information, only 25% pregnant mothers get at least one antenatal care (ANC) during the period of her pregnancy (according to WHO it should be at least three follow ups) and 5% deliveries are conducted by trained personnel. TBAs are responsible for *95%* or over four million deliveries in the countries every year. (T. Blanch et. 1984 chow M1995).

A large number of epidemiological studies conducted in cross cultural settings show that the complications of birth can be associated with a Varity of separate maternal, neonatal and environmental factors. Such ethnographic studies have revealed that "self-care" is pervasively the most predominant source of health care. The family network and neighborhood still play important role in the management of sick persons as well as in the child delivery. In contrast with the modern, technological model of birth, most births world-wide-especially in rural areas of the developing world-are delivered in a very different way, usually by female birth attendants. In 1978 a report of the World Health organization supported the further training of TBAs, who already deliver about two-thirds of the world's babies. TBAs are found in almost every village and in many urban neighborhoods throughout Africa, Asia and Latin America.

It is a tradition in Bangladesh that a TBA takes a pregnant woman care. Firstly the TBAs do not only conduct labour but also available for immediate care for treatment of minor ailments (such as vomiting, backache) and they also give emotional support during pregnancy and labor. (T.Blanchet, 1988, 1984, chow. M.1995) TBAs are less expensive, accessible, well known to the rural people, whatever is given as her payment she accepts it. (T. Blanchet, 1984, 1994, chow. M.1995, Clarence maloney et. al 1981) In Muslim society, the TBA is not an essential participant at birth and her role is devoid of religious meaning. Among Hindus, the function of the Dai is intimately linked to the hierarchy of casts. She is an essential pollution-removing specialist who has a ritual role to play not only at birth but also often at marriage and first menstruation as well. The role of the Dai in Hindu society is well articulated and ancient. By contrast, that of the Die in Bengali Muslim society appears less developed and more nebulous (T. Blanchet, 1984).

It is estimated that a quarter of all pregnancies is high risk. Mostly untrained relatives, neighbors, conduct only 10 percent of the deliveries in rural areas; attend trained persons while the rest. Dais etc. institutional deliveries take place only in 4.4% cases in these areas. Training of TBAs has much potential and can lower neonatal and maternal mortality and morbidity, by improved identification and referral of high-risk pregnancies, management of labor and delivery and maternal and infant nutrition. Training programmes of TBAs has been taken up by the Government of Bangladesh, with an ultimate goal of providing one trained TBA for each of the 68000 villages of the county. Nationwide, TBA training has been trained so far. (H.H. Akhter et. al. 1995).

Miscarriage:

Mostafa-G et. al carried out a study was to examine the relationship between socio-demographic variables and pregnancy loss in rural Bangladesh. The data for this study was gathered in Matlab, a rural area of Bangladesh where thy International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) has been operating a demographic surveillance system since 1966. The study took place from 1982-1984. Data from 24,172 pregnancies was miscarriage was increased in mothers less than 20 of over 35 years of age. Those mothers who had experience two of more previous spontaneous miscarriages were 2.5 times more likely to again miscarry. Less educated mothers had a lower risk than mothers with secondary level education. Miscarriage was more common when the pregnancy had taken place within two years of a previous pregnancy. The risk of stillbirth was greater in women over 34 years of age, in women having their first baby and in women who had previously lost a pregnancy. Particularly at risk were older mothers with two or more previous foetal losses, where the risk of stillbirth was eleven times higher than that for younger women with no previous foetal loss (Mostafa-G et. al. 1991).

Low Birth Weight Baby, Short Birth Interval and morbidity:

Low birth weight child is triggered by a complex interplay of factors, such as maternal nutritional deficiency, proper timely antenatal check ups, adequate rest with the progression of pregnancy etc. Nahar-N et. al a prospective study was conducted in urban affluent, slum and rural communities of Bangladesh during Feb '94 to Feb '95. From each community, 250 pregnant mothers were recruited in the study and at the end total 660 live births were studied to determine the incidence and risk factors of low birth weight.

Incidence of low birth weight was highest in urban slum (36.8%) followed by rural area (20.9%) and lowest in urban affluent community (18.3%). The area of residence had a significant influence on birth weight suggesting that environmental stress had detrimental effect on birth weight. Age, weight and height of mothers were also risk factors for low birth weight of their babies. Mothers of less than 20 years and more than 35 years, weighing less than 40kg and having height less than 140 cm had the higher risk of giving birth to low birth weight babies. Incidence of low birth weight was highest (73.2%) among the primigravidae mothers and 36.8% among the mothers who had no antenatal check-up, but it was 15.9% among those who had check-up more than 7 times. The distribution of low birth weight babies was higher (48.2%) among the mothers who had never gone to school. To reduce the incidence of low birth weight, upliftment of socio-economic condition has got no alternative, which is very much related to education level of the people. Emphasis should be given on mothers' education, which is one of the influencing factors of birth weight of babies (Nahar-N et. al. 1995).

Successive pregnancies without safe spacing period are also identified as a major factor that risks the health of mothers and infants. Ronsmans-C Campbell, O, et. al mentioned that closely spaced births increase the risk of maternal death. This study reviews the literature for evidence supping an association between short birth intervals and maternal mortality and presents empirical evidence to address the question of whether short birth-to-conception intervals alter the risk of maternal death. In this nested case-controls study selected from a cohort of women under demographic surveillance in Matlab, Bangladesh, the length *of* the preceding births that are too close increase the risk of maternal death (Ronsmans-C Campbell et. al. 1998).

Karim et. al. conducted a study the relationship between birth weight, socio-demographic variables and maternal anthropometry was examined in a sample from an inner urban area of Dhaka, Bangladesh. About 21% of babies were of low birth weight (LBW) using the World Health Organization cut-off value of < 2500g. LBW was more common in younger (<20 years) and older (> 30 years) mothers, the low-income group and those with little or no education. The mean birth weights of the higher educated, higher-income groups and male children were on average 290, 260 and 120 g, respectively, higher than uneducated, lower-income groups and female children. The best cut-off for detecting LBW and

normal-weight infants was maternal weight of 50 kg (odds ratio = 4.6), maternal arm circumference of 23 cm (odds ratio = 5.0) and body mass index of 20.5 (odds ratio = 6.5) The sensitivity and specificity were best for maternal weight (69% and 68%, respectively). Logistic regression analyses show that mothers' weight at term was the best single predictor of LBW (31%), while maternal weight along with age, educational level and income group correctly predicted just over 35% of LBW. Regression analyses also confirmed that mother's weight at term was the best predictor of birth weight, with a correlation coefficient of 0.49 (KarimE et. al. 1997).

Hasin et. al a cress-sectional study was carried out to investigate relationship of birth weight with selected biochemical indices of nutritional status of mothers at delivery in poor urban population of Dhaka, Bangladesh. One hundred and fifty one pregnant women of known gestational length, aged 20-30 years, who attended a local maternity hospital for delivery, participated in this study. All of them were free from any pregnancy complications or diseases, and delivered a singleton full term baby. Socio-economic and obstetric histories were taken by interview. Anthropometric data and blood samples were collected on the same day. Twenty per cent of the participants were anemic (Hb<11.0 g dl-1), 49% had subnormal (<4.0 g dl-1) serum albumin and 32.5% had serum vitamin A lower than adequate level (<30.0 micrograms dl-1). Mothers who gave birth to low birth weight babies had lower levels of hemoglobin (p=0.06), serum albumin (p=0.02) and serum vitamin A (p=0.05) at delivery compared with the mothers who give birth to normal weight babies. After adjustment for various confounding factors, only serum albumin level remained significantly lower in the mothers of low birth weight babies. Using multiple regression analysis for birth weight, the overall F-ratio was calculated to be 12.5 and was highly significant (p=0.0000). The adjusted R2 was 0.32. Gestational age, father's occupation, mother's body weight and serum albumin level were found to have significant independent effect on birth weight (Hasin A et. al.1996

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SE Arifeen et. al. carried out of a study to Investigate the effect of low birth weight (LBW), intrauterine growth retardation (IUGR), prematurity, and breast-feeding on infant growth Methodology: The sample consisted of 1,654 infants born in selected slum areas of Dhaka city. They were enrolled at birth and followed up prospectively till their first birthday. Apart from repeated anthropometric measurements, the mothers were also interviewed for information on infant feeding and morbidity at each follow-up visit. Analytical techniques included correlation analysis and random effect regression for modeling infant growth. Results: Correlation was high and stationary between repeated body weight measurements from 3 months onward. Correlation between weights before 3 months and later weights was lower and declined rapidly with increasing age gap, suggesting greater plasticity of growth in the first 3 months of life. After adjusting for remanded constant throughout infancy. For example, low-and normal-birth-weight infants differed by 556-603 g, while the differences between symmetric and asymmetric IUGR babies were 172-184 g, A positive impact of exclusive breast-feeding in the first 3-5 months on infant growth was detectable at 12 months of age (+95g). The overall growth in this sample was of the pattern that heavier babies grew even heavier. However, exclusive breast-feeding appeared to counteract this pattern by equally benefiting the lighter and heavier infants. Conclusion: The study has demonstrated the important role of weight at birth and appropriate breast-feeding practices in determining nutritional status in infancy.

Effective strategies for improving birth weight, till now a poorly addressed issue in Bangladesh, are urgently needed. The sustained effect on growth and the beneficial effect on LBW infants are compelling reasons for increased and effective promotion of exclusive breast-feeding in early infancy (SE Arifeen et. al.1998).

Breast feeding behavior:

M.A. Khalique Barbhuiya et. al a prospective study was conducted among the infants of 5 large urban slums in Dhaka City to study the feeding practices and its relationship with morbidity and nutritional status. The sample size was 250 infants initially but some of the respondents left the slum subsequently due to various reasons. Among the infants 49.6% were male and 50.4% were female. The rate of exclusive breast-feeding was highest (65.4%) at the age of 2 to 2.5 months and only 32% infants were exclusively breast fed at the age of 5 to 5.5 months. Ninety three percent of mothers were practicing breast-feeding throughout the year. There was significant difference between frequency of breast-feeding and morbidity ($p<0.05$), at the age group 2 to 2.5 months. There was statistical significant difference between exclusively and non-exclusively breastfed babies at the age of 4 to 5.5 months and their nutritional status at the age of 6 months ($p<0.05$). There was no statistical significant difference between the nutrition status at 12 months among the exclusively and non-exclusively breastfed babies up to the age of 5.5 months. Out of 250 only 56 mothers (22.4%) rejected feeding of colostrums. About ninety five percent of mothers were housewives and there was no significant difference between the occupation of mother and the types of breast-feeding ($p>0.05$) (MA Khalique Barbhuiya et. al.1995).

Abdul Bayes Bhuiyan et. al Breast Feeding pattern and fertility status was studied on 75 post - partrum women with healthy living children during June 1995 to May 1996. All the mothers were booked for the study within the first month of delivery and followed up for a period of 9 months. Data on Infant feeding practice including breast feeding frequency, night feeding status, weaning practice and fertility status was collected using structured data collection instrument. Menstruation of pregnancy in the post partrum period was used as indicators for returning to fertility. Out of 75 women, during the study period, 61 returned to fecundity by menstruation and four women by pregnancy. Fertility as indicated by menstruation and pregnancy did not return to ten women in the study period. Fifty seven percent mothers practiced exclusive breast-feeding at the time of interview. More

than four fifth of the mothers practiced on demand feeding during the study period. Fifty six percent babies were given weaning food in the fourth month. Infant formula was the first weaning food to sixteen percent of cases. Among the 61 mothers who became fertile at least by one indicator, the mean time of returning to fertility was 7.25 months (range 2 to 9 months). Maximum number (34) of women became fertile in the 3rd month as indicated by menstruation. Due to time limitations, the study could not be extended to document the events after 9 months in cases where fertility did not return (Abdul Bayes Bhuiyan et. al 1995).

Wise P carried out a study was to investigate the contraceptive potential of breastfeeding in Bangladesh and thus determine whether guidelines on post-partum contraception (derived from the Beluga mixed-t strategy) can be applied, considering local patterns of lactational amenorrhoea. Data used in this survey was derived from 1989 Bangladesh Fertility Survey, which was carried out from December 1988 to April 1989. In this nationally representative study, 11,905 women of less than 50 years of age were selected from 64 different districts of Bangladesh. Women whose most recent birth had taken place in the 30 months prior to the survey were included. Almost 100% of Bangladeshi women breastfeed their children with the prevalence falling to 60% at 30 months. Rural women and those with no formal education breastfeed for longer than do their urban and more educated counterparts. Post-partum amenorrhoea starts at a prevalence of 100% and declines in an almost liner fashion to 10% at 24 months post-partum the median duration being 12 months. The uptake of contraception in the post-partum period is slow but steady, with contraceptive prevalence reaching 30% at 30 months. Conceptions were rare until 15 months post-partum. In lactation amenorrhoeic women, no pregnancy was observed in the first twelve months and few later compared to those who had resumed menstruation. The study argues that there in no need to offer contraception to amenorrhoeic lactating women in Bangladesh in the first 12 months post-partum (Wise P 1993)

A K M Haque et. al cared out a study breast-feeding practice in children attending Private Chambers of Barisal town. A total of 1000 mothers were interviewed. The age of the children varied from one hour to 2 hours after delivery. 76.4% gave prelactal feeds with sweet water, honey, plain water, artificial milk and cow's milk. 84.6% mothers rejected their colostrum. Exclusive breast-feeding was found in 23.2% without prelacteal feeds at 1

month, but gradually declined to 16.2% at 5 months. Lactation failure occurred in 76.8% due to insufficient breast milk, faulty technique, habit of bottle-feeding, children's illness, cracked or sore nipples, mother's illness and occupation mother (A K M Haque et. al. 1996).

Sexually Transmitted Diseases (STD):

In the recent decades fatal diseases, AIDS and HIV are found to directly related to sexual transmission which are becoming incredibly dangerous for human health, both men and women. Such disorders are arising mostly from drug addiction and unsafe sex practices. Women are also the victims of highly dangerous sexually transmitted diseases (STD) despite the fact male people are the carriers of such disorders.

This situation is exacerbated by the worldwide increase in incidence of sexually transmitted diseases and HIV infection and by the fact that women often lack access to the means to prevent pregnancy and to protect themselves against infection. (Rivera Z E et. al 1994, Mlimarvalye L.1990) With increasing awareness and concern about the role men play in the transmission of STDs/HIV and AIDS, marginalizing men in family planning and reproductive health services is not appropriate. Ignoring men's needs greatly increases their health risks, as well as those of their partners (Heise LL 1994).

Women in Rural Bangladesh suffer from a broad array of reproductive health problems, which have an adverse impact on this health, their marital and familial relationships, and their economic contributions. In Bangladesh, 25% of almost 3000 women surveyed reported symptoms of a reproductive tract infection (RTI), and two - thirds of these had clinical or laboratory evidence of infection. (H. H. Akhler et. al 1992).

The information on sexual health is also too scanty to warrant any meaningful interpretation of the prevalence of sexually transmitted diseases can be considered to be high, considering the experience of professionals working in the area, the prevalence of secondary infertility, the unsanitary living condition and lack of access to reproductive health information. In a hospital based study, the prevalence of genital ulcer was found to be 9.6% among 301 patients attending the clinic (Hyder et. al. 1993). Women are also the victims of highly dangerous sexually transmitted diseases (STD) despite the fact male people are the carriers of such disorders. This situation is exacerbated by the worldwide increase in incidence of sexually transmitted diseases and HIV infection and by the fact

that women often lack access to the means to prevent pregnancy and to protect themselves against infection. (Rivera Z E et. al. 1994, Mlimarvalye L.1990).

JBM Jafar Siddique made a paper on analyses 1150 cases of sexually transmitted diseases (STDs) in relation to the socio-economic condition of the patient during the period from January 1987 to June 1992. Suspected patients who reported for treatment to skin out patient who reported for treatment to skin out patient department of military hospital and to private chambers of practicing dermatologists were enrolled in this study for evaluation. The patients were divided into three different groups A (higher class), B (middle class) and C (lower class) on the basis of their monthly income. The majority of patients were between the age group of 19 to 30 years (56.52%). Seven hundred thirty five out of 1150 patients were unmarried (63.91%) and rest were married (36.09%). The diagnosis in all cases was based on clinical suspicion and positive laboratory findings. During study, the following observations have been noticed: A) among higher calss gonorrhea (41.14%), non-gynecological urethritis (NGU) (25.72%) and herpes progenitalis (12.57%) were more prevalent than other STDs. B) syphilis (26.36%), gonorrhea (14.55%) and chancroid (33.64%) were more common in middle calss and C) in lower class people-chancroid (53.42%), gonorrhea (14.55%) and syphilis (21.64%) were more prevalent and considered as high risk group (JBM Jafar Siddique 1994).

Keller S discussed that many adolescents are embarrassed of unwilling to take precautions against sexually transmitted diseases (STDs). In African countries polygamy or sex with older partners can increase for young women the risk of contracting HIV and other STDs. Their feeling of insecurity and lack of self-confidence prevents them from seeking reproductive health services and rejecting unwanted sexual advances. The Girl's Power Initiative in Nigeria offers confidence-building meetings to girl's 10-18 years old. It also teaches job skills. Through empowerment they realize their capacity to cope with their own prejudices and those in society. In Bangladesh girls are not allowed to leave their homes, ride a bicycle, or go to the marketplace alone.

With increasing awareness and concern about the role men play in the transmission of STDs/HIV and AIDS, marginalizing men in family planning and reproductive health services is not appropriate. Ignoring men's needs greatly increases their health risks, as

well as those of their partners (Heise LL 1994). This situation is exacerbated by the worldwide increase in incidence of sexually transmitted diseases and HIV infection and by the fact that women often lack access to the means to prevent pregnancy and to protect themselves against infection. (Rivera Zea E et. al. 1994, Mlimarvalye L.1990)

Bangladesh is no more an AIDS free country but AIDS is not yet a health problem in Bangladesh. A National AIDS committee was formed in 1985 but earnest implementation of the AIDS prevention programme actually started in 1988. The zero surveillance activities carried out so far revealed that up to November 1994, thirty three persons were detected to be HIV sero-positive and tow persons were diagnosed as AIDS cases and died (Akhter H H. et. al 1993).

Health care delivery services:

Sundari T K emphasized the health care delivery services for women section of the society. Prevention and control of maternal mortality is dependent on structural factors and women resources such as their time, money, information they have, and their authority over decision making. 5% of gross national product is the usual expenditure for health by most developing countries, and less than 50% is devoted to primary health care and a very small amount to maternal and child health. Women's health regardless of maternal status needs attention (Sundari T K 1992).

Male involvement in reproductive health:

A distinctive characteristics of gender related biological risk is that only female, as opposed to their male counterparts, bear the burnt of all hazards involved with reproductive function. Male sex remains absolutely immune from the burden and complications of reproductive constraints, endowed by natu e. In sterility or infertility, though may occur with regard to the male sex, is often attributed to the female sex.

This discriminatory position of women contributes to increased health risks and their inferior as well as subordinate status in the society in comparison to their male counterparts, The gender inequalities of health in Bangladesh and in other developing countries are of particular consequences to women to be reproductive in childhood, violence against girls and women, occupational and environmental hazards. These inequalities exist because of emphasis upon women's childbearing roles, preference for male children over female

children, excessive female workloads, lack of female autonomy, and the prevalence of early marriage (Heise L L, 1994, Cook R J 1993, Black M, 1993).

The role of a family in reproductive health in any society bears an important aspect for discussion. The behaviour of the members of the family towards women's reproductive health is intimately related with the beliefs, attitudes, customs, rituals, religious activities (Sawandeey 1988, Onidyi A. K. 1987, Clarence 1981). The nature of the relationship between women's status and maternity is evident in the bast majority of the world's societies, where women's worth is measured by the number of children she bear; her status may be further enhanced if she prolifically produces male offspring (Mc cauly N et. al. 1994 carole H. 1994). Sheila Kitzinger's work offers the first extended discourse on how the experience of motherhood is structured by broader socio cultural dynamics. So beliefs, ideas, views of the people play important role in the pattern of marriage, pregnancy, childbirth, and (Clarence maloney 1981, Aziz K. M A 1985) It is evident from the review of available literature that the marriage pattern in rural Bangladesh society, decision making regarding pregnancy, practice of child birth, health care seeking pattern during pregnancy, size of the family and other behaviors related to reproduction depends largely on the males perception their attitudes, views, which is very much existent in that society. (Lee E 1994, Mc cauley AP et. al 1994).

CHAPTER - 3
METHODOLOGY

3.1 Research Setting:

Santinagar slum Chittagong is the main industrial and port city of Bangladesh, geographically situated on the mouth of Karnafully river and the Bay of Bengal in the eastern part of the country. The port has its existence back in the age of Mughal rule. During the years under colonial rule, Chittagong received less commercial interest with the creation of the port of Calcutta by the British. In the later years, beginning from the creation of Pakistan, this port began to receive due recognition in view of its potentiality as an industrial and commercial center. With the emergence of Bangladesh, industrialization took place in a relatively speedier pace and the city became the focal point of migration from various other resource-scarce districts of the country for search of a better living. The city gained population more than what its economic, commercial and industrial structures could provide. The present population of Chittagong Metropolitan City is estimated as about 4 million. As a result of growing urbanization, in-migration of poor, uneducated, landless population have created a class of somewhat 'floating population' in the city who have taken refuge mainly in slums. The number of slums now in Chittagong approaches to about 1535 according to the report of Urban Community Health Program- Slum Survey, made in 1997. The number of total households in all these slums is 75,615 with a resident population of 4,45 864 in the slums in all.

The present research was conducted in a slum named 'Santinagar' located in a Ward no7: West Sholashahar under Biazid Bostami police station within Chittagong City Corporation. The slum under survey is situated in an industrial zone and ecologically is characterized by hill hillocks, canals and cleared uplands.

Santinagar slum is the biggest among 1537 slums, which contains 5600 households Urban Development Center Survey: 2001). Looking retrospectively, the emergence of Santinagar slum was associated with the establishment of Amin Jute Mill, Amin Textile and Asiatic Cotton Mill in 1950s. In the earlier time, it was named as 'Hemapur - a suburb with barren hills and paddy lands. The 'Hemapur slum encompasses an area of 48.5 acres of both hilly and plain land.

A common belief exists that once a folk drama (jatra) was organized here, as is done elsewhere. An appealing character 'hema' in the drama attracted the rural spectators. The village took its new name after that character. Around in late 1970s a religious school, 'madrasha' was established in the locality and a religious teacher re-labeled Hemapur as 'Santinagar. With the passage of time, this locality, once a typical village came under the grip of expanding urbanization. Santinagar, as is popularly known to be, is a landscape is surrounded on three sides by a canal, namely, 'Tripura khal which originated from this place, Until now there is no good communication system here with the city around in the year 1993, Chittagong City Corporation (CCC) made infra-structural developments under the funding of UNICEF under the Slum Improvement Project (SIP) which included installment of tube wells, street lights, drainage and walkways. Apart from this, BRAC and PROSHIKA undertook development of this locality.

It was found that at present there are 6 pharmacies, 6 quakes (village paramedical practitioners, 9 kabiraj, 4 Homeopathy doctors, 3 mosques, 3 madrasas, 1 shrine and 1 cooperative society formed by the slum dwellers. BRAC, Proshika, ASA, Thengamara, DORP, Image, and UDC are the main NGOs, which are operating in this slum. Urban Development Center (UDC) is offering counseling services on women' s health having a permanent office here, while BRAC and Proshika are helping the local people through volunteers on health awareness. The central focus in the activities of these NGOs is concentrated on micro credit program. Proshika

has formed 36 cooperatives on micro-credit. Apart from this Proshika and BRAC run satellite, Non-formal schools for adult education. IMAGE,an another NGO organizes a week camp for providing health services to mothers and children using paramedic. The slum has only on trained traditional birth attendant (TTBA) until now.

From socio- economic and demographic viewpoint, Santinagar slum is no exception from typical slums of big cities like Dhaka and Chittagong. It depicts similar magnitude of settlements, over-crowding and congestion, paucity of proper ventilation over- dependents on the utilization of surface water (canal) for the purposes of bathing, cleaning of cooking utilities, (except drinking - in all such matters from health perspective, the slum of santinagar nourishes deleterious environment for protection against contaminated and infectious diseases like diarrhoea, hooping cough, fever, influenza, respiratory and intestinal disorders.

3.2 Reasons for Selection of the study place:

Shantinagor is a typical slum having all the characteristics slum life like other 's else where in Bangladesh. I worked in that area as a Polio Eradication Facilitator, near the Shantinagor slum. During the working period which is about two year's in that locality, I developed a good relations with the slum dwellers and become familiar with their life styles. I also got the opportunity to be accustomed with the attitudes and behavior of the people. This opportunity of understanding the nature of the slum dwellers helped me to build confidence on the people about the interaction which might be faced at the time of conducting such type of study in a slum settings.

An NID volunteer of Shantinagor slum residing at that slum with whom I had a good relation. The NID volunteer is one of the influential person in that slum, economically solvent, socially regarded as a respectable man .

Prior to the data collection I was successful in obtaining the assurance from NID Volunteer helping in various way during the acted period of data collection.

3.3 Data Collection Process:

Methodologically, the present research was designed in a framework involving the data gathering techniques of research as well as anthropological tools of observation, in-depth interviewing, Focus group Discussion (FGD), social mapping. The application of such techniques was deemed important to obtain insightful exploration of the dynamics that affect the life of the currently married male and females. The data collecting procedure yielded both quantitative and qualitative data and provided a wide range of information on the problems of reproductive health of the currently married slum women

3.3.1 Sampling and Quantitative data:

The quantitative data were collected through two structured questionnaires one on the married males numbering 100 subjects and the other on the females of equal number who were selected randomly following the criteria of random sampling from all the slum households. Only the families, which had at least one child aged half year, were enlisted in the sampling plan from which the sample families were ultimately selected. The questionnaire for the female component was elaborately developed incorporating the issues specified in the objectives, provided in Chapter-1. Another questionnaire contained variables relating to the selective role of the husbands that essentially influences the reproductive health of their wives. The questionnaires on the female samples were administered by female interviewers who had previous exposure to survey research. Before administration

of the two questionnaires, these were pre-tested in a non-sampling area, and necessary medications were incorporated in order to avoid ambiguity. At the end of each day's of data collection, the filled-in-questionnaires were edited, and inconsistent schedules were re-interviewed. These procedures ensured the reliability and validity of the obtained data. The data from both questionnaires were quantified using a code plan consisting of pre-coded responses and were converted into univariate tables.

3.3.2. Qualitative Data:

As cited above, anthropological techniques of several kinds, namely, in-depth interviewing, life stories, focus group discussions with key informants of both sexes were applied which invoked more meaningful and analytical overview of the problem. A female research assistant, professionally trained in qualitative research method conducted the FGDs and case studies on female subjects. On the contrary, the main investigator executed those with male informants. The obtained qualitative information's have been complimentarily used with the tabular analysis in conjunction with the quantitative data. Besides, macro level data used in this respect were obtained from various official records, NGO's reports and published literatures.

Anthropological approach means more qualitative approach. Intensive fieldwork and participant observation are the main thing of anthropological methods. To research among the slum people on this issue like reproductive health, the anthropological method is the most effective to reveal the objectives. There are so many private information's what is not possible to know with out following the anthropological method.

It is a micro-level study. Its an in-depth study. Through the intensive fieldwork this study has been done intensively. The techniques under this method what are followed for the research are summarized under the following headings:-

Rapport Building:

To be a friend of the respondents is the main thing of the rapport building. Without establishing rapport is not easy to enter the researched people and collect the important information. Firstly a researcher establish rapport with his/her researched group. To be an easy goer to the respondents. I have established very well rapport with my researched people.

Informal interview:

This is an unstructured interview through the informal discussion. Focus group discussion is a from of this interview. or informal discussion is a from of this interview. Anthropologists follow the systematic way of informal interview or informal discussion. Through the participatory observation is occurred between respondents and anthropologists. Hence the anthropologists sometimes call it informal interview as conservation (Burgess, 1984).

In the research of anthropology successful interviewer have to have the honesty, initiative, interest, the power of adjustment of the environment of the interviewee, personality and patience, appropriate mind set, and enough educate, mental preparation for conducting interview. Researcher should be careful to how much interest has a respondent has for the reply and also the asking questions are not illogical. Though the anthropologists don't use the structural questionnaire but the use kind of checklist. It's a chit type. What they won't to know through their research they just keep these note in the checklist. That is why "Ethnographers do not decide beforehand the questions they want to ask, though they may enter the interview with a list of issuer to be covered not do ethnographers restrict

themselves to s single mode of questioning. On different occasions, or at different points in the same interview, the approach may be non-directive, depending on the function that the questioning is intended to serve." (Hommerslay & Atkinson 1999; 112-3).

In this regard another question of his. " As unstructured interview has no fixed set of questions. This do not mean that respondents are interrogated at random. The questioning may be centered on a particular incident of topic, or it may be based on checklist of topics to be covered of no list of questions that the interview modifies as he goes alone. " (1917; 48).

In my methodology of research I have followed this way. I carried on my research based on informal discussion in the different environment through unstructured way. I did not keep my pleasure on the respondents. I was alert for the easy atmosphere of the respondents.

Focus Group Discussions :

The focus group method is now widely used in basic and applied research. Focus groups do not replace surveys, but rather complement them. Sometimes this type of technique of the data collection is called focus group discussion. "Focus group discussion as a qualitative research method with a definite goal, is essentially a group discussion taking place between people of more or lees identical age, socio economic status, sex and other common characteristics" (Achinatya Dus Gupta 1989' 15).

A famous anthropologist P.J Pelto told in a contemporary discussion on the Focus Group Discussion, in Dhaka "Focus Group discussion is a method of getting information from a group of persons (usually 4 to 8). The individuals who have a common background and brought together, to discuss a particular interest. Not

only that, "..The focus group method of information gathering will often be most successful after researcher have been gathering information in individual interviews with key informants as well as from other sources." (Pelto 1994)

I have applied this theory in my research. I have selected different group, who are in the similar age rank, a community.

Participatory observation:

I have already pointed to the intensive fieldwork as a method of my present study. In different ways, it is the anthropological approach, which I have followed in my study. The anthropological method, which involved direct participator and observation in the field seems to us the most useful method for this type of study . "Participant observation is a research methodology for human studies that places the research indirect contact with people in everyday life setting" (Pelto 1994) According to Khuckhon- "Participant observation and on occasion, in the interests and affects of a group of person. Its purpose is to obtain data about behavior through direct contact and in term of specific situation in which the distortion that results from the investigations being an outside agent is reduced to a minimum." (Florence R. Kluckhohn 1940; 331)

It is necessary to say that the ultimate goal of participant observation is to generate practical and theoretical truths about human life that are grounded in the realities of daily consistence. In this a researcher can collect the reliable information of his research.

I have applied the techniques through my study. I followed every thing for getting the information for the study. I have kept this in my mind and sharply applied. Participate observer may face a problem called culture shock and life shock. But I would like to say that this problem was overcome by me easily. I was very much conscious about that before the study.

To Stay with the respondents:

It is another significant task to stay with respondents during the fieldwork. Without staying with them it is not possible to observe them well. According to Malinowski, " To get integrated picture, a community worker must learn the language. Live with the people, share their food and custom and learn as far as possible to feel and think as they do. " Besides that we find in "The tools of Social Science". By living in the village, Malinousli was able to see the customs, ceremonies and transactions of native life over and over again and so achieved a group of what he called the imponderable of actual life, which can not possibly be recorded by questioning of consulting documents (Madge 1965; 139)

I lived with them, share their food and custom and etiquette as far as possible. I have followed the style of their living, taking food etc.

To Participate with the life of the respondents:

I participated in the various aspect of the respondents lives. I played an active role as a member of respondents marriage ceremony, Birth rituals others functions and occasions. I went to many places with my respondents.

Pelto talks about the root of participatory observation" Participant observation focuses on human interaction and meaning viewed from the insiders viewpoint in everyday life situations and settings, It aimed to generate practical and theoretical truths of participant observation involves a flexible, open-ended opportunistic process of inquiry through which what is studied is constantly subject to redefinition baded on field experience and observation. Participation is a strategy for gaining access to inaccessible dimensions of human life and experience (Pelto 1994).

Life history/memory method:

In the research of an individual is asked various questions due to know the life history through description discussion. That respondents try to remember his past, It is to justify the change what occurred between the specific individual and the society. Sometimes this type of method is called memory method or life history method. Spradly and Macarthy opened "Life history to the restraints placed or them by their culture and to events that happened in their lives." (1975; 56) According to Pelto, Life histories represent the exceptional rather than the representative or average persons in the community." (:Pelto, p 99) It is noticeable that the life pattern, traditions and events are historic analysis of the existence values and beliefs by the life history method. There fore "the richness and personalized nature of life histories offered a vividness and integration of cultural information that are great value of understanding particular life ways." (Pelto' p 99) Life history materials may be more useful for examining the patterning of general values, face of cultural interest, and perception of social and natural relationships than as turn histories. I followed this method and applied in my study to reproductive health behaviour. Through this method I wanted to illuminate their reproductive behavior, it was very helpful to my studies for collecting the valuable and important information of such type of issue.

Key informants:

In the field research of anthropology the anthropologists depend on the key informants when they have close connection and collect important information. The key informants have the very helpful mind and acquainted the researched people and environment to the researcher. The key informants can give vivid picture of the researched people; there are some persons in the group who can hold the clear view on the research topic related to his group; Sometime the are called well-infirmed informants. I use this type of key informants in my study partially. According to Ridge, "The identification and selection of key informants available

in a community may take some time to accomplish. Since your knowledge of local culture must be sufficiently advance to be able to recognize the vital status, positions and you must have established personal relationships in your work that will allow you to approach such persons for their help in the study (197097)."

In my researched people there was some female respondents. So, it was easy to every thought about the female characteristics related to the research issue thought a female key informants. I used method practically.

Case study:

Case study method occur a significant rate in the research of anthropological method. In the case study method a respondents gives vivid descriptions or him/her life and views on a specific issue. If researcher gets significant and valuable information for the related topic is marked it as a special focus and gives on elaborate description. Researcher takes one or two cases as a special item and focused them vividly for the more clear presentation or his researched goal. Collecting information in a large scale and focused on small sample is the main them at the case study method.

An important part of the anthropological research is to present the different elements and sample of characteristics related to the researched issue. This sample represents the whole research in a small farm. It acts lime a representative of the research objectives.

I focused some case study in my research. I took some sample related to the reproductive health. The different type of issued of reproductive health education, Knowledge from the behavioral aspect influences the respondent life and how it is absorbed through his/her life. I tried to show that by the following case study method. I have tried to draw a vivid picture in a small page through the case study. My case studies can give an idea about the knowledge of reproductive health conditions and behavior in the life of researched group. According to Pelto "The term case study method has been applied to the study of same delimited call of social events a large number of instances' (pelto' 1970; 247). Evans Velson called it extended case method and Fortes said structural frame of research. According of Fortes " The structural frame of reference gives us the procedures for investigation and analysis by which a social system can be apprehended as a unity made up of parts and process that are liked to one another by limited number of principles of wide validity societies," (Fortes 1953; 39). In the case study of my research this truth was revealed. My case studies are able to focus the real condition of the knowledge of he reproductive health among the focused group.

Documentary evidence:

In the anthropological research observation participant, Informal interview, case study, life history method are the major sources of study. But go through the documentation and collect information from them also belong a important role and it is considered as a secondary source of collecting information a the research topic. In the literate society this method is applied more lay the researcher. According to Almost anthropologists, "The presence and significance of documentary products provides the researcher with a rich vein of analytic topics, as well as a valuable sources of information." (Hnmmersley A Atkinson 1992; 142) Those sources are treated as documentary evidence where the picture of the respondent's viewe, thoughts are reflected.

I have applied this method in my study, I checked out some documentary evidence both official and private. Private documentary evidence is like personal diary of the respondents where I found a picture of his/her life style. View on life what is related to the reproductive health. And the official documentary evidence included various reports on reproductive health. In this regard Pleto said. "Fieldworkers should make every attempt to obtain official archival data whenever possible, even though these materials frequently are incomplete or distorted for particular communities. Fieldworker wills in most cased need to check official concuss statistics by means of other kinds of observation in their research communities." (pelto 1971; 134)

Familiarity with the local language & the uses of interpreter:

The use of local terms is very significant in the anthropological research. Anthropologist acquires the capacity to about the local language for their self-interest as if they face no barrier to collect the valuable information their study, because 'The actual words people use can be of considerable analytic importance. The 'studied vocabularies' employed provide us with valuable information about the way in which members if a particular culture organize their perception of the world and so engage in the "social construction' of reality." (hammersley & Alkinson, 1992;153)

It is said in the anthropological research "researcher have mastered the local language may be true for some aspects of daily life, but understanding of the more suitable and conceptual parts if life requires years of experience" (Beals 1977; 72). I personally acquainted with the technical term of the local language and especially reproductive health related terms also learned.

It is noticeable that in my study it is not needed to engage any interpreter. I myself conduct the part of any interpreter. But for the more accuracy I got some help from local person who plays a role of interpreter partially. According to famous anthropologist Fnanz Boas, "The use of local person as researchers have been of treat importance to the work of anthropological field research."

Taking notes & maintaining Field Diary:

The meaning of fieldwork is the collecting information and analysis of information of data regularly. This data and information is collected through the keeping notes and maintaining a field dairy by an anthropologists. We know that in anthropology the first attempt of the fieldwork is to collect the information through the direct observation and the second attempt is to write down systematically of the collecting information and experience through the fieldwork. Every researcher of anthropology uses the field notes and maintains a diary. According to Hammersley and Atkinson," field notes are the traditional anthropology for accordance with anthropology's commitment to discovery field notes consist of relatively concrete description of social processes and their contexts

It should write in details the time, date, name of the respondents place atmosphere, the related issue, the information etc. It is easy to prepare a concrete report from the help of the field notes and dairy. It is a great significant method of the research. I have maintained a dairy and field notes during my study, which helped me a lot to write their report.

According to Burgess, "The main purpose of these note is reflection." (1964; 172) "Keeping a set of methodological field notes will, there fore, allow the researcher to be reflexive and to engage in some form of self analysis during the research process, a social anthropologists (Malinowski 1967, splinder, 1070) and which is to be recommended to all who engage in field research ". (Burgess, 1984, 173)

This type of maintaining field notes is the main thing to analysis the data from the field research. Such memos may included summaries that are writing at the end of a day in the field in which researcher indicates themes that prepared thought about the analysis regularly period it will mean that the index in prepared. I have applied this method in a great dial to of my study. In the gap of my interview on investigation. I just finish the moment I took the notes and after getting free hours I wrote in the diary on my study.

Involvement :

It is also a significant aspect in the intensive fieldwork through anthropological method. Some body says that it is not possible to collect the accurate information without involvement. On the other hand someone argues form not the obvious of involvement. But it is necessary and useful technique to collect valuable information. Involvement refers something difficult and tactful job. Some one says that involvement difficult and tactful job. Some one says that involvement means to do exact things on participate with the respondents what he/she acts. Physical attachment also sometimes indicates the instance of involvement. On the other hand to involve himself (a researcher) in the daily life of respondents also mint. I wanted to try to apply this method in my study. I involvement was necessary for the sake of the study. I followed this without any hesitation. What involvement with researched people it is not possible to find out those truth what is very much related to my research.

3.4 Data processing and analysis:- At the end of each day's of data collection, the filled-in-questionnaires were edited, and inconsistent schedules were re-interviewed. These procedures ensured the reliability and validity of the obtained data. The data from both questionnaires were quantified using a code plan consisting of pre-coded responses and were converted into univariate tables. Some figures were prepared by using Excel programme.

CHAPTER- 4

FINDINGS AND ANALYSIS

The present chapter summarizes the findings generated by (a) two questionnaires, one on male respondents and the other on their wives (b) FGDs (c) In-depth Interviewing. Later being the main focus for examination with regard to their reproductive health.

4.1 Socio-economic and demographic characteristics:

Age:

The age distribution of under study families is highlighted in Table-1 and Table-2. Looking at the age structure of the female subjects, 22% belonged to the age grade of 19 years or below, 32% in the 20-24 age category, 27% in 25-20 year age group, and 19% in the higher age grade, 30-and above (Table-1). Among the male respondents, the group aged between 21-30 year constitutes 52%, and nearly one fifth belong to 31-40 year and 41 & above respectively. Only an insignificant proportion of the male respondents (4%) are aged 20 year or below (Figure-1 and 2).

Educational Status:

The level of education attained by the slum couples under review is predominantly limited to primary and secondary schooling at best, in both male and female components as presented in Table-3, 4 and Figure- 3. A large proportion in both sexes has not enrolled in even primary level education (57% among female samples and 45% among the male subjects). Among those who had attended schools, 40% of the female and 32% of the male respondents had primary level education. Only a marginal portion in both sexes crossed to the secondary level: 13% and 22 % respectively. This indicates the slum dwelling people, irrespective of sex difference, could attain education necessary for gaining meaningful vocational skills. This also shows that the literacy among the lower strata of urban population particularly those residing in slum sub-culture is somewhat similar One could say that slums are extensions of the ruralism in Socio-cultural terms. As a matter of fact, the cities are centers of attraction of impoverished segment of rural population in Bangladesh. The slum, 'Santinagar' in Chittagong is no exception to this phenomenon.

Migrational status:

The scrutiny of data in Table-5 provides evidence to the observation made above. It can be seen that 70% of the surveyed families are in-migrants from their own villages. Additional families who are reported to have shifted here from other slums (17%) are likely to share the same background (in-migrants). This being the case, the total figure approaches close to 90% of the total respondents. The remaining subjects are born and brought up in the slum environment. They are the people who can be characterized as 'floating population' in proper sense of the term. The known causes of exodus of rural people to urban places include river erosion, landlessness, natural calamities, and lack of opportunity for a source of income at the countryside under excessive pressure of population on the carrying capacity of land.

The outside-districts from which have been the original places of residence of the surveyed male respondents are illustrated in Table- 6 and Figure-4. It can be observed that the about one third of the male respondents migrated from Comilla/Chandpur districts (34%), another one third from Brahmanbaria (32%), 14% came from greater Barisal, 10% from Noakhali district, and 4% from each Netrokona and Mymensingh districts. As for reasons behind migration, a number of factors were reported which include landlessness (10%), displacement caused by river erosion (5%), and lack of employment opportunities in the village (58%), documented in Table-7.

An account of the duration of residence of the families in the present slum is recorded in Table- 8. A fairly sizable number of the subjects (42%) are residing here since 7 years ago from the time of survey. The proportion of the respondents who are residents in this slum for a period of 1-4 years stands at 38%. One fifth (20%) of the subjects are a recent resident (one-year).

Occupational status:

The present occupational positions of the respondents are examined in Table-9 and Table-10 and Figure-5 for male and female samples respectively. As far as the male respondents are concerned, vocations for earning livelihood include day laboring (54%), Rickshaw pulling (20%), job in offices/industries (23%), and petty trading (5%). It is important to

look at the nature of vocation performed by the male respondents which are primarily 'non-skilled' pursuits and are accompanied with low income, which will be analyzed later. On the other hand, the female segment of the samples, more illiterate in volume, are not engaged in any income generation activities (91%) which can be partly attributed to their recent motherhood and resultant child-rearing tasks. Yet only 9% of the female subjects are found to be involved as vendors, tailor and garment workers at the time of the survey.

Family Income:

The survey data depict, by and large, a picture of the economic marginality of the slum dwelling people, confronted in any similar setting elsewhere. Given their background of high scale illiteracy as well as the lack of vocational skill, the monthly income tends to be seasonally variable and inadequate for bare survival. Table- 11 and – Figure-6 indicates that the average monthly income of the male respondents (household head) at the maximum level reaches Tk. 4000 for the bulk of the cases (60%); only 8% are reported have a monthly income between Tk. 4001-and above. One- fourth of the male respondents (24%) earn about Tk 2001-Tk 3000 per month. This unveils the serious economic insolvency of the slum population in general.

When we turn our attention to the level of income of their female counterparts, the results are far worse than the one observed for male subjects. As noted before, most of the females are housewives (91%), they are fully dependent on their husbands for subsistence. The income of the remaining women (9%) varies between Tk 2000 (6%) and Tk 3000 per month (3%). One can easily anticipate the deleterious consequences that may emerge from such depressing scale of poverty that prevails in the slum environment (Table-12).

Type of dwelling house:

Our curious inquiry into the nature of dwelling house revealed that the slum locality is typically a cluster of temporary sheds, constructed with bamboo made structures (Katcha) which account for 82% of the surveyed households (Table- 13). The tenants of other types, relatively fewer in number, mainly consist of 'semi-pacca' (14%) and brick- built house (4%). Table- 14 examines the rental cost involved in slum housing: The tenant subjects in large number rent house in the range of Tk 301-400 per month (40%) and still

a significant number can afford to spend an amount of 401 or above for dwelling (26%). 8% of the respondent household heads managed to live on their own plot. The resident of thatched structure dwellers (10%) pay a rent of Tk 200 per month.

4.2 Health Culture and Hygienic Environment of the Slum:

The hygienic and environmental conditions prevalent in the slum households have been scrutinized against the following parameters: sanitation, latrine use, drinking of safe water, and personal cleanliness.

Type of latrine:

The members in the households under study are predominantly dependent on the use of unsanitary latrines like, open space (53%), and pit (40%), which are by normal health standard, detrimental to cause contamination. Only a smaller number of families (7%) are found to have access to quasi- sanitary latrines (Table- 15).

Type of drinking water:

It was revealed that the slum people irrespective of their difference in many matters are adapted to the drinking of tube well water from the neighboring place, which is cognized ad being safe from contamination. This is true in both rural and urban settings across all classes. It is now recognized that the consumption of insufficient quantities of water of poor bacteriological quality seems to be a major factor contributing to high incidence of gastro-intestinal diseases. The use of surface water even for non-drinking purpose may invoke contamination through other routes.

Overall hygienic management:

Inquiries into the hygienic management was done using a scale incorporating 5 items namely, 1) cleanliness of clothing, 2) protection of drinking water against contamination, 3) bodily cleanliness (nail cutting), and 4) cleanliness of the room. According to the obtained score, the households were classified into two categories, such as, 'positively Health conscious" group and 'negatively health conscious group. The scale indicated that 65% of the families are negatively oriented in health management, and the rest was classed under the 'moderately oriented category. None of the interviewed families could

achieve the score to be identified as positively oriented. as depicted in Table- 16. The use of surface water for using in bathing, cleaning dishes and dresses invokes the risk of contamination-related disorders. Hence from the findings on the personal cleanliness, there is an increased risk of infection associated with using water from culture negative sources (canals, ponds, river etc) for cooking, bathing or washing, than culture-positive source of water being used for drinking (tube well water).

4.3 Dimensions of the Reproductive Health:

The present research is an attempt to investigate the various dimensions of reproductive health which described below: Perception on biological conception:

Cultural values regarding sexuality and gender roles and economic disadvantage exert powerful influences on how married females make sexual and reproductive decisions. As part of the decision making process, adolescent often look to their peers for cues regarding the various aspects sexual behavior and to evaluate the degree to which their beliefs agree or disagree with group norms. The use of contraception is inter-related with the concept of biological conception. Adolescents' perception of conception, even among the educated class is likely to be ambiguous; only it is understood to be linked with sexual behavior in a general sense.

In the absence of proper knowledge about the biological dynamics of conception, the culturally ingrained practice of non-use of contraception by may adolescent girls in our country, most new brides become pregnant soon after marriage. Evidence suggests that unwanted pregnancies often arise from the ignorance about conception and reproduction. One of the goals of this investigation, among many others, was to assess the cognitive knowledge of the married women about their views on the biological mechanism involved in 'conception'. The issue being a delicate one was considered to be probed by informal discussions by way casual conversation.

Concept of pregnancy:

In-depth interviewing, in other words, revealed that there is a mixture of ambiguity and speculation on such matters among the married adolescent women who identified a number probable causality on the notion of 'pregnancy' or 'conception'. The responses

give more meaning when qualitatively analyzed than in quantified figure. In-depth interviewing yielded certain observation worth to be mentioned in this context. 1) It is analogous like harvesting, that is,, planting seeds in soil. Semen of male acts likes seeds; women's body is a field which produces. 2) Reproductive process is the result of physical union between members of two opposite sexes. 3) Reproduction is the outcome of divine wish. 4) The presence of child in the womb of mother symbolizes pregnancy or reproduction and 5) the occurrence of coitus resulting in the stoppage of menstruation implies pregnancy.

Cognition of conception:

Intensive probing also focused on their predictive knowledge about the sex of the child to be born. Quite a number of tentative forecasting was obtained which deserve to be adjudged through subsequent vigorous medical scrutiny. The lay notions emphasize that: 1) When conception takes place in the first half of the lunar month, the sex of child is likely to be male. It occurs in the second half, the child would be a female in sex. 2) If a couple have coitus in the deep night, accompanied with conception, the offspring would be male child. 3) Alternatively, if the gap between menstruation cycle and conception is relatively longer, there is the possibility of a female child. 4) When a pregnant woman carries a male child in her womb, her skin becomes darker. On the other hand, if the child in her womb is a girl, mother's skin turns brighter and charming. 5) If any couple has coitus in the early part of the night, and wife, when conceived, the child would be a girl. 6) When a mother carries a male child in her belly, she becomes often physically weak.

Folk women maintain a series of beliefs pertaining to possible consequences that may occur on the life of the 'yet to be born' baby correlated with their activities in the context of natural world, such as lunar eclipse. Scientists often view those beliefs as being superstitions. Anthropologists, unlike them call such conceptions as 'folk wisdom gained from long-term observation of the interaction between nature, environment and human being. The body of such knowledge also called as 'Indigenous Knowledge System (IKS) by anthropologists has the potentials of empirical validity, though not derived from systematic scientific experimentation. The slum women, being an representation of the broader stratum of rural culture also harbor some views which deserve to be given due

importance having academic values. The finding from FGDs produced some unique examples of such causality connected with deformity of baby-in-womb associated with pregnant mother's activities: 1) If any couple has coitus in the time of lunar eclipse leading to conception, the offspring will be malformed. 2) If any pregnant woman takes any food during the time of solar eclipse, the child, when born will be deformed. 3) Cutting / peeling any food item like fruit with a sharp instrument during lunar or solar eclipse, may cause abnormality on the baby in the womb. 4) At full moon night or on moonless night, if any pregnant woman pierce fish may cause damage on the body of the baby in the womb. 5) Non-regularity of a pregnant woman in the performance of daily routine works may cause harm to the physique of the baby in the womb. 6) Outdoor visits by a pregnant woman during inauspicious time/hour may lead to serious deformity of the baby while in the womb. 7) Committing sin by the pregnant mother or the curse of elder forefathers may cause deformity in child yet to be born.

Rituals and restriction during menarche:

The attainment of menarche marks the passage from girlhood to adolescence. It is a biological development for womenfolk (onset of puberty) which signal the reproductive maturity. In rural and slum settings, are specially observed and taboos are imposed on certain types of activities for those who have entered into the menarche status: any type of religious performances, namely, offering prayers, fasting, visiting shrines, reciting holy Quran, etc are prohibited for a women during menstruation. Such females are restricted from visiting outdoors in bare head especially at the time of daybreak, noon, and dusk. Additional restrictions on movement include going into bushes and crossing river.

Age at menarche:

Table- 17 reveals that the age at which menarche occurs depends on varying factors like climate, environment, dietary habits, and to some extent the biological predispositions. The present study hints that the age at which menarche occurred varied between 11-years age (2%) to the maximum age of 15 years (12%). Nonetheless, 43% of the females under study experienced menarche at the age of 14, next followed by those aged 13 (24%), and 12 years (18%).

Age at marriage:

As in rural area of Bangladesh, marriage of teen aged girls are common, slum culture continues to present a quite close pattern, More than one fourth of the sampled females (26%) entered into marital life by the period when they were 14 years old only. A more dominant mode appears to be the age between 15-17 years for being wedded. With advancing age beyond this period, there is a declining trend: 18% and 5% of the surveyed females entered into conjugal life respectively. It is amply testified by the data that adolescent at early age in the slum begin their reproductive function as a distinct pattern within the domain of a family (Table- 18 and figure 7).

Duration of conjugal life:

It was mentioned in the methodological chapter that the age range of the women was restricted to 15- 49 years, it was deemed important to assess the duration of the conjugal life. Table- 19 illustrates that close to 60% of the women began their conjugal life over 5 years from the time of this survey. About 20% of the women in the samples started their marital life since the last 4 years. The recently married couples having an experience of child delivery account for also 20%.

Age of women at first childbirth:

Woman's age at which the first child is born is crucially significant for the health of both mother and her child. From the viewpoint of reproductive cycle, a U-shaped pattern of child mortality has been frequently cited in literature. The curve implies that the rate of child death is extremely high at the early age as well as at the late period until menopause is reached in woman's reproductive life cycle. Curious enough, 67% of the women subjects aged 15-18 years experienced their first childbirth in the slum. The corresponding figure for the age group 19-22 years is 32%, and for those aged above 23 years
Is limited to 3% only. It indicates that the rate of reproduction is highest in the critical age period than in the relatively safer period (Table- 20 and Figure-7).

Age of the last child:

Data in Table-21and Figure-8 shows the present age of the last child in the surveyed households. 40% of the last born infants happen to be aged 136-180 days old. The last

born children in the age groups, under 45 days, 46-90 days, and 91-180 days old are proportionately even varying between 17% to 20%.

Birth interval:

Birth interval factor is instrumental for maternal health and also for child survival. Closely spaced birth is highly detrimental to cause depletion of mother's health and pose additional threat to the children in question. On the other hand, an interval minimum 3 years has been to be associated with re-generation of maternal and child survival. Our findings in this study as presented in Table- 22 and Figure-9 clearly indicate pattern suggestive of a normal curve. The closely spaced childbirth's (below 2 years) accounts for 13%, followed by moderately spaced child group (2-3 years interval) claims the highest lot (37%), ending up finally with a fairly smaller group of children having 4 year birth interval (24%).

Total number of children:

The parity status (number of children) is illustrated in Tablee-23. Little more than half of the families under investigation (54%) has 1- 2 children. 29% of the families tend to close to 4 children, while higher parity (5-6 children) is observed among 16 of the households. It can be assumed that the lower parity is likely to be limited to only younger aged couples, who are just beginners in their reproductive career. When aged, the numbers of children in those families are supposed to increase in the absence of non-compliance with fertility regulation, as observed in the next Tables on the use of contraceptive methods.

Contraceptive Prevalence:

Fertility regulation at the early stage of adolescence is considered important for reproductive health. The knowledge and practice of family planning method among the slum dwelling couples under study is presented in Table- 24 and Figure-10. Strikingly, 55% of the families had avoided the adoption of family planning and thus child bearing began quite early soon after their marriage. This is a reason why female fertility is found to be higher in the slum families. Notably Another 25% who were once adopters of family planning eventually discontinued the practice. Only 20% of the selected families at present have been controlling fertility using FP methods.

Current status of contraception use:

A deeper look at Table-25 and Figure-11 will show that presently 8 in every 10 families are non-users of FP. This finding speaks of the poor knowledge of the importance of fertility control as a measure of sound reproductive health among married women.

Currently using FP methods:

Among the limited couples who are adopters of FP method (20%), the use of injectable method is restricted to 8 couples, the use of pills to 5 adopters, Norplant and Condom to 4 families (Table- 26 and Figure-12). These data indicate the lower response of the proportion of interviewed families to the intensified programme of population control programme in the slum sub-culture.

Reasons for not using contraception:

Focus group discussion results validate that newly married women have learnt from the aging married women section who were once adopters of PF methods about the adverse effects of use of pills, injections, IUD and norplant in varying degrees that develop over the years. Such narrations act as negative factors among the currently married women about FP interventions. Often it was reported that the use of such methods cause headache, irregularity in menstruation or excessive bleeding, weight gain, etc. On the other hand, permanent sterilization method (vestectomy and tubectomy) is seen as sinful act associated additionally with social stigma of being sexually turning as impotent.

It seemed pertinent to search for the reasons behind non-adoption of the method of contraception. The female respondents cited the following causes for non-adoption of contraception: Table- 27 and Figure-13 further demonstrates that about 14% of the mothers are not using FP methods deliberately in order to have a baby, postpartum amenorrhea (25%), opposition of husband (24%), Physical discomforts associated with the use of contraception (22%), and breastfeeding (15%), It is worthwhile to mention here that among those who are non-users of FP, a section has become mothers in recent time which is also a factor for withholding the use of such methods.

Future use of contraception:

The data in Table 28 and Figure-14 points out that more than one fifth of the female respondents (22.5%) are not at all interested to be user of FP in future and desire to be

reproductively active in future years57.5% of them expressed their intent to be users of FP in the future and another 20% of them are yet undecided about their future course of action in this regard.

Future FP method use:

Curiously enough, although the practice rata is markedly low among the interviewed females their knowledge of family planning methods is very high, as indicated in Table-29 and Figure-14 the non-user respondents could mention the name of methods such as pill, injectable method, IUD, and tubactomy. Would-be-adopters categorically expressed their opinion about their choice of preferred method in later period which include pill (54.3%), injectable method (33%), tubectomy (6.7%), and IUD (4.4%). In total out of presently 80 non-users 46 females (50%) have mention their willingness to become adopters of such methods altogether.

Decision making with about FP:

There is indication of sharing views on contraception use with their husbands. Table -30 shows that 81% of the total respondents involve in exchanging views with their husbands with regard to the use of contraception methods. This suggests the nature of mutual decision making among the partners in fertility regulation.

Decision making process about pregnancy:

It is found that 65% of the couples remain unconcerned about sharing the decision about planning pregnancy before it occurs. Only in the remaining portion of the families, couples are reported to take such decision through mutual understanding (Table-31).

The issue was further raised in in-depth interviewing with the key informants which unveiled the effect of patriarchal nature of the society in which the male household head's views and decisions predominate virtually in vital matters like family planning adoption (discussed above), or planning of pregnancy. This is considered to be sole a male's domain of action, where the views of women are thought to be undesirable. Often the women themselves are complacent about talking on culturally sensitive and tabooed issues, with even their husbands.

Discussion about pregnancy related issues:

The women respondents were asked the source to which they first disclose about their being pregnant. Once pregnant, the women usually inform the event to a few sources only, which include husbands (33%), mother/mother- in-law/sister (26%) and also sometimes neighbor (21%). It is not that the confine their discussion with one or either source; rather sharing of views go in multiple directions, involving all the categories cited above (Table-32).

Dietary behavior during pregnancy:

The state of pregnancy requires additional intake of food than what is consumed in normal condition. It is necessary for proper development of the baby in the womb who needs to be nourished from mother's nutritional intake. Our investigation in this respect reveals that the majority of the pregnant women depended on normal foods during pregnancy. Around 67% pregnant subjects believed that there is no need to intake protein- rich food during pregnancy. However, the emphasis is given on the casual consumption of vegetables, seasonal fruits, and eggs by the respondents in question (Table-33).

Food restriction during pregnancy:

In rural Bangladesh, food feeds and pregnant women because of time-honored beliefs strictly observe taboos. The slum women subjects demonstrated observance of similar food restriction in some kinds of food items, which are however eaten in normal time. The tabooed foods include "Trout', 'Carp', 'Waking fish' and 'Sheat-fish' 'Hilsha fish' and mutton. Among the fruits and vegetables, prohibition is imposed on coconut water, pineapple. 'Calery' (red leafy vegetable). They offered no reasons or explanations against such food feeds.

Work load and rest during Pregnancy:

The nature of daily work pattern daily performed during the period of pregnancy was observed and also discussed with the sample women. A minimal number of the pregnant could spend enough time for rest. Although many of the pregnant women were not engaged in income generation activities, yet the volume of workload related to household chores remained as usual. It was only in the tri-semester of pregnancy, they were forced to reduce the normal workload because of physical discomforts. One reason for

withdrawal from heavy workload was the complications that accompanied their pregnancy at that stage. Poor nutritional store in their health caused weakness to prolong the household chores at advanced stage. When asked, 28% of the pregnant women reported that they took rest after mid-day meal, 20% hold that resting occurred whenever they felt discomfort, and 52% of the pregnant women felt fatigue and which forced them to leave bed little later than their normal habit (Table- 34).

Sharing of husband the household activities at wife pregnancy:

It appeared that most of the husbands (91%) did not share the burden of household work during this critical stage of their wives. The lack of urgency among the male respondents is rooted in the traditional definition of the role of male persons as being the caretakers of subsistence activities beyond the confines of a home setting (Table-. 35).

Pattern of ritual performed at the time of pregnancy:

Folk women, no matter living in rural or urban slums, follow some customary practices during pregnancy inherited from their traditions. The observance of typical rituals include 'Satosha, and 'Milad'. It is found that 'Satosha' is a ritual when special foods involving several manus are prepared and served to the pregnant mother. The ritual food is often shared by and distributed among the members of relatives and neighbors for welfare of the 'to be mother'. It is indicated that about 89% of the families under study performed this ritual at the 7th month of pregnancy. Apart from this, about 9% families arranged 'milad manful' for the safety of the pregnant women during child delivery (Table-36).

Pregnancy-related Complications:

Pregnancy and childbirth-related complications constitute the leading causes of maternal morbidity and mortality in rural Bangladesh.

Findings obtained from FGD indicate that women have limited knowledge of life-threatening complications of pregnancy and childbirth. Husbands, the decision-makers for use of obstetric care services, are even less knowledge than their wives are. In case of serious complication, local service providers are consulted first who have no training in handling emergency obstetric cases. It is also found in FGD qualitative data that husbands and relatives are usually the primary decision-makers with regard to the persons to be consulted for obstetric complications. Women's knowledge of symptoms relating to

pregnancy, delivery and after-delivery was found to be very low. The following symptoms appear to be important:

a) Pregnancy related complication include bleeding during pregnancy, Oedema, leaking membrane before delivery, convulsion, severe vomiting, anemia.
b) Complications during delivery include prolonged labor, severe bleeding, Retained placenta, Malpresentation, Perennial tear.
c) After delivery related complications include fever more than three days, convulsion, severe bleeding, smelly vaginal discharge, Vasio-vaginal fistula (VVF), Recto-vaginal Fistula (RVF) and prolapsed uterus.

It is well recognized that the reduction of maternal morbidity is largely related with antenatal care (ANC), tetanus toxoid immunization, and iron supplementation. Essentially all women are at risk of complications during pregnancy and childbirth. Maternal morbidity cannot be substantially reduced unless women have access to emergency obstetric care (EOC).

Antenatal Care:

A key to the management of a risk-free reproductive health as well as child survival is the recognition of the importance of the antenatal care during pregnancy, delivery assistance, and child immunization. A well-designed and implemented antenatal care program facilitates detection and treatment of problems during pregnancy, such as anemia and infection, and provides an opportunity to disseminate messages to women and their families. Antenatal care coverage from a trained provider is important to monitor pregnancy and reduce the risks for the mother and child during pregnancy and delivery. To be most effective, there should be a regular antenatal care throughout pregnancy.

Pregnancy-related complications:

In the present sample set, 17% of the pregnant women reported 3 or more morbidity -- the majority linked to the postpartum period (Table- 37). The complications reported by such women include 1) bleeding during pregnancy (11%), 2) Oedema (17.6%), 3) Severe vomiting (17.5%), 4) Convulsion (11.7%), 5) Leaking membrane before delivery (17.6%), and Anemia (23.5%), as presented in Table- 38. Besides these syndromes, incidences of

hemorrhage, puerperal sepsis and prolonged labor. Also constitute additional hazards to pregnant women to some extent (Table-38).

Antenatal care during pregnancy:

It is revealed in Table-39 that more than half of the mothers (53%) did not receive any antenatal care (ANC). Only 47% mother receive antenatal care during pregnancy period.

First took antenatal care:

Only 17% of the pregnant women took antenatal check up in the first semester of their pregnancies, while about 47% received ANC check ups in the second semester, and most alarmingly 36 % of the women had the same at the last semester just before child delivery (Table 40).

Number of antenatal check-up:

Further queries indicated that 42% of the mothers received only one ANC visit and 15% had two ANC checkups. Only little more than one third of the pregnant women (37%) completed 3 visits. The proportion of those who had 4 ANC visits is restricted to only 4% (Table-41).

Last antenatal check-up:

The insensitivity regarding the importance of ANC checkups among the slum-dwelling couples can be additionally obtained from the data presented in Table-42. A dominant pattern prevalent among the surveyed families is reflected in the avoidance of getting crucial ANC tests in the last 3 weeks before the expected delivery. About 62% of such women at advanced level obtained the last ANC check up six weeks back prior to their deliveries. Those who completed ANC test 3 weeks ago account for 32% of the women. The proportion of the women who obtained ANC check up within 2 weeks time is very low approaching 4% only, followed by the group visiting one week ago (2%), as shown in Table-42.

Immunization status of women during pregnancy:

Maternal Immunization during the pregnancy period (three doses of TT injections) is vital for the safe childbirth. The present study reveals that 88% of the pregnant women received TT injections (Table-43), which can be featured as a positive development. The satellite camps created by different NGO, namely, IMAGE, offer such services to this locality. Other similar organizations also promote health education program in Santinagar slum.

Reasons for vaccination during pregnancy:

A close examination of the perception of the women subjects depicted that the lay notions of the women about the benefits of immunization are cited as follows: 1) vaccine protects women against tetanus (46%), 2) Vaccine minimizes the risk of illness among women (25%), and 3) Child remains safe in the womb if mother is vaccinated (13%) (Table-44).

Reasons for not taking vaccine:

Among 100 female samples, 17 did not receive immunization. When probed, it appears that some misconceptions tend to refrain them from taking vaccines which include 1) the fear of being hurt as a result of injection (29.4%), 2) the suspicion that vaccine harms the baby in the womb (17%), 3) vaccine brings about physical weakness (29%), and 4) non-availability of opportunity for vaccine in the locality (23%), as described in Table-45.

Total number of vaccine received:

Next that requires examination is the total number of vaccines received by the pregnant women. Data in this respect are displayed in Table-46. It becomes clear that among the 83 recipients, 60% completed two courses of vaccines, while only a fragment of the subjects (4%) received three TT injections. 19% have taken only one dose of TT vaccine.

Husband accompanied wife at ANC check-up:

It is observed that in case of 89% of visits for ANC check-up, the husbands did not accompany their wives to the health center/clinic (Table-47).

Reasons for not accompanying wife at ANC check-up:

Various reasons were given by the male respondents for failing to accompany their wives in such important matter, such as, 1) males know little about ANC (7.4%) , 2) husbands have other works to do (31.5%) , and 3) such matter is embarrassing for a man to face (4.6%) (Table-48)

It was known from FGDS that the indifference of the male partners in accompanying their wives to health centers remain to be a paramount factor for poor rate of reception of antenatal care services in the slum environment. There are some health care providers in the locality, run by NGOs specially to cater to the needs of women of reproductive age, which remain virtually under-utilized.

Place of stay during first Childbirth:

The preference of home setting in place of formal clinic or hospital setting for child delivery is a common occurrence in rural and slum culture. The survey data bear evidence to the traditional customary preference of home setting as the place of child delivery, a decision in which husband's view predominates. Table-49 amply brings forth that 69% of the childbirth take place at husband's residence and 31% in wife's paternal house.

Reasons for staying at women father house at first childbirth:

A characteristic behavior pattern for choosing father's home as the place of first child delivery springs from several considerations. In-depth discussions yielded some clues to the fact that the delivery the presence of close kin's, particularly of her mother reassure the confidence of the pregnant woman. The known environment is congenial for the pregnant woman provides a feeling of relief. Parents take special care in all her matters, especially at a time of such critical event. The new born baby immediate after birth also receive due attention and care from elderly relatives who have previous experience of rearing a just born baby. All these considerations are taken into account while childbirth time approaches.

Perception about labour pain:

Delivery of a child often is a traumatic experience for a woman experiencing first childbirth. Prolonged labor, leaving aside the question of delicate obstetrics, cause pains of serious magnitude. The onset of labor pain indicates the signal timing of delivery. The slum-married women were asked to ventilate their experiences of childbirth. In response, they pointed out various dimension of labor pain. In their views, the size of the baby is a potential factor in both lengthening the delivery and the associated intensity of pain (FGD) One informant expressed "It is kind of pain never to be understood by a man It is severe in nature women cry while in the labor pain".

Place of child delivery:

The husbands play the decisive role in this selection. In Table-50, one can find the places where the child delivery took place. In the study area, almost all the deliveries (97.9%) took place at homes. Only 2.1 % of the deliveries were conducted at the governmental healthcare centers or NGO hospitals.

Delivery attendants:

For traditional and cultural reasons, many poor families still prefer a TBA, rather than a medically trained person attends the births.

In Santinagar slum, most deliveries were attended by the traditional birth attendants and relatives (95%), while only another 5% deliveries were conducted by paramedics, nurses, or doctors (Table-51).

Reasons for delivery conducted by untrained TBA:

The huge expenses involved in admitting in clinic and fees of doctors and medicines exert effect on the choice of TBAs. As Table-52 exemplifies, slum people like those of rural areas attach high priority to 'Dai' on the grounds of 1) easy and instant availability of the TBAs in the community (78%), 2) whose call fees and services charges are within the limits of the poor families to spend (10%), and, above all, 3) the behavior of the 'Dais' are cordial and easy going (12%).

Community is an important factor that affects safe-delivery practices in slum and rural settings. This underscores the need for appropriate behavioral change communication

strategies to make the uneducated families and relatively younger women aware of the benefits of safe delivery by medically trained persons.

Delivery-related complications:

As can be seen in Table-53, 15% of the pregnant women reported to have suffered from severe complications during the delivery period. The types of complications are cited as 1) prolonged labor (46.6%), 2) severe breeding (33.3%), and 3) retained placenta (20%), and 4) Perennial tear (26%). Such ailments, though could be fatal, were coped by traditional birth attendants (TBAs).

The remuneration against the services offered by the TBAs:

The remuneration against the services offered to the TBAs came ion two kinds, namely, offering of money (82.6%) and 'Sari" for the remaining TBAs (Table-54). They also receive some kinds of gift from the husbands in honor of their successful effort.

Rituals performed after childbirth:

Some rituals are essential embodiments associated with the arrival of a new baby in the family. In the slum setting, 89% of the couples observed rituals on such occasions (Table-55). On the nature of rituals performed, FGD reveals that immediate after birth, if the baby is a male, "Azan" is loudly uttered close to the ears of the new born baby. On the contrary, when the baby is a female, "Ekamat Azan" is cited close to her body in a lower voice. Home made cakes and sweets are offered to the relatives and neighbors as a gesture of joy. In some cases, special 'manats" (prior commitment to the Almighty) are fulfilled and 'shirni' (holy food are sent to 'Mazar' (shrines) or mosques.

Postnatal Care:

Any successful pregnancy outcome immediately demands postnatal care for the mothers, which remains severely vulnerable for many kinds of morbidity. Several complications tend to gradually crop up in the subsequent period that pose additional threats to the health o the mother. According to findings of this survey, It is alarming to find that 85% of the mothers did not seek any postnatal check up,

Only 15% mothers took postnatal check up. Postnatal check-up took from NGO satellite clinic (53%), physicians (13%), allopathic quakes (20%), and Hospitals (13%), as shown in Table-56 and Table-57.

The nature of complications confronted by mothers after childbirth is as identical as observed elsewhere (Table-58 and Table-59). Out of 100 female respondents 15%faced complications after childbirth. They include continual fever for three days ((17%), convulsion (17%), severe bleeding (32%), smelly vaginal discharge (11.7%), and prolapsed uterus (11.6%).

Post partum rest:

It is essential that the mothers need to take postpartum rest following childbirth for a considerable period of time. In-depth interviewing revealed that the slum women very quickly return to their normal work within weeks of childbirth. By religious sanction, 4o days' of withdrawal from domestic and religious duties (prayer, fasting, outdoor visit) are tabooed during postpartum period. The slum women hardly maintain the restrictions imposed socially.

Child-feeding:

Child feeding in the early stage exerts immense impact on the health of mother and the baby in equal proportions. The investigation carried by Ahmed F.H. Choudhury showed that there is "gradual decline in breastfeeding among rural women in Bangladesh and the duration of full breastfeeding is shrinking down to a significant scale ... Malnutrition in mothers put limits to adequate lactational performance. The excessive severity of malnutrition of child in pre-natal age, reflected by the low birth weight is largely due to fetal under-nutrition during gestation and pregnancy' (1988: 447). The findings obtained in this study corroborate the observation cited above to a great extent.

Colustrum feeding practices:

Among the mothers living in the slum, 55% of the babies are fed colustrum (Table- 60). The knowledge on the high nutritional value of colustrum milk among the mothers is somewhat absent. There is a wide misconception that such milk is not suitable being impure in its substance, which is quite wrong. It has the protective resistant power to enable the newborn child in gaining biological immunity against many infectious diseases.

Exclusive breast feeding practices:

However, a positive sign is that about two third women (74%) tend to practice full breastfeeding by the female respondents. Normally, from scientific standard, breastfeeding should continue for at least 3 years. Contrarily, the slum mothers tend to begin feeding supplementary food to their children side by side with breastfeeding (25%), given in Table-61. Such a move generates among them from the fear of their poor lactational performance. The physical weakness, itself a product o heir own malnutritional state confers upon them a sense of urgency for giving their babies additional food for proper growth. As a matter of fact early supplementation pose extra risk of contamination-related disorders (diarrhoea, mal-absorption, intestinal problems. etc).

Age of child at birth:

Pre-matured birth is seen as an essential outcome of many combined factors that include low nutritional store of mother during pregnancy, non-compliance with the consumption of adequate food during pregnancy and undertaking of excessive work load at that time, etc. Such conditions may concomitantly lead to miscarriage, pregnancy

Wastage or abortion. The children who are born as pre-matured run the burden of high morbidity in their subsequent years; it has been found that about one-quarter of the offspring in the study population are somewhat pre-matured infants, documented in Table- 62.

Perception about birth weight of last child:

The present study traced the syndrome of low birth weight babies among the couplers to a considerable degree. Table-63 provides testimony to the observation that about 43% of the newborn babies are identified as low weight children. This occurs primarily as a result of mother's proper nutritional state during their pregnancy.

Child immunization:

It is widely recognized that the immunization of newborn babies against the deadly diseases like polio, diphtheria, whooping cough, tetanus and tuberculosis, are essential for their survival, Increased

Immunization overage executed by NGOs and GOBs in recent years resulted in striking reduction of infant morbidity and mortality in the recent years. Urban slum development

program has been trying to extend health care services at the grass root level over the last one decade. The national coverage rate is considered to be quite satisfactory. Public health consciousness has increased substantially because of health promotion related activities.

Status of child immunization:

The immunization status of the children of the survey families is documented in Table-64. The children who have been vaccinated account for 65% of the families, whereas infants of 18% of the households remained totally non-immunized. However, Infants of 17% of slum families are yet to reach the age required for the first TT vaccine.

Sickness of child:

Among the study households, as depicted in Table- 65 ,35% experienced illness of varying types. Such diseases primarily include diarrhoea (20%), Pneumonia (34%), fever (20%), and whooping cough (27%) shown in Table-66. In coping with the illness of infants, parents usually take refuge of multiple sources of treatment namely, allopathic quake (54%), Homeopathic (5.7%), physician (2.8%), Governmental hospital (5.7%), and NGO satellite clinic (31.4%) shown in Table-67. Now days, the services being offered by NGO satellite clinic, seem to play key institutional role in meeting the health needs of the disadvantaged segment of populations in Bangladesh. The attitude of the male household heads in the utilization of available health care facilities in the community particularly for their wives and infants seem to be yet a matter of great concern. As Table-78 unfolds, about 83% of the male household heads failed to turn up with their sick children to the health centers. Most often, it is the mother who performs the responsibility to look after their sick offspring as well as for their treatment.

Knowledge on HIV/AIDS:

In recent years, the incidence of sexually transmitted diseases is increasing in alarming rate in many developing countries. A great number of Asian counties are already in the grip of more deadly diseases of HIV and AIDS. The occurrence of diseases, though have not become major health problem in Bangladesh, yet the possibility of HIV and AIDS among our population cannot be totally ruled out in the absence of scanning of blood for such diseases. At a time of rapid population mobility which is now taking place, the virus for such diseases can easily enter into our population through enhanced rate of out-breeding and for non -use of protective measures against the infection. Besides many other possible routes, slum culture runs the high risk of being a stage of infection due to

unregulated sexuality that characterize most slums. An inquiry from the respondents demonstrated that 75% of the male and 65% of the female respondents possess no knowledge of either AIDS or HIV (Table-69). This calls for urgent health education about the danger posed by unregulated, unsafe, and promiscuous sexual life among the slum dwellers. This is more important, it is the slums that may be the quick recipient of such sexually transmitted diseases in future.

CHAPTER-5

DISCUSSIONS

The present research was conducted in a slum named 'Santinagar' located in a Ward no7: West Sholashahar under Biazid Bostami police station within Chittagong City Corporation. The slum under survey is situated in an industrial zone and ecologically is characterized by hill hillocks, canals and cleared uplands. Santinagar slum is the biggest among 1537 slums, which contains 5600 households Urban Development Center Survey: 2001). Looking retrospectively, the emergence of Santinagar slum was associated with the establishment of Amin Jute Mill, Amin Textile and Asiatic Cotton Mill in 1950s. In the earlier time, it was named as 'Hemapur -- a suburb with barren hills and paddy lands. The 'Hemapur slum encompasses an area of 48.5 acres of both hilly and plain land.

From socio- economic and demographic viewpoint, Santinagar slam is no exception from typical slums of big cities like Dhaka and Chittagong. It depicts similar magnitude of improvisation in settlements, over-crowning and congestion, paucity of proper ventilation over- dependents on the utilization of surface water (canal) for the purposes of bathing, cleaning of cooking utilities, (except drinking - in all such matters from health perspective, the slam of santinagar nourishes deleterious environment for protection against contaminated and infectious diseases like diarrhea hoping cough fever influenza, respiratory and intestinal disorders.

The age distribution of under study families is highlighted in Table-1 ,Table-2and Figure-1, Figure-2. Looking at the age structure of the female subjects, 22% belonged to the age grade of 19 years or below, 32% in the 20-24 age category, 27% in 25-20 year age group, and 19% in the higher age grade, 30-and above (Table-1). Among the male respondents, the group aged between 21-30 year constitutes 52%, and nearly one fifth belong to 31-40 year and 41 & above respectively. Only an insignificant proportion of the male respondents (4%) are aged 20 year or below (Table-2).

The level of education attained by the slum couples under study is predominantly limited to primary and secondary schooling at best, in both male and female components as

presented in Table-3, Table-4 and Figure-3. A large proportion in both sexes has not enrolled in even primary level education (57% among female samples and 45% among the male subjects). Among those who had attended schools, 40% of the female and 32% of the male respondents had primary level education. Only a marginal portion in both sexes crossed to the secondary level: 13% and 22 % respectively. This indicates the slum dwelling people, irrespective of sex difference, could attain education necessary for gaining meaningful vocational skills. This also shows that the literacy among the lower strata of urban population particularly those residing in slum sub-culture is somewhat similar One could say that slums are extensions of the ruralism in Socio-cultural terms. As a matter of fact, the cities are centers of attraction of impoverished segment of rural population in Bangladesh. The slum, 'Santinagar' in Chittagong is no exception to this phenomenon.

The scrutiny of data in Table-5 provides evidence to the observation made above. It can be seen that 70% of the surveyed families are in-migrants from their own villages. Additional families who are reported to have shifted here from other slums (17%) are likely to share the same background (in-migrants). This being the case, the total figure approaches close to 90% of the total respondents. The remaining subjects are born and brought up in the slum environment. They are the people who can be characterized as 'floating population' in proper sense of the term. The known causes of exodus of rural people to urban places include river erosion, landlessness, natural calamities, and lack of opportunity for a source of income at the countryside under excessive pressure of population on the carrying capacity of land.

The outside-districts from which have been the original places of residence of the surveyed male respondents are illustrated in Table- 6 and Figure-4. It can be observed that the about one third of the male respondents migrated from Comilla/Chandpur districts (34%), another one third from Brahmanbaria (32%), 14% came from greater Barisal, 10% from Noakhali district, and 4% from each Netrokona and Mymensingh districts. As for reasons behind migration, a number of factors were reported which include landlessness (10%), displacement caused by river erosion (5%), and lack of employment opportunities in the village (58%), documented in Table-7.

An account of the duration of residence of the families in the present slum is recorded in Table- 8. A fairly sizable number of the subjects (42%) are residing here since 7 years ago from the time of survey. The proportion of the respondents who are residents in this slum for a period of 1-4 years stands at 38%. One fifth (20%) of the subjects are a recent resident (one-year).

The present occupational positions of the respondents are examined in Table-9, Table-10 and Figuer-5 for male and female samples respectively. As far as the male respondents are concerned, vocation for earning livelihood includes day laboring (54%), Rickshaw pulling (20%), job in offices/industries (23%), and petty trading (5%). It is important to look at the nature of vocation performed by the male respondents which are primarily 'non-skilled' pursuits and are accompanied with low income, which will be analyzed later. On the other hand, the female segment of the samples, more illiterate in volume, are not engaged in any income generation activities (91%) which can be partly attributed to their recent motherhood and resultant child-rearing tasks. Yet only 9% of the female subjects are found to be involved as vendors, tailor and garment workers at the time of the survey.

The data depict, by and large, a picture of the economic marginality of the slum dwelling people, confronted in any similar setting elsewhere. Given their background of high scale illiteracy as well as the lack of vocational skill, the monthly income tends to be seasonally variable and inadequate for bare survival. Table- 11and Figure-6 indicates that the average monthly income of the male respondents (household head) at the maximum level reaches Tk. 4000 for the bulk of the cases (60%); only 8% are reported have a monthly income between Tk. 4001-and above. One- fourth of the male respondents (24%) earn about Tk 2001-Tk 3000 per month. This unveils the serious economic insolvency of the slum population in general.

When we turn our attention to the level of income of their female counterparts, the results are far worse than the one observed for male subjects. As noted before, most of the females are housewives (91%), they are fully dependent on their husbands for subsistence. The income of the remaining women (9%) varies between Tk 2000 (6%) and Tk 3000 per

month (3%). One can easily anticipate the deleterious consequences that may emerge from such depressing scale of poverty that prevails in the slum environment (Table-12 Figure-6).

Our curious inquiry into the nature of dwelling house revealed that the slum locality is typically a cluster of temporary sheds, constructed with bamboo made structures (Katcha) which account for 82% of the surveyed households (Table- 13). The tenants of other types, relatively fewer in number, mainly consist of 'semi-pacca' (14%) and brick- built house (4%). Table- 14 examines the rental cost involved in slum housing: The tenant subjects in large number rent house in the range of Tk 301-400 per month (40%) and still a significant number can afford to spend an amount of 401 or above for dwelling (26%). 8% of the respondent household heads managed to live on their own plot. The resident of thatched structure dwellers (10%) pay a rent of Tk 200 per month.

The hygienic and environmental conditions prevalent in the slum households have been scrutinized against the following parameters: sanitation, latrine use, drinking of safe water, and personal cleanliness.

The members in the households under study are predominantly dependent on the use of unsanitary latrines like, open space (53%), and pit (40%), which are by normal health standard, detrimental to cause contamination. Only a smaller number of families (7%) are found to have access to quasi- sanitary latrines (Table- 15).

It was revealed that the slum people irrespective of their difference in many matters are adapted to the drinking of tube well water from the neighboring place, which is cognized ad being safe from contamination. This is true in both rural and urban settings across all classes. It is now recognized that the consumption of insufficient quantities of water of poor bacteriological quality seems to be a major factor contributing to high incidence of gastro-intestinal diseases. The use of surface water even for non-drinking purpose may invoke contamination through other routes.

Inquiries into the hygienic management was done using a scale incorporating 5 items namely, 1) cleanliness of clothing, 2) protection of drinking water against contamination, 3) bodily cleanliness and 4) cleanliness of the room. According to the obtained score, the households were classified into two categories, such as, 'positively health conscious" group and 'negatively health conscious group. The scale indicated that 65% of the families are negatively oriented in health management, and the rest was classed under the 'moderately oriented category. None of the interviewed families could achieve the score to be identified as positively oriented. as depicted in Table- 16. The use of surface water for using in bathing, cleaning dishes and dresses invokes the risk of contamination-related disorders. Hence from the findings on the personal cleanliness, there is an increased risk of infection associated with using water from culture negative sources (canals, ponds, river etc) for cooking, bathing or washing, than culture-positive source of water being used for drinking (tube well water).

Obviously in a male dominant society, husbands are valued more, respectable section of the society, symbol of power and security. Inferior status of women, less empowerment, least cared, socially secluded, and to a great extent excluded in the societal affairs, more dependence on male, socio economic support and security, with all these factors create different attitudes towards husband's survival and his better health. Whether women become physically weak or needs more care and attention during period is getting least importance by the women themselves. In a traditional pleasant society that dose not provide much scope to explore the needs and knowledge on women affairs by the women themselves as well as the male section. The very socio cultural pattern, the customs, beliefs, attitudes leave a little scope for the male to concern with the women health.

Cultural values regarding sexuality and gender roles and economic disadvantage exert powerful influences on how married females make sexual and reproductive decisions. As part of the decision making process, adolescent often look to their peers for cues regarding the various aspects sexual behavior and to evaluate the degree to which their beliefs agree or disagree with group norms. The use of contraception is inter-related with the concept of biological conception. Adolescents' perception of conception, even among the educated

class is likely to be ambiguous; only it is understood to be linked with sexual behavior in a general sense.

In the absence of proper knowledge about the biological dynamics of conception, the culturally ingrained practice of non-use of contraception by may adolescent girls in our country, most new brides become pregnant soon after marriage. Evidence suggests that unwanted pregnancies often arise from the ignorance about conception and reproduction. One of the goals of this investigation, among many others, was to assess the cognitive knowledge of the married women about their views on the biological mechanism involved in 'conception'. The issue being a delicate one was considered to be probed by informal discussions by way casual conversation.

In-depth interviewing, in other words, revealed that there is a mixture of ambiguity and speculation on such matters among the married adolescent women who identified a number probable causality on the notion of 'pregnancy' or 'conception'. The responses give more meaning when qualitatively analyzed than in quantified figure. In-depth interviewing yielded certain observation worth to be mentioned in this context. 1) It is analogous like harvesting, that is, planting seeds in soil. Semen of male acts like seeds; women's body is a field which produces. 2) Reproductive process is the result of physical union between members of two opposite sexes. 3) Reproduction is the outcome of divine wish. 4) The presence of child in the womb of mother symbolizes pregnancy or reproduction and 5) the occurrence of coitus resulting in the stoppage of menstruation implies pregnancy. Dr. Lubana Ahmed also confirms this in her study (Lubna Ahmed 1996). There is a mixed type of beliefs, that pregnancy not only the result of sexual intercourse between husband and wife yet it happens when Almighty Allah wishes to give child to that couple (Haque E 1996). The belief system in rural area regarding pregnancy is consistent with the classical analogy that woman is the land and man it's cultivator, that the womb is a field to be planted with male semen (bij) which is found in both the Muslims and Hindu traditions (T.Blanchet 1984).

Intensive probing also focused on their predictive knowledge about the sex of the child to be born. Quite a number of tentative forecasting was obtained which deserve to be

adjudged through subsequent vigorous medical scrutiny. The lay notions emphasize that: 1) When conception takes place in the first half of the lunar month, the sex of child is likely to be male. It occurs in the second half, the child would be a female in sex. 2) If a couple have coitus in the deep night, accompanied with conception, the offspring would be male child. 3) Alternatively, if the gap between menstruation cycle and conception is relatively longer, there is the possibility of a female child. 4) When a pregnant woman carries a male child in her womb, her skin becomes darker. On the other hand, if the child in her womb is a girl, mother's skin turns brighter and charming. 5) If any couple has coitus in the early part of the night, and wife, when conceived, the child would be a girl. 6) When a mother carries a male child in her belly, she becomes often physically weak.

Folk women maintain a series of beliefs pertaining to possible consequences that may occur on the life of the 'yet to be born' baby correlated with their activities in the context of natural world, such as lunar eclipse. Scientists often view those beliefs as being superstitions. Anthropologists, unlike them call such conceptions as 'folk wisdom gained from long-term observation of the interaction between nature, environment and human being. The body of such knowledge also called as 'Indigenous Knowledge System (IKS) by anthropologists has the potentials of empirical validity, though not derived from systematic scientific experimentation. The slum women, being a representation of the broader stratum of rural culture also harbor some views, which deserve to be given due importance having academic values. The finding from FGDs produced some unique examples of such causality connected with deformity of baby-in-womb associated with pregnant mother's activities: 1) If any couple has coitus in the time of lunar eclipse leading to conception, the offspring will be malformed. 2) If any pregnant woman takes any food during the time of solar eclipse, the child, when born will be deformed. 3) Cutting / peeling any food item like fruit with a sharp instrument during lunar or solar eclipse, may cause abnormality on the baby in the womb. 4) At full moon night or on moonless night, if any pregnant woman pierce fish may cause damage on the body of the baby in the womb. 5) Non-regularity of a pregnant woman in the performance of daily routine works may cause harm to the physique of the baby in the womb. 6) Outdoor visits by a pregnant woman during inauspicious time/hour may lead to serious deformity of the baby while in the womb. 7) Committing sin by the pregnant mother or the curse of elder

forefathers may cause deformity in child yet to be born. Congenital abnormalities in the newborn babies in Bangladesh are not rare rather it is increasing in an alarming way. Deformity of newborn baby is caused by various factors. Hereditary, radiation, cytotoxic drugs, infection of the pregnant mother, trauma during pregnancy are responsible for congenital abnormalities. A deformed baby is a social burden as well as economically unproductive to a family.

Specially observed and taboos are imposed on certain types of activities for those who have entered into the menarche status: any type of religious performances, namely, offering prayers, fasting, visiting shrines, and reciting holy Quran. The attainment of menarche marks the passage from girlhood to adolescence. It is a biological development for womenfolk (onset of puberty) which signal the reproductive maturity. In rural and slum settings, are an, etc are prohibited for a women during menstruation. Such females are restricted from visiting outdoors in bare head especially at the time of daybreak, noon, and dusk. Additional restrictions on movement include going into bushes and crossing river. At the time of menstrual period the blood is regarded as polluted one and the same time the women are

Considered as polluted. Pollution and women during menstruation has deep-rooted beliefs, which is originated from the traditional life pattern of this area. In Islam, menstruation (Masik) is called a 'Napak' period for the women. The actual meaning of Napak is a state, which is not pure. So in Islam all sorts of religious activities are prohibited during menstrual period for women. The women do not say prayers, cannot touch the Holy Quran, sacred scriptures, they are not allowed to visit the mosque, mazar sharif etc. There are other proscriptions during menstrual period, like abstinence from coitus.

The cultural pattern and attitudes toward menstruation and other rituals reflect not only the religious belief system but also the common beliefs of Hindu culture. Therese Blanchet also states this in her study in Bangladesh (Blanchet T 1984). Age is one of the most important variables, which bears significant implications in the reproductive health of any population. Throughout the world pregnancy and childbearing are occurring at younger ages than in the past, resulting in adverse health, demographic and social consequences.

Age at menarche, age at marriage and birth of first child obviously directly related to the reproductive health of women as well as family. The trend toward earlier menarche appears to be universal, although it seems to have leveled off in a few developed countries. To day girls every where are sexually mature at an earlier age than previous generations In Europe the mean age at menarche has decreased by about 10 months each generation. According to Pankes, 50 percent of the girls in 1845 were menstruating by age 15, while 50 percent in 1962 were menstruating by age 12. Similar decreases have been found in the age at menarche in the USA and Japan. Genetic, health and socio economic factors influence the wide variations in the age at menarche among different cultures. Recent date suggest that the attainment of a certain body size and accumulation of a curtain proportion of body fat are necessary to trigger menarche. Better nutrition in childhood also appears to be a major cause of early menstruation. Thus whenever nutritional improvements occur, the age at menarche is likely to decline gradually for several generations before reaching plateau at 12 – 13 years (William Burr –Hunt 11, 1976). The data indicate that the age of onset of menarche has increased, specially in rural areas. This increasing age at menarche is related to the increased malnutrition characteristic of the time since 1971. Body weight is seen to be one the most influential factor associated with menarche concept,. Age is another, but less, influential, factor. The seasonal peak of menarche concept occurs during that time of the year when food is most available and malnutrition at a minimum. Age at marriage among these rural populations has increased, possibly due to increased age at menarche. It is likely that a decline in fertility will result among 15 to 19 years old (A.K.M A Chowdhury 1976).

Table- 17 reveals that the age at which menarche occurs depends on varying factors like climate, environment, dietary habits, and to some extent the biological predispositions. The present study hints that the age at which menarche occurred varied between 11-years age (2%) to the maximum age of 15 years (12%). Nonetheless, 43% of the females under study experienced menarche at the age of 14, next followed by those aged 13 (24%), and 12 years (18%). This shows that husbands are least concerned and reluctant to be familiar with this subject. Lack of awareness regarding their wives menstrual history and related physiological events clearly reflects discrimination about the spouses' health situation in a male dominant society. It is not necessarily and intentional attitudes rather it is the normal

phenomenon in the society where traditional beliefs, attitudes, customs, values related to women, regarding their health and childbearing, giving a particular shape within a defined culture of that society. This is the culture of that society or community determines the health and illness behaviour of the people and this is handed from one generation to next generation. Therese Blanchet and Maloney Clarence also provided the similar explanations regarding menstruation and ritual, restriction of different activities at this period in their studies (Clarence Maloney et al 1981).

Though slum peasant society in Bangladesh is not like that of developed countries, but trend toward earlier menarche is also observed. The girls attain the sexual maturity earlier than before and due to the existing socio cultural trend early marriage is practiced for long that of developed countries, but trend toward earlier menarche is also observed. The girls attain the sexual maturity earlier than before and due to the existing socio cultural trend early marriage is practiced for long before in rural Bangladesh. It revealed that still their is prevalence of early marriage. Of course in a traditional agrarian society in Bangladesh it is not an unnatural behaviour.

Many developing countries in Asia and Africa traditionally encouraged early marriage for girls, prior to or shortly following puberty consequently sexual relations and child bearing begin early but the incidence of non-marital pregnancy was reduced. For example in rural areas of India girls were frequently married before, menarche (first menstruation) although sexual relations did not begin until several years later. It was believed that the menstrual blood formed the primary material of the embryo, and to lose any of it before entry of sperms amounted to infanticide. In areas of East Java, it was considered a disgrace to have a daughter experience her first menstrual period before being betrothed (Willum Burr Hunt 11 1996). As in rural area of Bangladesh, marriage of teen aged girls are common, slum culture continues to present a quite close pattern, More than one fourth of the sampled females (26%) entered into marital life by the period when they were 14 years old only. A more dominant mode appears to be the age between 15-17 years for being wedded. With advancing age beyond this period, there is a declining trend: 18% and 5% of the surveyed females entered into conjugal life respectively. It is amply testified by the

data that adolescent at early age in the slum begin their reproductive function as a distinct pattern within the domain of a family (Table- 18 and Figure-7).

Table-19 illustrates that close to 60% of the women began their conjugal life over 5 years from the time of this study. About 20% of the women in the samples started the It was mentioned in the methodological chapter that the age range of the women was restricted to 15- 49 years, it was deemed important to assess the duration of the conjugal life. Table- 19 illustrates that close to 60% of the women begun their conjugal life over 5 years from the time of this survey about 20% of the women in the samples started their marital life since the last 4 years. The recently married couples having an experience of child delivery account for also 20%.

Woman's age at which the first child is born is crucially significant for the health of both mother and her child. From the viewpoint of reproductive cycle, a U-shaped pattern of child mortality has been frequently cited in literature. The curve implies that the rate of child death is extremely high at the early age as well as at the late period until menopause is reached in woman's reproductive life cycle. Curious enough, 67% of the women subjects aged 15-18 years experienced their first childbirth in the slum. The corresponding figure for the age group 19-22 years is 32%, and for those aged above 23 years is limited to 3% only. It indicates that the rate of reproduction is highest in the critical age period than in the relatively safer period (Table- 20 and Figure-7).

Data in Table-21and Figure-8 shows the present age of the last child in the surveyed households. 40% of the last born infants happen to be aged 136-180 days old. The last born children in the age groups, under 45 days, 46-90 days, and 91-180 days old are proportionately even varying between 17% to 20%.

Birth interval factor is instrumental for maternal health and also for child survival. Closely spaced birth is highly detrimental to cause depletion of mother's health and pose additional threat to the children in question. On the other hand, an interval minimum 3 years has been to be associated with re-generation of maternal and child survival. Our findings in this study as presented in Table- 22 and Figure-9 clearly indicate pattern

suggestive of a normal curve. The closely spaced childbirth's (below 2 years) accounts for 13%, followed by moderately spaced child group (2-3 years interval) claims the highest lot (37%), ending up finally with a fairly smaller group of children having 4 years birth interval (24%).

The parity status (number of children) is illustrated in Tablee-23. Little more than half of the families under investigation (54%) has 1- 2 children. 29% of the families tend to close to 4 children, while higher parity (5-6 children) is observed among 16 of the households. It can be assumed that the lower parity is likely to be limited to only younger aged couples, who are just beginners in their reproductive career. When aged, the number of children in those families are supposed to increase in the absence of non-compliance with fertility regulation, as observed in the next Tables on the use of contraceptive methods.

Salway-S et. al. carried out a study in urban Bangladesh, as in many other settings, an immediate postpartum family planning strategy prevails, where providers seek to promote and provide contraception at 40-45 days following birth to women regardless of their breastfeeding or menstrual status. Despite such practices, the majority of women choose to delay the initiation of contraception until menses resumes, often several months after birth. The present paper seeks to explain this discrepancy by describing poor, urban women's understandings regarding the chances of conception and the risks associated with contraceptive use in the postpartum period. Findings from in-depth interviews reveal that the majority of women perceive no personal risk of pregnancy during amenorrhoea, though most do not recognize an association between this diminished risk of conception and breastfeeding. In addition, the data illustrate that women are primarily concerned with their own and their newly born child's health and well being in the period following childbirth, both of which are perceived to be extremely vulnerable. These perceptions, plus an understanding that modern methods of contraception are "strong" and potentially damaging to the health, mean that the majority of women are reluctant to adopt family planning methods soon after birth, particularly during postpartum amenorrhoea. The paper advocates that, since breastfeeding affords good protection against pregnancy for six to nine months following birth, efforts should be made to actively incorporate lactational amenorrhoea into postpartum family planning strategies in Bangladesh. Recommendations are also made for ways in which women may be encouraged to adopt contraception during

amenorrhoea beyond the period of high natural protection. The paper highlights the importance of taking the client's perspective into consideration in attempts to improve the quality and effectiveness of family planning programmes (Salway et. al. -1998).

Fertility regulation at the early stage of adolescence is considered important for reproductive health. The knowledge and practice of family planning method among the slum dwelling couples under study is presented in Table- 24 and Figure-10. Strikingly, 55% of the families had avoided the adoption of family planning and thus child bearing began quite early soon after their marriage. This is a reason why female fertility is found to be higher in the slum families. Notably Another 25% who were once adopters of family planning eventually discontinued the practice. Only 20% of the selected families at present have been controlling fertility using FP methods.

A deeper look at Table-25 and Figure-11will show that presently 8 in every 10 families are non-users of FP. This finding speaks of the poor knowledge of the importance of fertility control as a measure of sound reproductive health among married women.

Among the limited couples who are adopters of FP method (20%), the use of injectable method is restricted to 8 couples, the use of pills to 5 adopters, Norplant and Condom to 4 families (Table- 26 and Figure-12). These data indicate the lower response of the proportion of interviewed families to the intensified programme of population control programme in the slum sub-culture.

Focus group discussion results validate that newly married women have learnt from the aging married women section who were once adopters of PF methods about the adverse effects of use of pills, injections, IUD and norplant in varying degrees that develop over the years. Such narrations act as negative factors among the currently married women about FP interventions. Often it was reported that the use of such methods cause headache, irregularity in menstruation or excessive bleeding, weight gain, etc. On the other hand, permanent sterilization method (vestectomy and tubectomy) is seen as sinful act associated additionally with social stigma of being sexually turning as impotent.

It seemed pertinent to search for the reasons behind non-adoption of the method of contraception. The female respondents cited the following causes for non-adoption of contraception: Table- 27 and Figure-13 further demonstrates that about 14% of the mothers are not using FP methods deliberately in order to have a baby, postpartum amenorrhea (25%), opposition of husband (24%), Physical discomforts associated with the use of contraception (22%), and breastfeeding (15%), It is worthwhile to mention here that among those who are non-users of FP, a section has become mothers in recent time which is also a factor for withholding the use of such methods. Those who did not accept the methods of family planning showed many reasons. Majority of this group (nonusers) believed that it is an act of sin to accept family planning methods because Allah gives children to couple, creating obstacle is a punishable act, couple will be liable to Allah for it". It reflects the deep-rooted belief in religion, which is very natural for a traditional Bengali Muslim society. Various side effects of contraceptive methods is one of the reason for not accepting it. Those who have no children yet and those who have got children after a long treatment they also did not accept any method. These findings are similar to other studies in Bangladesh (Clerance Maloney 1981, K M a Aziz1985 and Haque e 1996).

The data in Table 28 and Figure-14 points out that more than one fifth of the female respondents (22.5%) are not at all interested to be user of FP in future and desire to be reproductively active in future years57.5% of them expressed their intent to be users of FP in the future and another 20% of them are yet undecided about their future course of action in this regard.

Curiously enough, although the practice rata is markedly low among the interviewed females their knowledge of family planning methods is very high, as indicated in Table-29 and Figure-14 the non-user respondents could mention the name of methods such as pill, injectable method, IUD, and tubectomy. Would-be-adopters categorically expressed their opinion about their choice of preferred method in later period which include pill (54.3%), injectable method (33%), tubectomy (6.7%), and IUD (4.4%). In total out of presently 80 non-users 46 females (50%) have mention their willingness to become adopters of such methods altogether.

There is indication of sharing views on contraception use with their husbands. Table -30 shows that 81% of the total respondents involve in exchanging views with their husbands with regard to the use of contraception methods. This suggests the nature of mutual decision making among the partners in fertility regulation.

This issue of the newsletter of the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies seeks to increase the knowledge of family planning program staff about male reproduction and contraception. The 1993-94 Bangladesh Demographic and Health Survey indicated male methods were used by only 4.1% of couples, while female methods were used by 40.5%. Increased acceptability of male contraceptive use will require re-evaluation of culturally determined gender roles, research and development on additional methods, operations research on the promotion of male methods, and modifications in existing service delivery systems. Topics covered in this special issue are the male reproductive system, spermatogenesis, biological characteristics of human spermatozoa, steroid feedback mechanisms regulating testicular function, and current and future methods of male contraception (Halida Hanum Akhter et. al. 1996).

It is found that 65% of the couples remain unconcerned about sharing the decision about planning pregnancy before it occurs. Only in the remaining portion of the families, couples are reported to take such decision through mutual understanding (Table-31). The issue was further raised in in-depth interviewing with the key informants which unveiled the effect of patriarchal nature of the society in which the male household head's views and decisions predominate virtually in vital matters like family planning adoption (discussed above), or planning of pregnancy. This is considered to be sole a male's domain of action, where the views of women are thought to be undesirable. Often the women themselves are complacent about talking on culturally sensitive and tabooed issues, with even their husbands. It reflects that both husband and wife felt the necessity about discussion among themselves whether they what a baby or not, There is an increase in realization for joint decision about pregnancy which indicates a good husband-wife communication development in the study area. The contraceptive prevalence rate is lower among the study sample than that of national rate that is 54 percent CPR. All informants who accepted the contraceptive method told that they talk about methods with their

spouses before taking decision about the use of any method for birth control This indicates that birth control process involves communication between spouses, couple understands the need for discussion before adopting any method. It reflects that family planning workers play vital role in family planning movements in slum area. The family members of the users know the fact of the acceptance of contraceptive method of the couple but they passed no bad remarks rather all of them have a support for it. It is a good indication that people are aware of population problem and make no obstacle to the family planning movements in slum life. Bangor et. al. mentioned their study one frequently cited barrier to more widespread adoption of family planning in Moslem countries is religious opposition. To examine the depth and extent of such opposition in Bangladesh, 106 men who had been identified by their wives as religiously opposed to family planning were interviewed. Unexpectedly, 26 percent of the "opposing" husbands reported that they were current users of a contraceptive and an additional 50 percent, although not practicing said they were in favor of family planning on religious grounds. One-fourth of this last group was able to cite specific Islamic injunctions against family planning. It appears on the basis of these data, which were collected in the religiously conservative area of Lakshimipur, that the perception of widespread Islamic-based resistance to contraception in Bangladesh is not founded in fact (Berngart-MH et. al. 1990).

The physiological change that occur to an woman due to pregnancy is a new experience specially in case of first pregnancy. Women react to these changes with difference notion. From the beginning of the conception, they are to go though various physiological events till delivery of the baby. Morning sickness, nausea, vomiting, loss of appetite, weakness, pain in the abdomen, fetal movements, swelling of the feet etc. are the usual changes that cause psychological as well as physical concern for the women. Pregnant women in rural Bangladesh usually discuss about these pregnancy related events with the household members, neighbours, relatives, elderly women, health workers, TBA. In the first pregnancy the women become more conscious about these physiological changes but on subsequent pregnancies they are to discuss if any difficulty arises during pregnancy. The women respondents were asked the source to which they first disclose about their being pregnant. Once pregnant, the women usually inform the event to a few sources only, which include husbands (33%), mother/mother- in-law/sister (26%) and also sometimes

It is not that the confine their discussion with one or either source; rather sharing of views go in multiple directions, involving all the categories cited above (Table-32).

In a traditional society pregnancy is always welcome if it happens to a newly married couple and if pregnancy occurs as expected by the members of the family. Usually the female members those who have experiences on this matter come forward to encourage the recently conceived women. Now a day's antenatal care is available in most of the slums though government health care facilities. Other NGOs are also engaged in providing antenatal care services to the pregnant women. Not only the antenatal care services are provided, postpartum services, child health care services are available to the slum level. Besides the services provided by the government and non-government organizations, rural people still depend on traditional health care providers. In case of pregnancy, women visit health care centre for ANC, at same time they seek advises from elderly female members, grand mother, TBA, traditional healer, religious healers, Pallichikitsaks, Quack etc. MCH-FP services includes ANC which is still perceived as a new way of health care to most of the slum dwellers.

The state of pregnancy requires additional intake of food than what is consumed in normal condition. It is necessary for proper development of the baby in the womb who needs to be nourished from mother's nutritional intake. Our investigation in this respect reveals that the majority of the pregnant women depended on normal foods during pregnancy. Around 67% pregnant subjects believed that there is no need to intake protein- rich food during pregnancy. However, the emphasis is given on the casual consumption of vegetables, seasonal fruits, and eggs by the respondents in question (Table-33).

In urban slum of Bangladesh, food feeds and pregnant women because of time-honored beliefs strictly observe taboos. The slum women subjects demonstrated observance of similar food restriction in some kinds of food items, which are however eaten in normal time. The tabooed foods include "Trout', 'Carp', 'Waking fish' and 'Sheat-fish' 'Hilsha fish' and mutton. Among the fruits and vegetables, prohibition is imposed on coconut water, pineapple. 'Calery' (red leafy vegetable). They offered no reasons or explanations against such food feeds. Food restriction during pregnancy (Lubna Ahmed 1995).

There is more or less similar food habit and taboos which are followed by the people in the study area to that of other areas in Bangladesh. Similar food behaviour is also noted by other researchers in this regard in traditional Bangladeshi society. Dr. Lubna also noticed the food bevaviours in native Bangladesh immigrants in English reflects the traditional beliefs and attitudes towards food intake and pregnancy.

The nature of daily work pattern daily performed during the sample women. A minimal number of the pregnant could spend enough time for rest. Although many of the pregnant women were not engaged in income generation activities, yet the volume of workload related to household chores remained as usual. It was only in the tri-semester of pregnancy, they were forced to reduce the normal workload because of physical discomforts. One reason for withdrawal from heavy workload was the complications that accompanied their pregnancy at that stage. Poor nutritional store in their health caused weakness to prolong the household chores at advanced stage. When asked, 28% of the pregnant women reported that they took rest after mid-day meal, 20% hold that resting occurred whenever they felt discomfort, and 52% of the pregnant women felt fatigue and which forced them to leave bed little later than their normal habit (Table- 34). Many respondents also having knowledge that careful activities and movements is necessary to avoid physical trauma o the child in the womb. Heavy and laborious jobs are not allowed to perform by the pregnant women. The behavioral pattern regarding restriction of movements during pregnancy reflects their own explanation based on perceptions, belief system of human reproduction, relates it with body mechanism to nature.

It appeared that most of the husbands (91%) did not share the burden of household work during this critical stage of their wives. The lack of urgency among the male respondents is rooted in the traditional definition of the role of male persons as being the caretakers of subsistence activities beyond the confines of a home setting (Table-. 35). The study revealed that female respondents are aware of their situation and take measures according to their ability than male section. Husbands are less concerned about the care and needs of the women even during pregnancy. This statement clearly reflects the division of labour

related to gender issue and it is due to the male dominant societal pattern of female working area.

Folk women, no matter living in rural or urban slums, follow some customary practices during pregnancy inherited from their traditions. The observance of typical rituals include 'Satosha, and 'Milad'. It is found that 'Satosha' is a ritual when special foods involving several manus are prepared and served to the pregnant mother. The ritual food is often shared by and distributed among the members of relatives and neighbors for welfare of the 'to be mother'. It is indicated that about 89% of the families under study performed this ritual at the 7th month of pregnancy. Apart from this, about 9% families arranged 'milad mahful' for the safety of the pregnant women during child delivery (Table-36). Various types of rituals are observed during pregnancy in a traditional society in Bangladesh.

Due to know about different rituals to be observed during pregnancy. Constant economical hardship faced by the family, majority of the people cannot observe the rituals though they know about different rituals to be observed during pregnancy.

Haque E also mentioned that Those who told that they observed rituals informed that majority of them (about 100 percent male and 93.18 percent female) performed "Satosha", one type of rituals observed at 7months of pregnancy when sweetmeats are prepared and distributed among the relatives and neighbours. Millad Mahfil is also arranged by some families, in some cases musical program is arranged where female singers take part, mike, cassette player is used to listen to songs (Haque E 1996). These type of rituals performed to give psychological support to the pregnant women at 7 months of pregnancy (Haque E 1996). It also indicates sharing the feelings of the pregnant women by the relatives, welcoming the baby.

Pregnancy and childbirth-related complications constitute the leading causes of maternal morbidity and mortality in slums of Bangladesh.Findings obtained from FGD indicate that women have limited knowledge of life-threatening complications of pregnancy and childbirth. Husbands, the decision-makers for use of obstetric care services, are even less knowledge than their wives are. In case of serious complication, local service providers are consulted first who have no training in handling emergency obstetric cases. It is also

found in FGD qualitative data that husbands and relatives are usually the primary decision-makers with regard to the persons to be consulted for obstetric complications. Women's knowledge of symptoms relating to pregnancy, delivery and after-delivery was found to be very low. The following symptoms appear to be important:

A. Pregnancy related complications include bleeding during pregnancy, Oedema, leaking membrane before delivery, convulsion, severe vomiting, and anemia.

B.Complications during delivery include prolonged labor, Severe bleeding, Retained placenta, Malpresentation and Perennial tear.

C..After delivery related complications include fever more than three days, convulsion, severe bleeding, smelly vaginal discharge, Vasio-vaginal fistula (VVF), Recto-vaginal Fistula (RVF) and prolapsed uterus.

BIRPERHT was conducted a survey to assess maternal morbidity during pregnancy, labor, and postpartum among a nationally representative sample of 6493 women from 8 unions and 4 divisions in Bangladesh (study population total of 145,500) between September and December, 1992. The study included a household survey of population and interviews and longitudinal data collection from a selected cohort of women who had experienced a pregnancy termination within the previous 2 years from the date of listing. The findings indicated that more than 50% had about 33% had Intrapartum or chronic morbidities. About 80% of the women had one or more morbidities among the sample nationally was 42.6% prenatal, 71.8% Intrapartum, 34.4% postpartum, 61.1% chronic, and 16.2% all morbidities. Regional morbidities were identified for Dhaka, Khulna, Rajshahi, and Chittagong. Chittagong had the highest morbidities at all points in time, followed by Rajshahi. There were around 2 morbidities reported for each pregnancy. Intrapartum morbidities occurring during delivery were the most serious because of their life threatening nature. About 20% of women reported excessive bleeding. The next highly reported condition was prolonged labor, followed by seizures. These conditions were reported in Chittagong by 33% of the women and in Rajshahi by 19.8% of women. The most frequently reported chronic morbidity was uterine prolapsed, which occurred among

approximate 15.1% of the women, followed by vesico-vaginal fistula (VVF) and / or incontinence (7.7%). 28.1% of women in chittagong and 14.0% of women in Khulna reported VVF / incontinence. Other postpartum causes were indicated for fever, shock, foul discharge, breast abscess, painful urination, mild depression, and severe depression. Intrapartum problems were indicated for fits, excessive bleeding, and labor > 18 hours, torn vagina or cervix, cesarean section, instrument delivery, and episiotomy. Prenatal morbidities were bleeding, fits, preeclamptic toxemia, edema, hypertension, fever > 3 days, severe vomiting, and urinary problems. (Akhter H H et. al. 1994).

It is well recognized that the reduction of maternal morbidity is largely related with antenatal care (ANC), tetanus toxoid immunization, and iron supplementation. Essentially all women are at risk of complications during pregnancy and childbirth. Maternal morbidity cannot be substantially reduced unless women have access to emergency obstetric care (EOC).

A key to the management of a risk-free reproductive health as well as child survival is the recognition of the importance of the antenatal care during pregnancy, delivery assistance, and child immunization. A well-designed and implemented antenatal care program facilitates detection and treatment of problems during pregnancy, such as anemia and infection, and provides an opportunity to disseminate messages to women and their families. Antenatal care coverage from a trained provider is important to monitor pregnancy and reduce the risks for the mother and child during pregnancy and delivery. To be most effective, there should be a regular antenatal care throughout pregnancy.

The prevalence of high maternal morbidity and mortality in Bangladesh reflects the health status of the people specially the women of childbearing age and also the health care seeking behaviour of the people of the people in a traditional peasant society. The existing belief system which is responsible for a patterned behaviour and inadequate health care services bear tremendous implication on maternal health in slums of Bangladesh. Most of the maternal deaths result from one of the five major causes of pregnancy related deaths that is abortion, eclampsia, infection, hemorrhage and obstructed labour, it is estimated that a quarter of all pregnancies are high risk. 4 Edema in the feet, convulsion during

pregnancy, severe vomiting, vaginal bleeding, abdominal pain, blurring of vision considered serious complications of pregnancy to the informants.

In the present sample set, 17% of the pregnant women reported 3 or more morbidity -- the majority linked to the postpartum period (Table- 37). The complications reported by such women include 1) bleeding during pregnancy (11%), 2) Oedema (17.6%), 3) Severe vomiting (17.5%), 4) Convulsion (11.7%), 5) Leaking membrane before delivery (17.6%), and Anemia (23.5%), as presented in Table- 38. Besides these syndromes, incidences of hemorrhage, puerperal sepsis and prolonged labor. Also constitute additional hazards to pregnant women to some extent (Table-38). It is due to the existence of a close relation between the slum people and the health care provider, they are part of the slum society and shares the world view of their patients. Physically and socially they are most accessible, also cheapest. Qualified doctors are still considered outsiders, as well as relatively high rate of their consultation fees, people depend mostly on the care provider who are from there own society. Again pregnancy is considered a natural phenomenon and also an women's affair, so less importance is given by the male section. Allopathic quake informed that they consult with the husbands of the husbands of the pregnant women regarding any complains or difficulty faced by the women during pregnancy. They further fold that pregnant women seldom come to them with their difficulties, usually the husbands are sent and consult with the Allopathic quakes. This indirect consultation from the Allopathic quake has little influence on pregnancy outcome, the reason is mainly the 'purdah' system of Bengali Muslim society and pregnancy is a women affair perceived by most of the rural people in a traditional society. Though Allopathic quaks are practicing allopathic medicine and they are recognized by the government, having good knowledge on medical science with regard to the slum level health problems of the people. It is revealed from the discussion with the Allopathic quaks that they have quite good knowledge on female physiology related to menstruation, pregnancy and childbirth, antenatal care, immunization complications of pregnancy etc. Therese Blanchet wrote in her "Maternal Mortality in Bangladesh, An anthropological assessment report, Dhaka, 1988", that the provision of medicines and medical care to women as dependents of men, carries a variety of social meanings and messages and is not always related to medical needs as understood in western medicine. The kinship, political and religions institutions which support male dominance and authority remain strong and intact while the associated

sanctions which ensures that male's carryout their responsibilities to women have weakened (T blancet 1988).

It is revealed in Table-39 that more than half of the mothers (53%) did not receive any antenatal care (ANC). Only 47% mother receive antenatal care during pregnancy period.

Only 17% of the pregnant women took antenatal check up in the first semester of their pregnancies, while about 47% received ANC check ups in the second semester, and most alarmingly 36 % of the women had the same at the last semester just before child delivery (Table 40). M. Ullah conducted a study on the barriers in obtaining antenatal care in a rural community of Bangladesh, two adjacent unions, Sardah and Charghat in Rajshahi District. In the study, it was shown that majority (70.74%) of the study women had to the household for any type of decision. Only 20.26% of the study women had freedom of decision making for antenatal care. Other barriers were financial problem, transportation, family works, previous children responsibilities, dissatisfaction of the government health personnel, lack of awareness about ANC, fear of allopathic treatment (Ullah MA 1994).

Further queries indicated that 42% of the mothers received only one ANC visit and 15% had two ANC checkups. Only little more than one third of the pregnant women (37%) completed 3 visits. The proportion of those who had 4 ANC visits is restricted to only 4% (Table-41).

The insensitivity regarding the importance of ANC checkups among the slum-dwelling couples can be additionally obtained from the data presented in Table-42. A dominant pattern prevalent among the surveyed families is reflected in the avoidance of getting crucial ANC tests in the last 3 weeks before the expected delivery. About 62% of such women at advanced level obtained the last ANC check up six weeks back prior to their deliveries. Those who completed ANC test 3 weeks ago account for 32% of the women. The proportion of the women who obtained ANC check up within 2 weeks time is very low approaching 4% only, followed by the group visiting one week ago (2%), as shown in Table-42.

Maternal Immunization during the pregnancy period (three doses of TT injections) is vital for the safe childbirth. The present study reveals that 88% of the pregnant women received TT injections (Table-43), which can be featured as a positive development. The satellite camps created by different NGO, namely, IMAGE, offer such services to this locality. Other similar organizations also promote health education program in Santinagar slum.

A close examination of the perception of the women subjects depicted that the lay notions of the women about the benefits of immunization are cited as follows: 1) vaccine protects women against tetanus (46%), 2) Vaccine minimizes the risk of illness among women (25%), and 3) Child remains safe in the womb if mother is vaccinated (13%) (Table-44).

Among 100 female samples, 17 did not receive immunization. When probed, it appears that some misconceptions tend to refrain them from taking vaccines which include 1) the fear of being hurt as a result of injection (29.4%), 2) the suspicion that vaccine harms the baby in the womb (17%), 3) vaccine brings about physical weakness (29%), and 4) non-availability of opportunity for vaccine in the locality (23%), as described in Table-45. This reflects the perception about modern medicines and non reliability on modern health care facility. Provision of health care facilities is tacking the concept of cultural background of the traditional peasant society.

Next that requires examination is the total number of vaccines received by the pregnant women. Data in this respect are displayed in Table-46. It becomes clear that among the 83 recipients, 60% completed two courses of vaccines, while only a fragment of the subjects (4%) received three TT injections. 19% have taken only one dose of TT vaccine.

It is observed that in case of 89% of visits for ANC check-up, the husbands did not accompany their wives to the health center/clinic (Table-47).

Various reasons were given by the male respondents for failing to accompany their wives in such important matter, such as, 1) males know little about ANC (7.4%) , 2) husbands have other works to do (31.5%) , and 3) such matter is embarrassing for a man to face (4.6%) (Table-48) It was known from FGDS that the indifference of the male partners

in accompanying their wives to health centers remain to be a paramount factor for poor rate of reception of antenatal care services in the slum environment. There are some health care providers in the locality, run by NGOs specially to cater to the needs of women of reproductive age, which remain virtually under-utilized. This statement reflects the notion that the shame of childbearing, childbirth, care of the pregnant women determines the location, the attendance and many of the practices related to pregnancy in rural Bangladesh. Therese Blanchet and Maloney et. al. also noticed the similar pattern of behaviour in their studies(Clarence Maloney 1981). It was also observed by the author that in health centre women, most of them came alone r with the neighbours. They usually consult with the family welfare visitor regarding family planning methods, immunization and some times talk to the other male health personnel's. The family welfare visitor also confirmed that husbands accompany the wives rare because of their busyness with daily earning activities. NGO workers, specially female health workers visit the house as their routine job and talk or discuss on various issues related to family planning, pregnancy, child health, breast feeding etc. only with the wives. It was also observed that male pay little attention to the female health workers. It seemed that the husbands know the fact of jobs of family planning worker or health workers. Approach to both husbands and wife has great implication on the issue of health and family planning for the couple. Mare discussion only with the women reflects the female centered activities and male gets chance to keep them away from the responsibility of women's health and other pregnancy related events.

The preference of home setting in place of formal clinic or hospital setting for child delivery is a common occurrence in rural and slum culture. The survey data bear evidence to the traditional customary preference of home setting as the place of child delivery, a decision in which husband's view predominates. Table-49 amply brings forth that 69% of the childbirth take place at husband's residence and 31% in wife's paternal house.

A characteristic behavior pattern for choosing father's home as the place of first child delivery springs from several considerations. In-depth discussions yielded some clues to the fact that the delivery the presence of close kin's, particularly of her mother reassure the confidence of the pregnant woman. The known environment is congenial for the pregnant

woman provides a feeling of relief. Parents take special care in all her matters, especially at a time of such critical event. The new born baby immediate after birth also receive due attention and care from elderly relatives who have previous experience of rearing a just born baby. All these considerations are taken into account while childbirth time approaches. Again women can take adequate rest, her jobs done by other members of the family if she stays at her own mother's home. At first pregnancy the wife gets less time to adjust at husband's residence with other members, the time interval between marriage and first pregnancy is short, new experiences due to pregnancy make them embarrassed, get frightened, less cared by the members and the traditional behavioral pattern favours the women to stay at her own parents home. They become easy, get least fear, take adequate rest, achieve psychological relief, get good care, required amount of food is provided at her own home. It reflects the strong bondage between one with her own parents. Mother, sisters and other female mummers can take proper care during delivery and after birth and at first pregnancy the women know very little about the new born care and whole child birth event takes place in a homely and familiar environment for the women, these factors play vital role in preference for staying at won parents residence, revealed from the study (Haque E 1996).

At subsequent pregnancies, the women accustomed to the environment of her husband's house, actively participate in the house hold works, she is regarded as the mother of the child that is her status is changed after first child birth in the household, so more importance is given to her. Again husband started depending on wife for various household activities, at the same time delivery of a child is considered a normal biological phenomenon, the women in most cases stay at husband's residence. Moreover in a nuclear family, wife is sent to her parent's home at the time of birth of child not only in case of first pregnancy but on subsequent pregnancies also. In a nuclear family husband can not manage the whole childbirth and other related events alone, so complied to send wife with her won parent's residence.

Delivery of a child often is a traumatic experience for a woman experiencing first childbirth. Prolonged labor, leaving aside the question of delicate obstetrics, cause pains of serious magnitude. The onset of labor pain indicates the signal timing of delivery. The

slum-married women were asked to ventilate their experiences of childbirth. In response, they pointed out various dimension of labor pain. In their views, the size of the baby is a potential factor in both lengthening the delivery and the associated intensity of pain (FGD) One informant expressed "It is kind of pain never to be understood by a man It is severe in nature women cry while in the labor pain".

The husbands play the decisive role in this selection. In Table-50, one can find the places where the child delivery took place. In the study area, almost all the deliveries e at homes. Only 2.1 % of the deliveries were conducted at the governmental healthcare centers or NGO hospitals. (97.9%) took place.

For traditional and cultural reasons, many poor families still prefer a TBA, rather than a medically trained person attends the births.

In Santinagar slum, most deliveries were attended by the traditional birth attendants and relatives (95%), while only another 5% deliveries were conducted by paramedics, nurses, or doctors (Table-51).

The huge expenses involved in admitting in clinic and fees of doctors and medicines exert effect on the choice of TBAs. As Table-52 exemplifies, slum people like those of rural areas attach high priority to 'Dai' on the grounds of 1) easy and instant availability of the TBAs in the community (78%), 2) whose call fees and services charges are within the limits of the poor families to spend (10%), and, above all, 3) the behavior of the 'Dais' are cordial and easy going (12%).

Less expenditure, availability of TBA (Dai) who are considered expert and competent in conducting delivery, presence of family members at home encourages the pregnant woman to deliver at her own their own place, mother and sisters can help, TBA is also well known, reliable, from their own community, these factors are responsible for preference of home delivery by the slum people. On the other hand people perceive that only the complicated pregnancies should be sent to the hospital, again a negative attitudes prevail among the slum people towards hospital which is originated from the ill behaviour

of the health professionals, expensive treatment, patients and his relatives are treated as outsider and these factors are responsible for refusal to attend the hospital for delivery. It is not only a tradition that women are to deliver at home moreover institutional deliveries are not encouraged in a proper way for the poor people. Many slum people believe the hospitals are for the rich, educated and privileged group of the society. "Dai (TBA) is a very important person during delivery of a baby in slum area", "They are expert in delivery and care of the baby", Dai is always available in the slum.

This statement clearly reflects the level of dependence on TBA by the slum community during delivery. TBA has a great role in practice of childbirth in slum settings. They are easily available, affordable, greatly reliable, and familiar to the slum dwellers. The are from their own community, know and share the same perception, beliefs of traditional life. In many cases it is observed that TBAs are conducting delivery of woman, again she has to call for conducting the delivery when the daughter of that woman became pregnant, in this way they develop a strong bandage with the family. TBAs appear not only as medical person at the delivery, rather they created a different professional attitudes and behavioral pattern which is more that the services of a midwife of western medical world. The behaviour and attitudes adopted by the TBAs during birth of a child has a great influence on the psychological state of the pregnant women which facilitates easy, fearless outcome of delivery.

Community is an important factor that affects safe-delivery practices in slum and rural settings. This underscores the need for appropriate behavioral change communication strategies to make the uneducated families and relatively younger women aware of the benefits of safe delivery by medically trained persons.

As can be seen in Table-53, 15% of the pregnant women reported to have suffered from severe complications during the delivery period. The types of complications are cited as 1) prolonged labor (46.6%), 2) severe breeding (33.3%), and 3) retained placenta (20%), and 4) Perennial tear (26%). Such ailments, though could be fatal, were coped by traditional birth attendants (TBAs).

The remuneration against the services offered to the TBAs came in two kinds, namely, offering of money (82.6%) and 'Sari" for the remaining TBAs (Table-54). They also receive some kinds of gift from the husbands in honor of their successful effort. At the same time there is no strict rule that TBAs claim money or Shari as a charge for the service, it is a tradition of giving some thing to the attendant as remuneration. From the discussion with the TBAs it is also confirmed from their statements on remuneration. Most of them informed they never claim or charge anything for the job, but it is the pleasure of the family and also a prestigious issue to give Shari or money as remuneration. Moreover they are very close the families, well known and claiming charges is a shameful act on their part. TBAs attending the deliveries when they are asked to attend delivery, they do not think of whether the family is rich or poor. Poor families most of the time cannot offer any thing, still they get services from them. All the TBAs told that their job is a honorable one and they are satisfied in doing such activities and whatever they get as remuneration matters little to them. Recently, government started a programme to train the TBAs, NGOs also trained TBAs. This makes their status to a prestigious position; the feeling of getting importance from government health services brings a change in their attitudes towards their profession. Therese Blanchet wrote about the payment of Dais in her book, "Women, Pollution and Marginality, meanings and Rituals of birth in Rural Bangladesh", that Muslims Dai's who work to earn a living and therefore payment, are looked down upon a law rank women whose status is comparable to the Hindu Dai (T Blanchet 1988).

The similar findings are revealed in this study. Though the Dai's are given money or Shari in most of the cases but they never demand or claim for it. She takes whatever is given for her job. All the TBAs interviewed were Muslims and not all are from well off family, still they hold the same view. Halida Hanum Akhter et. al. also documented in her study that 64 percent of mother did not give any remuneration to the attendants and nearly 11 percent gave assurance. One fourth of the mother gave remuneration to TBAs and they received mostly in cash, untrained TBAs got in kinds (Shari). More then one thirds of the mothers think that TBAs accept whatever is offered to them and about 16 percent think that the TBAs need not be paid at all (Akhter H.H.).

Some rituals are essential embodiments associated with the arrival of a new baby in the family. In the slum setting, 89% of the couples observed rituals on such occasions (Table-55).

Due to mass poverty, now days many families are not able to perform such rituals informed by the majority of the informants. Those who performed rituals they informed that if the newborn is a male child then 'Azan' is performed, so he could listen to verses from the Holy Quran(Haque E 1996).

The study similar that all the ritual performed by the informed by the informants on the occasion of childbirth has a religious meaning in the Bengali Muslim society. People believe that blessings of these famous religious leaders still have good effect on their lives though they are not living in this world but the souls can see everything. So displeasing or dishonor of the mazar sharif is detrimental to the village people. This is on of the reasons that people visit the mazar sharif, Darga sharif etc. on various occasion and offer shirni as a 'manat' and it is not only in case of child birth, there are other issue too when this type of rituals are performed (Haque E 1996).

On the nature of rituals performed, FGD reveals that immediate after birth, if the baby is a male, "Azan" is loudly uttered close to the ears of the new born baby. On the contrary, when the baby is a female, "Ekamat Azan" is cited close to her body in a lower voice. Home made cakes and sweets are offered to the relatives and neighbors as a gesture of joy. in some cases, special 'manats" (prior commitment to the Almighty) are fulfilled and 'Shirni' (holy food are sent to 'Mazar' (shrines) or mosques.

Any successful pregnancy outcome immediately demands postnatal care for the mothers, which remains severely vulnerable for many kinds of morbidity. Several complications tend to gradually crop up in the subsequent periods that pose additional threats to the health o the mother. According to findings of this survey, It is alarming to find that 85% of the mothers did not seek any postnatal check up,

Only 15% mothers took postnatal check up. Postnatal check-up took from NGO satellite clinic (53%), physicians (13%), allopathic quakes (20%), and Hospitals (13%), as shown in Table-56 and Table-57.

The nature of complications confronted by mothers after childbirth is as identical as observed elsewhere (Table-58 and Table-59). Out of 100 female respondents 15%faced complications after childbirth. They include continual fever for three days ((17%), convulsion (17%), severe bleeding (32%), smelly vaginal discharge (11.7%), and prolapsed uterus (11.6%).

It is essential that the mothers need to take postpartum rest following childbirth for a considerable period of time. In-depth interviewing revealed that the slum women very quickly return to their normal work within weeks of childbirth. By religious sanction, 4o days' of withdrawal from domestic and religious duties (prayer, fasting, outdoor visit) are tabooed during postpartum period. The slum women hardly maintain the restrictions imposed socially.

Child feeding in the early stage exerts immense impact on the health of mother and the baby in equal proportions. The investigation carried by Ahmed F.H. Choudhury showed that there is "gradual decline in breastfeeding among rural women in Bangladesh and the duration of full breastfeeding is shrinking down to a significant scale ... Malnutrition in mothers put limits to adequate lactational performance. The excessive severity of malnutrition of child in pre-natal age, reflected by the low birth weight is largely due to fetal under-nutrition during gestation and pregnancy' (1988: 447). The findings obtained in this study corroborate the observation cited above to a great extent.

M.A. Khalique Barbhuiya et. al. a prospective study was conducted among the infants of 5 large urban slums in Dhaka City to study the feeding practices and its relationship with morbidity and nutritional status. The sample size was 250 infants initially but some of the respondents left the slum subsequently due to various reasons. Among the infants 49.6% were male and 50.4% were female. The rate of exclusive breast-feeding was highest (65.4%) at the age of 2 to 2.5 months and only 32% infants were exclusively breast fed at

the age of 5 to 5.5 months. Ninety three percent of mothers were practicing breast-feeding throughout the year. There was significant difference between frequency of breast-feeding and morbidity ($p<0.05$), at the age group 2 to 2.5 months. There was statistical significant difference between exclusively and non-exclusively breastfed babies at the age of 4 to 5.5 months and their nutritional status at the age of 6 months ($p<0.05$). There was no statistical significant difference between the nutrition status at 12 months among the exclusively and non-exclusively breasted babies up to the age of 5.5 months. Out of 250 only 56 mothers (22.4%) rejected feeding of colostrum. About ninety five percent of mothers were housewives and there was no significant difference between the occupation of mother and the types of breast-feeding ($p>0.05$) (M.A. Khalique Barbhuiya et. al.1995).

Abdul Bayes Bhuiyan et. al. Breast Feeding pattern and fertility status was studied on 75 post - partrum women with healthy living children during June 1995 to May 1996. All the mothers were booked for the study within the first month of delivery and followed up for a period of 9 months. Data on Infant feeding practice including breast feeding frequency, night feeding status, weaning practice and fertility status was collected using structured data collection instrument. Menstruation of pregnancy in the post partrum period was used as indicators for returning to fertility. Out of 75 women, during the study period, 61 returned to fecundity by menstruation and four women by pregnancy. Fertility as indicated by menstruation and pregnancy did not return to ten women in the study period. Fifty seven percent mothers practiced exclusive breast-feeding at the time of interview. More than four fifth of the mothers practiced on demand feeding during the study period. Fifty six percent babies were given weaning food in the fourth month. Infant formula was the first weaning food to sixteen percent of cases. Among the 61 mothers who became fertile at least by one indicator, the mean time of returning to fertility was 7.25 months (range 2 to 9 months). Maximum number (34) of women became fertile in the 3rd month as indicated by menstruation. Due to time limitations, the study could not be extended to document the events after 9 months in cases where fertility did not return (Abdul Bayes Bhuiyan et. al. 1995).

A K M Haque et. al. cared out a study breast-feeding practice in children attending Private Chambers of Barisal town. A total of 1000 mothers were interviewed. The age of the

children varied from one hour to 2 hours after delivery. 76.4% gave prelactal feeds with sweet water, honey, plain water, artificial milk and cow's milk. 84.6% mothers rejected their colostrum. Exclusive breast-feeding was found in 23.2% without prelacteal feeds at 1 month, but gradually declined to 16.2% at 5 months. Lactation failure occurred in 76.8% due to insufficient breast milk, faulty technique, habit of bottle-feeding, children's illness, cracked or sore nipples, mother's illness and occupation mother (A K M Haque et. al. 1996).

M A Ullah cared out a study of exclusive breast feeding up to 5 months of infant's age among the urban mothers attending pediatric outdoor of Rajshahi Medical College Hospital was done. The mean duration of exclusive breast-feeding was 13.4 weeks. At the end of 5 months, 50% of the infants terminated exclusive breast-feeding. This duration was significantly associated with maternal education, use of hormonal contraceptive within 3 months after delivery, time of first breast feed and choice of the first feed. The most frequent reason for supplementing the diets to infants before 5 months was the mother's perception about their inadequate breast milk. During designing of interventions to protect and to promote breast-feeding, the determinants of duration of exclusive breast-feeding should be considered (M A Ullah 1994).

Among the mothers living in the slum, 55% of the babies are fed colustrum (Table- 60). The knowledge on the high nutritional value of colustrum milk among the mothers is somewhat absent. There is a wide misconception that such milk is not suitable being impure in its substance, which is quite wrong. It has the protective resistant power to enable the newborn child in gaining biological immunity against many infectious diseases.

However, a positive sign is that about two third women (74%) tend to practice full breastfeeding by the female respondents. Normally, from scientific standard, breastfeeding should continue for at least 3 years. Contrarily, the slum mothers tend to begin feeding supplementary food to their children side by side with breastfeeding (25%), given in Table-61. Such a move generates among them from the fear of their poor lactational performance. The physical weakness, itself a product o heir own malnutritional state confers upon them a sense of urgency for giving their babies additional food for

proper growth. As a matter of fact early supplementation pose extra risk of contamination-related disorders (diarrhoea, mal-absorption, intestinal problems. etc).

Pre-matured birth is seen as an essential outcome of many combined factors that include low nutritional store of mother during pregnancy, non-compliance with the consumption of adequate food during pregnancy and undertaking of excessive workload at that time, Wastage or abortion. The children who are born as pre-matured run the burden of high morbidity in their subsequent years, It has been found that about one-quarter of the offspring in the study population are somewhat pre-matured infants, documented in Table-62.etc. Such conditions may concomitantly lead to miscarriage, pregnancy

The present study traced the syndrome of low birth weight babies among the couplers to a considerable degree. Table-63 provides testimony to the observation that about 43% of the newborn babies are identified as low weight children. This occurs primarily as a result of mother's proper nutritional state during their pregnancy.

Nahar-N et. al. a prospective study was conducted in urban affluent, slum and rural communities of Bangladesh during Feb '94 to Feb '95. From each community, 250 pregnant mothers were recruited in the study and at the end total 660 live births were studied to determine the incidence and risk factors of low birth weight. Incidence of low birth weight was highest in urban slum (36.8%) followed by rural area (20.9%) and lowest in urban affluent community (18.3%). The area of residence had a significant influence on birth weight suggesting that environmental stress had detrimental effect on birth weight. Age, weight and height of mothers were also risk factors for low birth weight of their babies. Mothers of less than 20 years and more than 35 years, weighing less than 40kg and having height less than 140 cm had the higher risk of giving birth to low birth weight babies. Incidence of low birth weight was highest (73.2%) among the primigravidae mothers and 36.8% among the mothers who had no antenatal check-up, but it was 15.9% among those who had check-up more than 7 times. The distribution of low birth weight babies was higher (48.2%) among the mothers who had never gone to school. To reduce the incidence of low birth weight, upliftment of socio-economic condition has got no alternative, which is very much related to education level of the people. Emphasis should

be given on mothers' education, which is one of the influencing factors of birth weight of babies (Nahar-N et. al. 1995).

SE Arifeen et. al. carried out of a study to Investigate the effect of low birth weight (LBW), intrauterine growth retardation (IUGR), prematurity, and breast-feeding on infant growth Methodology: The sample consisted of 1,654 infants born in selected slum areas of Dhaka city. They were enrolled at birth and followed up prospectively till their first birthday. Apart from repeated anthropometric measurements, the mothers were also interviewed for information on infant feeding and morbidity at each follow-up visit. Analytical techniques included correlation analysis and random effect regression for modeling infant growth. Results: Correlation was high and stationary between repeated body weight measurements from 3 months onward. Correlation between weights before 3 months and later weights was lower and declined rapidly with increasing age gap, suggesting greater plasticity of growth in the first 3 months of life. After adjusting for remanded constant throughout infancy. For example, low-and normal-birth-weight infants differed by 556-603 g, while the differences between symmetric and asymmetric IUGR babies were 172-184 g, A positive impact of exclusive breast-feeding in the first 3-5 months on infant growth was detectable at 12 months of age (+95g). The overall growth in this sample was of the pattern that heavier babies grew even heavier. However, exclusive breast-feeding appeared to counteract this pattern by equally benefiting the lighter and heavier infants. Conclusion: The study has demonstrated the important role of weight at birth and appropriate breast-feeding practices in determining nutritional status in infancy. Effective strategies for improving birth weight, till now a poorly addressed issue in Bangladesh, are urgently needed. The sustained effect on growth and the beneficial effect on LBW infants are compelling reasons for increased and effective promotion of exclusive breast-feeding in early infancy (SE Arifeen et. al.1998).

It is widely recognized that the immunization of newborn babies against the deadly diseases like polio, diphtheria, whooping cough, tetanus and tuberculosis, are essential for their survival, Increased Immunization coverage executed by NGOs and GOBs in recent years resulted in striking reduction of infant morbidity and mortality in the recent years. Urban slum development program has been trying to extend health care services at the

grass root level over the last one decade. The national coverage rate is considered to be quite satisfactory. Public health consciousness has increased substantially because of health promotion related activities.

The immunization status of the children of the survey families is documented in Table-64. The children who have been vaccinated account for 65% of the families, whereas infants of 18% of the households remained totally non-immunized. However, Infants of 17% of slum families are yet to reach the age required for the first TT vaccine.

Among the study households, as depicted in Table- 65, 35% experienced illness of varying types. Such diseases primarily include diarrhoea (20%), Pneumonia (34%), fever (20%), and whooping cough (27%) shown in Table-66. In coping with the illness of infants, parents usually take refuge of multiple sources of treatment namely, allopathic quake (54%), Homeopathic (5.7%), physician (2.8%), Governmental hospital (5.7%), and NGO satellite clinic (31.4%) shown in Table-67. Now days, the services being offered by NGO satellite clinic, seem to play key institutional role in meeting the health needs of the disadvantaged segment of populations in Bangladesh. The attitude of the male household heads in the utilization of available health care facilities in the community particularly for their wives and infants seem to be yet a matter of great concern. As Table-78 unfolds, about 83% of the male household heads failed to turn up with their sick children to the health centers. Most often, it is the mother who performs the responsibility to look after their sick offspring as well as for their treatment.

The research done by Kane et al on the issues of reproductive health that pose a continuing challenge involve contraception, abortion, fertility, sexually transmitted diseases (STDs), maternal mortality and morbidity, and invent and child mortality. in the villages of Abhaynagar, Shirajganj, and Mirsarai in Bangladesh which indicated that women's awareness and knowledge of reproductive tract infections (RTIs) and STDs was low. Only 33% of women reported that their husbands had a genital problem. While the abortion rate was on the rise and 15% of women had multiple induced abortions; over 90% of deliveries occurred at home assisted by untrained attendants). Apart from this, the contraceptive use was the lowest among adolescent married women. About 50% FP users discontinued during the first year (Kane TT et. al. 1997).

In recent years, the incidence of sexually transmitted diseases is increasing in alarming rate in many developing countries. A great number of Asian counties are already in the grip of more deadly diseases of HIV and AIDS. The occurrence of diseases, though have not become major health problem in Bangladesh, yet the possibility of HIV and AIDS among our population cannot be totally ruled out in the absence of scanning of blood for such diseases. At a time of rapid population mobility which is now taking place, the virus for such diseases can easily enter into our population through enhanced rate of out-breeding and for non -use of protective measures against the infection. Besides many other possible routes, slum culture runs the high risk of being a stage of infection due to unregulated sexuality that characterize most slums. An inquiry from the respondents demonstrated that 75% of the male and 65% of the female respondents possess no knowledge of either AIDS or HIV (Table-69). This calls for urgent health education about the danger posed by unregulated, unsafe, and promiscuous sexual life among the slum dwellers. This is more important, it is the slums that may be the quick recipient of such sexually transmitted diseases in future.

CHAPTER - 6

CONCLUSION AND POLICY IMPLICATIONS

6.1 CONCLUSION :

The research results depict that the schooling among the slum-dwelling married women is extremely minimal, few crossing the secondary level education. Nor do they have and vocational skills that could allow them for a better wage job. This has been observed that only few female samples from the study setting are engaged in garments factories - enterprise which is overwhelmingly staffed by females.

The results obtained from this study show that childbearing at an early age, have a number of risk factors related to maternal health and outcome of pregnancies. Despite rising levels of contraceptive use in Bangladesh, slum dwelling families effectively fail to plan their pregnancies, and achieved fertility is higher than expressed desires.

Available information on dietary behavior suggests that most of the adolescent girls live on marginally nutritious food, not adequate for proper health management. The nutritional deficiency at pregnancy one the one hand invites much morbidity associated with malnutrition, and concomitantly leads to a low birth weight child at birth. Consequently, the newborn child becomes exposed to the high risks of infection. The new born children are not provided with life saving immunization. The husbands are quite complacent about the treatment of the wives or their children unless the maladies reach a critical stage. The ailments are usually ignored or met by home therapies.

The hygienic condition in the slum is extremely depressing with no provision for safe drinking water or sanitary latrines. The overall environment in which childbirth takes place is not highly dreadful for either the health of pregnant women or for their newborn children. There is virtually no prior knowledge about reproductive health among the female respondents. Soon after their early marriage, a large section of the adolescent women conceive and rarely adopted a strategy of fertility regulation. The adoption rate of family planning methods usually is absent and for the respondents who adopted earlier abandon the use of methods altogether.

The present study provided convincing evidences that early child bearing (under 20 years of age) bears adverse negative health consequences, who are most likely to suffer from severe complications during pregnancy, delivery and neonatal health of child. The socioeconomic consequence equally impose an additional crisis in earning their minimal subsistence. As the findings suggest that most of the sample women abandoned their income generation activities with the onset of pregnancy. The slum dwelling families even in normal period live in precarious economic scarcity, which is further jeopardized by their stoppage of work, The reduction in the daily earnings puts strains in meeting the survival needs of the family. It is also found that the slum couples receive virtually no health care services in the community for the antenatal check of the adolescent women or in obtaining proper counseling against the pregnancy-related morbidities. Very negligible portion of mothers in all age groups investigated have depended on 'self care', with no coverage from NGOs or GOBs. Although, a strong media campaign is advanced, the slum people are deprived from antenatal coverage from a trained source. Data indicate that most of the surveyed mothers did not receive antenatal care during pregnancy. Most importantly, antenatal care is slightly higher for births to higher order age groups than those of lower birth order. Most of the deliveries occurred in the hands of traditional birth attendants with no safe delivery kits for childbirth assistance. Delivery related complications, as reported in the present survey, were handled by local dais and TBAs which include prolonged labor, hemorrhage, and retained placenta. Pre-eclampsia and eclampsia, pregnancy induced hypertension. Besides these, uterine prolapsed and dyspareunia also constituted major forms of morbidities among the female respondents in the slum during their child delivery.

There is confirmation of the findings validated by much other research that repeated pregnancies and short intervals are associated with wasting of the mother. Maternal morbidity and malnutrition during pregnancy result in low birth weight of the newborn, posing it to a higher risk of death. It is , therefore, important to view activities towards reduction of maternal morbidity and malnutrition, not only as isolated activities, but as keystones of child survival.

About child feeding practices, it is observed that the knowledge of the high nutritional value of colostrums among the mothers is absent. The child feeding practices center around breastfeeding for the few months followed by supplemental food feeding. The switch over to bottle feeding or early solid food feeding comes from the perceived poor lactation performance by mothers, arising from their low nutritional store in the biology. The mean years of duration of breast-feeding is around one year.

Breastfeeding appears to be a significant mechanism of disease control, caring practices, and food security. A child who is breastfed has 4 times less chance of dying from diarrhoea and ARI than a child who is a bottle-fed. The present research show an alarming trend in breastfeeding practices which is likely to contribute towards increased morbidity and mortality from infectious diseases. To discourage early complementary feeding and discontinuation of breastfeeding, a promotional program should give more emphasis to building up the mother's confidence in her ability to breastfeed and to supporting her efforts to do so.

The study pointed out that people still preferred traditional healer for their illness. It is due of the deep-rooted belief about the indigenous health care system which have great influence on slum people through modern health care services are available but they do not rely in most of the cased because the western modern medical system do not recognize the cultural constructions of traditional slum people. Different attitudes are observed among the slum people towards modern medicines. The perceptions about the cause of the disease and the illness behaviour determine the health care seeking behavioural pattern of any society. The illness behaviour and related to health care seeking behaviour also reflects the belief systems within the cultural constructions of a traditional society.

The present study gave empirical evidence to the fact that the age of onset of menarche has increased, especially in slum areas. This increasing age at menarche is related to the increased malnutrition characteristic of the time since 1971. Body weight is seen to be one the most influential factor associated with menarche concept,. Age is another, but less, influential, factor. The seasonal peak of menarche concept occurs during that time of the year when food is most available and malnutrition at a minimum. Age at marriage among these slum populations has increased, possibly due to increased age at menarche. It is likely that a decline in fertility will result among 15 to 19 years old.

6.2 POLICY IMPLICATIONS:

Very few studies until today have looked into the reproductive health problems of slum women particularly living in large numbers in the expanding urbanized sectors of Bangladesh. Against the increased fast expanding urbanization, now underway in Bangladesh, the segment of slum-dwelling adolescent mother need to be addressed both in the policy making and interventions, in the context of the worsening socio-economic and cultural conditions to which they are exposed today.UNICEF is undertaking initiatives to bring about major changes in policies and attitudes towards improvement of the reproductive health of the disadvantaged female. It will require changes for women empowerment, removing the gender based health care services, women education etc.

It is being now increasingly recognized that more urgent interventions are to be directed towards transformation of changes in both men's and women's knowledge, attitudes and behavior and other conditions for achieving the harmonious partnership of men and women. The whole domain of women's reproductive health needs to be prioritized in research and intervention. The present study gave documentary evidences to the finding that the problems of maternal morbidity and mortality coupled with child survival are integrally related to the life cycle of reproduction of women and their behavior in specific stages of this cycle.

The findings of this study will be helpful for the government and other policy makers to provide appropriate intervention to reduce maternal and child mortality and morbidity in this sub - culture.

The views, ideas, perceptions, beliefs, attitude of male section certainly influence the reproductive health of women in a traditional society. The determinants of reproductive behavior within a given cultural construction, specially in relation to male perspectives of female reproductive health provides an opportunity to explore the dynamics of human reproduction will be helpful for the formulation of policy, and implementation of a better health care delivery services to bring about expected changes in women reproductive health.

Though awareness to some extent is developed among the slum people about age at marriage, internal between marriage and first pregnancy, attitudes towards immunization, use of contraceptive methods. The awareness about health and family planning is due to the government health workers and other NGO health workers essential services and awareness build up programmes at grass root level. The contraceptive prevalence rate is quite satisfactory but female contraceptive methods are used higher than that of male method. Though decision is made by the husbands but they are reluctant to use male method which reflects the less motivation of the male part due to the existence of female centered family planning activities. The status of women is also responsible for dependence on the male, denying the women's reproductive rights and choice of contraceptive methods. Sexually transmitted diseases are thought to be the diseases of women, prostitutes and dirty women who do not maintain personal hygiene. This belief reflects the gender biased attitude and lower status of women in the society.

Finally, it is revealed from the study that modern health care services are only the effective means to improve the women health specially the reproductive health of slum women. Reproductive health services will be acceptable when the cultural constructions of target population are considered at the time of planning the programme and it should be provided effectively. Without giving due attention to the existing belief systems regarding health care delivery services to the people, the desired outcome will not be achieve. Cultural construction of any community should be considered as one of the important criteria for planning any programme.

Findings of this nature bear implications for urgent health interventions in the slum areas in order to meet the health needs of the currently married women in particular. Given the fact that slums population has increased to an alarming population in recent years, the policy makers and health planners need to turn their attention to the disadvantaged women living under the impoverished conditions. The future plans should also address the issue of proper rehabilitation of the slum dwellers, who have been victims of natural calamities, river erosion, and landlessness at their ancestral rural home. National and International Organizations should take the share of burden towards the elimination of causes that jeopardize the risks of the life of the slum women in their future agenda on development.

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TABLES
Findings

Table:-1 Age distribution of the female respondents

Age	No	%
19 years and below	22	22
20-24 years	32	32
25-29 years	27	27
30 years and above	19	19
Total	100	100

Table :-2 Age distribution of The Male respondents

Age	No	%
20 Years and below	04	04
21 Years- 30 years	52	52
31 years- 40 years	21	21
41 years & above	23	23
Total	100	100

Table:-3 Educational status of the female respondents

Status	No	%
Illiterate	57	57
Primary	40	40
Secondary (vi-ix)	13	13
Total	100	100

Table:-4 Educational status of the male respondents

Education	No	%
Illiterate	45	45
Primary	32	32
Secondary (vi-ix)	22	22
S. s C.	01	01
Total	100	100

Table: -5 past residence location

Status	No	%
Another Slum	17	17
Own Village	70	70
Others town	05	05
By Born	08	08
Total	100	100

Table:-6 Distribution of the male respondents according to district

Name of the district	No	%
Comilla	34	34
Brahmanbaria	32	32
Nowakhali	12	12
Netrakona	04	04
Borishal	14	14
Mymensing	04	04
Total	100	100

Table:-7 Reasons for slum dwelling

Reasons	No	%
There was no scope of work in village	58	58
For better life	09	09
No wealth in village	10	10
River erosion	05	05
By birth	18	18
Total	100	100

Table:-8 Duration of slum dwelling life

Age	No	%
Below 1 year	20	20
1 Years- 4 years	38	38
5 years & above	42	42
Total	100	100

Table :–9 Occupational status of the male respondents

Occupation	No	%
Day Labour	45	45
Rickshaw puller	20	20
Small Business	12	12
Service	23	23
Total	100	100

Table:-10 Occupational status of the female respondents

Type of Occupation	No.	%
Purely house wife	91	91
Garments worker	06	06
Swing	01	01
Small Business	02	02
Total	100	100

Table:-11 Monthly income of the male respondents

Income	No	%
1001-2000	08	08
2001-3001	24	24
3001- 4000	60	60
4001 & above	08	08
Total	100	100

Table:-12 Monthly income of the female respondents

Income	No.	%
Tk 2000 or below	06	66.77
Tk 2001 – 3000	03	33.33
Total	09	100

Table: –13 Type of dwelling house

Type of dwelling house	No.	%
Katcha	82	82
Semi-pacca	14	14
Pacca	04	04
Total	100	100

Table:-14 House rent

Taka	No	%
200 or below	10	10
201 – 300	26	26
301 – 400	40	40
401 – 500	26	26
Own house	08	08
Total	100	100

Table:- 15 Nature of Latrine

Nature of Latrine	No.	%
Open space	53	53
Pit	40	40
Safety Tanks	07	07
Total	100	100

Table:-16 Over all hygienic conditions

Score obtained	No	%
Low(1-32)	65	65
Average (33-66)	35	35
High (67-100)	00	00
Total	100	100

Scale items: Score-100 (1)Cleaning of clothing. (2)Protection of drinking water against contamination. (3)Bodily cleanliness. (4)Cleanliness of rooms.

Table:-17 Age at menarche

Age	**No**	**%**
11 years	02	02
12 years	18	18
13 years	24	24
14 years	43	43
15 years	12	12
16 years	01	01
Total	100	100

Table:-18 Women age at first marriage

Age	No	%
14 years and below	15	15
15 –17 years	52	52
18- 20 years	18	18
21 years and above	05	05
Total	100	100

Table:-19 Duration of conjugal life

Duration	No.	%
2 years and below	20	20
3 years- 4 years	21	21
5 years and above	60	60
Total	100	100

Table:-20 Age of the respondent when gave birth to her first child

Age	No	%
15 years-17 years	67	67
18 years-20 years	32	32
21 years-23 years	05	05
Total	100	100

Table:-21 Age of the Last Child

Age	No	%
0-45 Days	17	17
46-90 Days	23	23
91-135 Days	20	20
136-180 Days	40	40
Total	100	100

Table:-22 Birth spacing between last two child

Age	No	%
Below 2 Years	13	13
2-3 Years	37	37
4 Years	24	24
N A	26	26
Total	100	100

Table:-23 Total number of children

Number	No	%
1-2	54	54
3-4	29	29
5-6	17	17
Total	100	100

Table:-24 Family Planning Methods status among the respondents

Status	**No**	**%**
Past	25	25
Present	20	20
Did not received	55	55
Total	100	100

Table:-25 Current use of Contraception among the respondents

Status	**No**	**%**
User of FP	20	20
Non user of FP	80	80
Total	100	100

Table: –26 Distribution of contraceptive users by method used

Methods	**No**	**%**
Pill	05	25
Condom	02	10
Injectable	08	40
IUD	01	5
Norplant	02	10
Tubectomy	01	5
Kobirazi (traditional)	01	5
Total	20	100

Table:-27 Reasons for not using Contraceptive methods

Reasons	No.	%
Physical discomfort	18	22.5
To have baby	11	13.75
Husband opposed	19	23.75
Postpartum amenorrheic	20	25
Breast feeding	12	15
Total	80	100

Table:-28 Future status of FP Methods

Status	No	%
Future	46	57.5
Yet not decided	16	20
No intention	18	22.5
Total	80	100

Table:-29 Future use of contraception

Methods	No	%
Pill	25	54.34
Injectable	15	32.60
IUD	02	4.34
Tubectomy	03	6.54
Kobiraji	01	2.17
Anemia	46	100

Table:-30 discussion of family planning methods with Husband

Status	No	%
Yes	81	81
No	19	19
Total	100	100

Table:- 31 Whether the decision of pregnancy taken jointly by the couple.

Response	No	%
Yes	65	65
No	35	35
Total	100	100

Table:-32 Discuss on pregnant mother about pregnancy related problem

Person	No.	%
Husband	33	33
Relatives	26	26
Neighbour	21	21
TBA and Health worker	20	20
Total	100	100

Table:- 33 Additional food during pregnancy

Status	No	%
Yes	33	33
No	67	67
Total	100	100

Table -:34 Pattern of utilization of adequate rest during pregnancy

Pattern	No	%
After middy meal	28	28
Whenever felt discomfort	20	20
Whenever felt fatigue	52	52
Total	100	100

Table:-35 Sharing the house hold activities by the husband at wife's pregnancy

Response	No	%
Yes	09	09
No	91	91
Total	100	100

Table:-36 Pattern of ritual performed during pregnancy period

Rituals	No	%
Satosha	89	89
Milad mahfil	09	09
Musical program	02	02
Total	83	100

Table:-37 Complication faced during pregnancy

Response	No	%
Yes	17	17
No	83	83
Total	100	100

Table:-38 Type of Complications faced during pregnancy

Complications	No = 17	%
Bleeding during pregnancy	02	11.76
Oedema	03	17.67
Severe Vomiting	03	17.67
Convulsion	02	11.76
Leaking membrane before delivery	03	17.67
Anemia	04	23.53

Table:-39 Antenatal care during pregnancy

Status	No.	%
Sought ANC	47	47
No ANC	53	53
Total	100	100

Table:-40 Pregnant mothers whose took 1st antenatal check-up

Stage	No.	%
1st three months (1st semester)	08	17.02
4-6 Months (2nd semester)	22	46.80
7-10 Months (3rd semester)	17	36.18
Total	47	100

Table:-41 Time of Antenatal check-up during pregnancy period

Time	No.	%
One time	20	42.55
Two times	15	31.91
Three times	10	21.28
Four times and above	02	4.26
Total	47	100

Table:-42 Last antenatal check-up taken before delivery

Week	No.	%
Within one week	01	2.13
Within two weeks	02	4.26
Within four weeks	15	31.91
Five weeks and above	29	61.70
Total	47	100

Table:-43 Immunization status of women during pregnancy

Status	No.	%
Immunized	83	83
Non immunized	17	17
Total	100	100

Table:-44 Reasons for vaccination during pregnancy

Reasons	No-83	%
Vaccine protect women against tetanus	39	46.99
Child may die in the womb if vaccine is not given to pregnant mother	11	13.25
Women do not become ill if vaccine taken	21	25.30
Vaccine is given for a healthy baby	04	4.82
No idea	08	9.64

Table:- 45 Reason for not taking vaccine during pregnancy

Reasons	No-17	%
Due to fear vaccine was not taken	05	29.41
Vaccine harms the baby in the womb	03	17.65
Vaccine was not available	04	23.53
Vaccine brings about physical weakness	05	29.41

Table:-46 Number of TT injection received during pregnancy

Number of TT	No	%
One TT	19	22.89
Two TTs	60	72.28
Three TTs	04	04.81
Total	83	100

Table:-47 Husband accompanied with wife for ANC check-up

Response	No	%
Accompanied wife	05	10.64
Did not accompanying	42	89.36
Total	100	100

Table:-48 Reasons for not accompanying wife at the time of ANC visit to health center.

Response	No-42	%
Wife can visit alone	20	47.42
Husband does not know much about ANC	03	7.14
Husband remain busy with other activities	17	40.48
It is embarrassing to go with wife at pregnant state	02	4.76

Table:-49 Place of stay during 1st child birth

Place	No	%
Husband residence	31	31
Women's father residence	69	69
Total	100	100

Table:- 50 Place of delivery performed

Place	No	%
Home	97	97
Hospital	03	03
Total	100	100

Table:-51 Sources of services for delivery

Status	No	%
Untrained birth attendants	92	92
Trained birth attendants	08	08
Total	100	100

Table :52 Opinions about the presence of TBA (Dai) during labour

Opinion	No =100	%
Dai is always available	78	78
The behaviour of Dai is always cordial	10	10
TBA does not claim anything	12	12

Table:-53 Types of Complications during child birth

Type of complication	No =15	%
Prolonged labour	07	46.66
Severe bleeding	05	33.33
Retained placenta	04	26
Perennial tear	03	20

Table :54 Remuneration for TBA (Dia) for conduct delivery

Items	No-95	%
Money	45	47.36
Sari	35	36.48
Nothing paid	15	15.78

Table :55 Rituals observed on the occasion of child girth.

Response	No	%
Observe	89	89
Not observe	11	11
Total	100	100

Table:-56 Postnatal care after delivery

Status	No	%
Yes	15	15
No	85	85
Total	100	100

Table:-57 Sources of PNC service

Place	No	%
NGO Satellite	08	53.33
MBBS	02	13.33
Allopathic quake	03	20.01
Govt. Hospital	02	13.33
Total	15	100

Table:-58 Complications faced after Child birth

Status	No	%
Yes	15	15
No	85	85
Total	25	100

Table:- 59Types of complications faced after child birth

Type of complications	No-17	%
Fever more than 3 days	03	17.06
Convulsion	03	17.06
Severe bleeding	05	33.33
Smelly vaginal discharge	02	11.76
Prolapsed uterus	02	11.76

Table:-60 Colustrum feeding practices soon after delivery

Status	No	%
Colustrum feeding	55	55
No colustrum feeding	45	45
Total	100	100

Table:-61 Exclusive breast feeding status

Status	No	%
Yes	74	74
No	26	26
Total	100	100

Table:-62 Age of child at birth

Age	No	%
8 Month	01	01
9 Month	34	34
10 Month	75	75
Total	100	100

Table:-63 Perception of the female respondents about the last child at birth

Status	No	%
Law weight child	43	43
Normal weight child	57	57
Total	100	100

Table:-64 Status of Child immunization

Status	No	%
Vaccinated	65	65
Not vaccinated	18	18
Not yet time for 1ST TT	17	17
Total	100	100

Table: 65 Sickness of Child

Status	No	%
Yes	35	35
No	65	65
Total	100	100

Table: 66 Criteria of child diseases

Status	No	%
Diarrhoea	7	20
Pneumonia	12	34.28
Fever	07	20
Cough	09	26.72
Total	35	100

Table:-67 Treatment for child sickness

Status	No	%
Allopathic Quake	19	54.28
Homeopathic	02	5.71
M.B.B.S	01	2.85
Govt. Hospital	02	5.71
Pharmacy	11	31.42
Total	35	100

Table:- 68 Whether father attended sick child

Status	No	%
Attended	06	17.15
Not attended	29	82.85
Total	35	100

Table: 69 Knowledge on HIV/AIDS

Status	Male		Female	
	No	%	No	%
Yes	75	75	65	65
No	25	25	35	35
Total	100	100	100	100

Figure-01

<19 and 19	22
20-24	32
25-29	27
>30 and 30	19

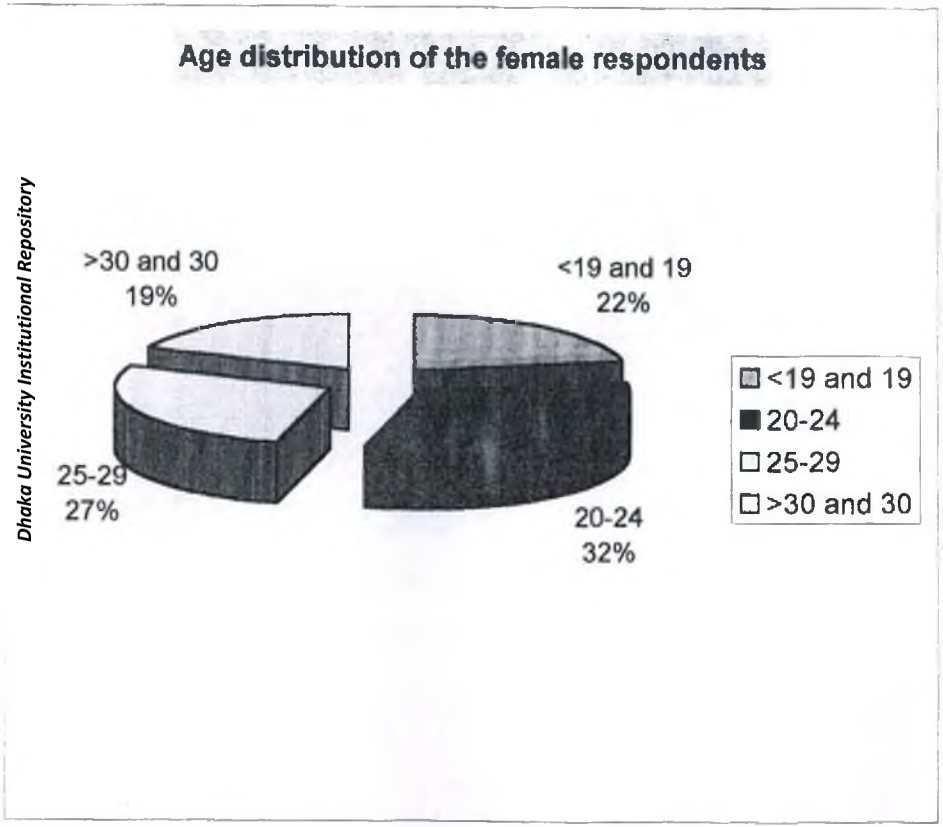


Figure-02

<20 and 20	4
21-30	52
31-40	21
>41 and 41	23

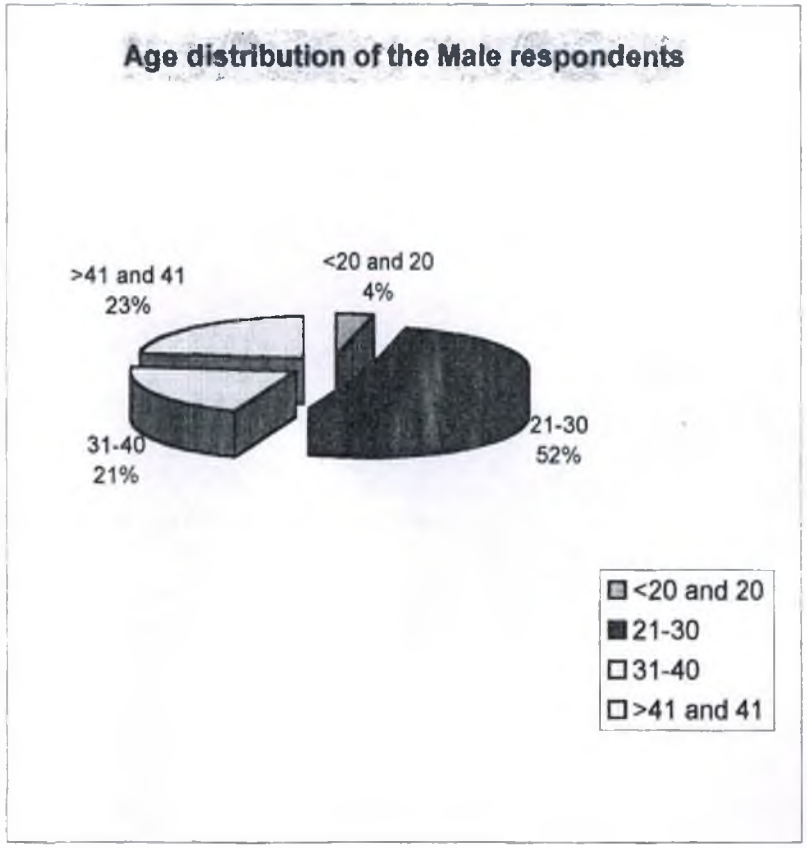


Figure-03

	Femal	Male
Illiterate	57	45
Primary	40	32
Secondary	13	23

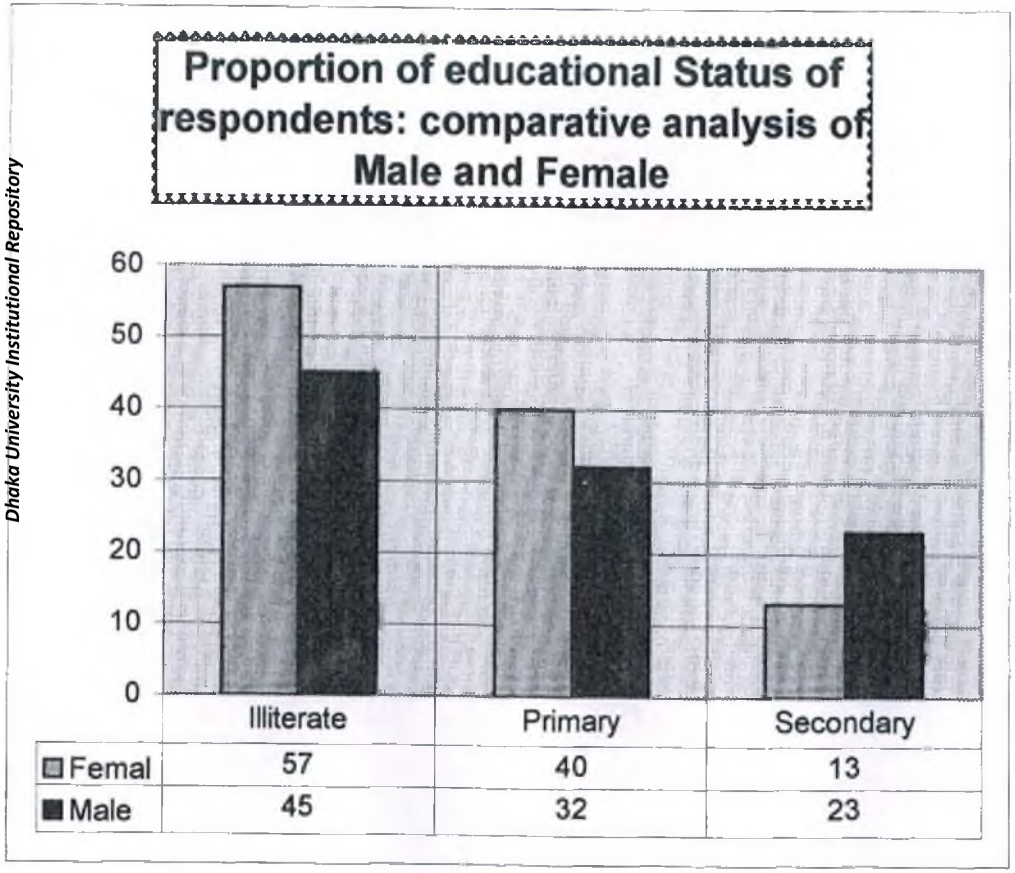


Figure-04

Comilla	34
Brahmanbar	32
Nowakhali	12
Netrakona	4
Borishal	14
Mymensing	4

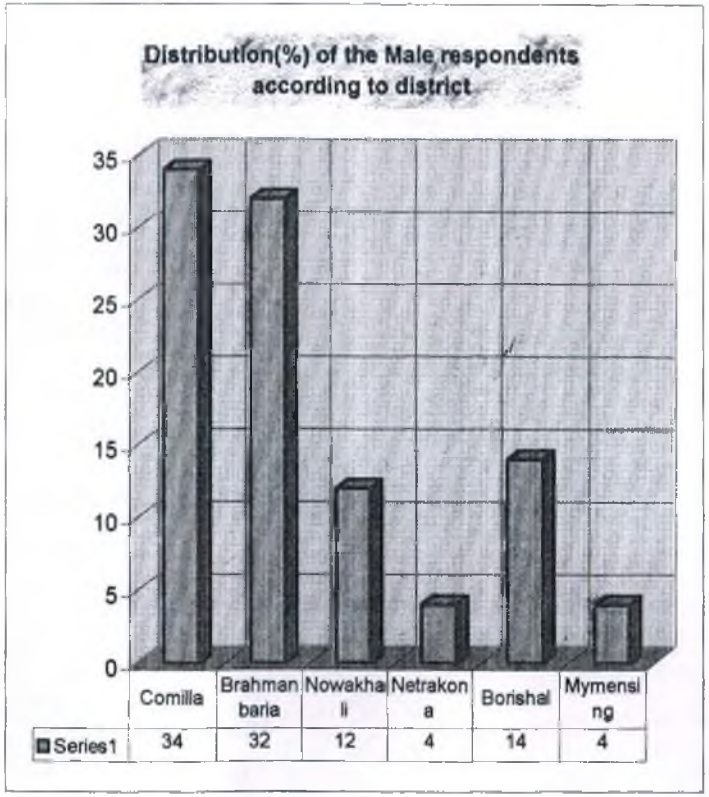


Figure-05

Small Business	12
Service	23
Purely housewife	0
Garments worker	0
Swing	0

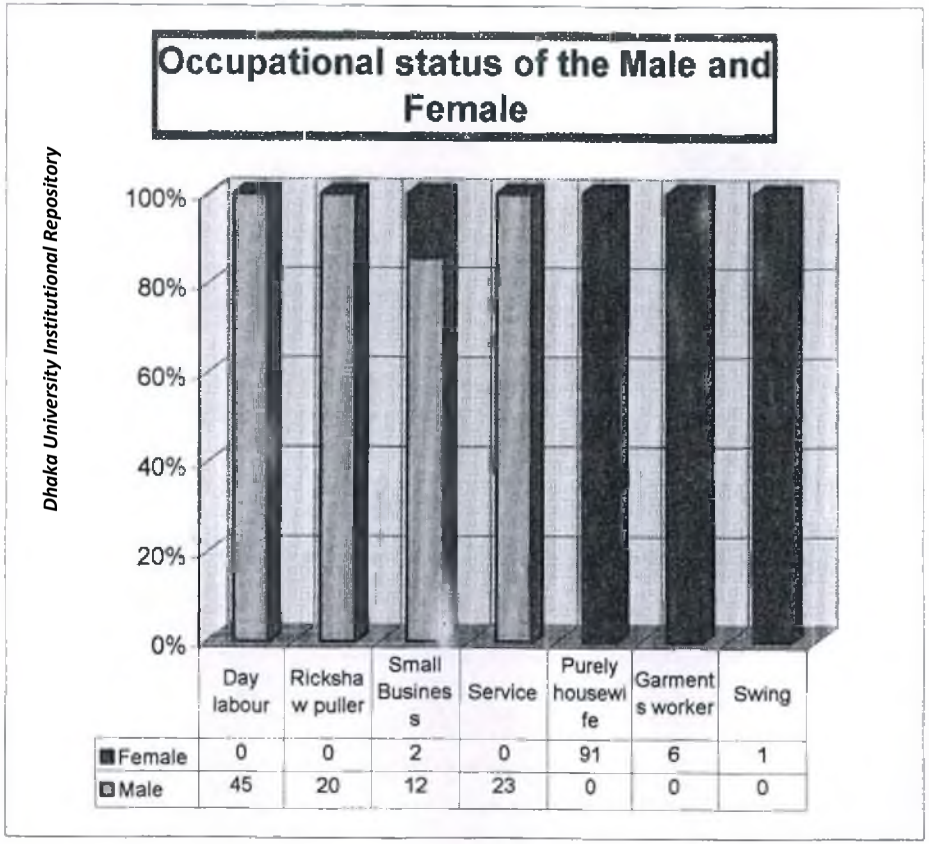


Figure-06

	Male	Female
1001-2000	8	6
2001-3000	24	3
3001-4000	60	0
>4001 and	8	0

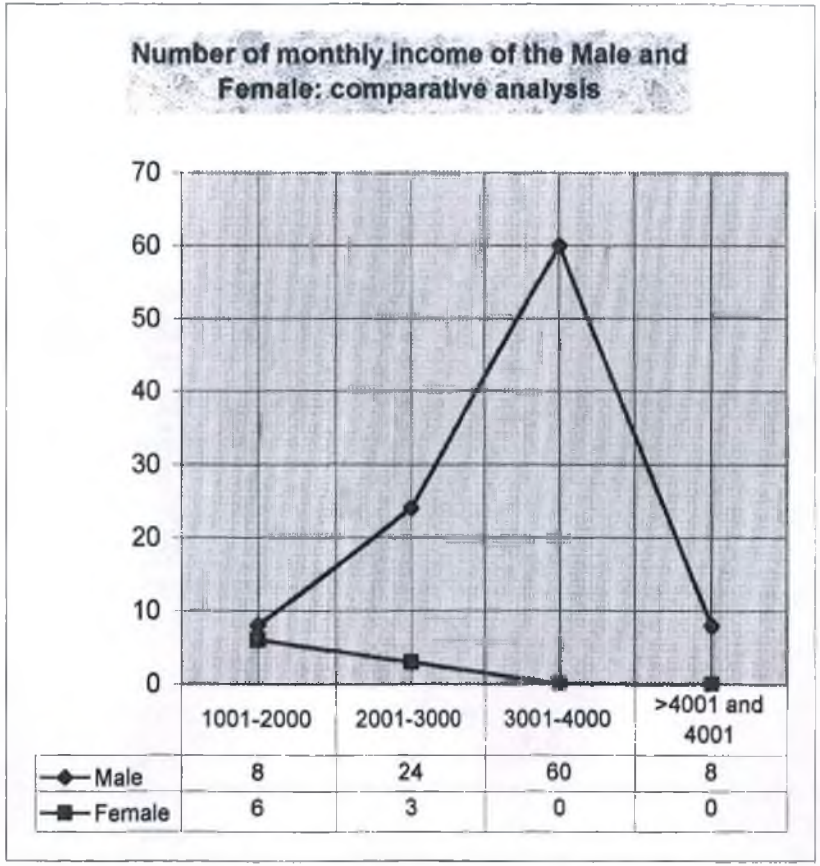


Figure-07

	First marriag	First child
<14 and 14	15	0
15-17	52	67
18-20	18	32
21-23	5	5

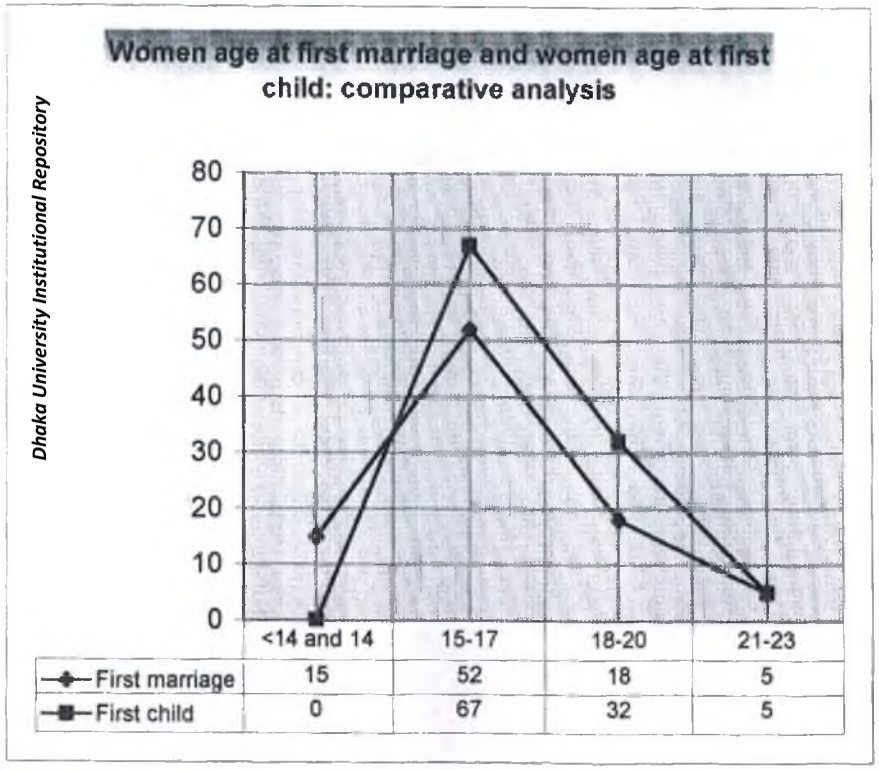


Figure-08

0-45 days	17
46-90 days	23
91-135 day	20
136-180 da	40

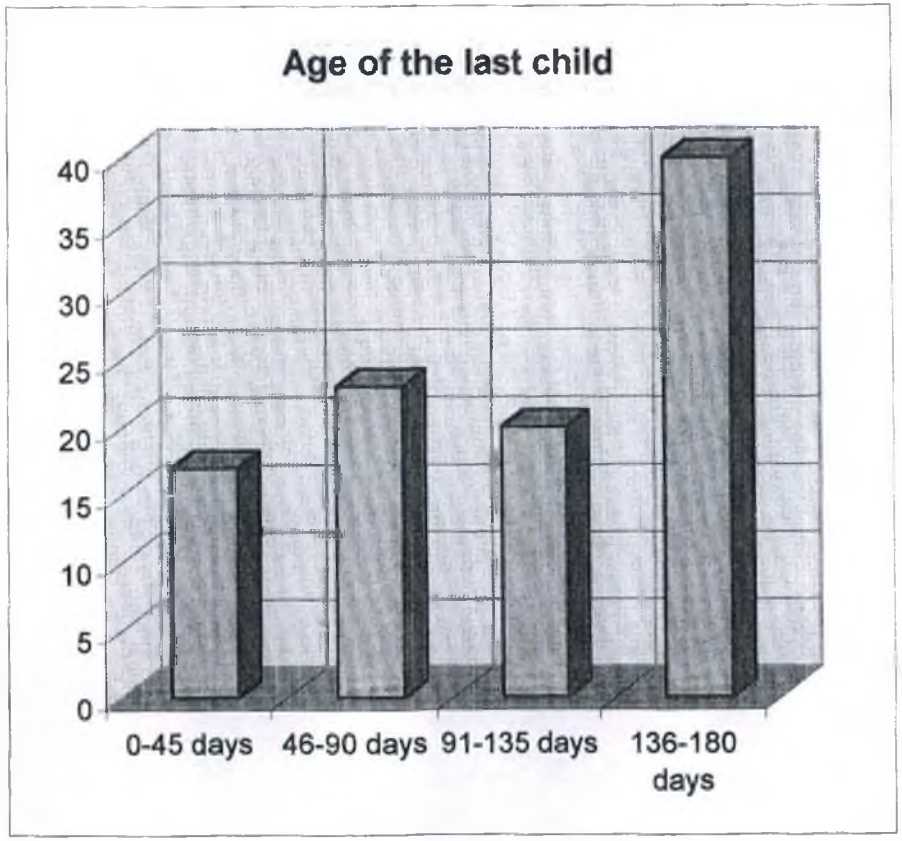


Figure-9

<2 years	13
2-3 years	37
4 years	24
N A	26

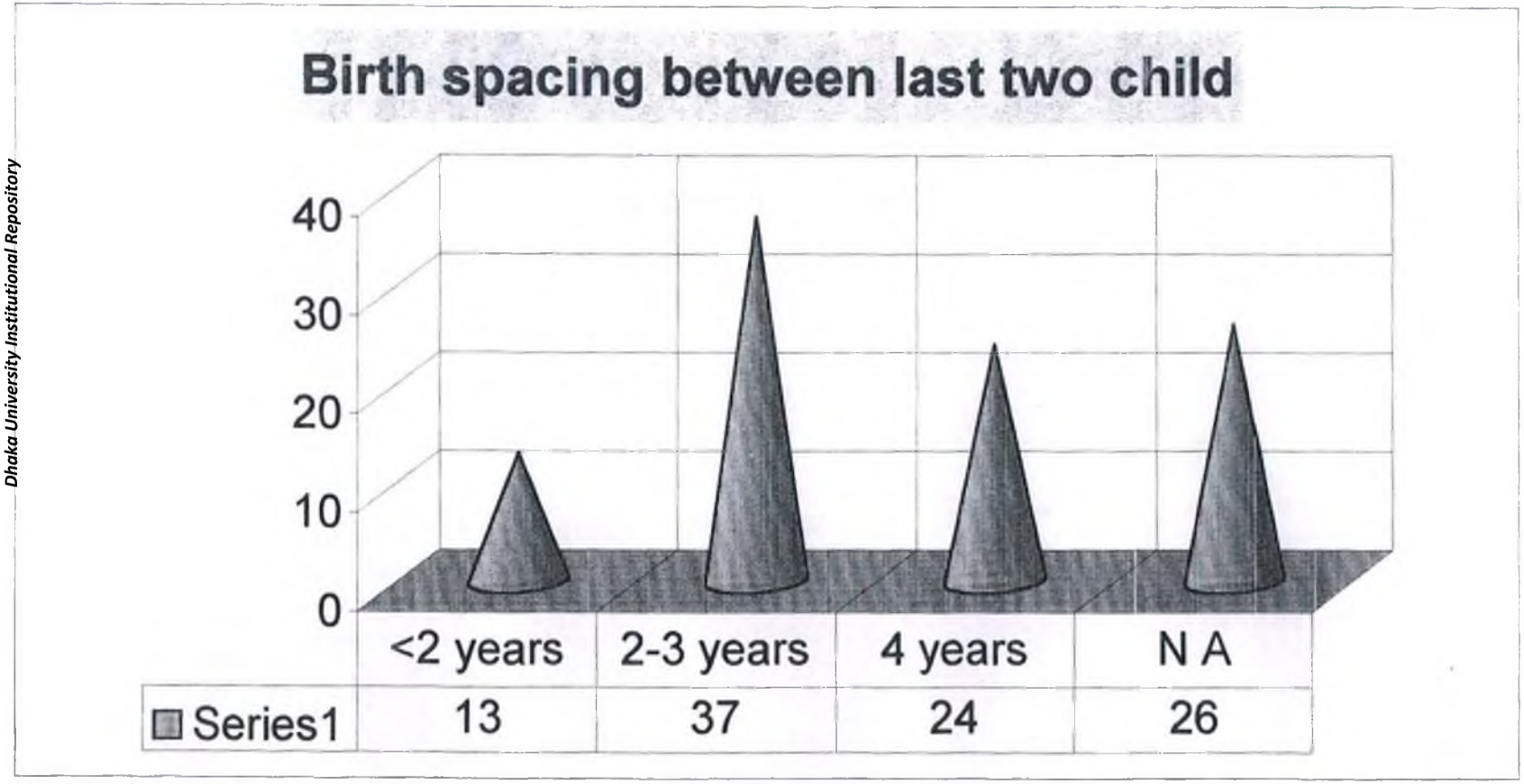


Figure-10

Past	25
Present	20
Did not received	55

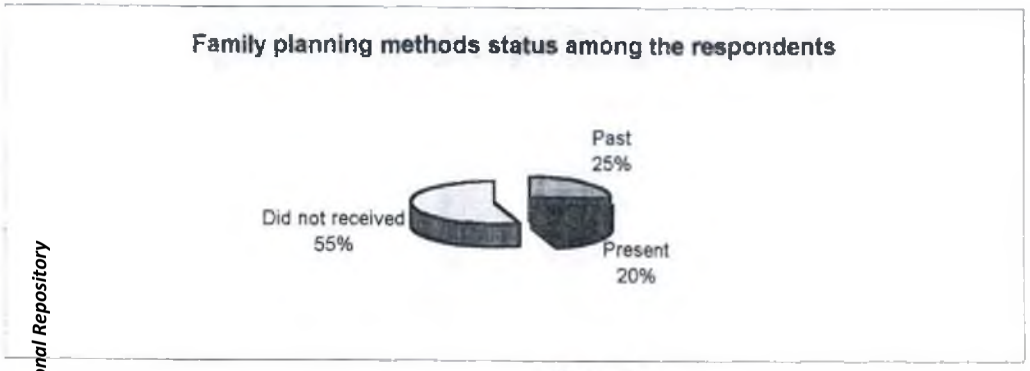


Figure-11

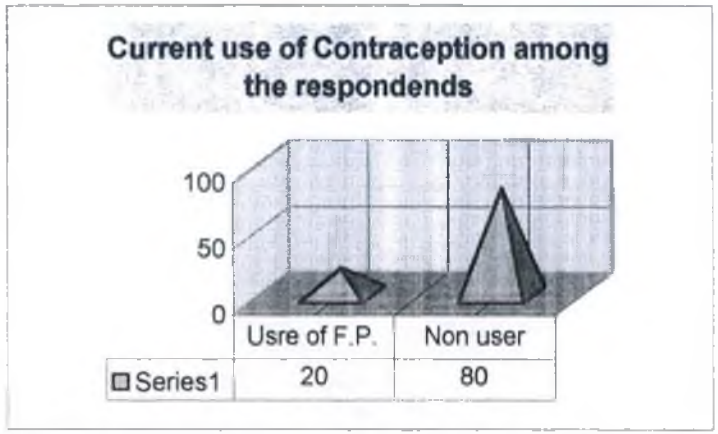


Figure-12

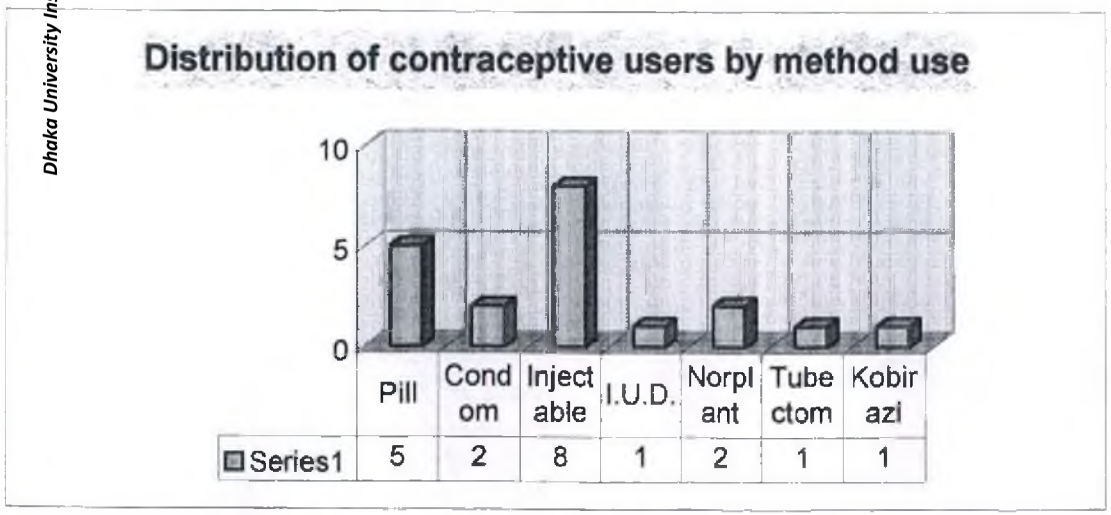


Figure-13

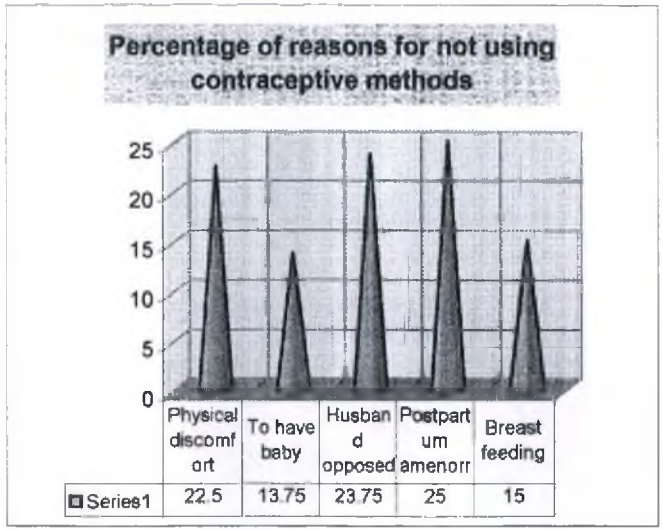


Figure-14

Pill	54.34
Injectable	32.6
I.U.D.	4.34
Tubectomy	6.54
Kobiraji	2.17

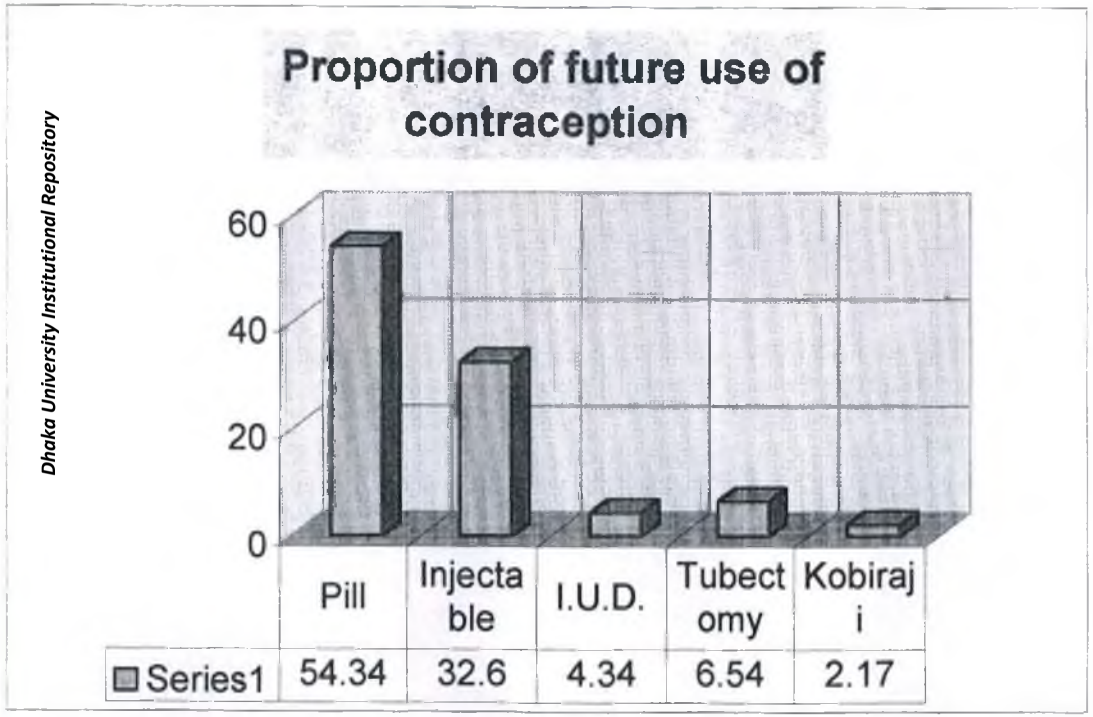
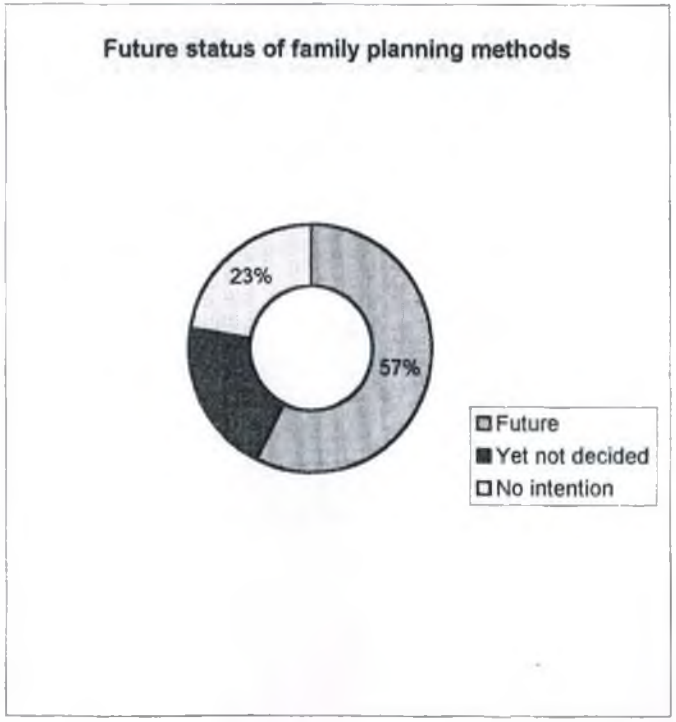


Figure-15



Title: Reproductive Health Behaviour : An Anthropological Study Among the Slum Dwelling Couples of Chittagong City

Female Questionnaire

দম্পতি নং

বস্তির পরিচিতি ঃ

বস্তির নাম ঃ ---------- জমিদারের নাম ঃ ----------

মহল্লার নাম ঃ ---------- ওয়ার্ড নং- ----------

১। উত্তর দাত্রীর পরিচিতি নং

২। আপনার নাম কি? .....

৩। আপনার স্বামীর নাম কি? .....

৪। আপনার বয়স কত?.....

৫। আপনার ধর্ম কি? (ক) মুসলিম খ) হিন্দু (গ) বৌদ্ধ (ঘ) খৃষ্টান (ঙ) অন্যান্য .....

৬। আপনি কোন শ্রেণী পর্যন্ত পড়াশুনা করেছেন? (ক) নিরক্ষর (খ) প্রাথমিক ১ ২ ৩ ৪ ৫
(গ) মাধ্যমিক ৬ ৭ ৮ ৯ ১০ (ঘ) উচ্চ মাধ্যমিক ১১ ১২ (ঘ) স্নাতক ১৩ ১৪ ১৫ (ঙ) অন্যান্য .....

৭। আপনি গৃহের কাজ ছাড়া অন্য কোন কাজ করেন কি? (ক) কিছু করে না (খ) গার্মেন্টস শ্রমিক (গ) আয়া/বুয়া
(ঘ) বাঁশ বেতের কাজ (ঙ) সেলাই (চ) অন্যান্য .....

৮। আপনার মাসিক আয় কত? .....

৯। ঘরের ধরণ ঃ ক) কাঁচা (খ) সেমি পাকা (গ) পাকা

১০। ল্যাট্রিনের ধরণ ঃ (ক) আধুনিক ল্যাট্রিন (খ) সেপটিক ট্যাংক
(গ) জলাবদ্ধ/স্লাব ল্যাট্রিন (ঘ) খোলা ল্যাট্রিন (ঙ) অন্যান্য

১১। আপনাদের পরিবারে যারা বর্তমানে এই বস্তিতে একত্রে বসবাস করছেন তাদের মোট সংখ্যা কতজন? .....

১২। আপনি (প্রথম) কত বৎসর বয়সে বিবাহ করেছেন? .....

১৩। আপনি কত বৎসর যাবৎ বিবাহিত? .....

১৪। প্রথম সন্তান জন্মের সময় আপনার বয়স কত ছিল? .....

১৫। আপনার বর্তমানে ছোট সন্তানের বয়স কত মাস? ..... মাস

১৬। বর্তমানে ছোট বাচ্চার সঙ্গে পূর্বের বাচ্চার বয়সের ব্যবধান কত?
(ক) প্রযোজ্য নয় (খ) ..... মাস।

১৭। আপনি কি বর্তমানে গর্ভবতী (ক) হ্যাঁ খ) না।

১৮। (উত্তর হ্যাঁ হলে) আপনি বর্তমানে কত মাসের গর্ভবতী? মাস .....

১৯। বর্তমানে আপনি কোন পরিবার পরিকল্পনার পদ্ধতি ব্যবহার করছেন?
(ক) না (খ) খাবার বড়ি (গ) আই.ইউ.ডি. ঘ) নরপ্ল্যান্ট
(চ) ইনজেকশন (ছ) আজল (জ) কনডম (ঝ) অন্যান্য .....

২০। নিয়মিত ভাবে ব্যবহার করছেন কি? (ক) হ্যাঁ (খ) না।

২১। শেষবার কোথা থেকে জন্মনিয়ন্ত্রণ পদ্ধতি গ্রহণ করেছেন?
(ক) ঔষধের দোকান (খ) মুদি দোকান (গ) হাতুড়ে ডাক্তার (ঘ) সরকারী ক্লিনিক/হাসঃ
(ঙ) এনজিও ক্লিনিক (চ) মাঠকর্মী (ছ) অন্যান্য ..... (জ) প্রযোজ্য নয়।

২২। বর্তমানে কোন পরিবার পরিকল্পনা পদ্ধতি ব্যবহার না করলে তার কারণ কি?
(ক) সন্তান লাভের আশায় (খ) স্বামীরআপত্তি (গ) শারীরিক অসুবিধা (ঘ) পার্শ্বপ্রতিক্রিয়ার ভয়ে
(ঙ) ধর্মীয় কারণে (চ) বুকের দুধ কমে যায় (ছ) বুকের দুধ খাওয়নোর কারণে মাসিক বন্ধ
(জ) অনিয়মিত যৌন সম্পর্ক (ঝ) বতমানে গর্ভবতী (ঞ) অন্যান্য ..... (ট) প্রযোজ্য নহে।

২৩। আপনি অতীতে কি পদ্ধতি ব্যবহার করেছিলেন? (ক) করেন নি (খ) কনডম (গ) বড়ি (ঘ) কপারটি
(ঙ) আজল (চ) ইনজেকশন (জ) অন্যান্য .....

২৪। কত দিন যাবৎ ব্যবহার করছিলেন। ..... মাস

২৫। ভবিষ্যতে কোন পদ্ধতি ব্যবহারের ইচ্ছা আছে কি? (ক) ইচ্ছা নেই (খ) কনডম (গ) বড়ি (ঘ) ইনজেকশন
(ঙ) কপারটি (চ) নরপ্লান্ট (ছ) মহিলা বন্ধাকরণ (জ) পুরুষবন্ধাকরণ(ঝ) অন্যান্য .....

২৬। পরিবার পরিকল্পনা পদ্ধতি সম্পর্কে স্বামীর সাথে আলাপ আলোচনা/পরামর্শ করেন কি?
(ক) হ্যাঁ (খ) না

২৭। (উত্তর না থাকলে) স্বামীর সাথে আলোচনা/পরামর্শ না করার কারণ কি?

২৮। গত গর্ভকালীন সময়ে স্বাস্থ্য সেবা বা চেক-আপ করিয়েছেন কি? (ক) হ্যাঁ (খ) না।

২৯। হ্যাঁ হলে, কত মাস সময় থেকে? ..... মাস

৩০। মোট কত বার সেবা নিয়েছেন? ..... সংখ্যা

২৯। সর্বশেষ বার কোথা থেকে বা কার কাছ থেকে সেবা নিয়েছেন (ক) এনজিও ক্লিনিক/সেটেলাইট
(খ) এম.বি.বি.এস.ডাক্তার (গ) হাতুড়ে ডাক্তার (ঘ) নার্স (ঙ) অন্যান্য ..... (চ) প্রযোজ্য নয়।

৩০। সন্তান প্রসবের বা ডেলিভারীর কয় দিন/ কয় সপ্তাহ/কয় মাস পূর্বে সর্ব শেষ বার কোন ডাক্তার বা ক্লিনিকে গিয়ে স্বাস্থ্য সেবা নিয়েছেন এবং তখন সঙ্গে কে ছিল?
(ক) দিন ..... (খ) সপ্তাহ ..... (গ) মাস .....
কার সঙ্গে (ক) স্বামী (খ) অন্যান্য .....

৩১। আপনি গত গর্ভকালীন সময়ে কয়টি টি. টি (ধনুষ্টংকার) ইনজেকশন নিয়েছিলেন?
(ক) একটিও না (খ) ১ ডোজ (গ) ২ ডোজ (ঘ) ৩ ডোজ

৩২। সর্বশেষ গর্ভকালীন অবস্থায় আপনাকে বাড়তি /বিশেষ ধরনের খাবার দেওয়া হয়েছিল কি?
(ক) হ্যাঁ (খ) না

৩৩। কি কি বিশেষ / বাড়তি খাবার খেয়েছেন?

খাবারের ধরণ ঃ	নিয়মিত	মাঝেমধ্যে
(ক)	(ক)	(ক)
(খ)	(খ)	(খ)
(গ)	(গ)	(গ)

৩৪। শেষ গর্ভকালীন সময়ে কি কি খাবার পরিহার করেছিলেন?

খাবারের ধরণ	পরিহারের কারণ
(ক)	(খ)
(খ)	(খ)

৩৫। শেষ গর্ভকালীন অবস্থায় আপনাকে বাড়তি বা বিশেষ খাবার না দেওয়ার কারণ কি? .....

৩৬। আপনার এই সন্তানটি কোথায় হয়েছিল?
(ক) হাসপাতাল/ক্লিনিক (খ) স্বামীর বাড়ী (গ) বাপের বাড়ী (ঘ) অন্য কোন স্থানে .....

৩৭। কে আপনার এই সন্তান প্রসব করিয়েছেন? (ক) এম. বি. বি. এস, ডাক্তার (খ) নিকট আত্মীয়/দাই/প্রতিবেশী (গ) প্রশিক্ষণ প্রাপ্ত দাই (ঘ) স্বাস্থ্য / পরিবার পরিকল্পনা কর্মী (ঙ) নার্স (চ) অন্যান্য .....

৩৮। আপনার এই সন্তানটি কত মাসের সময় হয়েছিল? (ক) ৭ মাস (খ) ৮ মাস (গ) ৯ মাস (ঘ) ১০ মাস।

৩৯। আপনার এই সন্তানটির আকার কেমন ছিল? (ক) ছোট (খ) মাজারী (গ) বড়।

৪০। সন্তান প্রসবের পর পর শালদুধ বাচ্চাকে দিয়েছেন কি? (ক) হ্যাঁ (খ) না।

৪১। উত্তর না হলে কেন দেওয়া হয়নি? প্রযোজ্য নহে।

৪২। এই সন্তানকে শুধু মাত্র বুকের দুধ না দেওয়ার কারণ কি?

৪৪। সন্তানকে বুকের দুধ খাওয়ানোর সময় আপনাকে বাড়তি খাবার দেওয়া হয়েছে কি?

(ক) হ্যাঁ (খ) না।

৪৫। হ্যাঁ হলে, কি ধরনের খাবার দেওয়া হয়েছিল?

খাবারের ধরণ	নিয়মিত	মাঝেমধ্যে
(ক)	(ক)	(ক)
(খ)	(খ)	(খ)
(গ)	(গ)	(গ)

৪৬। সন্তান প্রসবের ৪২ দিনের মধ্যে আপনি কি কোন প্রসবোত্তর সেবা গ্রহণ করেছিলেন? (ক) হ্যাঁ (খ) না।

৪৭। উত্তর হ্যাঁ হলে, কার কাছ থেকে বা কোথা থেকে সেবা গ্রহণ করেছেন?

(ক) এনজিও ক্লিনিক/হাসপাতাল/সেটেলাইট (খ) হাতুড়ে ডাক্তার (গ) কবিরাজ

(ঘ) এম. বি.বি.এস ডাক্তার (ঙ) নার্স (চ) হাতুড়ে ডাক্তার (ছ) অন্যান্য .....

৪৮। উত্তর না হলে, প্রসবোত্তর সেবা গ্রহণ না করার কারণ কি? (ক) ঐতিহ্য বিরোধী (খ) পারিবারিক আপত্তি (গ) মা ও শিশুর স্বাস্থ্যের জন্য ক্ষতিকর (ঘ) মা শারিরীক ভাবে ভ্রমণের জন্য অনুপযুক্ত (ঙ) প্রয়োজন মনে করি নাই (চ) অন্যান্য .....

৪৯। এই শিশু জন্মের কত দিন পর টিকা কেন্দ্রে নিয়ে টিকা দিয়েছিলেন?

(ক) ..... দিন। (খ) টিকা দেওয়া হয়নি (গ) প্রযোজ্য নহে।

৫০। এই শিশুকে কি কি টিকা দিয়েছেন? (ক) বি. সি. জি. ১ ২ ৩ (খ) পোলিও ১ ২ ৩ ৪

(গ) ডিপিটি ১ ২ ৩ (ঘ) হাম (ক) নিয়মিত (খ) অনিয়মিত

৫১। নবজাতক সন্তান কে কত দিনের মধ্যে সবগুলো টিকা দেওয়া শেষ করতে হয় জানেন কি?

(ক) হ্যাঁ (খ) না।

৫২। হ্যাঁ হলে কত দিনের মধ্যে (ক) এক বৎসরের মধ্যে (খ) দুই বৎসরের মধ্যে (গ) প্রযোজ্য নহে।

৫৩। আপনার কত জন সন্তান সন্ততি আছে? (ক) ছেলে ..... (খ) মেয়ে ..... (গ) মোট .....

৫৪। আপনি কি আরও সন্তান চান? (ক) হ্যাঁ (খ) না।

৫৫। আপনি কত জন সন্তান সন্ততি চান? (ক) ছেলে (খ) মেয়ে (গ) যে কোন (ঘ) প্রযোজ্য নয়

৫৬। আপনি পরবর্তি সন্তান কত মাস পরে নিতে চান? (ক) ..... মাস (খ) প্রযোজ্য নয়।

৫৭। আপনাদের সন্তান নেওয়ার ব্যাপারে কে সিদ্ধান্ত নিয়ে থাকে?

(ক) নিজে (খ) স্বামী (গ) উভয়ে (ঘ) বাবা/মা, শ্বশুর/শাশুড়ী

৫৮। সর্বশেষ গর্ভকালীন সময়ে, সন্তান প্রসবের সময়ে এবং প্রসবের পর নিম্নোক্ত সমস্যা / জটিলতার কোনটি হয়েছিল কি? হ্যাঁ হলে, এই সমস্যা জটিলতার জন্য কোথায় গিয়েছিলেন, এবং কার সঙ্গে গিয়েছিলেন?

সমস্যা ঃ সন্তান পেটে থাকা কালীন কোথায় গিয়েছিলেন কার সঙ্গে গিয়েছিলেন।

(ক) সন্তান পেটে থাকা কালে রক্তস্রাব

(খ) পা ফোলা, চোখে ঝাপসা দেখা, তীব্র মাথা ব্যাথা

(ঘ) সময়ের আগে পানি, ভেঙ্গে যাওয়া

(ঙ) খিচুনি

(চ) অতিমাত্রায় বমি

(ছ) রক্ত স্বল্পতা

(জ) অন্যান্য .....

ডেলিভারীর সময় ঃ কোথায় গিয়েছিলেন কার সঙ্গে গিয়েছিলেন

(ঝ) দীর্ঘস্থায়ী প্রসব ব্যথা (সময়)

(ঞ) প্রচুর রক্তপাত

(ট) প্রসবের পর ফুল না পড়া (৩০ মিনিট এর বেশী) পর্যন্ত

(ঠ) প্রসবের রাস্তা ছিড়ে যাওয়া

(ড) অন্যান্য .....

প্রসবের পরে ঃ

(ঢ) তিনদিনের বেশী জ্বর

(ণ) খিচুনী

(ত) প্রসবের রাস্তা দিয়ে প্রস্রাব বের হওয়া

(থ) দুর্গন্ধ যুক্ত স্রাব

(দ) জরায়ু বের হয়ে আসা

(ধ) প্রসবের রাস্তা দিয়ে পায়খানা বের হওয়া

(ন) অন্যান্য .....

** কোথায় গিয়েছিলেন?

(ক) কোথাও না (খ) সরকারী হাসপাতাল (গ) এনজিও ক্লিনিক (ঘ) হাতুড়ে ডাক্তার

(ঙ) এম.বি.বি.এস (চ) হেমিওপ্যাথ (ছ) কবিরাজ (জ) মৌলানা/ফকির (ঞ) ট্রেনিং প্রাপ্ত দাই

(ট) স্বাস্থ্য কর্মী (ছ) অন্যান্য .....

*** কার সাথে গিয়েছিলেন (ক) স্বামী (খ) নিজে নিজে (গ) প্রতিবেশী/আত্মীয় (ঘ) শ্বশুড়/শাশুড়ী

(ঙ) অন্যান্য ..... (চ) প্রযোজ্য নহে।

৫৯। আপনি কি এইডস রোগের নাম শুনেছেন? (ক) হ্যাঁ (খ) না

৬০। কি কি কারণে এইডস হতে পারে?

(ক) (খ) (গ)

৬১। কিভাবে এই রোগ প্রতিরোধ করা যায়?

(ক) (খ) (গ)

সাক্ষাৎকার গ্রহণ কারীর নাম ও তারিখ ঃ

ধন্যবাদ

Title: Reproductive Health Behaviour : An Anthropological Study Among the Slum Dwelling Couples of Chittagong City

Male Questionnaire

বস্তির পরিচিতি

বস্তির নাম ঃ ---------- জমিদারের নাম ঃ ----------

মহল্লার নাম ঃ ---------- ওয়ার্ড নং----------

১। উত্তর দাতার পরিচিতি নং ঃ

২। আপনার নাম কি? .....

৩। আপনার স্ত্রীর নাম কি? .....

৪। আপনার বয়স কত?.....

৫। আপনার ধর্ম কি? (ক) মুসলিম খ) হিন্দু (গ) বৌদ্ধ (ঘ) খৃস্টান (ঙ) অন্যান্য

৬। আপনি কতদিন যাবৎ এই বস্তিতে বসবাস করছেন? .....মাস/বৎসর

৭। আপনি এই বস্তিতে আসার আগে কোথায় ছিলেন?

(ক) অন্য বস্তিতে (খ) নিজের গ্রামে (গ) অন্য শহরে (ঘ) অন্যান্য

৮। আপনি কোন জেলার বাসিন্দা?

৯। বস্তিতে বসবাসের কারণ কি? (একের অধিক উত্তর হতে পারে)

০১) দেশে কাজ করার সুযোগ নেই ০২) উন্নত জীবন যাপনের আশায়

০৩) গ্রামে কোন সহায় সম্বল নাই ০৪) নদী ভাংগনের কারণে

০৫) শহরে বিভিন্নভাবে সাহায্য পাওয়ার কারণে ০৬) গ্রামে থাকার জায়গা নেই

০৭) দেশে নিরাপত্তার অভাব ০৮) বাচ্চাদের ভাল শিক্ষার সুযোগ নেই

০৯) অন্যান্য .....

১০। আপনার পেশা কি?

১) কিছু করে না ২) শ্রমিক/দিন মজুর ৩) গার্মেন্টস শ্রমিক

৪) রিক্সা চালক ৫) ক্ষুদ্র ব্যবসায়ী ৬) চাকুরী

৭) হকার/ফেরিওয়ালা ৮) অন্যান্য .....

১১। আপনি কোন শ্রেণী পর্যন্ত লেখা-পড়া করেছেন?

(ক) নিরক্ষর (খ) প্রাথমিক ১ ২ ৩ ৪ ৫

(গ) মাধ্যমিক ৬ ৭ ৮ ৯ ১০ (ঘ) উচ্চ মাধ্যমিক ১১ ১২ (ঘ) স্নাতক ১৩ ১৪ ১৫ (ঙ) অন্যান্য .....

১২। আপনার মাসিক আয় কত? .....

১৩। আপনি কত টাকা ঘরভাড়া দেন? .....

১৪। আপনি জন্ম নিয়ন্ত্রণের পদ্ধতি সম্পর্কে স্ত্রীর সাথে আলোচনা করেন কি? (১) হ্যাঁ (২) না।

১৫। উত্তর না হলে আলোচনা না করার কারণ কি?

১৬। সুখী পরিবারের জন্য জন্ম নিয়ন্ত্রণ পদ্ধতি ব্যবহারের প্রয়োজনীয়তা মনে করেন কি?

(১) হ্যাঁ (২) না।

১৭। হ্যাঁ হলে কার ব্যবহার করা উচিৎ? ১) স্বামীর ২) স্ত্রীর ৩) যে কেউ

১৮। আপনি স্ত্রীকে জন্ম নিয়ন্ত্রণের জন্য প্রয়োজনীয় সহযোগিতা করেন কি?

(১) হ্যাঁ (২) না।

১৯। গর্ভকালীন সময়ের প্রাথমিক অবস্থায় একজন মহিলার কি কি উপসর্গ/লক্ষণ/সমস্যা দেখা দিতে পারে?

(ক) মাসিক বন্ধ থাকে (খ) দুর্বলতা (গ) বমি (ঘ) প্রভাতিক বমি বমি ভাব (ঙ) টক বা টক জাতীয় খাবার খাওয়ার ইচ্ছা পোষণ করে (চ) পোড়া মাটি খাওয়ার ইচ্ছা পোষণ করে (ছ) স্বাভাবিক খাবার খেতে অনিহা প্রকাশ (জ) সবকিছুতে গন্ধ অনুভব করে (ঝ) তলপেট বড় হওয়া (ঞ) ওজন বৃদ্ধি (ট) জানি না (ঠ) অন্যান্য

২০। আপনার স্ত্রী সর্বশেষ গর্ভাবস্থায় কতগুলো গর্ভকালীন পরিচর্যা/যত্ন গ্রহণ করেছিলেন?
(ক) একবারও না (খ) একবার (গ) দুবার (ঘ) দুইবারের বেশী (ঙ) জানি না

২১। আপনার স্ত্রী সর্বশেষবার গর্ভাবস্থায় কোথা থেকে গর্ভকালীন পরিচর্যা বা সেবা গ্রহণ করেছিলেন?
(ক) এনজিও ক্লিনিক/সেটেলাইট (খ) এম. বি. বি. এস ডাক্তার (গ) নার্স (ঘ) হাতুড়ে ডাক্তার
(ঙ) প্যারামেডিক (চ) সরকারী হাসপাতাল (ছ) অন্যান্য .....

২২। সর্বশেষ গর্ভকালীন অবস্থায় আপনার স্ত্রী টি টি ইনজেকশন নিয়েছিলেন কি?
(ক) একটি (খ) ২টি (গ) ৩টি (ঘ) নেয়নি (ঙ) জানি না

২৩। গর্ভাবস্থায় মহিলাদের বাড়তি বা অতিরিক্ত খাবারের প্রয়োজন হয়, আপনি কি বাড়তি খাবরের ব্যবস্থা করেছিলেন? (ক) হ্যাঁ (খ) না।
উত্তর হ্যাঁ হলে কি কি ব্যবস্থা করেছিলেন?

খাবারের ধরণ ঃ	নিয়মিত	মাঝেমধ্যে
(ক)	(ক)	(ক)
(খ)	(খ)	(খ)
(গ)	(গ)	(গ)

২৪। আপনি কি মনে করেন, একজন মহিলার গর্ভখালাসের স্থান এবং সহায়তাকারী কে হবে তা পূর্বে থেকেই নির্ধারণ করে রাখা উচিত? (ক) হ্যাঁ (খ) না (গ) জানি না

২৫। আপনার মতে একজন মহিলার সন্তান প্রসব হওয়া উচিৎ?
(ক) হাসপাতাল/ক্লিনিক (খ) স্বামীর বাড়ী (গ) স্ত্রীর পিতামাতার বাড়ী (ঘ) সরকারী হাসপাতালে
(ঙ) এনজিও ক্লিনিক/হাসপাতালে (চ) বেসরকারী হাসপাতালে (ছ) অন্য কোন স্থানে (জ) জানি না

২৬। কার দ্বারা সন্তান প্রসব করানো উচিত? (ক) এম. বি. বি. এস. ডাক্তার (খ) নিকট আত্মীয়/দাই/প্রতিবেশী
(গ) প্রশিক্ষণ প্রাপ্ত দাই (ঘ) স্বাস্থ্য / পরিবার পরিকল্পনা কর্মী (ঙ) নার্স (চ) অন্যান্য .....

২৭। আপনার স্ত্রীর সর্বশেষ সন্তান প্রসবের জন্য আপনি পূর্ব থেকে কোন স্থান ঠিক করে রেখেছিলেন?
(ক) ঠিক করিনি (খ) নিজের ঘর (গ) শ্বশুর বাড়ী (ঘ) সরকারী হাসাপাতাল
(ঙ) এনজিও ক্লিনিক/হাসপাতাল (চ) বেসরকারী/হাসপাতাল (ছ) অন্যান্য .....

২৮। আপনার স্ত্রীর প্রসবের সহায়তা করার জন্য আপনি পূর্ব থেকে কারও ব্যাপারে সিদ্ধান্ত নিয়েছিলেন?
(ক) প্রশিক্ষণ ছাড়া আত্মীয় (খ) দাই (গ) প্রশিক্ষণ প্রাপ্ত দাই (ঘ) প্যারামেডিক
(ঙ) এম.বি.বি.এস (চ) নার্স (জ) অন্যান্য (ঝ) ঠিক করিনি।

২৯। গর্ভকালীন সময়ের সম্ভাব্য অসুবিধার কথা ভেবে চিকিৎসার জন্য আপনি কি টাকা পয়সা জমিয়েছিলেন?
(ক) হ্যাঁ (খ) না

৩০। আপনার স্ত্রী প্রসবের ৪২ দিনের মধ্যে প্রসবোত্তর সেবা গ্রহণের জন্য কোন সেবা দান কেন্দ্রে গিয়েছিলেন?
(ক) হ্যাঁ (খ) না

৩১। সন্তান প্রসবের পর বুকের দুধ খাওয়ানোর সময় মায়েদের অতিরিক্ত খাবারের প্রয়োজন হয়। আপনি কি কি অতিরিক্ত বা বাড়তি খাবারের ব্যবস্থা করেছিলেন?
(ক) হ্যাঁ (খ) না
উত্তর হাঁ হলে কি কি খাবার

বাড়তি খাবার ঃ	নিয়মিত ঃ	মাঝেমধ্যে ঃ
(ক)	(ক)	(ক)
(খ)	(খ)	(খ)
(গ)	(গ)	(গ)

৩২। আপনার সর্বশেষ সন্তানটি কি (আল্লাহ না করুন) গত ১৫ দিনের মধ্যে অসুস্থ হয়েছিল?
(ক) হ্যাঁ (খ) না

৩৩। যদি হ্যাঁ হয় তবে সর্বশেষ কি অসুখ হয়েছিল?
(ক) ডায়ারিয়া (খ) শ্বাস কষ্ট (গ) জ্বর (ঘ) খোস পাঁচড়া (ঙ) কৃমি (চ) রাতকানা (ছ) হাত-পা অবশ
(জ) সর্দি-কাশি (ঝ) ---------- (ঞ) ----------

৩৪। উক্ত অসুস্থতার জন্য আপনি কি তাকে কোন চিকিৎসা কেন্দ্রে বা কারো কাছে নিয়ে গিয়েছিলেন?
(ক) হ্যাঁ (খ) না

৩৫। (যদি চিকিৎসা করে থাকে) তবে কোথায় বা কার কাছে চিকিৎসা করিয়েছিলেন?
(ক) এম. বি. বি. এস. ডাক্তার (খ) হোমিওপ্যাথিক (গ) সরকারী হাসপাতাল
(ঘ) স্বাস্থ্য / পরিবার পরিকল্পনা হাসপাতাল (ঙ) ফার্মেসী (চ) হাতুড়ে ডাক্তার (ছ) অন্যান্য

৩৬। আপনি কি তার সাথে সেখানে গিয়েছিলেন?
(ক) হ্যাঁ (খ) না

৩৭। আপনি গত ১ সপ্তাহের মধ্যে সন্তানের জন্য নিম্নোক্ত কোন কাজ করেছেন?
(ক) ন্যাপি বদলানো (খ) মলমূত্র ত্যাগের পর পরিষ্কার পরিচ্ছন্ন (গ) সর্দির সময় নাক পরিষ্কার করা
(ঘ) গোসল করানো (ঙ) খাওয়ানো (চ) কাপড়-চোপড় পরিস্কার করা (ছ) রাত্রি জাগরণ (বাচ্চার জন্য)
(জ) অন্যান্য

৩৮। সর্বশেষ গর্ভকালীন সময়ে সন্তান প্রসবের সময়ে এবং প্রসবোত্তর কালে আপনার স্ত্রীর কি কোন জটিলতা দেখা দিয়েছিল?
(ক) হ্যাঁ (খ) না (গ) জানি না

৩৯। যদি হ্যাঁ হয়ে থাকে কি কি অসুবিধা হয়েছিল? কোথায় তিনি গিয়েছিলেন এবং কত টাকা খরচ হয়েছিল?

সন্তান পেটে থাকাকালীন	কোথায় গিয়েছিলেন	মোট খরচ (টাকা)
১		
২.		
ডেলিভারীর সময়		
১.		
২.		
প্রসবের পরে		
১.		
২.		

কোড ঃ

**** কোথায় গিয়েছিলেন - (ক) কোথাও না (খ) সরকারী হাসপাতাল (গ) বেসরকারী হাসপাতাল (ঘ) এনজিও ক্লিনিক/হাসপাতাল (ঙ) হাতুড়ে ডাক্তার (চ) কবিরাজ (ছ) হোমিওপ্যাথ (জ) এম.বি.বি.এস ডাক্তার বাড়ীতে (ঝ) এম.বি.বি.এস চেম্বারে (ঞ) প্যারামেডিক (ট) নার্স (ঠ) ধাত্রী প্রশিক্ষণ প্রাপ্ত (ড) ধাত্রী পশিক্ষণ ছাড়া (ঢ) অন্যান্য .....

৪০। আপনি জানেন কি সঠিকভাবে টিকা দিলে একটি শিশু ৬টি মারাত্মক রোগ থেকে রক্ষা পায়, রোগগুলো কি কি?
(ক) যক্ষ্মা (খ) ডিপথেরিয়া (গ) হুপিং কাশি (ঘ) ধনুষ্টংকার (ঙ) পোলিও (চ) জানিনা

৪১। আপনি কি এই সব টিকার নাম জানেন?
(ক) বি.সি.জি (খ) ডি.পি.টি (গ) ও.পি.ভি (ঘ) মিজেলস/হামের টিকা (ঙ) জানি না।

৪২। আপনি কি এইডস রোগের নাম শুনেছেন?
(ক) হাঁ (খ) না

৪৩। কি কারণে এইডস হতে পারে?
(ক) (খ) (গ)

৪৪। কিভাবে এই রোগ প্রতিরোধ করা যায়? .....

.....

সাক্ষাৎকার গ্রহণকারীর নাম ও তারিখ ঃ

ধন্যবাদ

Pictures of Shantinagar slum

In-depth interviewing with male key informant

In-depth interviewing with female key informant

Hyjenic condition of the latrine

Face to face interviewing with female respondent

Exchange of viewing with slum women about their slum life style

Exchange of viewing with slum male and female informants about their rituals life

Check- List

Reasons for not acceptance of family planning method.

Pattern of health care seeking behavior during pregnancy.

Behavioral pattern about care during pregnancy.

Wife accompanied by husband during antenatal visit to health centre.

Reason for not accompanying wife at the time of ANC visit to health centre.

Knowledge / Belief regarding food intake during pregnancy.

Opinion regarding restrictions of movements and activities during pregnancy.

Utilization of adequate rest during pregnancy.

Pattern of utilization of adequate rest during pregnancy.

Sharing of house hold activities by the husband at wife pregnancy.

Reasons for not sharing house hold works.

Reasons for staying at home during child birth.

Reasons for vaccination during pregnancy.

Reason for not taking vaccine during pregnancy.

Rituals performed during pregnancy.

Pattern of naturals performed during pregnancy.

Perception/ knowledge about complication of pregnancy

Perception about labour pain.

Place of delivery preferred by Informants

Reasons for preference about home delivery.

Opinion about the presence of TBA during labour.

Knowledge of postpartum rest.

Pattern of rituals observed on the occasion child birth.

Perception about sexually transmitted diseases.