Women's Income and Reproductive Rights: A Sociological Study in Rural and Urban Settings in Bangladesh

PhD Dissertation

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CERTIFICATE

This is to certify that Ms. Leema Hoque, Assistant Professor, Department of Sociology, University of Chittagong was enrolled as a PhD student under the Department of Sociology, University of Dhaka in the academic session 2004-05 registration no. 111 and 2009-10(Re) registration no. 9 (Re). The title of her PhD thesis is "Women's Income and Reproductive Rights: A Sociological Study in Rural and Urban Settings in Bangladesh". I have acted as her Supervisor in her PhD program. During the tenure of her study, I have supervised her overall works in particular formulating the title of the thesis, preparation of field study materials, literature review, drafting PhD thesis.

This thesis or any part of it has not been submitted to any other institution for conferring any degree.

I wish her every success in life.

23.01.2010

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Abstract

This study focuses on women's income and reproductive rights and explores the underlying relationship between them taking samples from urban and rural areas and considering the heterogeneity of the respondents selected by multiple methodological techniques. The data of this study comes from two distinct fields selected through divergent methods with consequent techniques and the total number of respondents is 542. Among them, 272 respondents are garment workers, who are interviewed through a simple random survey technique from a garment factory in Tongi and 270 respondents are from Madhabpur village in Manikgang district,who are also interviewed by selecting process through purposive and systematic sampling technique. Another 15 sample were drawn for in-depth interview from both rural and urban areas. Because of maintaining scientific criteria, 15 informants are divided into two segments like- income group and non-income group, to get the full-fledged feature about the subject matter of the study. The sample size is drawn by following the well developed scientific process i.e. W.G. Cochran's sample selection procedures (Sampling Techniques, 1963) by accommodating 95 percent confidence level.

This study uses very discerning and also pertinent theoretical perspectives like Marxist theory, Feminist Sociological theories, Role Incompatibility theory, Gender-Stratification theory and theory of Selective Rationality to understand and probe the underlying concerns about the income structure and practices of reproductive rights by the respondents.

The objectives, predominantly and astutely, of this study are (a) exploring the demographic and socio-economic characteristics of working women in general and non-working women in particular, (b) examining the relationship between income and non-income group women and their state of reproductive rights, (c) evaluating the nature of change in income pattern and its impact on reproductive rights, (d) illustrating the comparison between rural and urban settings in terms of the above objectives.

The respondents were asked 53 questions to understand, and to explore as well as examine, the real experience of their different backgrounds to ascertain objectives and testable hypothesis.

Findings of this study for quantitative part - in urban area 65 percent of the respondents were over 20 years of old and average household size is 3.Whereas in rural area 35 percent of the respondents were over 20 years old and average household is 5. Cent percent of the respondents were garment workers in urban area and in rural area more than 70 percent are small entrepreneurs. In urban area average income was Tk.4000 and average expenditure was Tk.3000. In rural area it is Tk. 7000 and Tk.2500 respectively. About 66 percent of the urban respondents are aware of reproductive rights and among them 52 percent are in a position to take decision about having children on their own. On the other hand, 44 percent of the rural respondents know about reproductive rights and among them 48 percent of the respondents can take decision about having children without intervention of their husband or third parties. In urban sector 60 percent of the respondentshave exercised their right to make protest against husband and it is 40 percent in rural settings. Almost every respondent, both in rural and urban settings, know about reproductive health and family planning. Rate of using contraceptive is higher in urban area than in rural sector. In rural area, "natural method" is a popular method which is barely seen in urban area. Awareness of STD (sexually transmitted disease) is high in urban settings than in rural settings.

The summary of the significant association and relation found at chi-square and correlation test is noteworthy, which is at α=.01 and in some cases α=.05 levels of significance.

The findings of this study for qualitative part- awareness about reproductive right are seen in both areas but it is more in urban area. There are dissimilarities between urban income and urban non-income respondents. For example, urban income group believe income creates decision–making power but urban non-income group differ with that. According to them, income is not the obvious factor for exercising power or taking decision. There are multiple intervening factors, the combined effect of which may create a congenial situation for acquiring decision making power by a woman. These

intervening factors include poverty, education, attitude of husband and level of income generating power on the part of woman. Rural income group believe that income creates awareness about reproductive rights and non-income group believe that earning is merely about gaining the ability to participate in the decision making process. For them, income works as an instrument to fulfill the basic need first. Strong correlation has been found between income and reproductive rights in urban respondents. According to rural non-income respondents, education appeared to be an important factor apart from income for taking decision about reproductive issues.

From the findings of the urban and rural respondents, it can be concluded that there is a connection between income and reproductive rights. But it is not so strong in rural areacompared to that of urban area. Although an extensive focus was not given in digging out the role of intervening factors for acquiring or lack of decision making power despite having income generating capacity, considering the social fabric, it can be concluded that taking account of those intervening factors income plays a vital role in acquiring decision making power.

While finding the strong correlation between income generating capacity and reproductive right, it appeared that being involved in income generating activities also plays as an auxiliary factor in creating awareness about other social issues including raising child, social interaction, adverse economic impact of having too many children, importance of education for children. What is most revealing about creating awareness about education and raising children was that the rural working women were more concerned about the well being and proper up-bringing of their children. This awareness was seen irrespective of income generating capacity or standard of education. They see the education of their children as an instrument of their emancipation. This may sound cliché, but this is still true that to rural people their children are the binocular through which they see their future.

No attempt has been made to make any judgment on the conditions of rural and urban and working and non-working women. Since this study focused to find out the link between income and its impact on women's decision making power, suggesting a future

direction would have been fruitless exercise. For the income of a woman would not ipso facto create the environment of empowerment, albeit it plays a contributory role.

Finally, this study attempted to draw a sociological landscape in the sphere of women's empowerment, particularly in case of reproductive issues, where the income has a vital role to exercise decision making power vis-a-vis non-income group women. This study also attempts to understand their situation both in rural and urban areas where patriarchal ideology is much stronger than income considering other important issues for practicing power like occupational variety, education, present social status, class position, and social areas.

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Leema Hoque

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CHAPTER EIGHT: FINDINGS OF THE QUANTITATIVE STUDY

List of Acronyms

UN	United Nations
FP	Family Planning
RR	Reproductive Rights
RH	Reproductive Health
WB	World Bank
BBS	Bangladesh Bureau of Statistics
PFA	Platform for Action
GOB	Government of Bangladesh
NGO	Non-governmental organization
WID	Women in Development
NAP	National Action Plan
WID	Women in Development
B+5	Beijing Plus Five
B+10	Beijing Plus Ten
B+ 15	Beijing Plus Fifteen
ILO	International Labor Organization
UPE	Universal Primary Education
CSW	Commission on the Status of Women
HIV	Human Immunodeficiency Syndrome
LFS	Labor Force Survey

FWA	Family Welfare Association
VAW	Violence against Women
SVRS	Sample Vital Registration System
TFR	Total Fertility Rate
EHC	Essential Health Care
CBR	Crude Birth Rate
CDR	Crude Death Rate
MMR	Maternal Mortality Rate
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
AIDS	Acquired Immune Deficiency Syndrome
STD	Sexually Transmitted Disease
CSW	Commission on the Status of Women
RHC	Reproductive Health Care
MCWC	Maternal and Child Welfare Centre
ICPD	International Conference on Population and Development
BPFA	Beijing Platform for Action
UDHR	Universal Declaration of Human Rights
FWCW	Fourth World Conference on Women
UNDP	United Nations Children's Program
NFLS	Nairobi Forward Looking Strategies

NCBP	NGO Coalition on Beijing Process
DFID	Department for International Development
BRAC	Bangladesh Rural Advancement Committee
IPPF	International Plant Parenthood Federation
FWCW	Fourth World Conference on Women
CEDAW	Convention for Elimination of Discrimination against Women
UNICEF	United Nations Children's Fund
MOWCA	Ministry of Women and Children Affairs
MOHFW	Ministry of Health &Family Welfare
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
ICDDR, B	International Center for Diarrheal Disease Research, Bangladesh
WGNRR	Women's Global Network for Reproductive Rights

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CHAPTER ONE

Introduction

1.1 Statement of the Problem

Women are half the world's population, receive one-tenth of the world's income accounts for two-thirds of the world's working hours, and own only one hundredth of world's property (ILO 1980). This is a painful picture from the women's statuses point of view. However, this picture gives more painful news in the case of Bangladesh.

Half a million women-wives, daughters, sisters, mothers of families, "pillars of community"- die each year from causes to pregnancy and child birth. Only a tiny fraction (6,000) of those 500,000 deaths takes place in developed countries. All the rest occurred in developing countries. Over half of all maternal deaths occur in South Asia, predominantly in Bangladesh, India and Pakistan (Smyke 1991:13). In Bangladesh, maternal mortality ratio per 100 live births is 3.15 (Bangladesh Bureau of Statistics 2003: 655).

One of the least developed countries in the world, Bangladesh ranks the world's ninth populous country, contained in a limited land area of 143,778 square kilometers. The population is 140.6 million where men and women are about 72.0 million and 68.6 million respectively. The sex ratio is about 105.0. The density of population per square kilometer is 953 (Database on Women and Children Issues 2008:20). An important part of women's status is her material fulfillment that depends on her independent income and obviously her control over the income. In this respect, education can play an important role to increase their independent income and create a consciousness among them to control over their own income. Besides, education helps to remove the cultural constraints that pose obstacles to outside work. Moreover these are the key elements in enhancing the productivity of female workers. Thus,

education and skill generation are the most important inputs that can have a multipronged impact on the status of women.

Over the last two decades, Bangladesh has undergone an improvement in female education sector. Female literacy rate is 33.4 in 2001 which was 19.5 in 1991 and 13.2 in 1981. In 2006, female literacy rate (%) age 7+ was 49.1 (Bangladesh Bureau of Statistics, 2006). A major demographic transition is observed as well. In 2000 the TFR was 2.59 which turned into 2.51 in 2004 (BBS Dec. 2004). In 2003 the maternal mortality ratio per 1000 live birth was 3.76 and in 2006 it has turned into 3.37 (Database on Women and Children Issues 2008:88). Education and employment are regarded as effective interventions in controlling population explosion. Despite this achievement, it is really a tragedy that most of Bangladeshi women are inferior to men because of their inferior status.

Status of women in Bangladesh

In Bangladesh, women constitute about half of the total population and almost half of the potential labor force. The majority of women are not only poor but deprived in two ways: First: because of the general impoverishment of the society, and second: because they are women in a social situation where gender severely limits their access to resources of all kinds. Traditional attitudes and gender – stereotyped role of women often prevent society as a whole to recognize women's rights in both domestic and public spheres. The position of women in a tradition-bound society like Bangladesh is very difficult. For most practical purposes women belong to a world different from that of men.

In the following few paragraphs an endeavor has been made to examine the status of women and the position of women at different times to demonstrate that in Indian society the position and status of woman has been continuously changing in the course of time.

Women in Rigvedic Age: In 'Rigvedic Society' the position of woman was fairly satisfactory. Despite the attitude of indifference towards a female child, a daughter was entitled to the privileges of a son. She was educated like a boy and had to pass through a period of Brahmcharya. Daughter enjoyed as much freedom as the son. There was no seclusion of sexes. Women enjoyed equality with man in religious matters too. The main disabilities from which woman suffered in this age were proprietary rights (Jain and Singh 2001: 31).

Woman in Later Vedic Age: The position of woman was not the same throughout the Vedic Period. During the Later Vedic Period, her position deteriorated. There was a gradual decline in female education as the period advanced. Religious rights and privileges of the average woman were curtailed. Despite this, the woman still was given much latitude.

Woman in Jainism and Buddhism: Jainism and Buddhism especially by the ascetic ideals and the tenets of the Upanishads, may be considered as a revolt against the Brahmanical religion. During this time, there were highly educated woman, holding honorable positions in society and their households. Both these religion laid great stress on physical chastity which eventually discouraged widow remarriage.

Woman in Pre-Mughal Period: The position of woman deteriorated considerably in this period. Widow re-marriage was prohibited. The only sphere in which the position of woman improved in this age was one of the proprietary rights. Thus the position of woman was not altogether disappointing.

Woman in Mughal India: The position of woman in India underwent many changes with the advent of Muslims invaders. Her honored position deteriorated. A woman was supposed to worship her husband like a God.

Woman in British Period: The position of woman in Indian Society had reached its lowest ebb. in this period. Describing the chaotic condition of

women, Neural Desai writes, "Ideologically woman considered a completely inferior species, inferior to the male, having no significance, no personality, socially she was kept in a state of utter subjection, denied any right, suppressed and oppressed. The patriarchal joint family, the custom of polygamy, the purdha, the property structures, early marriage, self-immolations of widows (sati); or a state of permanent widowhood, all these contributed to the something of the free development of woman" (Jain and Singh 2001).

In this type of situation in the society at that time, it is easily understood that there is no evidence of reproductive rights in woman's life.

The Position of women in the beginning of the 19th century was indeed most deplorable. English education opened the flood gates of Western ideas which brought new conception of social justice and political rights. Nineteenth century witnessed for the first time social legislation enacted by the Government. Inspired by the wave of liberalism in the West and the vigorous campaign of Raja Ram Mohan Roy against Sati, Lord William Bentinck declared on 4th December, 1829 by Regulation17, Sati to be illegal in the Bengal Presidency. The Hindu Widow's Remarriage Act was passed on July 26, 1856. Though Pandit Ishawrchandra Vidyasagar put his heart and soul in propogating reform, yet the actual number of widow's remarried under this Act was quite inconsiderable (Majumder, R.C.1951 :260).

A regular system of female education was practically unknown at the beginning of nineteenth century. It is significant to mention that the social reformers and the British Government made positive attempts to educate Indian girls. More and more educational institutions for women were opened and by the end of the 19th century.

Woman in Post-Independent India: Another feature of the 20th century is the entry of the women into professions due to the expansion of educational

facilities for them. A large number of them were able to engage them in gainful employment. The women are now being looked as an equal partner in the family life and were considered as an asset in the family rather than a liability. Another significant factor which provided new dimensions to the women's liberation was the acquisition of the political rights of women. Many factors of change such as industrialization urbanization, higher education and new value system have greatly affected the women's position.

The social causes of crimes against women include causes like inferior status of women due to social conditioning, patriarchal structure of society, unwholesome family atmosphere, lack of proper training, broken homes, too much interference by the parents, lack of love of parents, addiction to drugs, sickness etc. Although they did not use the term reproductive right but it is expressed in their opinion that, women are controlled by men and they are subordinate to men. They think that, Indian society is male dominated. Man occupies a superior status and the woman is merely his appedage. A woman is never an entity in her own right, she is, first the daughter, next the wife, and last the mother of a man." Discrimination against girls starts at the moment a child is born and continues to the maintained and reinforced through the process of different socialization throughout her life. Sex role distinctions are evident in terms of occupation and education. It makes every women convinced about her subordinate status (Jain and Singh 2001:11-12).

Bangladesh society lays great emphasis on tradition; any innovation or deviation from the past, is generally viewed with suspicion and disfavor. This especially affects attempts to change the position of women. The patriarchal nature of society in Bangladesh is evident in almost every sphere of life. Almost all the formal and informal sources of power and authority are invested in the male. The life patterns of most Bangladeshi women are conditioned by various male-dominated institutions.

By custom, the life of a woman in Bangladesh is shaped by the patriarchal, patrilineal and patrilocal nature of the social system. A woman's father or husband or in their absence, her son or distant male relative assumes responsibility for protecting her welfare. From childhood, the discrimination starts and dominates the life of a woman. The patrilineal system of Bangladesh has given high value to sons as potential providers and perpetuators of family names and daughters are temporary members of their natal homes.

Marriage is an universal phenomenon in Bangladesh. By the age of 15 to 19 years about 70 percent of the females in Bangladesh are married (Population Crisis Committee, 1988). After adolescence, the position of a woman is defined exclusively in terms of her marital status. After marriage, a woman moves to her husband's household and is transferred to her husband's family. In the case of a divorced, widowed, or abandoned woman, the responsibility for her protection reverts to her family.

After marriage, women's identity shifts from natal family to in law's family and her custody moves from father to husband. Society has dictated that her major responsibility includes the maintenance of the family. Early marriage has been a traditional practice in Bangladesh. The reason behind the practice of early marriage is the common belief that girls are much more manageable at an early age; the prevalence of poverty and large families, especially in rural areas, is another reason. One major issue related to marriage and which affects the social status of women quite adversely, is the system of dowry. Dowry is the gift in cash or kind given by the parents to their son in laws at the time of marriage.

The status of single women is very low in Bangladesh society. Whatever may be the cause for their single state, most of them face great problems in getting employment and accommodation. The very poor are usually work as domestic servants; the better educated ones can get good jobs only with difficulty.

Nevertheless, in women's middle age, there is a risk of divorce or abandonment. Divorce is regarded with disfavor by Bangladeshi society. Divorce women are usually rejected by society are thus very vulnerable in almost respect (Sultana 2004:76). With increasing poverty and economic pressure, husbands are increasingly deserting their wives, thus raising the divorce rate in Bangladesh. In 2002 the general divorce rate was 0.99 and in 2006 it has turned into 10.2 (Database on Women and Children Issues 2008:95).

In Bangladesh a woman's reproductive role is emphasized by social, cultural and religious traditions. To fulfill this role, a daughter is married off as soon as she reaches puberty and immediately taken into high fertility patterns.

In male dominated society, violence against women at household level is a common feature. A report from the UN population fund in September 2000 asserted that 47 percent of adult women reported physical abuse by their male partner_ the highest proportion in the world.

Gender disparity in Bangladesh is embeded in its patriarchy which considers women as inferior to men. Women are seen in reproductive roles and there is almost a complete denial of their potentiality as individual. Their lives are largely influenced by traditional and religious beliefs and social norms which make them economically dependent. Thus gender gaps exist in all spheres of life e.g. health, legal rights, economic participation and decision making.

The status of women in Bangladesh is closely linked with the patriarchal values embedded in the socio-cultural pattern reflecting systematic subordination and inequality of women (Khan 2003:37). In Bangladesh women's participation in decision-making is very poor. Within the strong base of patriarchy, women in Bangladesh have been assigned a role to be performed within the house-hold; and corresponding to that role, women have been ascribed an inferior and dependent status. Rigid role expectations, socio-cultural tradition following patriarchal ideology play an important role to sustain

the subordinate position of women in our society. Patriarchy determines the status of women throughout her life. Some of these are the examples of that--

- **Women's productive or labor power**: Men control women's productivity both within the house hold and outside. Within the house hold women provide all kinds of free service to their children, husbands and other members of the family throughout their lives. In what Sylvia Walby calls the "patriarchal mode of production". Men also control women's labor outside the home in several ways.

- **Women's reproduction:** Men also control women's reproductive power. Apart from individual male control, male dominated institution, like state also controls women's reproductive right. The patriarchal state tries to control women's reproduction through its family planning programs. Patriarchy not only forces women to be mothers, it also determines the conditions of their motherhood. This ideology of motherhood is considered one of the bases of women's oppression because it restricts women's mobility and reproduces male dominance.

- **Control over women's sexuality**: This is a very important area of women's subordination. Women are obliged to provide sexual services to their men according to their needs and desires. In order to control woman's sexuality their dress, behavior and mobility are carefully monitored by familial, social, cultural and religious codes of behavior.

- **Property and other economic resources:** Most property and other reproductive resources are controlled by men and they pass from one man to another, usually from father to son.

Subordination of women to men and their static domestic functions have rendered them insecure and helpless. Most of them are unaware of their rights – especially of reproductive rights.

Reproductive rights:

The United Nations defines reproductive rights as "Reproductive rights refer to the rights of the couples and individuals to decide freely and responsively the number, spacing, and timing of their children, and have the information, education and means to do so, and the rights to attain the highest standard of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence" (United Nations 1995).

Reproductive right was first recognized as a human right in 1968. Reproductive health and rights agenda has been considered as an important issue only after the 1994 International Conference on Population and Development (ICPD) in Cairo, the Fourth World Conference on Women (Beijing, 1995), the World Summit for Social Development (Copenhagen, 1995) and the World Conference on Human Settlements (Istanbul, 1996) [Begum, 2003:119]. Specifically, the ICPD Program of Action and the Beijing Platform for Action recognize sexual and reproductive rights as human rights, there by affirming them as an inalienable, integral and indivisible part of universal human rights. This issue is highly linked with women's empowerment which is also highlighted in ICPD. The following international women's conferences held at various locations over the last few decades:

*** The First International Conference on Women. 1975. Mexico.**

*** The Second World Conference on Women.1980. Copenhagen.**

*** The Third International Conference, 1985. Nairobi.**

*** Agenda 21 of the Earth Summit. 1992. Rio de Generio.**

*** World Population Programe of Action. 1994. Cairo.**

*** ICPD+5. 1999. United General Assembly.**

*** The Fourth World Conference. 1995. Beijing.**

*** Beijing+5 and 54th session of United Nations General Assembly (UNGA).**

The tradition of Bangladesh society emphasis high priority of motherhood. Therefore, society expects a girl to give birth immediately after her marriage. This is the reason behind the high fertility rate in the last two decades in Bangladesh. In 1982 CBR (Crude Birth Rate) was 34.8 and in 1992 it was 30.8 (Bangladesh Bureau of Statistics 2003: 33). The infant mortality rate remains high at 77 per thousand live births (BBS 1996:145).

But the situation has been changing with the passage of time. The fertility rate has declined to 19.9 in 1998 (Bangladesh Bureau of Statistics 2003: 33). In 2006 the crude birth rate is 20.6 (Database on Women and Children Issues 2008:35). The decline of total fertility is observed as well. According to Population Census, 2001 the total fertility is now 3.4. Number of child marriage is reducing. Average age at marriage has risen. In 2004 the mean age at marriage was 21.95 where the female mean age at marriage was 19.03 (Database on Women and Children Issues 2008:88). But there is no change in the average age of first birth. Use of family planning method has increased (Chowdhury 2006:23). 54% of women (ages 15-49) use the contraceptive method (World Bank 2005:13). The number of female university student has risen dramatically. In 1992 the university student was 11923 and in 2002 it has turned into 23223 (BBS 2004:592).

This is due to women's participation in labor force. Women's participation in the labor market has been increasing over the years. According to labor force survey, 1999/2000 women's participation in the labor market was 23.9 percent and in 2005/2006 it has turned into 29.2 (Database on Women and Children Issues 2008:178). Now-a-days, a large number of women are engaged in various types of income earning activities and it has been widely argued that participation of women in income earning opportunities elevates women's position in the family and consequently assures power to control over their reproductive life. Therefore, it can be concluded that there is a relationship between reproductive rights and income.

This study attempts to demonstrate the linkage between the income status of women in urban and rural settings in Bangladesh and the exercise and practice of their reproductive rights.

1.2 Sociological Significance of this Study:

Gender is socially constructed for identifying male and female, but sex is biologically determined. When this social and biological notion of male and female make distinction between them, the patriarchal tradition ignores the social identity occupying attention to biological one. In Bangladesh, candidly speaking, reproductive rights and women's health is not very well-discussed issue. Our socio-cultural tradition does not encourage discussing openly as to women's reproductive issues and their rights. But in order to establish women's existence with dignity, it is necessary to think about these issues within the framework of gender equity. Besides, it is necessary to have adequate knowledge about women's reproductive rights and income for every female member of society, irrespective of whether she is educated or illiterate, service holder or house wife and also whether she belongs to high or low socio-economic group. Here the term 'sociological' means, of course for this study, the task of identifying causal factors behind the reproductive issues connecting to income and non-income group women and the underlying causes of women's deprivation from their rights and privileges.

By analyzing the present status of women it can be said that there is a direct connection between reproductive rights and socio-economic status. It is significant to show that connection in working and non-working women's life in our society or particularly in my studied people, from sociological perspective.

This study is based on proper theoretical framework which indicates the apposite guideline for doing this research piece as more reliable and predictable as possible. Eventually, it is vividly patent that in terms of sociological view, this study incorporates the concepts and variables that are directly related to the sociological research. Though,

according to the hypothesis of this study, the income influences the reproductive issues, it is also connected others social-economic variables like – occupational diversity, education, present social status, class position, social areas.

The contemporary situation of women and their reproductive rights and disadvantaged situation have a past tradition under the patriarchal ideology. Because, after the invention of agriculture, as parallel the last phase of Vedic period, the situation of women in society was deteriorated which Engel's called "historical defeat" of women.

They were then thrown out from the mainstream social arena and eventually their religious rights and privileges in addition to other basic needs were truncated. And from that that time the patriarchal society started to make binary oppositions- whereas all goods for man and all bads for woman. Deliberately and of course- from the ill intention, society then fixed women's position from open place into the hearth and bed whereas they were not been treated as social being. This situation is being drastically unwavering before the Renaissance and French Revolution in all over the world. But in Subcontinent, the women's situation started to change from a certain phase of British period by the modern educated people. Because the modern education cut some prejudice against women and weakened the stoutly embedded superstition in society.

So, based on this social background connecting to theoretical milieu, this study attempts to draw a sociological savor in the sphere of women empowerment, basically in reproductive issues, where the income has a vital role to practice decision making power along non-income group women and their situation both in rural and urban areas of Bangladesh as a whole and particularly in Tongi and Manikgong.

1.3 Objectives

In a working configuration of human rights, the reproductive rights, off course, is a scrupulous side that is specially deals with the socio-economic structure connecting to get the basic advantages for the women. Here, in this study, the main objectives are inextricably link with the income pattern to the reproductive issues in rural and urban settings. However, for this study, the main purposes which derived from the hard core field experience are to see the impact of income on controlling the reproductive issues by the women themselves. Therefore, the specific objectives, obviously practical, are delineating the bellow-

1. to analyze the demographic and socio-economic characteristics of working women in general and non-working women in particular
2. to examine the relationship between income and non-income group women and their situation of reproductive rights
3. to explore the nature of change in income pattern and its impact on reproductive rights
4. to show the comparison between rural and urban settings in terms of the above objectives.

CHAPTER TWO

Status of Bangladeshi Women in Different Sectors

In this chapter the status of Bangladeshi women in different sectors has been described. Let's define the concept "status of women". Max Weber defines status "as the social position a person occupies and the rank or esteem he or she enjoys". According to Mason, the main conceptual indicators about the status of women are mainly based on social, economic and political situation of the society. While attempting to define status of women Mason analyzed the terms and definitions of status of women given by Dixon (1975, 1978), Dyson and Moore (1983), Caine et.al. (1979), Safillos – Rothschild (1980), Caldwell (1981) and lined up a common thread, quoting three basic dimensions of gender inequality viz., (1) inequality in prestige, (2) inequality in power, (3) inequality in access to or control over resources.

2.1 Social Status of Women

Each society has its own social, cultural, religious traditions and practices. These inform the norms and perceptions that define the roles and behavior of men and women within that particular society.

By custom, a patriarchal and patrilocal system exists in Bangladesh and the life of a woman in Bangladesh is therefore dominated by this social system. Such a system upholds a rigid division of labor that controls women's mobility, roles and responsibility and sexuality. In the traditional patriarchal system of Bangladesh the father or, in absence of him, the next male kin is the head of the family. As a result, both decision making powers and economic control are in male's hand.

Over time, Bangladesh's patrilineal system has given high value to sons as potential providers and perpetrators of family names. They receive preferential treatment and access to education, better nutrition, and health care. Women, on the other hand, are generally viewed in their reproductive roles and are a given a subsidiary status as economic dependents.

Girls are viewed as potential mothers and homemakers, thus priority is given to their training in domestic chores rather than to their right to an education. A

woman, on an average, is married before reaching the age of 20 years. On the average a Bangladeshi woman has four pregnancies in her lifetime and she needs to consolidate her position in the new family by giving birth to male children. Socio-cultural norms have discouraged remarriage for widows and divorced women.

Abandoned women are yet another category, constituting the majority of the hard-core poor who enter the labor market for survival, as heads of their households. In the case of a divorced, widowed, or abandoned woman, the responsibility for her protection reverts to her family.

In spite of serious and sincere efforts by the women's movement in the last three decades, and some measures adopted by the government, the incidence of VAW (Violence against Women) in Bangladesh is increasing alarmingly both in dimension and depth. News of rape, assault, trafficking, death due to dowry, etc. are common features of Bangladeshi society. The four broad categories of violence against women in Bangladesh are domestic violence, violence at the workplace, trafficking in women and forced prostitution, and sexual abuse. Recently violence against women has reached another dimension with the rise in the number of trials through the "fatwa" (religious judgments) in rural areas.

In male dominated society, violence against women at household level is a common feature. Perhaps Bangladesh is one of the few countries in the world where despite the legal interventions except trafficking and acid throwing most kinds of violence against women have increased by 2008 computed 2005 as shown in the following table-

Table 2.1: Various types of Violence against women in various years

Year	Acid Throwing	Abduction	Rape	Murder after rape	Trafficking	Murder	Injured	Others
2005	177	2069	2796	22	138	97	49	2949
2006	135	2087	2566	14	107	109	75	2558
2007	137	2736	3495	33	113	142	74	3374
2008	120	2874	3387	65	105	131	87	3023

Source: NCBP October, 2009. P.22

Violence against women remains largely unreported mainly due to prevailing norms and values regarding women's honor, the insecurity of victims and due to lengthy legal procedures that discourage people from seeking legal support. There are a number of contributing factors to this violence in Bangladesh. Two of the major root causes are patriarchy and the existing discriminatory laws, particularly family law.

2.2 Economic Status of Women

With a population growth rate of 1.8%, Bangladesh ranks 144th out of 175 countries with an estimated GNP per capita of US$ 253 (World Bank, 1996). At least 70% million people live in absolute poverty, and of this, 35 to 50 million from the extreme ultra poverty group (BIDS, 1990-92).

Since the economic status of most of the population in our society is poor, the position of women is worsened. In any poor country, the under-privileged and the dependent suffer the most in economic terms, and as the previous discussion on social status on women will have made clear, women are certainly those. This means that by most definitions of economic status, such as the degree of access and to economic resources as and when needed, and the degree of control over macro-economic and micro-economic activities, women are in a very disadvantaged position.

A women's work is confined inside the household. Thus, typically a woman is almost entirely responsible for all cooking, cleaning, collecting firewood and water, wasting, child-care, handicrafts, and agriculture crop-processing. As a family member, a woman's labor in the household production unit is taken for granted and is un-enumerated. Not only a woman's contribution to the economy is unvalued but also her status in the society is classified as a "dependent" of the family.

The pressing need to survive due to shifts in the economy over the last two decades has left the male population to allow women members to take paid employment. Initially women preferred paid jobs that could be performed within their homes. But with the increasing need to the family income, women are being forced to go outside their households for jobs. Increasingly large numbers of women are becoming integrated into the labor market as wage

workers. In many cases women's status in the family is using as a direct result of their ability to earn income (Bangladesh Strategy paper 1990:7).

Women participate in agricultural production extensively. Men enjoyed a lion share of agricultural credit and extensive services while women received very little of this although women's involvement in agriculture is as high as 43% (Agricultural sector review 1989).

Women are entering into industrial employment in larger numbers. Of those employed in manufacturing about 24% were women and 76% men in 1984-85 (LFS) by 1985-86 women's participation rose to 36% however, majority of women are in low paid manual work. The low rate of literacy and low level of education of women worker are held responsible for this. Women's access to credit is far less than it is for men.

With the growth of population the size of economically active population is also increasing. But there is a large difference in number in economically active men and women. The following table shows that difference.

Table 2.2: Economically Active Population by sex, 1961-2001

Census year	Both Sexes	Male	Female
2001	34.20	30.10	4.10
1991	30.67	2838	2.29
1981	23.62	22.43	1.19
1974	20.52	19.65	0.87
1961	17.44	14.80	2.64

Source: Bangladesh Population census 2001

Women in Bangladesh have proved their tremendous potential in undertaking micro enterprise with the help of micro credit provided by various micro-credit-oriented development program of the government, Grameen Bank and other NGOs. With the help of micro-credit, women in Bangladesh have started a variety of nontraditional business. These micro-enterprises contribute about 14% of GDP. Women constitute more than 85 per cent of the work force employed in the garment sector which contributes about 75 per cent of total

foreign exchange earnings of Bangladesh. Women's contribution is higher in this sector (NCBP 2009:37-38).

2.3 Employment Status of Women

Since the employment situation is the most measurable index of the general economic status of women, an assessment of it is relevant. Constitutionally the right to work is guaranteed. Article 20 of the constitution of the Peoples Republic of Bangladesh States: "Work is right, a duty and a matter of honor for every citizen who is capable for working, and every one shall be paid for this work on the basis of the principal from each according to his abilities to each according to his work".

The following table will describe the labor force participation rate-

Table 2.3: Labor force participation Rate

	1999-2000	2005-2006
Total	**54.9**	**58.5**
Male	**84.0**	**86.8**
Female	**23.9**	**29.2**

Source: Database on Children and Women Issues, 2008. P.178

Labor force surveys (LFS) of Bangladesh show that the rate of female labor force participation, which was 23.9 in 1999-2000 increased to 29.2 percent in 2006. In the manufacturing sector, while male participation is more or less stagnant, female participation during the same period increased from 8 percent to 17 percent (NCBP 2009:37). But even after such improvement in women's participation in the labor market there remains wide gender gap and discrimination in employment in each and every sector. Women were found to be employed in those occupations of a sector where wages are low, work-hours are long and prospects of occupational mobility are very slim.

A review of the available female employment situation presents a gloomy picture. Though there is no bar in the employment of women in the public offices the percentage of women employed is much below the target. There are some factors affecting female employment in our society. These are -----

2.3.a Socio cultural conventions:

The generally negative attitude of men is perhaps the main obstacle. Whether they are family members, employees, fellow employees, or subordinates, family members (especially husbands) are usually unsettled by any degree of female economic independence, and thus often actively discourage it. Furthermore, the fear that she may not be able to fulfill her domestic roles of wife and mother properly leads many husband to oppose outside work for this spouses.

2.3.b Lack of congenial work atmosphere:

A healthy and congenital work atmosphere is not only necessary for better productivity but is also a pre-requisite for occupational safety. In mast factories and offices women often do not have separate rest-rooms, toilets and dining places to protect their privacy.

2.3.c Transport and accommodation problem:

Housing accommodation for women employee, especially for single unmarried or divorced women is a major problem. Landlords are often reluctant to rent out accommodation to single women. Lack of transport is another problem. Buses are overcrowded and rickshaws are too expensive.

2.3.d Lack of child care facilities:

The lack of baby care centers is also hindering female participation in the labor force. The establishment day care center is an essential pre-requisite for women to take up employment outside home.

2.3.e Differential wage rates for women:

In the organized service sector there may not be any wage rate difference between the male and female employees, but in the agricultural and industrial sectors sex-discrimination in matters of wages is more marked. Low salary/wage is certainly a hindrance to women employment, but women do accept such jobs only under compelling economic situations. Female employment in garment factories is an example of such female exploitation which needs a through probing.

2.4 Educational Status of Women

Education is a fundamental right of the people and a major constitutional obligation of the State and Government. It is a vehicle of social transformation. Since independence in 1971, the Government of Bangladesh has given high priority to the principal of Universal Primary Education (UPE) and literacy. However, effective measures to enhance female education actually started with the third Five year plan (1985-90).

The Fourth- Five year plan (1990-95) has identified 11 objects on the basis of the fundamental principle of "education for all by year 2000." Including the main objective of compulsory primary education these are mainly concerned with the development of technical and science education and increase of physical facilities. Out of these only one objective is specially addressed to women and that is to "ensure women's participation in each field of education. Women of all age groups lag behind men in literacy. The following table will show the difference.

Table 2.4: Educational Status of Women

URBAN

Gender	1961	1974 URBN	1981	1991	2001
Both Sexes	38.7	37.7	34.8	40.3	51.2
Male	47.7	45.3	42.3	46.2	55.4
Female	26.1	27.9	25.5	33.3	46.3

RURAL

Both Sexes	16.5	18.5	17.0	21.2	32.7
Male	24.6	25.7	22.6	25.8	35.5
Female	7.8	10.8	11.2	16.3	29.7

Source: Bangladesh Population Census 2001 (p.73)

Table 2.5: Literacy Rate (%) Age 7+ by Sex 1999-2006

	2006	1999
Both	52.5	48.2
Male	55.8	53.7
Female	49.1	39.0

Source: Report on SVRS 2004, BBS Dec. 2006

The level of women's literacy is more acute in rural areas. Rural parents give various reasons for keeping their daughters out of school viz fear of too much freedom; lack of birth certificate which is often required for school attendance; the need for girl's household or agricultural labor, a preference for investing limited resources in their son's education with a view to parental support in old age (UN: the world women 1995).

Forty-seven percent of the adult population of Bangladesh is illiterate and two-thirds of them are women The enrolment rate at the primary level is on the increase but 20% of primary school-age children (6-11) do not enroll in school at all (ADB 1997; BBS, 1997a) During 1985-90 female enrolment at the primary level has been 40%-45% range of total primary enrolment with an exception in 1987 (49%). At the secondary level female enrolment rate in 1990 is about 34% of the total enrolment. Female participation rate in employment is increasing faster than that for males. But the rate has to increase much faster. The most important factor that may contribute to create such a situation in female employment is widening women's access to education.

Although women earn lot of foreign exchange of the country through their labor the rate of employment of women, as we have discussed earlier, in the industrial, agricultural, technical and even in educational sectors is much less than that of men. Very few women are placed in higher level of occupation. To improve this situation what we must have to do are as follows:

1) Female entry and retention into primary education needs to be ensured.

2) Adequate number of skill centers should be set up to deliver vocational training to women.

3) Science education should be made relevant.

4) More female teachers should be recruited as they serve as role models to the new generation.

5) Above all commitment to reducing gender gaps in all respects.

2.5 Health and Fertility Status

Females are more disadvantaged than males in Bangladesh in terms of health and nutrition. The low status of women, their ignorance, poverty, the system of purdah and the traditional image of women as self sacrificing, and women's belief system prevent them from receiving the services of modern medicine under modern treatment, they simultaneously follow traditional practices. Many well educated women also visit faith-healers and practitioners of magic. With these types of superstitious beliefs and fatalistic attitudes, women's health behavior is thus interwoven with their values and traditions. Any attempt to improve women's health condition must investigate all these above mentioned issues.

Women's health problem arise due to early mating, a continuous cycle of pregnancy and lactation, and inadequate diet. Health risks also arise because while a young girl is growing, her body is still going through hormonal changes which control her development. Pregnancy may affect this process and stunt her growth. It is therefore, not unusual that pregnancy and childbirth or miscarriages and abortion are the major factors responsible for higher female mortality.

The following statistics about women's health will help to understand the real situation.

Table 2.6: Crude Birth Rate

Year	National	Urban	Rural
1986	39.4	25.9	35.4
1996	25.6	19.0	27.8
2006	20.6	17.5	21.7

Source: BBS (2007), 2005 Statistical Yearbook of Bangladesh

2.7: Total Fertility Rate

Region	2000	2004
National	2.59	2.51
Rural	2.89	2.67
Urban	1.68	1.91

Source: Report on SVRS, 2004 BBS December 2006.

In a male dominated society of Bangladesh reproductive and sexual health related decision are controlled by men. Most of the time women have to wait for their husband's or in laws decisions to seek health services, even in advanced pregnancy stage and which is a threat for women life as well as children.

It is the general social custom that husbands normally take their meal first, followed by the children, or the husband eats with the children first. Women are habituated to being the last one in the family to have her daily meals. They thus take the least and deprive themselves from nutritious food. This differentiation in terms of poorer and lower calories allocation of food seriously affects the health of women. In the long run, the children born of these nutrition handicapped women either die prematurely or survive with similar nutritional deficiencies. Despite this poor situation, a positive aspect of nutrition practice in Bangladesh is, almost universal breast feeding of babies in both rural and urban areas.

Table 2.8: Maternal Mortality Ratio (per 100 live births)

Year	National	Rural	Urban
2006	3.37	3.75	1.97
2003	3.76	4.02	2.7
2000	3.18	3.29	2.61

Source: Report on SVRS, 2004, BBS December 2006

Though the rate of maternal mortality has gone down over time, it still remains high. In the case of maternal mortality, 13-25 percent of deaths are due to septic abortions, 20 percent due to eclampsia, 5-10 percent of women

die due to postpartum sepsis, and another 5-10 percent of women die due to tetanus. The remaining major causes of female death are bleeding, prolonged labor, and violent deaths. Most of these factors are preventable with proper health care, but the majority of women in Bangladesh have inadequate access to health services (ADB 2001: P7).

Young age and frequent pregnancies are the main factors responsible for high maternal mortality rate. Besides these there are some other factors such as (a) inadequate food intake (b) too short interval between pregnancies (c) traditional beliefs and practices revolving around childbearing (d) absence of routine antenatal and post natal care (e) poor obstetric techniques. (f) lack of communication infrastructure etc.

Table 2.9: Infant Mortality Rate per 1000 live births and by residence

Year	National	Urban	Rural
1996	71	73	70
2000	58	59	57
2006	45	47	43

Source: BBS (2007), 2005 Statistical Yearbook of Bangladesh. Report on SVRS, 2004, BBS December. 2006

Factors influencing the health of mothers and children are same. Therefore, mothers and children deserve special care within health sector programs. MCH, including family planning, is one of the essential elements of Primary Health care and thus forms a key part of the strategies to achieve health for all by the year 2000.

Unfortunately, in Bangladesh little has been achieved in terms of appropriate involvement of women officials in the planning or decision making level of the health sector. Poverty, illiteracy, and gender discrimination combined with violence within and outside home contribute to the adverse effect on women's health.

Women's poor status of health is interwoven with the country's socio-cultural context. Starting from birth women become victim of sex biased parental treatment. However, a comparative look at the statistics of the past few

decades show that there has been some improvement in maternal mortality rate, post neonatal mortality rate and such others. Fertility rate has also decreased. Contraceptive prevalence rate has increased.

Table 2.10: Contraceptive Prevalence Rate by Residence, 1999-2003

Year	National	Rural	Urban
1975	7.7	-	-
1990SVR	39.2	38.6	46.8
2003SVRS	55.1	52.2	60.4

Source: BBS 2005 P.648

All of these are the results of international program launched by the government which has currently been multi-sectoral in approach. Education and employment are regarded as effective interventions in controlling population explosion and improving health. Therefore, health education programs, effective supervision and monitoring of health programs along with provision of more health centers and health care facilities are highlighted for sustaining this improvement.

2.6 Legal Status of Women

The legal status of women in Bangladesh is governed by the constitution, civil laws and the family laws of all religious groups. Women's status in this area is most interesting as the constitutional provisions are in perfect mismatch with social reality.

Secularism was one of the four fundamental principles of State policy enriched in the Constitution of Bangladesh, which was written within a year of the country's liberation. The constitution grants equal rights to women in all spheres of life. It embodies the fundamental rights relating to women in Articles 28 and 29 as follows; (i) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth"; and (ii) "Women shall have equal rights with men in all spheres of the State and of public life." Section 29 stipulates: "No citizen shall, on grounds of -- sex -- be ineligible for, or discriminated against in respect of, any employment or office

in service of the Republics". Article 122 of the constitution guarantees the right of voting to men and women.

Thus the constitution of Bangladesh upholds the principle of equality between men and women and forbids discrimination against women. Women have the right to vote according to Article 122. While the constitution ensures equality of the sexes, it also acknowledges an unequal status by reserving the right of making special provisions in favor of women. Power given under the constitution enabled the creation of 15 reserved seats for women in Parliament, which was subsequently increased to 30 in 1979. This quota was valid for 15 years and expired in 1987. A similar provision for local government was made in 1977 and is still in effect. In fact, the right to vote does not automatically ensure the right to be a candidate for office. Such participation depends on the good will of the party to which one belongs. This difference is acknowledged in the constitution by its reservation of seats for women. In terms of political reality, women members of Parliament could not make an effective impact on the political scene.

Labor laws provide many benefits for women: women are entitled to maternity leave six weeks before and six weeks after delivery, employees are obligated to provide child care facilities where more than 50 women are employed, and women are exempt from right work in factories and from being made to work overtime. However, in reality, women enjoy few of the benefits. A striking example is the garment factories where women workers, mostly employed on casual or temporary basis, are forced to work overtime.

Gender discrimination is most prominent in inheritance of property, marriage, divorce and guardianship rights. A daughter gets half of what her brother inherits from father. A man is permitted limited polygamy under Islamic law if he treats his wives equally. The Muslim law Ordinance of 1961 restricted this by imposing seeking permission from first wife. Although violation of this rule is punishable men do marry without getting wife's consent in the real sense. Women are also unequal with men in right to divorce as they need to produce marriage document with a clause stating right to divorce if they want to divorce their husbands. For men such rule does not apply. The Hindu woman in Bangladesh is no better. They live their lives to serve men and enjoy little right to father's property.

Although the Dowry Prohibition Act of 1980 made the taking and giving of a dowry an offence punishable by fine and imprisonment, the law has not been effectively enforced. The cruelty to women (Deterrent Punishment) act of 1983 repeated the prohibition of certain offenses already prohibited previously in the Penal Code 1960. It enhanced the punishments and tied them specifically to offenses committed in the content of demand, for dowry, dishonor of women, etc. But the problem lies in the failure to implement the law. This Act of 1983 has not been of any real benefit to women under the existing negative social attitudes towards women. The Government of Bangladesh has enacted women specific legislation more. Among these are: Women and children Repression Prevention Act 1995 amended in 2000, to protect women and children against any type of violence. Acid Crime oppression Act 2002 and the Acid control Act 2002 for death penalty of acid attack of perpetrators.

The Bangladesh State is also a signatory to various international instruments, resolutions and in recognition of and designed to secure gender equality. These include the Universal Declaration of Human Rights (UDHR), The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the ILO Convention on Women Workers, the CRC, and the International Convention on Population and Development (ICPD). The government is also committed to reaching the goals of the MDG's.

CEDAW: Bangladesh has ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The government has withdrawn reservations about some provisions of CEDAW, relating to personal rights such as family benefits and guardianship of children. The withdrawn reservations of Bangladesh pertain to Article 13(a) and Article 16(b) of the Convention. However in 2000 Bangladesh has ratified the new Optional Protocol that is intended to promote implementation of the Convention and strengthen its impact. The Optional Protocol provides for an international complaints procedure on violations of the Convention (as is available under other international human rights conventions).

The national policy for the advancement of women

The main goals of the policy are as follows:

. Establish equality between men and women in all spheres;

. Eliminate all forms of discrimination against women and girls;

. Establish women human rights;

. Develop women as human resource;

. Recognize women's contribution in social and economic spheres;

. Eliminate poverty among women;

. Establish equality between men and women in administration, politics, education, games, sports and all other socio-economic spheres;

. Eliminate all forms of oppression against women and girls;

. Ensure empowerment of women in the fields of politics, administration and the economy;

.Develop appropriate technology for women;

. Ensure adequate health and shelter to women;

. Provide housing and shelter to women;

. Create positive images of women in the media; and

. Take special measures for women in disadvantaged situations.

2.7 Status in Decision Making

In a patriarchal society like Bangladesh, women are dominated by men and men take the decision at home in every matters. Although they often consult wives but the final decision always lies with them. At the government level, women's status in decision making is worse. To ensure women's equal access to and full participation in power structures and decision making process, equal representation of women in the Parliament and other elected bodies is essential.

Although nearly 50 percent of the population of Bangladesh is women and women hold the position of the Prime Minister and the Leader of the Opposition, the status of women in decision making process is marginal. Woman participant as candidates in elections has increased both in parliament and at the local government level, but very few have been elected as a mainstream politician.

In the Parliamentary democracy of Bangladesh, the cabinet of Ministers and the Parliament are the highest and most powerful decision-making authority. Besides, bureaucracy play very important role as political government has to depend on the bureaucracy for the technical know-how and professional skill. The number of reserved seats was 30 in 1979 and onwards increased to 45 in 2001 and same in 2008.

Table 2.11: Population Participation in national assembly, 1973-2008

Year	Elected in General seats women	Men	No. of women "elected" in reserved seats
1973	-	300	15
1979	1	299	30
1986	5	295	30
1988	-	-	30
1991	4	296	30
1996	11	289	30
2001	6	294	45
2008	17	277	45

Source: NCBP October 2009. P.61

In recent years, an increasing trend in women's participation in the electoral process is being observed. At the local government level, in the last Union Parishad election which provided for direct election of women to one quarter of the seats at the local level, 12,828 women were elected. In addition, 20 women have been elected as chairpersons of their Union Parishad out of a total of 4276 and 110 women have been elected in the general seats. In four city corporations, there are 38 women commissioners in the reserved seats. (Khan 2003:39).

Table 2.12: Women and Men participation in the Ministerial level

Period	Women	Percentage	Men	Percentage
	No.	%	No.	%
1996-01	3	8	33	92
2001-02	3	5	57	95
2001-06	4	3	57	95
2008	6		39	94

Source: Statistical Profile of Women in Bangladesh, 2002 p.189

The presentation of women in the councils of ministers and state ministers gradually increased over the years but remained marginal and limited to unimportant portfolio until 2008. At present three very important portfolios of Home, Foreign Affairs and Agriculture are held by women and for the first time the Deputy Leader of the House is also woman.

In 2006, out of 4492 officers only 676 (18%) were women. The percentage of women in the rank of secretary was 1.56% and there was no woman in the rank of additional secretary. The percentage of women as joint secretary constituted 6.87%, deputy secretary 11.69%, senior assistant secretary 15.68% and assistant secretary 22.74%. (NCBP 2009:62)

Although there are few women in leadership positions there is limited involvement in party hierarchical structures. The Awami League and Bangladesh Nationalist Party (BNP) have the highest proportion of women in decision-making structures. Twenty three percent of the members of the Awami League's Presidium are female, while 9.2 percent are on the executive committee. The BNP has 14.7 percent women on its executive committee. Both the Awami League and the BNP have included women's issues on their agendas and aim for gender equality. The third largest party, the Jatiyo Party also supports equal rights for men and women. On the other hand, the Jamat-e-Islam and the Communist Party of Bangladesh, have no women in their top leadership (Huq 2000). Although Bangladesh has many political parties, only 16 parties had women as candidates for the 2001 Parliament election. According to Bar Council Report-2008, the total number of Lawyers in Supreme Court was 1780 of them 13.1% were women and 86.9% were men (NCBP 2009:62).

The importance of women's participation in the political process should be recognized by the Government and the political parties. Women's perception of their political role could be enhanced through education, training, awareness, advocacy, employment and legal measures. Mass media and other agencies can be used to help motivate women.

CHAPTER THREE

LITERATURE REVIEW

3.1 Review of the relevant literature

Roushan Jahan "Hidden Danger: Women and Family Violence in Bangladesh", 1994

Roushan Jahan in her "Hidden Danger: Women and Family Violence in Bangladesh" analyzed the gender-specific problem and their solutions. Violence is a serious social problem, especially gender-violence. According to her, to reduce gender-violence family violence needs to be addressed seriously. As family is the basic social unit and the primary training ground for socialization of individual, any serious attempts to reduce a grave and enduring social problem such as gender violence must begin at the family level.

Gender violence in the family in Bangladesh mirrors the prevailing pattern of gender-violence outside the home. "Gender inequality is deeply embedded in the structure of the patriarchal society of Bangladesh. Male dominance and female subordination are basic tenets to our social structure. All Bangladeshi social institutions permit, even encourage, the demonstration of the unequal power relation between the sexes and try to perpetuate the interests of patriarchy (Jahan 1994:4-5). As gender-violence is the subject of the study, gender-inequality is emphasized here as the principal cause of violence. However it is recognized that this is not the only inequality leading to violence in Bangladesh society. The statistics of gender-violence shows that while men, as the dominant group in relation to women, seldom suffer gender-violence (Jahan 1994:11). This indicates that men hold the power in every sector, especially in the reproductive sector.

This study shows that the success of the attempts designed to reduce violence in Bangladesh has been very limited. The implication of the limited success is extremely grave. We have seen that a majority of the Bangladeshi women have to suffer from the double load of patriarchy and poverty which reduce their lives to a state of acute deprivation. In view of this, some immediate

measures and strategies are suggested: (1) Laws have to be changed where necessary. Wife battering and marital rape will have to be given legal recognition as criminal offence. (2) Serious consideration should be given to the promulgation of a uniform family code, as proposed by Mahila Parishad and supported by various women's organizations. (3) Research and documentation should be encouraged and undertaken.

Alia Ahmed "Women and Fertility in Bangladesh", 1991

Alia Ahmed in her Women and Fertility in Bangladesh discussed the relationship between the status of women and fertility behavior. According to the author of this pioneering study, high fertility in Bangladesh is often explained in terms of either a high demand for children or the lack of knowledge about birth control methods. There is a gap in our knowledge about the way in which socio-cultural factors vis-à-vis the economic structure and government policies affect the economic status of women which is in turn of relevance to fertility behavior. This book mainly studies these relationships.

She has maintained that suitable policies aimed at ameliorating the socio-economic conditions of women in Bangladesh can have a direct impact on reducing fertility rates. However, there is little available data about the manner in which aspects of status are related to fertility and how status itself is affected by various factors. Based on in-depth interviews with cross-section of women, this book explores the links between the status of women and high fertility in Bangladesh.

The author first has identified those aspects of the status of women in Bangladesh which are directly related to fertility and develops an analytical framework to study this linkage. She has demonstrated how social institutions interact with the economic structure to perpetuate insecurity among the majority of women, especially when the government is unable to bring about socio-economic change.

The author has presented the results of her intensive investigations at the micro level. Based on this data, she has concluded that a stagnant economy essentially reinforces social institutions which determinate against women. She found that high fertility among poor women was the result not only of a lack of motivation, but also for uncertainty to control family size, preference

on son, costs associated with modern contraceptives. She also found that the size of family could be reduced even among the poor if women are assured of a stable income and have a greater say in shaping their lives. Though this book deals specifically with Bangladesh, it will greatly assist an understanding of the lot of women throughout the Third World.

Mohammed A. Mabud "Women's Development Income and Fertility", 1985

Mohammed A. Mabud in his "Women's Development Income and Fertility" has presented a relationship between women's trade skills and income, and also between income and women's status and reproductive behavior in rural Bangladesh. In seeking answers of two basic questions (what impact does a vocational training program have on the women being trained in the program with respect to their income, contraceptive and reproductive behavior? Has such a program any impact upon the contraceptive and reproductive behavior of the untrained village women?) This study has utilized the 1979 follow-up data concerning 520 trained (directly exposed), 655 program (indirectly exposed) and 312 non-program (unexposed) women.

The program is based on the assumption that the women, especially in the rural areas of the developing countries want to work outside home, provided opportunity is available to them. In this context, it is also thought that works outside home may have some liberating effect as it gives them some money to spend at will; bring them some knowledge of the outside world; and improve their self-image. These, in turn, would result in changing opinions on marital timing and a greater say in decision-making in the family with ultimate consequence of achieving a small family norm.

In Chapter 2, that is, Constraints to Women's Social Change the author have discussed the problem in the context of social, cultural and economic factors affecting women's social change and reproductive behavior. He has presented some constraints (like socio-cultural and economic) in the discussion of women's social change and reproductive behavior. According to him due to various socio-cultural and economic constraints women's status cannot improve. These are the following constraints--- (1) lack of women's organization is a serious obstacle to their social change (2) parental motivation that is son provides greater social and economic security than a daughter

creates a great literacy difference between men and women so that women are bound to depend on men (3) the social powerlessness of wives is also considered as a constraints (4) girls liberty to chose her spouse is limited. Parents play the key role in determining marriage partner (5) the laws of inheritance is also not favorable to women.

In the foregoing discussion, the problem identified is that in the less-developed countries, high fertility seems to co-exist with women's lack of employment, early marriage, social barriers to free mobility, and lack of both education and access to child health and family planning services. Lack of contextual knowledge in developing a comprehensive situation, which is impending the process of social and economic development, poses a serious obstacle to women's social change.

After analyzing the findings the author suggests three kinds of policies - social, economic and demographic. These policies have both fertility reducing potentials and scope for the rural women's welfare. (a) Social: In order to bring changes, the desirable step is to recognize women as equal to men. In order to ensure equality, the government should pursue an education policy which will ensure an equitable per capita increase in educational funds for both boys and girls from primary to secondary level to minimize dependence on parental support in this critical period (Mabud 1985:155) There is also a need for rural based national, regional and local level women's organizations to help socially depressed women, and to organize the rural women into a cohesive social group.

(b)Economic: In Bangladesh agriculture is the main industry and it will expand further. This sector can, in large scale, absorb rural women, literate and illiterate as compared to other sectors of the economy. This will provide home-based income-earning opportunities. According to the author, increasing women's income-earning opportunities will increase their spatial mobility and decrease the prevailing "seclusion" or "purdha" system.

(c) Demographic: The author suggests that for the decline in fertility, infant and maternal mortality, the Government of Bangladesh should pursue a policy discouraging early age at marriage for girls until age 20 (Mabud 1985:20).

Finally, the author recommend that, fertility decline program cannot be successfully overcome by only family planning program as long as income earning opportunities are one-sidedly oriented to men and do not take women into account.

Taslima Monsoor, "From Patriarchy to Gender Equity", 1999

Taslima Monsoor in her book "From Patriarchy to Gender Equity" has argued that the actual need of women in Bangladesh concerns protection from economic deprivation and violence. Bangladeshi women are not demanding the same as Western women, i.e. sexual equality, freedom and liberation as an individual. Rather they see their roles within social contexts and would prefer gender equity within the traditional framework. What they really want is not equality but freedom from violence and economic deprivation imposed by men (Monsoor 1999:2). Thus the main theme of the book is that women in Bangladesh need to be protected from economic deprivation and violence. These needs of women have not been adequately reflected in the legislation or judicial decisions. The author's analysis of the recent legal developments in Bangladeshi family law stresses that the real needs of women have not been given enough priority in the family law.

Kathleen Kelly Reardon "They Don't Get It, Do They?"1995

She focused about the communication gap between men and women in their working place. She identified the everyday interactions between women and men that, rather than bringing them closer to understanding, actually further separate them from each other. According to her, it's not discrimination, but in the enduring nature of dysfunctional communication patterns and the stereotypes that causes the gap between them in their working place.

Shanti Jayasuriya and D.C. Jayasuriya "Women and Demelopment- The Road From Beiging" 1999

They dealt with certain key international conventions or declarations of social significance such as The Fourth World Conference on Women. In Introductory chapter they traces the genesis of the relationship between empowerment and 'quality of life'; looks at the human rights culture to promote the status of women; summarizes the salient features of the Cairo

Conference on Population and Development where reproductive health and reproductive rights were accorded recognition. According to them there is no single magic wand to wave to improve the status of women (Jayasuria 1999:12). Decade of research, particularly since the Bucharest Conference, exemplify that there is no single approach or strategy that can bring about a significant elevation in the status of women. They thought the Beijing Conference provided an opportunity to examine what needs to be done to enable women and girls to improve their quality of life.

Mira Seth 'Women and Development The Indian Experience', 2001

Mira Seth discussed about the roots of women's development issues. In doing so, she has given a picture of the efforts made to accelerate women's development since Independence. The effort of development has been both in the social and economic spheres although it is clear that more emphasis has been placed on improving women's social status. When she asses this situation one basic and glaring cultural norm stares her and that is the continuing preference for a son over the birth of a girl child. This preference has been stronger than ever before and is present in all communities and classes.

She has also explained that there is a great difference between legislative rights and actual practice. According to her, though legal measures create an enabling atmosphere they have not been successful in giving women better empowerment and they are also definitely not the most important remedy for every social disease.

Nasra M. Shah "Fertility of Working Vs Non-Working Women in Pakistan", 1973

In this paper the author analyzed the rates and structure of female labor force participation in 1973 and fertility differentials between working and non-working women. In order to understand better the differentials between working and non-working women, data on the occupations that the women were engaged in, their employment status and their age and educational structure were also analyzed. It is found that the fertility of employed women is slightly lower than the fertility of non-working women. But the reason is not only employment itself according to the author. There are some hidden

reasons behind it such as: education, family structure, marital status etc. which also influences fertility. The study is, therefore, limited in the respect that it analyzes only the 'gross' relationship work participation and fertility.

Nasra M. Shah 'Female Labor Force Participation and Fertility Desire in Pakistan: An Empirical Investigation', 1975

While investigating the relationship between female labor force participation and fertility desires in Pakistan, the author found a weak bi-variate relationship between the two variables

Rafiqul Huda Choudhury, 'Female Status and Fertility Behavior in a Metropolitan Urban Area of Bangladesh', 1979

In this study an attempt is made to examine the relationship of certain aspects of status of married women such as employment status, education status and family decision-making power with the use of contraception and fertility behavior. Precisely the author wanted to determine the independent effects of these three variables on fertility behavior.

Of the three variables studied here education is found to be the strongest correlate of the use of contraception and fertility. Using the data of the present study, it is found that the higher educated respondents started using contraception right after marriage or the first birth but the respondents of the lower educational background used contraception only to prevent higher order births. Education is also found to be associated with longer spacing. Conjugal role relationship stands out as the second most important variable influencing contraception practice and fertility. Work experience has very little or no effect on the use of contraception and fertility behavior particularly among higher educated groups. But among the lower educated group, work experience effected fertility.

Mayone J. Stycos, and Robert H. Weller, 'Female Working Roles and Fertility', 1967

Using survey data in Turkey in 1963, the relationship between female employment and fertility is examined. Controlling for urban-rural residence, education and exposure to conception within marriage, no differences in

fertility by labor force status appear. Although there is a slightly greater tendency for employed than for non-employed women to hold attitudes more favorable to small families and family size limitation, the observed differences are slight and not significant statistically.

In short, only as the female working role approaches incompatibility with the wife and mother role does the relation between fertility and employment emerge. They conclude that the type of jobs the Turkish women were involved in were compatible with the mother-role and hence did not act as a deterrent to fertility.

Robert H. Weller, The Employment of Wives, Role Incompatibility and Fertility: A Study among Lower and Middle Class Residents of San Juan Peurto Rico', 1968

Weller, in his study, showed that the greater the incompatibility between the roles of mother and worker the greater were the fertility differentials between working and non-working women.

United Nations (UN), Status of Women and Family Planning. 1975

Female participation in the labor force has often been suggested as a means of reducing fertility. This suggestion is based on the assumption that working outside the home provides women alternative satisfactions to children. But it is confirmed only in the industrialized countries. There is no such uniform pattern in the case of less developed countries.

According to UN female labor force participation will not per se result in lower fertility unless there is greater incompatibility between the roles of mother and worker. It is absolutely true in the case of our society. Moreover, according to Huda, it is not only the labor force participation but a series of other variables associated with labor force participation (such as age at marriage, longer period of schooling etc.) which affect fertility level. He added that the lower fertility of the working women is also sometimes attributed to their sub-fecund status. According to Fredman, sub-fecundity is usually found to be higher among the working women.

S. C. Gulati and Rama Patnaik, "Women's Status and Reproductive Health Rights', 1996

This major study highlights intricately connected issues of socio-economic status and reproductive health rights of women in the four selected urban slums of Delhi Metropolis. It also highlights gender discrimination against girl children during their infancy, childhood and adolescence and also shows how this discrimination affects women's physical, mental and reproductive health and their income-generating abilities and thus their socio-economic status in the society in the long run.

Lack of education amongst women, having direct and significant effect on family planning program and thus fertility, is still not been effectively tackled right here in Delhi Slums. In this Study 74% of the women reported that it is their husbands or other relations in the family like mother-in-law or other members in the in-laws family decide about the size of her family. Very few women had the say or control in deciding the family size. 90 percent of women reported that their husbands had the major decision making power regarding the contraceptive methods used by them (Gulati 1996).

Women should have right on her fertility and contraception behavior. But her inferior economic status, derogatory social customs and feudal mindset were the major hurdles denying her the access of these rights. Reproductive health rights should be viewed in context of human rights and not merely related to maternity relief and welfare.

Edited by Richard Anker, Mayra Buvnic amd Nadia H. Youssef, Women's Roles and Population Trends in the Third World, 1982

Women's independent income has, certainly, some effects on their reproductive right. But there are some intervening factors variables between these two demographic variables such as: female power. Constantina Saffilios Rothschild examine female power relates to female status as well as to fertility. In developing her model, she distinguishes between two main types of power—power which is derived from men (which only allows women to have control over other women, over children or over young men, but not over their own lives or over adult men) and power which is derived independently of men (and which may result in autonomy). She also indicates how fertility

fits into her framework, hypothesizing that reproductive power becomes less important for women the more they have the other secure power bases. Thus, as women feel socially , economically and psychologically secure in economically productive activities they may become motivated to use birth control in order to have as many children as they enjoy rather than as many as they need (Anker ed. 1982)

Salma Khan, "The Fifty Percent" Women in Development and Policy in Bangladesh, 1988

She reviews the status and role of women in development in Bangladesh which reveals a general exclusion of women from development activities. Considering the fact that despite being in an extremely unfavorable situation, women contribute a great deal to the economy. According to the author, the experience of developed countries indicate that with increased education and labor force participation of women, a change in the reproductive role of women occurs to create a positive impact on the demographic pattern. Bangladesh also recognizes the fact that achievement of demographic goal is contingent upon the socio-economic status of women.

The experience of Grameen Bank also reveals that income earning opportunities contributed to a reduction of population growth. Nearly 80% of the Grameen Bank loanees are women. Hossain showed that nearly one-fourth of the eligible couples adopt family planning and 7.3 percent have adopted permanent methods (Khan 1988:126).

M. Afsaruddin, "Immortal Trafficking with Reference to Prostitution of Bangladesh, 1985

Greater investment on female education has a direct bearing on demographic dynamics and age specific fertility rate. From a number of studies it is found that there is a direct correlation between education level and family planning as well as age of marriage. The Planning Commission data demonstrate that the mean age at first marriage among the group having schooling beyond the secondary level of education increased to 16.5 years from 15.3 years among the groups having below secondary level of schooling.

Rafiqul Huda Chaudhury, "Female Labor Force Status and Fertility Behavior in Bangladesh: Search for Policy Interventions, 1983

In this study, an attempt is made only to examine the dynamics of the relationship between female labor force status and fertility behavior and also to evaluate the implications of the relationship for reduction of fertility in developing countries, particularly Bangladesh. Based on some assumptions, it is hypothesized that female participation in labor force will be inversely related to fertility and positively related to the use of contraception.

In doing so, they provide a review of the existing state of knowledge on the effect of mother's work on fertility behavior from Bangladesh and from neighboring countries like China.

According to the author, the current theory regarding labor force participation and fertility that female labor force participation will not result in lower fertility *per se* unless there is greater incompatibility between the roles of mother and worker. Role conflicts is more among women working in urban areas, particularly in big industrial centers and metropolitan areas than among those women who work in the traditional sector of the economy like cottage industries, trading in village market and family farm in rural areas. Because in rural areas, women are mainly engaged in farm work and traditional economic activities and they have the support to look after their child in their absence. In urban areas, this kind of support is not available. In view of this discussion, one may tend to hypothesize that there would be an inverse relationship between work status and fertility in the modern sector of economy but the relationship may be either positive or non-existent in case of participation in traditional sector of economy.

According to Huda, the involvement of women in productive activities will not only help them to improve their family and personal income but will also induce them to limit family size through wider use of contraceptives. The author also discussed about the indirect effects of employment on fertility. Interest and commitment to work, work experience and increasing age at marriage indirectly affect women's fertility.

In the end, the author opined that providing employment opportunities to rural poor women even in the traditional sector will not only prove their personal

and family income but also motivate them to limit their fertility through wider use of contraception.

S. Mahmud et al. 'The Impact of Women's Income Earning Activities on Status and Fertility', 1990

The focus of this study is to investigate the impact of employment on fertility through enhancement of women's domestic status. Four types of pictures has been focused in this study, these are as follows: 1. Demographic and Socio-economic Profile of Working and Non Working Women. 2. Socio-demographic and Employment Characteristics of Currently Married Rural Women. 3. Differentials in fertility behavior and desires between working and non-working women. 4. Relationship between employment status and fertility.

The results have shown that employment which produces a cash income can effectively lead to a restructuring of existing gender roles and a reduction of gender-based inequalities. The consequences of such a restructuring are an enhanced participation by women in household decision-making and an increased control over income and how it is spent. Women's enhanced participation in household decision-making could lead to a more balanced distribution of resources among household members. There is also evidence that when women are able to spend their own income, there is greater expenditure on food, clothing, medicine and shelter indicating an overall an improvement in the quality of life of all household members.

Rafiqul Huda Chaudhury, 'Attitudes of Some Elites Towards Introduction of Abortion as a Method of Family Planning in Bangladesh', 1975

The present analysis is delimited to discern the attitude of the elites towards introduction of abortion as a method of family planning by different variables such as: age, education, education of spouse, education of father, social mobility status, income, residential background and occupation of the respondents.

In the case of income, it is hypothesized that income would be positively associated with attitude towards abortion. This hypothesis is based on the assumption that higher income elites are possibly used to maintaining a certain

consumptions standard and this consumption norms are likely to be threatened if they have more children. Therefore, the elites of higher income group are expected to advocate for more effective methods of fertility regulation such as abortion. Moreover, knowledge and attitude towards family planning and practice of contraception is usually high among the higher income groups. Therefore, one can also expect higher endorsement for abortion among the higher income groups. The study findings proved the hypothesis true -that is- it shows a positive relationship between income and endorsement for abortion as a method of family planning.

Rafiqul Huda Chaudhury, Nilufer Raihan Ahmen, "Female Status and Fertility Behavior in Bangladesh"

In this study, the authors have examined the status of women with respect to law, education, employment, marriage, fertility and mortality. They have also examined the relationship between certain aspects of female status on the one hand and fertility and use of contraception on the other. According to them, the status of women is an important factor affecting the socio-economic development of a country. The long term socio-economic development of a country cannot be fully realized if women enjoy sub-ordination position to men. Therefore women must have the same rights as those enjoyed by men, irrespective of the fact whether it leads to economic development and/or reduction in fertility of a society.

O. Andrew Collver, Women's Work Participation and Fertility in Metropolitan Areas, 1968

This report examined the hypothesis that a high rate of participation of women in the labor force tends to reduce births rates in a community. Among metropolitan areas in eight countries about 1950 the proportion of women working was negatively correlated with the child-women ratio. This relationship held even when the percentage of women married was controlled by partial correlation. Among metropolitan areas of the United States in 1960, women's work participation was negatively associated with various measures of fertility. This was true for eight categories of women grouped by color and age. On the whole, the correlations for non-whites were lower than those for whites and fell into a somewhat different pattern. The evidence examined is

consistent with the hypothesis, but the nature of the casual connection between work participation and fertility is not directly demonstrated.

According to the author, work participation depresses (if any) the child-women ratio in two ways. Firstly, it may reduce the proportion of women married. Probably single women are attracted to areas where jobs are abundant. Moreover, some kinds of work tend to segregate women from eligible men, both on and off the job. And, finally, work is, to some extent, an alternative to marriage. The second way is by reducing the fertility of married women. Working women develop outside interests and contacts that compete with those of the family. They bring in earnings which would be cut off at least temporarily by the birth of a child. They develop high standards of consumption because of this additional income, and are reluctant to reduce their standard of living by having large families. Such influences would tend to reduce the fertility of working wives. So it can be said from the above discussion, that work participation affected fertility through both marriage and marital fertility. Up to this point, the author added another influential variable that is income or education.

In short, the author tried to say that in this kind of analysis, it is very important to take important variables (income or education for this study) into account.

Sidney Goldstein, The Influence of Labor Force Participation and Education in Thailand, 1972

Thailand's high fertility and low mortality levels place it among the fastest growing countries in the world. Utilizing special sample tabulations from the 1960 Thai census on children ever born, this analysis has explored the extent to which higher rates of female participation in the labor force and higher levels of literacy and education have negative effects on fertility. In doing so, both age of mother and rural-urban residence has been controlled.

The analysis points to a differential relation between labor force participation and fertility in rural, agricultural places and in the urban centre of Bangkok. In the urban area, fertility of women in the labor force is lower than that of rural area. This pattern suggests that the greater separation of work and family roles among employed women in the urban centre lowers the fertility of urban

working women, whereas the general absence of such conflict in rural society results in a minimum effect of labor force participation on fertility. Occupational differentials and literacy also affects fertility. Women engaged in farming have a higher average number of children than those in other occupations groups and the number of children ever born is lower for literate women in both rural and urban residence categories. Up to this point, it can be said from this study that to achieve reduction in fertility, three things should be cleared:(1) high rates of educational enrolment of women, (2) greater participation in the non-agricultural labor force and (3) greater exposure to the urban way of life (Goldstein 1972:419-36).

Jhon D. Kasarda, "Economic Structure and Fertility: A Comperative Analysis" 1971

There is a similarity between Goldstein's analysis of Thailand with Kasarda's analysis based on cross-societal comparisons. Exploring the relationship between economic structure of populations and the level of fertility in some fifty nations, Kasarda's analysis pointed to a strong negative association between fertility and the percentage of females employed for wages or salaries.

Mukherjee, B. N., "The Status of Married Women in Haryana, Tamilnadu, and Meghalaya", 1974

Mukherjee found no significant correlation between women's employment status and their role in household decision-making in three states in India. Of the 150 unskilled women laborers on nine major construction site in Delhi, almost all of whom earned as much income as their husbands, only 8% stated that they participated in decisions regarding education and marriage of their children, selection of jobs, etc (Mukherjee 1974:198).

Nadia H. Youssef, "The Interrelationship between the Division of Labor in the Household, Women's Roles and Their Impact on Fertility", 1982

After reviewing previous studies on the relationship between female labor force participation and fertility, Nadia H. Youssef concluded that the evidence to date on this relationship is inconclusive. Sometimes it is found positive, sometimes negative and sometimes neutral. She also stresses the need for

more detailed data on female activities than the simple labor force/non-labor force dichotomy. Yousssef related fertility to the sexual division of labor. She pointed out that the more economically active women are, the greater their resource base is like to be. According to her, economic activities become a necessary but not a sufficient condition for female autonomy and power relative to men. The author then discussed how the sexual division of labor is likely to change with economic development, and how these changes affect class structure and the level of agricultural complexity, which in turn help determine the demand for labor and, thus, the economic opportunities available to women.

She has pointed out two very important concepts responsible for decreasing fertility: (1) work commitment and (2) work satisfaction. In urban Greece, women with a high work commitment have fewer children and use birth control more effectively than women with low work commitment; working women who had a low work commitment had about as many children as housewives (Saffolis-Rothschild, 1972a). A woman's job satisfaction is inversely related to fertility because it influences a couple's fertility decisions (Yousef 1982:181). Throughout this discussion, Youssef argued that if researchers are to understand the linkage between work, status and fertility, they need to consider class differences in behavior, values and available work options.

Clearly, there is no causal sequence through which the sexual division of labor and\or different aspects of the role and status of women can separately influence fertility behavior. All interact in a dynamic way with stratification variables to structure requirements and constraints related to reproductive behavior (Youssef 1982:196).

Swapna Mukaapadhyay et al, Poverty, Gender Inequality and Reproductive Choice: Some Findings from a Household Survey in U.P.

This paper seeks to add to the existing knowledge based on the complex linkage between men's and women's reproductive roles and motivations. Their investigations reveal that poverty as measured by per capita household incomes is a strong determinant of fertility behavior. Media exposure, especially exposure to special broadcasts, is another factor that comes out as significantly and positively linked with the use of contraceptives. Child

mortality, predictably, has a deterrent effect on contraceptive use, while higher literacy levels are linked with higher incidence of use.

Simeen Mahmud, Abdur Razzaque and Lutfun Nahar, Women's Empowerment and Reproductive Change in Rural Bangladesh, 2001

In assessing women's empowerment this paper tries to clarify the concept of women's empowerment in the context of Bangladesh and uses multivariate techniques to examine the relationship between women's empowerment and reproductive change in one rural area. It was found that the links between women's access to resources like formal schooling, NGO loans or paid work and women's agency were not always consistent or well established. The results also suggested that the achievement of favorable reproductive outcomes like improved child survival was likely to be influenced by factors that were not directly related to either women's access to resources or their agency role. The lack of a relationship (between empowerment and reproductive change) can be attributed to the fact that there are more powerful forces operating at the household and community levels that shape household livelihood strategies and influence the health care seeking and fertility regulating behavior of individual women.

Asma Begum, Veiws on Women's Subordination and Autonomy: Blumberg Re-visited, 2002

In this article, the author has briefly explained the various components of Blumberg's theory and seeks to highlight the fact that women are discriminated in every society and they are forced by many socio-political and economic factors to lead a sub-human life. According to her, the empowerment of women depends not only on the legal ownership but also on the control over scarce resource. The empowerment of women leads to achievement of an enhanced status of women status, and the achieved status leads to their power of participation in the complex process of decision-making in the male dominated world. The thrust of this article is thus on the fact, that any discussion related to women's problems cannot remain confined within women's affairs only; it must necessarily by viewed in the perspective of the entire family and society.

Roushan Jahan and Mahmuda Islam, "Violence Against Women in Bangladesh Analysis and Action, 1997

According to them, women are vulnerable to exploitation, oppression and all other types of explicit violence from men in the society where cultural norms, tradition and legal system sanction women's subordination to men. They identified some socio-economic and cultural factors which have contributed to the increased vulnerability of women to male violence. These are the following—(1) the unquestioning acceptance of patriarchal gender ideology and gender relations in all the social structures, including family, community and the state. (2) increasing poverty and adverse condition brought about by changing socio-economic process and (3) societies basic reluctance to drastically change patriarchal laws and policies which perpetuate male dominance over women (Jahan and Islam 1997:20-21).

Mónica M. Alzate, "The Role of Sexual and Reproductive Rights in Social Work Practice," 2009.

The understanding and promotion of sexual and reproductive rights are essential in the social work profession, not only to improve the health status of affected populations but to advocate effectively for social justice and to respond to globalized realities. This article highlights the relevance of sexual and reproductive rights in the philosophical foundation and practice of social work, emphasizes the impact of reproductive health and rights on women's lives, and proposes a social work agenda that will embrace and promote sexual and reproductive rights. It uses policy statements from the International Federation of Social Workers as well as a human rights framework focused on sexual and reproductive rights that stems from the global feminist movement.

Reproductive health also includes the rights of men and women to timely and accurate information and to have access to contraceptive methods of their choice and to appropriate prenatal, delivery, and postpartum health care services. Reproductive health care involves all methods, techniques, and services that are needed in matters associated with reproductive health. According to the Fourth World Conference on Women (1995), reproductive health also includes sexual health whose purpose goes beyond counseling

and the treatment of sexually transmitted diseases; it involves the enhancement of life and personal relations. Petchesky (2000), a feminist scholar and activist, argued that the notion of sexual rights entails negative rights (freedom from violence or abuse) and positive rights (the capacity to seek pleasurable experiences in different ways, such as diverse forms of sexual orientation). Sexual rights have not been explicitly recognized by any international treaty; nevertheless, the language of the Program of Action (POA) of the International Conference on Population and Development (ICPD), held in Cairo in 1994, includes the concept of sexual pleasure, and this language may be the starting point for acknowledging these rights (Petchesky, 2000).

Some Sexual and Reproductive Health Concerns-

1. Contraception for individuals, regardless of their marital status and age, including emergency contraception, forced sterilization, or forced contraception.
2. Abortion (surgical or medical) at different stages of gestation among women of all reproductive ages and in countries or jurisdictions where it may be prohibited, highly restricted, or where services do not exist or are difficult to obtain.
3. Diverse sexual orientations as well as family and societal reactions toward disclosure.
4. Assisted reproductive technologies used by heterosexual and homosexual couples and single women.
5. Infertility and its psychological consequences.
6. Sexually transmitted infections (including HIV/AIDS), from prevention to treatment, as well as socio-cultural and economic factors that surround them.
7. The sexuality of individuals who are HIV-positive, issues of disclosure, protection of their partners, and prevention of greater risk.
8. Mother–child transmission of HIV during pregnancy and after delivery.
9. Drug use during pregnancy and lactation.
10. Prosecution of women accused of harming their newborn children during pregnancy with illegal drugs, as well as child custody issues of such women.
11. The sexuality and reproduction of certain populations, such as individuals with disabilities and those who are imprisoned.

legal and political; some are consequences of deeply rooted customs or cultural norms, including religious teachings; and others are a combination of several of these factors. This article will review some of these challenges confronting women and families. In a majority of developing countries, legal barriers restrict women's access to safe abortions. Laws prohibiting abortion for reasons other than to save the life of the woman exist in many countries, but as is well known, such laws do not prevent women from having abortions. They typically prevent women from having *safe* abortions, resulting in significant morbidity and mortality. At least 78,000 women die each year from complications of unsafe abortion and hundreds of thousands of women suffer from long- or short-term disabilities. In low-income countries, about 200 women die each day as a result of unsafe abortions. Unsafe abortions are responsible for 13% of all maternal deaths globally. Each year, an estimated 20 million unsafe abortions are performed worldwide, 95% of which are performed in low-income countries.

H. X. Zhang and C. Locke, Interpretation Reproductive Rights: Institutional Responses to the Agenda in the 1990s; 2004

This article reviews the way in which three very different international organizations concerned with reproductive health policy responded to the reproductive rights agenda during the 1990s. The intention is not to evaluate these responses but to describe how these organizations saw their roles with respect to establishing and promoting reproductive rights in developing countries. The organizations included were the Women's Global Network for Reproductive Rights, the International Federation of Family Planning Associations and the UK's Department for International Development. Their diverse understandings about implementing reproductive rights contribute to a plural political environment in which these rights and their interpretation are debated. For all the three, their particular conception of reproductive rights is an important organizing principle.

If we generalize all the opinions or information about women's reproductive right and income and status given by different authors we will find different views. In short, the different results are the following—(1) Alia Ahmed thought suitable policies can reduce fertility rate (2) M A Mabud thought,

12. Intimate partner violence, including rape within marriage/cohabitation/dating and coercion of women's contraceptive choices.
13. Rape in diverse circumstances, including war, natural disasters, and prostitution, particularly of minors.
14. Sexual trafficking, especially of young immigrants, refugees, and internally displaced populations.
15. Child sexual abuse.
16. Female genital mutilation.
17. Breastfeeding practices.
18. Cervical cancer and breast cancer of both men and women.
19. Chemotherapy and radiation during pregnancy.
20. Pregnancy-related diseases, such as anemia and diabetes (mainly as a result of poverty), as well as pregnancy-related disorders and postpartum depression.
21. Menopause (as a result of age or hysterectomy) and menarche and the physical and psychosocial effects of both.
22. Underage marriage and forced marriages, among others.
23. Each one of the aforementioned situations is suitable for social work interventions with individuals who need direct services, with families who face these situations, and with groups, organizations, institutions, and
24. Legislative bodies that provide, advocate, promote, control, and/or regulate needed services.

Ruth Macklin, Reproductive Rights and Health in the Developing World, quoted in A. W. Galston and C. Z. Peppard (eds.), *Expanding Horizons in Bioethics,* 2005

Women in all parts of the world face obstacles to their ability to exercise reproductive rights and maintain reproductive health. This is true in industrialized, democratic societies as well as in developing countries and those with oppressive political regimes. It is nevertheless true that the obstacles are much worse in those parts of the world in which women are systematically oppressed, have few civil rights, or are in such dire poverty that they are unable to afford preventive and therapeutic services that would otherwise be available to them. Some of the obstacles to women's reproductive rights and health are

legal and political; some are consequences of deeply rooted customs or cultural norms, including religious teachings; and others are a combination of several of these factors. This article will review some of these challenges confronting women and families. In a majority of developing countries, legal barriers restrict women's access to safe abortions. Laws prohibiting abortion for reasons other than to save the life of the woman exist in many countries, but as is well known, such laws do not prevent women from having abortions. They typically prevent women from having *safe* abortions, resulting in significant morbidity and mortality. At least 78,000 women die each year from complications of unsafe abortion and hundreds of thousands of women suffer from long- or short-term disabilities. In low-income countries, about 200 women die each day as a result of unsafe abortions. Unsafe abortions are responsible for 13% of all maternal deaths globally. Each year, an estimated 20 million unsafe abortions are performed worldwide, 95% of which are performed in low-income countries.

H. X. Zhang and C. Locke, Interpretation Reproductive Rights: Institutional Responses to the Agenda in the 1990s; 2004

This article reviews the way in which three very different international organizations concerned with reproductive health policy responded to the reproductive rights agenda during the 1990s. The intention is not to evaluate these responses but to describe how these organizations saw their roles with respect to establishing and promoting reproductive rights in developing countries. The organizations included were the Women's Global Network for Reproductive Rights, the International Federation of Family Planning Associations and the UK's Department for International Development. Their diverse understandings about implementing reproductive rights contribute to a plural political environment in which these rights and their interpretation are debated. For all the three, their particular conception of reproductive rights is an important organizing principle.

If we generalize all the opinions or information about women's reproductive right and income and status given by different authors we will find different views. In short, the different results are the following—(1) Alia Ahmed thought suitable policies can reduce fertility rate (2) M A Mabud thought,

parental motivation (son provides greater security than daughter) should be changed and social powerlessness should be established to established women's reproductive right (3) Mira Seth also asses that son preference is very much common in Indian Society (4) Rafiqul Huda Choudhury found education as most influential variable to affect women's fertility (5) In this context, Sydney Goldstein adds two points more that is greater participation in non-agricultural labor-force and greater exposure to the urban way of life (6) UN present a brilliant information. Generally we think labor-force and fertility are inversely related but it is only true in industrialized countries but not in developing country (7) Gulati and Patnaik thought lack of education has strong effect on women's fertility (8) According to Simeen Mahmud, income really reduce gender-based inequalities (9) Swapna Mukhapadhaya identified poverty as a strong determinant of fertility (10) According to Asma Begum, empowerment of women will highlight women's status and women's problem cannot be solved only if it is not viewed by the whole society. (11) Mukherjee finds no correlation between women's employment status and their decision-making power in family. (12) Whereas Youssef thought that the relationship between women's income and fertility might be positive or negative or neutral as well. She emphasizes on two sides that is work commitment and work satisfaction.

From the above discussion it is evident that, education and income are the most important variables in determining women's reproductive right. Participation of women in income-earning activities in Bangladesh Society is very essential for many purposes especially for establishment of her reproductive right. Women's independent income influences her reproductive right a lot. Because it increase her freedom\autonomy, self-confidence, security, decision-making power, dignity. But in the context of Bangladesh Society, it is not so influential both in urban and rural areas. We have seen this picture in the literature review. In Bangladesh, women's income is directly related to the basic needs of food, fuel, shelter because of poorness, not with reproductive rights.

CHAPTER FOUR

THEORETICAL APPROACH

To understand women's status and their reproductive right in Bangladesh society, Marxist and Feminist sociological theories have been discussed. Especially the different ideologies of feminism discussed here. Because these theories give us exact guidelines by which we can realize this burning issue that is reproductive right. Besides these, some other theories seem to be applicable in this context such as: role incompatibility theory, gender-stratification theory, theory of selective rationality etc.

The theoretical discussion of women's status and their reproductive right begin with the discussion about the relationship between female employment and fertility.

The current theory regarding female labor force participation and fertility postulates that female labor force participation will not *per se* result in lower fertility unless there is greater incompatibility between the roles of mother and worker (United Nations 1975). According to Stycos and Weller, "where the roles of mother and worker are entirely compatible, we should expect little relation between labor force status and fertility" (Stycos and Weller 1967:215-216).

The question of a relationship between female employment and fertility is of considerable importance for both sociologists and economic planners. For Sociologists, restriction of fertility among working women would be consistent with the theory of increasing role incompatibility (worker vs. mother). For planners, the possibility that female employment will help in

slowing the rate of population growth causes special enthusiasm for accelerating female labor force participation (Stycos and Weller 1967:210).

The common accepted generalization is that there is a strong relation among these variables. Thus, Blake stated that, "female labor force participation has long been known to bear one of the most impressive relationships to family size of any variable" (Judith Blake 1965:1195). But Youssef stated that the relationship between women's work and fertility is neither direct nor simple. Studies reveal that through various intermediary factors, work may have positive or negative effect on fertility. He suggested that the impact of women's non-domestic work on fertility differs by type of activity and occupation but there has been little consistency in either the strength or the direction of the observed relationship.

Indeed it should be instructive to separate the evidence for developed and developing countries. There is a little question about a relationship between fertility and female labor force participation for Western developed countries. Freedman concludes that, in the United States and Germany, both self-selection of in fecund women and conscious fertility controls account for the relation between employment and fertility (Freedman 1959:136-150). Whereas for the developing society, a certain level of economic development may be necessary before a relationship between fertility and female employment can emerge. Thus, based on data largely from India, Gendell found "little or no influence in at least the traditional sector of societies" (Gendall 1965). He noted that for developing countries the relation cannot be established.

Finally, assuming a causal relation between the variables, there is controversy over the nature of the intervening variables. Is the link between female employment and fertility mainly due to the utilization of birth control, to variations in marriage rates, or to differences in natural fecundity (United Nations 1975:212). With reference to Latin America, Heer maintained that the

"chief effect" of increasing labor force participation "is to raise the mean age at marriage and to increase the proportion of females who never marry" (Heer 1965). In a study on Peru, however, Heer concluded that "female labor force participation reduces fertility by reducing the fertility of married women"_ a statement referring to the use of birth control by married women (Heer 1964:79).

It is widely presumed that women's productivity and participation in the labor force have a positive effect on their children. By increasing women's autonomy in the household, as well as financial capacity which leads to less developed on others, alternative sources of social identity and support increase women's desire to delay marriage, and space or limit births (Dixon 1978; Safilios-Rothschild 1982).

In some contexts, it has been found that independent earning by poor women does appear to affect traditional gender relations within the household, enhancing women's participation and say in decisions. Also, those who earn independently appear to exercise a higher degree of autonomy, as shown by their higher use of birth control and significantly greater physical mobility (MAHMUD 1993; NELSON 1979). There is maximum benefit when women directly control the income they earn and such women were found to limit births (MAHMUD 1993).

It is seen, therefore, that the relationship between gainful employment and greater reproductive and sexual choice depend on many factors such as type of occupation, income, motivation, labor status, and terms and conditions of employment, commitment, job satisfaction etc. So we can see that women's independent income, like many other variables, has an influence on their reproductive right.

The analysis of women's economic position in the Third World requires a comprehensive historical framework from which to view the sexual division of labor, class structure and the requirements of capital accumulation. It is also necessary to theorize the relationship between production and reproduction. As these relationships have long been of interest to Marxists scholars, we begin by reviewing the contribution of Marx, Engels and more recent scholars.

- Marxist
- Feminist sociological theories
- Role incompatibility theory
- Gender-stratification theory
- Theory of selective rationality

4.1 Marxist Theory

Marx and Engels began with the premise that 'men must be in a position to live in order to "make history". But life involves before everything else eating and drinking, a habitation, clothing and many other things' (Marx and Engels 1976:30). Both of them explained women's subordination only in economic terms. They argued that once private property was abolished and women joined the labor force, patriarchy would disappear. Engels believed that women's subordination began with the development of private property, when, according to him, "the world historical defeat of the female sex" took place (Engels 1884:92).

Engels analyzed how this lowered position of women in society, especially in the sphere of family gave rise to monogamous patriarchal family, "the organization of a number of persons, bond and free, into a family, under the paternal power of the head of the family" (Engels 1884:93). Engels is insistent that historical analysis must emphasize the interaction between these two

aspects of the material life that is between the changing mode of production and the changing form of the family. But in his study, Engels (1972) failed to keep human reproduction and material production analytically separate (Carmen 1982:92-93) because in many pre-capitalist economies kinship relations structure both human reproduction and material production (Carmen 1982:93).

In Marx's writings women's social subordination was theorized in terms of the impact of capitalism traced primarily through the effects on the family of wage labor and private ownership of property. Marx and Engels were ambiguous about their interpretation: in the property less working class, there was no material basis for the family, no necessary reason for its continued existence, and it would consequently wither away. In the property-owning class, the material basis of the family in the concentration and inheritance of wealth would become all-engrossing, overpowering any positive aspects of family (Humphries 1977a). These pessimistic conclusions about the future of the family were reinforced by Marx and Engels's view that direct control of production by families would necessarily decrease.

According to Marx and Engels, working-class women, who had previously been integrated into family-based productive activities, found themselves reduced to idleness, a phenomenon discussed as a contemporary social problem in early Britain (Pinch-beck, 1969). These women faced three possibilities: (1) to be reduced to complete economic dependence on husband, son or father; (2) to follow that male relative into the labor market and substitute reliance on wages for a more personal dependence; and (3) to drift into the formal sector of economy, where home-based petty commodity production still provided for a marginal existence. Marx and Engels thought the second option would become the pre-dominant one for working-class women (Carmen 1982:95).

4.2 Feminist Sociological Theories

Webster's Dictionary defines the term 'feminism' as: (a) the principal that women should have political rights equal to those of men; (b) the movement to win such rights for women. The word 'feminism', however, must be understood in its broadest sense as referring to an intense awareness of identity as a women, and interest in feminine problems. Its meaning should not be restricted to the advocacy of women's rights. (Singh 1997:21).

In a study, "Women, History and Theory" (1948), Joan Kelly brilliantly demonstrated a solid, four-hundred-year-old tradition of women thinking about women and sexual politics in European society before the French Revolution. Feminism is generally thought of as a phenomenon of the 19th and 20th centuries. Christine de Pisan (1364-1403?) is the first to have held modern feminist views. She was the first feminist thinker of spark off the four-century-long debate on women which came to be known as "querelles des femmes." In the 1630s and 1650s many of the radical English sects supported religious equality for women. In this climate, there were women who effectively liberated themselves from the male clerical authority. They sought to control their own conscience, to preach, and to improve women's educational and economic opportunities. These women, like Anne Hutchinson, were "feminists in action," rather than theories (Singh 1997:14-5).

The feminism of the 19th and the early 20th centuries focused on the acquisition of a few basic political rights and liberty for women, such as the right of married of women to own property and enter into contracts, the right to defendants to have women on juries, and the crucial right to vote. The contribution of John Stuart Mill, in the discussion of feminism, cannot be overlooked. His "The Subjection of Women" (1869) was the most controversial and provoked strong hostility. In this book, he concentrated on the abilities of women and made a vigorous plea for their right to entry any

trade or profession. Mill believed that the liberty of the individual is absolutely necessary for the development of the society. He held the view that women's position is not natural but the result of political oppression by men (Singh 1997:17).

However, the credit for an organized movement for women's rights goes to America beginning with The Seneca Falls Declaration of Sentiments and Resolutions, drawn and signed at the obscure village, Seneca Falls, New York, in the summer of 1848.p.18 The radical demand for suffrage at Seneca Falls carried the social and political revolution for women's rights into a new era. Special support for this historic event came from Elizabeth Cady Stanton.

The period from 1920 to 1960 is known as the period of intermission in the history of the women's rights movement when a sense of complacency prevailed. A new Feminist Movement stared in the late1960s. This decade was a period of protest movements-civil rights, peace, the New Left, anti-poverty. According to Carden, "The new feminism is not about the elimination of differences between the sexes; nor even simply the achievement of equal opportunity: it concerns the individual's right to find out the kind of person he or she is and to strive to become that person" (Singh 1997:19).

Broadly speaking, the contemporary feminist movement worked for female equality as the earlier nineteenth century feminism had done. But the movements differ significantly in the basic arguments regarding the nature of the biological differences between the sexes. Today, feminists protests against the way the social institutions, supported by cultural values and normative expectations force women into an unreasonably narrow role. They object not to marriage or motherhood, but to the excessive restraints these roles involve. They argue that in a society with real equality women would be in a position comparable to that of men.

According to Donna Hawxhurst and Sue Morrow (1984) feminism has only working definitions because it is a dynamic, constantly changing ideology with many aspects including the personal, the political and the philosophical (Singh, S. 1997:23). Charlotte Bunch (1981) has pointed out that feminism is not about "adding in" women's rights, but about transforming society, so that feminism may be called "transformational politics". Because everything affects women, every issue is women's issue, and there is a feminist perspective on every subject (Encyclopedia of Feminism 1986:108).

Several distinct ideologies can be discerned within feminism. All ideologies stem from one fact that justice requires freedom and equality for women. But they differ on the philosophic questions about the nature of freedom and equality, the functions of the state, and the notion of what constitutes human, especially female, nature. Alison M. Jagger has outlined four ideologies.

4.2.a The Conservative View: They rationalize the differences between women's and men's social roles in two ways: (1) that the female role is not inferior to that of the male, (2) or that the women are inherently better adapted than men to the traditional female sex role. All conservatives emphasis that one of the main tasks of the state is to ensure that the individual performs his or her proper social function.

4.2.b Liberal feminism: Liberal feminism views liberation for women as the freedom to determine their own social role and to compete with men on terms that are as equal as possible. The liberal does not believe that it is necessary to change the whole social structure in order to affect women's liberation. The concept involves liberation for men, since they are not only removed from a privileged position but are also comparatively free of the responsibility for such things as the support of their families and the defense of their country.

4.2.c Classical Marxist Feminism: The classical Marxist feminist views the oppression of women as historically and currently a direct result of the institution of private property. It can only be ended, therefore, by the abolition of that institution. The special oppression of women results primarily from their traditional position in the family. Thus, for Marxists, an analysis of the family brings out the inseparability of class society from male supremacy. Though Marxists do not believe that women's oppression is a creation of capitalism, they believe that it intensifies the degradation of women and the continuation of capitalism requires the perpetuation of this degradation.

The Marxists indicate the direction in which women must move. Engels writes, "The first condition for the liberation of wife is to bring the whole female sex back into public industry". He added, "within the family the husband is the bourgeois and the wife represents the proletariate". Thus, the Marxist feminists see women's oppression as a function of the larger socio-economic system (Singh 1997:26-30).

4.2.d Radical feminism: They deny the liberal claim that the basis of women's oppression consists in their lack of political or civil rights. Similarly, they reject the classical Marxist belief that basically women are oppressed because they live in a class society. They hold that the roots of women's oppressing are biological and women's liberation requires a biological revolution. They believe that only through technology women can be liberated and both the biological and economic bases of the family will be removed by technology. It is formulated by TiGrace Atkinson and Shulamith Firestone. This is the only feminist theory which argues explicitly that women's liberation also necessitates children's liberation (Singh 1997:31).

Some radical feminists say there are two systems of social classes: (1) the economic class system which is based on relations of productions and (2) the sex-class system which is based on relations of reproductions. It is the second

system that is responsible for the subordination of women. According to them the concept of patriarchy refers to this second system of classes, the rule of men by women, based upon men's ownership and control of women's reproductive capacities. Because of this women have become physically and psychologically dependent on men (Kamla 1993:25-26). Bangladesh society is based on number two where women are subordinate to men.

4.2.5 Socialist feminism: They agree with Marxist feminists that capitalism is the source of women's oppression, and with radical feminists that patriarchy is the source of women's oppression. Following this outlook, Juliet Mitchell claimed in Women's Estate that women's condition is over determined by the structures of production (as Marxist feminists think), reproduction and sexuality (as radical feminists believe), and the socialization of the children (as liberal feminists argue) (Putnam 1998:5).

Our society is based on the second type of system where women are subordinate to men.

Social feminists try to combine the Marxist and radical feminist position because they feel both of them have something to contribute but neither is sufficient in itself. They take economic class and sex class as two contradictions in society and try to see the relationship between them. According to them, patriarchy is related to the economic system, to the relations of production, but it is causally related. There are many other forces which influence patriarchy; ideology, for example, which has played a very important role in strengthening it. Some believe that patriarchy preceded private property, that, in fact the exploitation of women made it possible. They also believe that, just as patriarchy is not a consequence only of the development of private property so, too, it will not disappear when private property is abolished. They look at both the relation of production and the relation of reproduction in their analysis. (Kamla 1993:27).

4.3 Gender-stratification theory

Contemporary Marxist feminists hold that the women of Bourgeoisie do not own property but rather they themselves are prorerty of bourgeoisie class. Since the bourgeoisie exploit the labor of the workers without producing their own necessities that sustain life, contemporary Marxists feminists hold that the bourgeoisie are parasites and their women are "parasites of parasites".

According to Mason, to theorize a direct linkage between women's status and fertility behavior the critical element, not taken into account usually by others', is the husband-wife relationship. This relationship does not exist in a vacuum, but is influenced by a couple's socio-economic status and their place in the kinship system as well as by the personal characteristics and values each spouse brings to the union (Youssef 1982).

According to this theoretical discussion it can be said that – as patriarchal system remain in Bangladesh so women are subordinate to and dependent on men and their reproductive right is undermined.

Engels thesis provides only one strand in the large corpus of the theories seeking to explain women's subordinate position-that is economic strand. Several theories in the field highlight a number of important aspects of women's subordinate position as well as the plausible factors responsible for them, which had not been adequately stressed by Marx and Engles. Gender Stratification theory proposed by Blumberg's is one of them.

Blumberg's gender stratification theory is largely a non- economic interpretation of the gender problem. Unlike the Marxists, she viewed the problem from a number of perspectives, and economic perspective is the only one of the angels of the dynamic problem. She found that gender inequality is

based on sex-division of labor. Blumberg made a cross-cultural study of the problem. This theory is very much applicable in the analysis of women's socio-economic status and reproductive rights (Begum 2002:86).

The same view is shared by Muhammad Yunus. According to him, 'whenever we make plans for providing employment to our vast population, we unconsciously plan for men only. It is assumed that women economically at least are an unnecessary part of society, and if they happen to be poor, then they simply do not enter into any economic picture at all'. He further states, 'Our society simply refuses to accept the fact that these women are 'persons' by their own right, having independent identities and potentials of their own. The sense of value of these women have gradually become so deeply influenced by male domination that they have come to accept the fact that it is only right for them to be repressed and persecuted" (Yunus 1991:137).

Moser (1989) argued that in current Western planning theory and practice, there is an almost universal tendency to make two assumptions, regardless of empirical reality. First, the household consists of nuclear family of husbands, wife and children. Second, that within the household there is a clear sexual division of labor in which man, as the breadwinner is involved in productive work outside home, while women as the housewife and the homemaker takes the overall responsibility for the reproductive and domestic work involved in the organization of the households. Moser argues that women play a 'triple role' in society. To quote Moser: "Women's work not only includes reproductive work (the child bearing and rearing responsibilities) required to guarantee the maintenance and reproduction of labor force but also productive work, often as income earners. In rural areas this usually take the form of agricultural work, while in urban areas women frequently work in formal sector enterprise.... In addition, women are involved in community managing work undertaken at a local community settlement level in both rural and urban areas."

4.4 Theory of selective rationality

Although Leibenstein's theory of Selective Rationality is not specifically addressed to the issue of the employment-fertility relationship but it points out two things that cannot be overlooked in the analysis of employment-fertility relationship. These are (1) to propose the need to focus on the individual (not the household) as the basic decision-making unit and (2) to assume that differential interests (as opposed to identity of interests) prevail within the household regarding the decisions related to fertility (Leibenstein 1977:3).

4.5 Role incompatibility theory

In fact, feminism is a 'raising of the consciousness' of an entire culture. From childhood on beliefs and attitudes help perpetuate women's inferior status. Some of these are sex-role stereotyping in text-books, unequal pay for equal work, and the traditional division of labor within the family. Other attitudes are more subtle: for example, hoping that a couple's first child will be a boy, thinking of a wife's salary as meant to buy 'extras' rather than as supporting the family. Feminism as a philosophy of reform envisages profound changes in traditional social structures such as the family, in the economic role and power of women, and finally in fundamental attitudes and personal relationships, leading to a just social order.

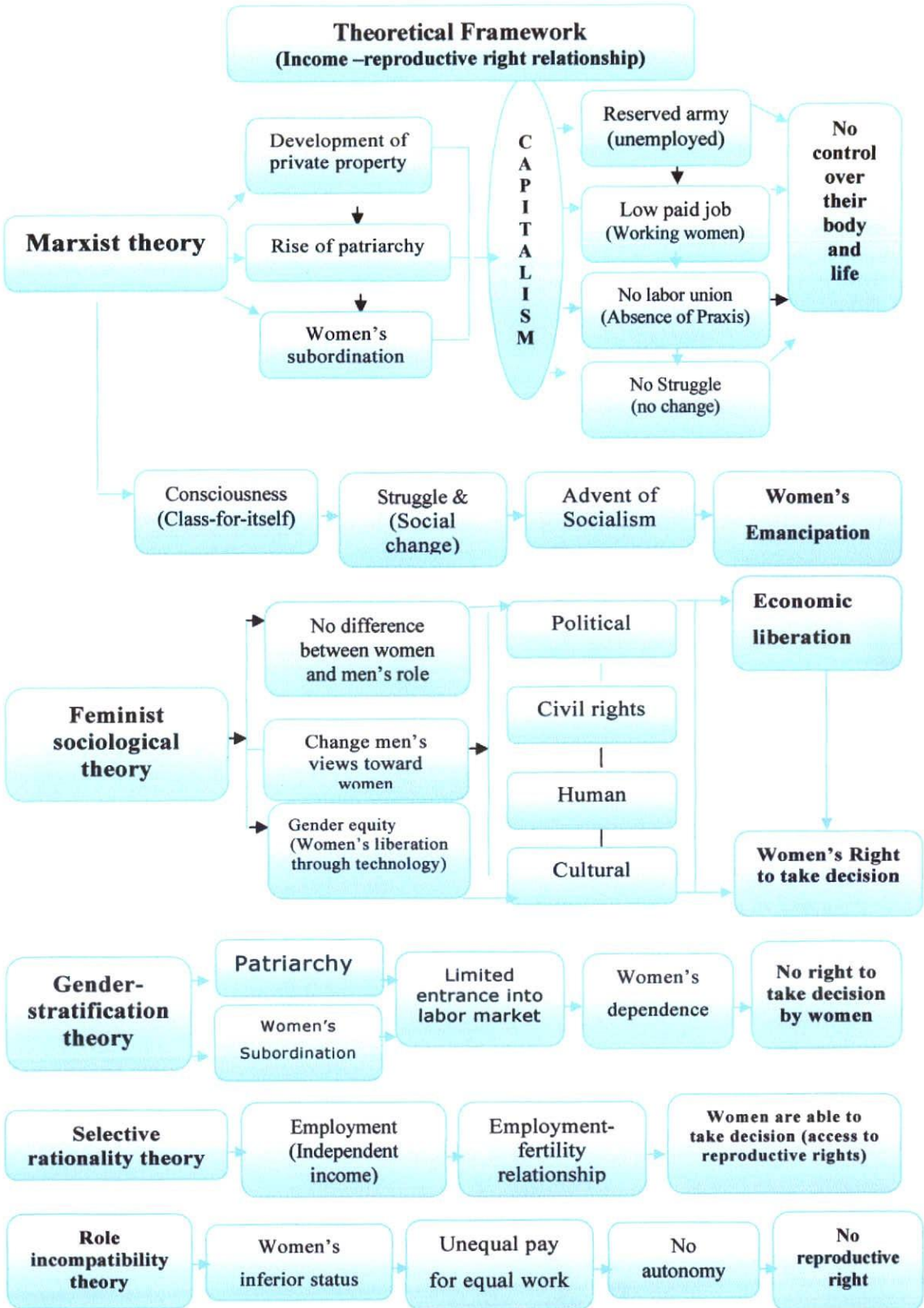
There is now evidence from many developing societies, including Bangladesh, where the low status of women has commonly been attributed to their segregation from paid employment and their consequent dependence on men for economic support, that independent income earning carriers the possibilities of women gaining social control over the use of family income, or at least over their contribution to it, and of their increased participation in decision-making. Contribution to family income is invariably accompanied by a higher value within the home as well as a more egalitarian husband-wife

relationship. Thus women directly participate in the "productive process", either on the family farm or in outside wage employment, they have a less subordinate position relative to men than those women who depend entirely on the earnings of their employed husbands (Mahmud 1990:10).

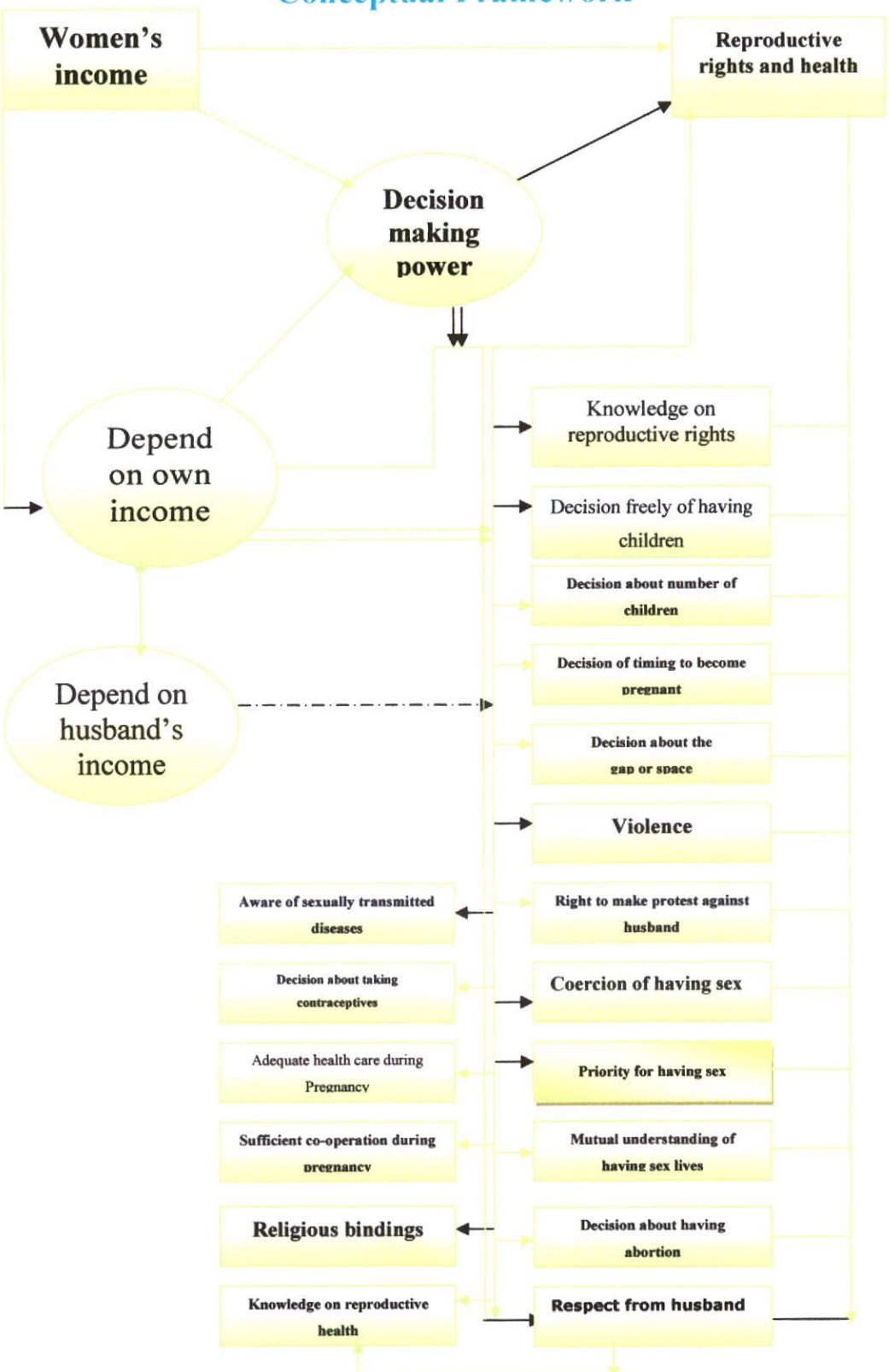
There is also evidence that, income earning provides women peer support and solidarity with other women in similar situations. Women's increased physical mobility, particularly in a male dominated society, reduces their dependence on male. Women also gain access to independent source of knowledge. All these are likely to have a positive impact on women's personal autonomy.

With this theoretical background it can be easily said that as the nature of the society of Bangladesh is patriarchal, women in Bangladesh live in a subordinate position and their reproductive rights may be violated both in rural and urban areas. As stated earlier that by several factors women's reproductive right may be influenced such as: women's role as wife and mother in family, type of work, condition of work, commitment, job satisfaction, income, education, son preference, gender relations within the household etc.. It is considered that a woman who has autonomy within the household would also have say in reproductive manners. And important elements of such autonomy are education and independent earning.

In this study one of the main objectives is to see the impact of women's income on their reproductive rights. So it can assume from the above discussion that income certainly has positive impact on women's reproductive rights. But at the same time, it has to realize that the influence of income on reproductive rights is significant but not definitive. A number of other factors can change the nature of influence. Thus a whole range of factors operating at different levels influences reproductive choice. Finally, the process of reproductive decision-making and behavior is complex because the significance of these factors varies with the society.



Conceptual Framework



CHAPTER FIVE

METHODOLOGY

Methodology describes the methods and techniques of survey design, sampling design, data collection and analysis. So this study also follows the following procedures and techniques step by step as-

5.1 Analytical Framework

5.2 The Survey Design

5.3 Sample Design

5.4 Population and Sample Size

5.5 Formula for Drawing Sample Size

5.6 Questionnaire Content

5.7 Time schedule and Interviewing

5.8 Data collection and Response

5.9 Data Collection Procedures

5.10 Techniques of Data Analysis

5.11 Limitations of the Study

5.1 Analytical Framework

Analytical framework usually includes the following issues:

5.1.a Hypotheses formulations

5.1.b Operational definitions of the variables

5.1.c Measures of dependent and independent variables

5.1.a Hypotheses Formulations

1. There is an impact of income on socio-demographic issues relating to reproductive rights and health
2. There is an effect of income on the decision-making process regarding any aspect of the family.
3. There is a positive effect of income on the decision-making process regarding reproductive rights and health
4. There is a relation between low paid job and the less status of a woman in family.
5. There is a negative relation between non-income group women and their conditions of reproductive rights and health

5.1.b Operational definitions of the variables

1. Reproductive Rights:

Reproductive rights would mean the right of a woman to participate in the decision making of giving or not to give birth to a child or the time gap to be given between the children to one another. It also refers to the rights of the couples and individuals to decide freely and responsively the number, spacing, and timing of their children, and have the information, education and means to do so, and the rights to attain the highest standard of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence.

2. Reproductive Health:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. People are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so.

3. Income:

In the context of our discussion, income of a woman would mean the income she earns by of her own effort through jobs and business.

5.1.c Measures of independent and dependent variables

1. Income: Monthly income in terms of money (*Taka*)

2. Reproductive Rights:

1. Access to information.
2. Access to contraception
3. Right to decide no. of children
4. Right to decide timing of childbirth
5. Right to decide spacing of birth

3. Reproductive health:

1. Health consciousness (Level of consciousness related to: healthy child birth, happy sex life, recognition of reproductive rights as a human right, control over body)
2. Health care (Access to obstetric services, co-operation of partners, co-operation of family members, nature of delivery, access to food during pregnancy, management of post-natal problems)
3. Health beliefs (Beliefs related to menstruation, healthy child birth, happy sex life, mother's health after child birth, causes of sexually transmitted diseases (STDS), prevention of STDS.)

4. Consciousness: Minimum ideas on reproductive rights and reproductive health

5.2 The Survey Design

This survey is a random sample survey in *Urban* and rural *Bangladesh.* This design made it possible to select a sample with known characteristics because I have drawn sample size from the two areas that are *Pagar* from Gazipur District *and Madhobpur* from Manikgang District.

5.3 Sample Design

The present study is concerned with describing the socio-economic and demographic characteristics of the urban and rural women and their households, their beliefs and views they hold. It is also concerned with discovering whether certain variables are associated. This study followed both the probability (social survey) and non-probability (case study) sampling on which sample design inextricably linked. For this study, sampling design includes two key issues likes – selecting areas and respondents.

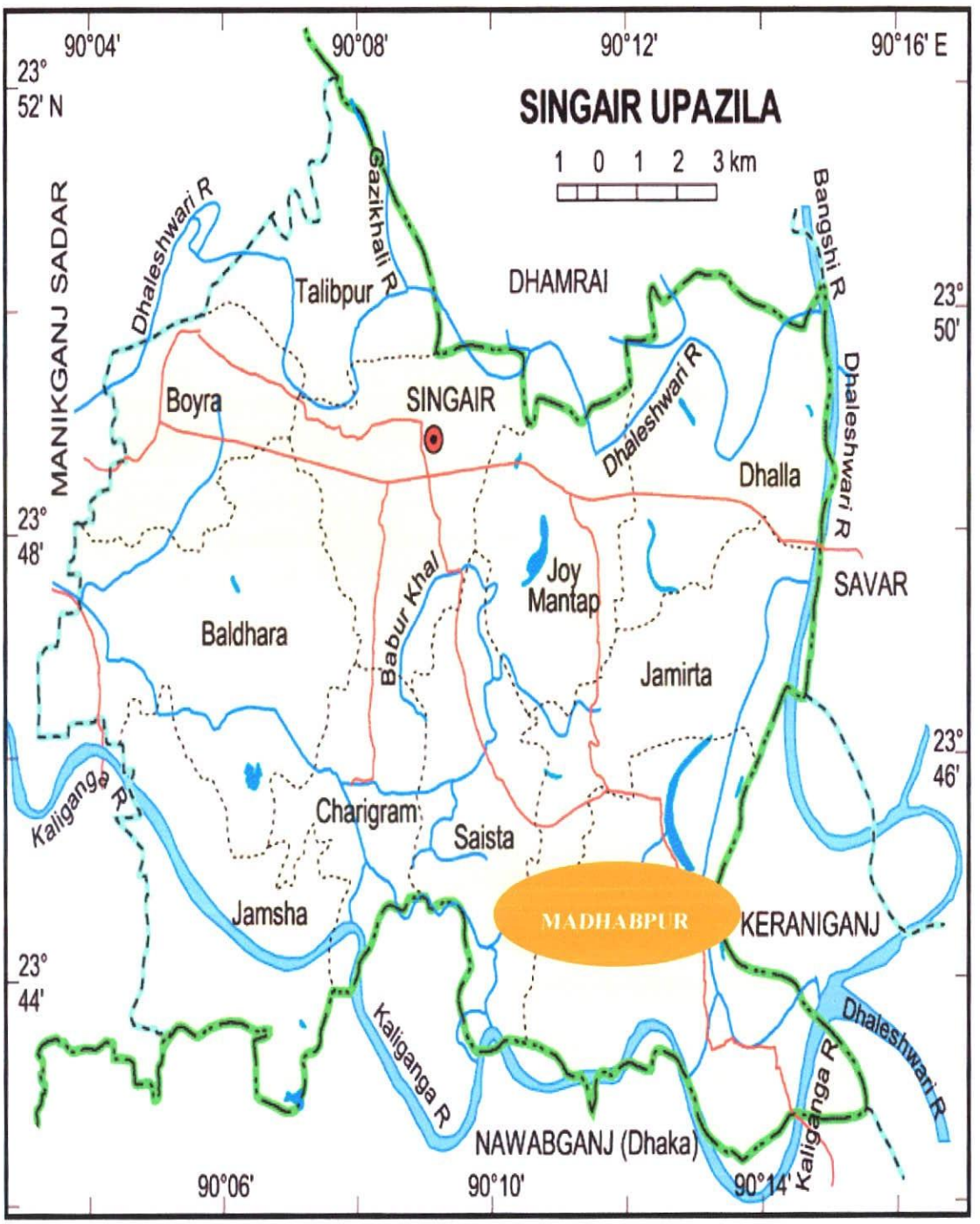
5. 3.a Area Section

Urban Area

This survey followed multi-stage stratified sampling procedures. Firstly, among the major urban areas (as Dhaka, Chittagong, Khulna, Rajshahi, ,Sylhet, Rangpur, Barisal, Mymensingh, Gazipur, Jessor, Nawabganj, Bogra, Comilla, Dinajpur, Sirajganj, Jamalpur, Pabna, Tangail, Naogaon, Brahmanbaria, Saidpur, Faridpur, Gopalgonj, Kustia) Gazipur, as a district, have been selected through purposive sampling technique. Gazipur district constitutes with four municipalities (thanas) as gazipur sadar, Sreepur, Kaliakoyer and Tongi. From these municipalities I had taken Tongi municipality by using purposive sampling technique. Because women with independent income were available as the place is surrounded by many garments factories. Tongi, as a municipality, has nine garments factories (Source: Tongi Municipal Office). From these garments factories I had selected **Sharp Knitting and Buying** factory for this study through random sampling technique. This factory is situated in *Pagar* under Tongi municipality. Furthermore, all of the workers of this factory have indipendent income so I had selected this type of area.

Rural Area

For the rural area I had selected Manikgonj through purposive sampling procedure. Manikganj as a District has seven thanas like Singair, Manikganj, Harirampur, Shaturia, Gheor, Daulatpur and Shibaloy.



From these thanas I had selected Singair through purposive sampling. Singair has eleven Unions as (i) Joymandap (ii) Jamirta (iii) Shayesta (iv) Talebpur (v) Jamsha (vi) Charigram (vii) Dholla (viii) Chandor (ix) Singair (x) Balldhora and (xi) Baira. From these Unions I had selected Chandor Union. This Union has 30 villages namely: (1) Madhobpur (2) Maniknagar (3) Chandor (4) Char Chandor (5) Char Palpara (6) Char Bagoli (7) Bagoli (8) Sonar Tengra (9) Adi Para (10) Sirajpur (11) Ali Nagar (12) Char Madhurchar (13) Ganga Lalpur (14) Boinna (15) Changta (16) Ribatpur (17) Fatehpur (18) Islampur (19) Barta (20) Nilambar Patti (21) Chalk Palpara (22) Mulbarga (23) Char Mulbarga (24) Char Adi Para (25)Madhur Char (26) Hogla Kati (27) Char Madhobpur (28) Dhani Para (29) Noy Number (30) Belokkho Para (Source: Union Parishad Office). From these villages I had selected Madhobpur by the purposive sampling technique. The main reason of selecting this village is, about 80 percent women of this village are small entrepreneur, day laborer and farmer.

5.3.b Respondents Selection:

For the urban area respondents were only women (married and independent income) who were in age group 10-49 years. Demographically, all of them were in reproductive cycle. I had selected respondents from the *Sharp Knitting and Buying Ltd. Factory* through simple random technique. Firstly I had listed their name by the help of the authority of that garment factory and rearranged it in an order and after that I picked up the estimated respondents through lottery.

For the rural area I had selected respondents through systematic sampling technique from the recorded information that provided by the health worker about the women of age group in 10-49 years. This information was also available in the voter list (957 females) about the village. From this two lists I had calculated population size (905 females) whereas one type of age group (43 females were in 10-17 years) was not included in voter list and another type of age group was above 49 years old (95 females) that are not in reproductive age group (see also population and sample size number in 4.4). So the estimated population size was 905 females. Here I used systematic sampling technique

for selecting respondents because all the females of this universe were not independent income. So I had to select it by the replacing method. The replacing method was like the following …

Systematic Procedure

1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45……..

Replacing Procedure

1,2,3,4,**5**,6,7,8,**9**,10,11,12,**13**,14,15,16,**17**,18,19,20,**21**,22,23,24,**25**,26,27,28,**29**,30,31,32,**33**,34,35,36,**37**,38,39,40,**41**,42,43,44,**45**……..

Non-income Group (controlled group) Women selection

For this study, I focused on income group women to built or examine the relation to reproductive rights and health. But according to scientific criteria of doing a research, a controlled group, in most cases, must have been regarded because of the increase of reliability and validity. So I drew a sample of non-income group for this purpose from rural and urban settings to judge the validity.

5.4 Population and Sample Size:

The Sample size of urban area:

Total Garments workers of '***Sharp Knitting and Buying factory'*** are 1208. Among them females are 992 in number. From this population I surveyed 272 females who were in 10-49 years old and had independent income. This sample size had been drawn from the universe by allowing 5 percent precision level. But for the case studies, from urban area, I took in-depth interview which found 3 distinct cases that indicated the overall pattern of my study objectives.

Sample size for rural area

Madhabpur has 3050 population and 1756 voters (male voters: 799 and female voters: 957). But I need those females who are in reproductive age (10-49) and have independent

income. This is why I found there 95 females who were above 49 years old and 43 females (age15-17) who were not included in voter list. Eventually the universe (population size) had been estimated as 905 [905= {(957-95) + 43}]. From this population the sample size had drawn 270. This sample size had been calculated by the sample drawing formula allowed 5 percent error level.

Total sample size of this study is 542 married females who were derived from urban (272 females) and rural 270 (females) areas for the quantitative study.

But for the case studies, from rural area, I took in-depth interview which found 3 distinct cases that showed the overall pattern of my study objectives.

Sample size of non-income group women

The total number of sample in nom-income group is 9. From that sample, 4 from rural settings and 5 from urban settings considering the distinct case to prove the objectives.

5.5 Formula for Drawing Sample Size:

For the known Universe

Equation- 1

$$n_0 = \frac{z^2 \times p \times q}{e^2}$$

Where,

n_0 = initial sampling

z = z score value

p = probability

q = 1- p

e = Precision level (i.e. error level 5% or 0.05/± .5)

Equation- 2

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

Where,

n = sample size

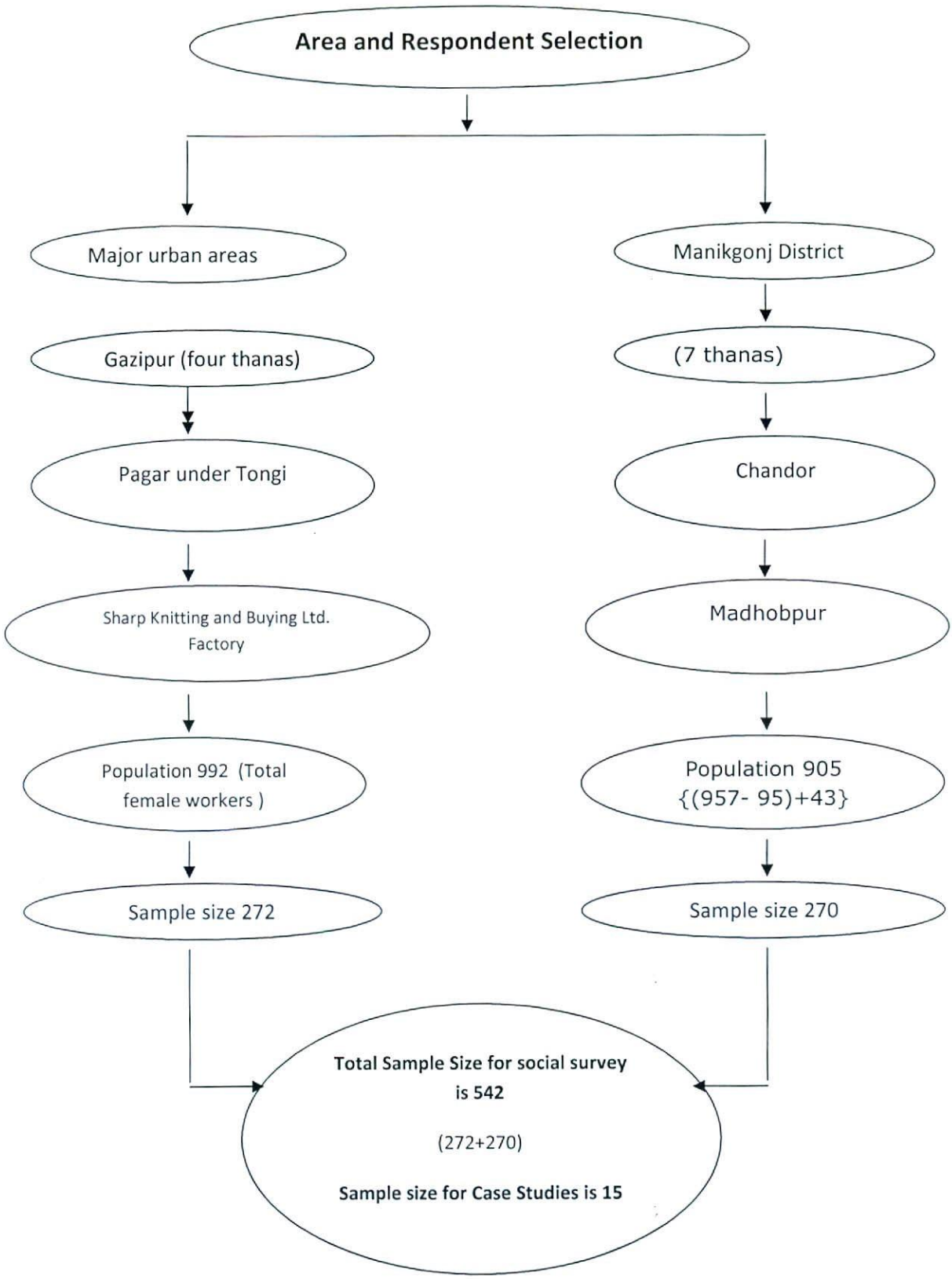
N = population size

Z score values

Confidence Level	Z score values
80%	1.28
85%	1.44
90%	1.65
95%	1.96
99%	2.58

5% precision level (calculated sample size from the known universe)

Population	Sample
50	44
75	63
100	80
150	108
200	132
300	168
400	196
500	217
1000	277
3000	340
5000	356
10,000	369
100,000	384



The above diagram represents the geographical area and the number of respondents selected for the study and the sample size. It would appear that almost equal number of respondents have selected from rural and urban settings.

5.6 Questionnaire Content

Pretest: The questionnaire had been thoroughly pre tested before finalization.

The main topics covered in the questionnaire were:

1. Demographic variables
2. Economic and social variables
3. Right to decide early or late marriage
4. Access to information.
5. Access to contraception
6. Right to decide no. of children
7. Right to decide timing of childbirth
8. Right to decide spacing of birth
9. Health
10. Nutrition
11. Medicare
12. Cooperation
13. Mental and physical support
14. Satisfaction and mutual understanding
15. Violence
16. Religious bindings
17. Consciousness about rights, health facilities and STD

5.7 Time schedule and Interviewing

5.7.a Time schedule

The duration of fieldwork has been divided in two parts. First part had taken place from 9th June 2007 to 16th October 2007 and the duration of second time survey was from 12th June 2008 to 30 September 2008.

5.7.b Interviewing

This study used a list of 53 questionnaires for the married women who had also independent income. A close-ended questionnaire with an option of being open-ended was directly administered to the respondents by the interviewers (I had appointed two research assistants for collecting data and processing collected information). The average length of interview was 90 minutes. But for some special cases it took over 100 minutes.

5.8 Data collection and Response

At *Pagar*, as an urban setting, it was difficult to build rapport to the garments factory authority. Because, all most every worker of that factory was busy with her works. So the authority was firstly in hesitation whether they gave me permission or not. But after knowing the purpose of my study they permitted me to talk to the workers. In most cases, I talked to them at launch or leisure time though some workers gave information at their working time. Response rate was quite satisfactory at this factory.

At *Madhobpur*, as a rural setting, it was also difficult to collect data from the respondents because most of the respondents were busy with their work. So I had to talk to them at 4.00 pm to 8.00 pm every day. As for the data collection I used systematic sampling technique, I had to follow the replacement procedures. The number of replacement was 197 out of 270.

5.9 Data Collection Procedures

Both quantitative (social survey method) and qualitative (case study) method has been used to collect data. For the quantitative method the technique was - face-*to-face* interview and for the qualitative method the technique was case study (in-depth interview).

5.10 Techniques of Data Analysis

The purpose of the data analysis is to provide answers to the research questions or objectives. The results of the study have been interpreted according to the univariate and bivariate statistics. Univariate presentation is consist of simply saying what the data look

like, signifying primarily the extent of a particular phenomenon or event. On the other hand, bivariate presentation has been used in the form of contingency tables or cross-tabulations to examine causal linkage and interrelations between two variables.

The collected data of this research are mainly of two types: quantitative and qualitative. Almost all the collected information organized, analyzed and presented with the use of SPSS (Statistical Package for Social Scientist). Graphics software and MS Excel also have been used for graphical presentation. By the SPSS program the raw data has been processed and at the same time this software has been used to analyze data and test hypotheses.

5.11 Limitations of the Study:

Any social research dealing with the human sciences is confronted with a variety of obstacles. During the study I encountered some limitations that are:

1. Some respondents were hesitant and some were reluctant to answer certain issues like income, expenditure, reproductive rights, health facilities and access, diseases, violence etc. After persuasion of the discussion and explanation they personated me to carry out the conversation.

2. The survey method has certain defects because it is highly individualistic. Sometimes to get information about income and household resources survey method has been failed. In those cases I have taken case study method for collecting data with long duration to understand the actual features of this study.

CHAPTER – SIX

Understanding Reproductive Rights and Health

6.1 Global perspective:

WHO defines reproductive health as "a condition in which reproduction is accomplished in a state of complete physical, mental and social well-being, and not merely as the absence of disease or disorders of the reproductive process" (WHO 1992). This definition should therefore be understood to mean that (a) people have the ability to reproduce as well as to regulate their fertility; (b) women are able to go through pregnancy and child-birth safety; (c) the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and (d) couples should be able to have sexual relationships free of the fear of unwanted pregnancy and of contacting disease (WHO 1988).

6.1.a Elements of Reproductive Rights: The basic elements of reproductive rights include the following:

1. Family planning counseling, information, education and communication services;
2. Referral for family planning services and management of side-effects;
3. Safe Motherhood; education and services for pre-natal care, safe delivery, post natal care including breast-feeding;
4. Infant and child-care;
5. Safe abortion facilities;
6. Adolescent reproductive health;
7. Prevention and appropriate invention of infertility;
8. Diagnosis and treatment of Reproductive tract infections (RTI) and sexually transmitted diseases (STD) including HIV/AIDS.
9. Diagnosis and treatment of cancers of breast and reproductive tract;

10. Reproductive health needs of disables;
11. Male participation and responsible behavior;
12. Access to Reproductive Health care through primary health care (PHC) system (Begum 2003:120)

The ideas of rights have been championed in many different ways throughout history. However the modern western conception of rights may be traced back through the English Megna Carta to US Declaration of Independence and Constitution, and the French Declaration of the Rights of Man and the Citizen (Oxford Dictionary of Sociology 1998:568). The Declaration set out at the outset that all human beings were born free and equal in their political rights and proceeded to set up a system of constitutional principles based on security, liberty and resistance to oppression. Furthermore, the Declaration recognized that all individuals had the prerogative to exercise their 'natural right'.

The right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so was first recognized as human rights in 1968. Reproductive health and rights agenda has been considered as an important issue only after the 1994 International Conference on Population and Development (ICPD) in Cairo, the Fourth World Conference on Women (Beijing, 1995), the World Summit for Social Development (Copenhagen, 1995) and the World Conference on Human Settlements (Istanbul, 1996) [Begum, 2003:119]. Specifically, the ICPD Program of Action and the Beijing Platform for Action recognize sexual and reproductive rights as human rights, there by affirming them as an inalienable, integral and indivisible part of universal human rights. This issue is highly linked with women's empowerment which is also highlighted in ICPD.

6.1.b The Bucharest Conference. 1974

The first World Population Conference or the Bucharest Conference was held between 19 and 30 August 1974 in Bucharest. The primary aim of this Plan of Action is to expand and deepen the capacities of countries to deal effectively with their national, sub-national population problems and to promote an appropriate international response to their needs

by increasing international activity in research. It emphasized the need to control fertility to reduce increasing population of the world for economic development.

6.1.c The First International Conference on Women. 1975

The United Nations declared 1975 as the year of Women with a view to ensuring social, political and economic advancement of women and their empowerment. The conference held in Mexico declared the period 1976-1985 as Decade for Women. The goals for these women's decade were equality, advancement and peace. Between 1975 and 1980, the concept of attitude regarding women's participation in economic activities went through a revolutionary change. It was finally admitted that women's contribution on the field of economy was necessary and had been sadly neglected and that in many areas it was equal and sometimes more than men's contribution. Before this conference, women's contribution in economic sector had been ignored.

6.1.d The Second World Conference on Women.1980

The second world conference on women was held in Copenhagen in 1980. In the second conference the progress achieved during the first five years of the Decade for women were reviewed. Another three areas that is education, health and employment were identified within the purview of the goals of Women's Decade. It was attended by women much more aware of where they stood and who united to demand not only economic but social, cultural and political emancipation as well. Along with the new agendas came the call for a comparative analysis of women's legal rights and privileges in order to make reforms.

6.1.e The Third International Conference, 1985

The third international conference on women was held in Nairobi, Kenya dealt extensively with the need for political and legal equality. It repeated in unequivocal terms that the question of women's development could not be resolved by using only an

economic yardstick. Women must be ensured of equality in social, cultural, political and legal spheres as well. The 1985 conference sought out legal action as a possible alternative for women seeking refuge from violence and discrimination (Kamal 1996:3). It was in the context of the main theme of the decade: Equality, Development and Peace. These strategies were adopted by consensus by the 157 countries represented at the conference. The sub-theme of the conference was "Employment, health and education" (Akhter 1995:106).

The Nairobi Forward Looking Strategy (NFLS) in many ways marks a turning point in the history of women at the UN. The Policy document recognizes women as "intellectuals, policy makers, decision makers, planners and contributors and beneficiaries of development" and obligates both Member States and the UN system to take this into consideration in policy and practice (Shaheed 2004:14)

6.1.f Agenda 21 of the Earth Summit. 1992

The action plan on environment and development was adopted in the Rio Earth Summit in 1992. There are two particular sections in the Agenda 21 which concerns health and women's issues (a) Social and economic dimension, protecting and promoting human health and (b) strengthening the role of major groups where women in sustainable development discuss concretely about women's issues. The Conference emphasized that we can no longer think of environment and economic and social development as isolated fields.

6.1.g World Population Program of Action. 1994

The International Conference on Population and Development (ICPD) held in 1994 in Cairo reiterated the empowerment of women as the main slogan of the conference. One of the most important contributions of the 1994 International Conference on Population and Development is that it succeeded in creating a definition of reproductive rights and reproductive health putting people at the center of program. The objectives are to promote women's health and safe motherhood to achieve a rapid and sustainable reduction in maternal morbidity and mortality and to reduce the difference between and

within developed and developing countries. The formal purpose of the conference was to formulate a consensus position on population and development for the next 20 years.

The ICPD Program of Action recognizes the importance of relationships between gender and reproductive health with respect to population and development. Dr. Nafis Sadik, the secretary general of ICPD commented on the closing session of the ICPD'1994: "There are many aspects of the ICPD Program of Action that represent a "quantam leap" for population and development policies. One of these aspects is "strong" language on the empowerment of women." (Cited in Akter 1996:141)

The main document emerged from the deliberations at Cairo, can be traced back to the Bucharest and Mexico City conferences, but the Cairo statements differs substantially in mood, tome and purpose from its predecessors. It reflects very different type of thinking about the population issue in the developing world. The objectives are to promote women's health and safe mother-hood, to achieve a rapid and substantial reduction in maternal morbidity and mortality and to reduce the difference between and within developed and developing countries; and on the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion. Actions that improve the health and nutritional status of women, especially of pregnant and nursing women are also recommended.

The document calls for a reduction in maternal mortality by one half of the 1960 levels by the year 2000 and a further half by 2015. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below one hundred per 100,000 live births and by 2015 a rate of below 75 100,000. All countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem.

6.1.h Principles of ICPD program of action

A set of fifteen principles have been formulated carefully balancing between recognition of individual human rights and the right to development of nations. The main issues in the field of population and development, included in the principles are:

1. Everyone is entitled to the rights and freedoms contained in the Universal Declaration on Human Rights and everyone has the right to development and a right to the means to realize their potentials, including a decent standard of living.
2. Women's rights are human rights. Equality and equity and the empowerment of women, elimination of all kinds of violence against women and ensuring women's ability to control their own fertility are the cornerstones of population and development related program.
3. States should take all appropriate measures to ensure universal access to health care services, including reproductive health care covering family planning and sexual health. It is the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.
4. Everyone has a right to have a good standard of health and education.
5. Children's right should be protected as well as the family in its many forms in order to support individuals and strengthen society.
6. The rights of migrants and refugees should be acknowledged
7. All countries have common, but differentiated responsibilities on the path towards sustainable development and sustainable economic growth (Barkat and Howlader 1997:253)

6.1.i ICPD +5 1999

In 1999 the United Nations General Assembly organized a special session to review progress towards meeting ICPD goals. The special session is known as ICPD+5. The ICPD+5 agreed on new set of benchmarks in four key areas: education and literacy, reproductive health care, maternal mortality reduction and HIV/ AIDS. Para 34 of the ICPD+ 5 states that governments, with the assistance of international donors, NGOs should work to achieve the conference goals of universal access to primary, eliminate gender gaps in primary and secondary education by the year 2005, and strive to ensure that by the year 2010 the net primary school enrolment ratio for children of both sexes

will be at least 90 percent compared with an estimated 80 percent in the year 2000 (UNFPA.org, 29 July 2003).

The ICPD+5 also called for promoting strategies and implementing programs to fight AIDS and reducing maternal mortality and morbidity.

6.1.j The Fourth World Conference. 1995

The fourth world conference was held in Beijing, China in 1995. The outcome of the conference emphasized the need for the promotion of reproductive and mental health and contraceptive practice, as well as research on treatment of complications of abortion and post-abortion care (UN 1996:72). The conference also urged for acknowledgement of beneficial traditional health care, especially that practiced by indigenous women with a view to preserving and incorporating the value of traditional health in the provision of health services, and support research directed towards achieving this aim.

It laid down an extensive platform of action containing twelve critical areas of concern which are as follows:

1. Poverty: The strategic object in this area of concern was to enable women to overcome poverty.
2. Education: The strategic objective was to ensure women' s access to quality education and training by removing gender disparities in education policies, bridging gaps in education between developing and developed countries by providing the same quality of education.
3. Health: The objective of this field was to increase women's access to affordable, appropriate and quality health.
4. Violence against Women: This is probably the most important concern. The objective here is to eliminate violence against women.

5. Effect of Armed Conflict: The objective here was the need to increase the participation of women in conflict resolution and protect women in armed and other conflicts.
6. Economic Structures and Policies: An environment has to be created which allows women to participate in economic activities and gives both men and women flexible time for family and economic responsibilities.
7. Inequality in Decision Making: Creating the factors that promote full and active participation of women in power structures and decision making.
8. Gender Equality: To integrate gender equality dimensions into policy, program, planning and implementation.
9. Women's Human Right: Making all human rights instruments effective and ratifying human rights conventions and implementing international norms in national practice.
10. Media: Enhance the role of traditional and modern communication media to promote awareness of equality between men and women. Eliminate gender stereotyping by encouraging more positive presentation of women in the mass media.
11. Environment: Women's contribution to managing and safeguarding the environment must be promoted.
12. The Girl Child: The survival, development and protection of the girl child must be promoted (Khan 2001:7-12).

The Platform for Action is an agenda for women's empowerment. It aims at removing all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making. This means that the principle of shared power and responsibility should be established between women and men at home, in the workplace and in the wider national and international communities (Beijing Declaration and Platform for Action 1995:5).

6.1.k Global Reproductive Health Situation:

Reproductive health status of a society is determined largely by its social-economic conditions, poverty, lack of optimal nutrition, lack of access to safe water and sanitation, lower status of women and environmental hazards.

- In low income countries, about 200 women die each day as a result of unsafe abortions;
- At least 78,000 women die each year from complications of unsafe abortion;
- Unsafe abortions are responsible for 13% of all maternal deaths globally;
- Each year, an estimated 20 million unsafe abortions are performed worldwide, 95% of which are performed in low-income countries. (Macklin 2005:87-101)
- 333 million new cases of STD occur every year (AIDS Watch, WHO/SERO, Feb'97) of them 1:20 are adolescent girls;
- 36.1 million people are infected with HIV every year. 14 million (40%) are women of them. (Khandaker 2001:40)
- Abortion causes a large number of maternal death- one quarter to one-third deaths out of 500,000 annual maternal deaths.(Jahan ed. 1994:3)
- WHO estimates that there are 60-80 million infertile couples worldwide.(Jahan et al. 1994:4)
- The annual mortality rate worldwide is more than 500,000 of which only 4000 take place in the developed world.(Weekly epidemiological record 1991)

6.2 BANGLADESH PERSPECTIVE

6.2.a State of Reproductive Health in Bangladesh:

The following statistics will help us to understand the extensity and intensity of reproductive health situation in Bangladesh context:

- As many as six of every hundred women (28,000 women annually) die from pregnancy related causes. (Kamal et al, 1993).
- 12 percent girls deliver pre-matured child (Unnayan Podokkhep vol.15 no.1,2000. p.28).
- In the whole Bangladesh, 7500 women suffer from violence among which 2563 are raped.(Unnayan Podokkhep vol.15 no.1,2000. p.28).
- Number of teenage pregnancy is also very high in Bangladesh. 50% of women between 15-19 years are already married and 60% of them became mother by the one year of marriage (UNICEF: Status of World Children 2000 Dec'99).
- UNICEF further states that 96% of girls and 86% of boys are not aware of any protection of STD/HIV/AIDS.
- Every year 2.8% of all pregnant women undergo M.R. and 1.5% induced abortion. These services are usually provided by untrained paramedics and incompletely trained doctors in a logistic constrain setting (Khandaker 2002:41).
- It is claime8d that 49% of married women are using any one contraceptive method. But the contraceptive use rate among adolescent married women is only 25% (BDHS, 1996-97)
- The infant mortality remains high at 77 per thousand live births (BBS, 1996)
- Every year four million give birth to children but over 60 percent of those mothers are anemic. About 50 percent of the babies are born with low birth weight (less than 2.5 kg.). (The Daily Star, 26 May 1998)
- Almost 70 percent of the women in this country are deprived of safe motherhood and reproductive health related services.(Unnayan Podokkhep,2000: 26)
- Bangladesh, at present, bears 21 thousand people with HIV. (Bhorer Kagaz, 24th July 1999)
- Two thirds of the children under six years of age are either under weighs or stunted and some 17% are moderate to severely wasted (BBS, 1997b)
- Approximately 20 million under five children, an estimated 380,000 die from pneumonia, diarrhea, measles and neonatal tetanus every year (Abedin, 1997; Baqui et al., 1998)

- Nationwide, one third of deaths in children under five years of age occurs during the first month of life (BBS,1996;Mostafa,1996).
- The life expectancy at birth is still 59 years; indeed, Bangladesh is one of the fewest countries in the world in which the life expectancy is lower for females than for males (Ahmed and Chowdhury 1999:55).
- Average daily calorie consumption is only 80% of the recommended level (World Bank,1998a).

6.2.b Population Policy and Reproductive Rights

The population policy of Government of Bangladesh is interventionist. Since the Government sees population as a problem and even declared it a number one problem of the country, the major objective of population policy is to control the population growth through family planning programs. Contraceptive Prevalence Rate in 1996 was 49 percent and the Government intends to raise it to 68 percent by the year 2005 and 72 percent by 2010 (GoB, 1998). The Government intends to lower Total Fertility Rate from 3.40 in 1996 to 2.20 by the year 2010. In order to achieve the demographic goals the following strategies and policies will be persued:

a. To accord top priority to population and family welfare programs and build up national commitment and generate a social movement to promote two-child-family norm through community participation and nation-wide approach;

b. To provide Reproductive health care services such as for family, Maternal and Child Health (MCH) , Reproductive Tract Infection (RTI) , Sexually Transmitted Diseases (STD), HIV etc, at appropriate level of service provision; special attention will be given to family planning for the under-served groups, newly- weds and low performing areas.

c. To meet the unmet demand and create new demand for contraceptive use by providing quality services.

d. To decentralize authority of program planning, strategy formulation resource mobilization and to encourage local level participation with ownership in program planning and implementation.

e. To reduce worker-population density and provide both family welfare and primary health care services more intensively; field workers of both family planning and health programs will be utilized under unified command of the Medical Assistant/Doctor in charge of the HFWC/Rural dispensaries, who in turn, will report FW activities to Thana Health Administrator (GoB, 1998).

It can. Therefore, be said that people's reproductive rights cannot be realized under interventionist population policy, as is the case in Bangladesh.

6.2.c Bangladesh Government Position on ICPD and Reproductive Health Agenda

Bangladesh played an active part in the ICPD conference and the many preparatory meetings that preceded the conference. Delegates from both the Government and NGO's represented Bangladesh at the Cairo Conference. In an effort to implement and follow-up on the recommendations of 1994 ICPD program of action document GoB has developed certain national mechanisms and strategies, viz. National Coordination Committee for ICPD follow-up, ICPD Task Force, National Steering Committee for Future Challenges in MCH-FP (GoB 1997:252)

GoB's Strategies are to:

1. Improve quality of care of clinical contraception.
2. Increase use of private sector and NGOs
3. Increase use of health facilities
4. Provide IEC on reproductive health through: interpersonal communication and mass media

5. Provide reproductive health care packages at all levels: Community, Union, Thana and District.

6.2.d Actions Taken at the National Level in Bangladesh

Prior to 1950's there was not any policy or strategy on population issues in Bangladesh (Akter 1996). Gradually greater attention was paid to the population questions partly due to international pressure and partly because the perceived problems of population growth. Later in 1976 population was identified as a number one problem and so interventionist policies and programs continued to get momentum aimed at controlling the population growth at any cost. It is only after the ICPD that the issues of reproductive rights of individuals and couples are being addressed at least to some extent both by the governments and national and international NGOs and donor agencies and UN bodies including UNFPA.

A number of task forces and expert committees were formed to identify program gaps and suggest action alternatives. In December 1993 when the National Family Planning Fortnight was observed, ideas emerging from these deliberations were disseminated and shared with wider groups of stakeholders (Islam 1997:291). Based on general consensus on program gaps, a Plan for Action was formulated to meet the future challenges in Bangladesh national FP-MCH programs in June 1994, prior to ICPD conference. The Plan of Action identified nine immediate priority action areas, which include the following:

1. Improved the quality of care and increasing the use of clinical methods
2. Intensifying program efforts in low-performing areas of the country
3. Focusing on critical undeserved groups
4. Implementing family planning services in Health Directorate
5. Improving performance reporting and follow-up
6. Strengthening IEC and community mobilization
7. Carrying out critical training

8. Enhancing collaboration between Government and NGOs
9. Improving MCH and reproductive health (Islam 1997:292)

6.2.e Family Planning Programs in Bangladesh

The Family Planning Program (FPP) has grown from a small clinic based initiative to a multi-spectral nation-wide effort. It started in 1953, that is, before the independence of the country (Begum 2003:120). The Family Planning Association was established through the initiative of professionals and social workers of the country. After the Liberation in 1971, population growth was considered to be the number one problem of the country. The family planning services were based on maternal and child health (MCH) (Begum 2003:121).

Akter (1996) identified several stages of family planning programs in Bangladesh:

a. Pre-intervention Period (before 1952): During this period a spontaneous awareness of the economic benefit of a small family, hence the need for birth control was taking shape.
b. Intervention Period (1952-60): In 1952, foreign private organizations sponsored the formation of the East Pakistan Family Planning Association, which is now known as the Bangladesh Family Planning Association (BFPA) with the objective to reduce the growth of population. This marked the beginning of the interventionist period. During the first phase the organization served as a pilot project and a center for research activities. Its major achievement is acknowledged in "informing the population of the possibility of family planning and its relation to food supply and national development. The population issue was brought into focus and generated some interest regarding the need for family planning" (ESCAP 1974:105)
c. Mass Scale Operation (1965-70): This phase involved the Government in population control programs on a mass level. The population strategy received maximum attention and the program was developed on the concept of maximum

administrative and financial autonomy. In this period people started to see female workers coming to them.

d. Short Gap (1971-72): Since 1970 there was a market increase in USAID funding of population control programs. During this period the UN and USAID played complementary roles in the development of family planning programs and a new entity, the United Nations Fund for Population Activities (UNFPA), was created in 1969 as a multilateral agency. In the years to come, the dominance of UNFPA was significant.

6.2.f Multinational and multi-sectoral Intervention (1973-78): A Phase of Experiments

During this phase, family planning had been integrated into health services. Workers who are involved in the malaria eradication program received three weeks training to register eligible couples and identify potential contraceptive acceptors. They also distribute contraceptive pills from door to door. Another distinguished feature of this phase was the injections. A Non-Governmental Organization, the Gono Shystha Kendra (People's Health Care) pioneered this introduction.

6.2.g Initiatives and Programs Related to Reproductive Health;

After the Cairo and Beijing Conference national policies and programs were changed. The following are the most important relevant activities and initiatives undertaken in the field of Reproductive Health :

- Formation of National Committee for the Implementation of PoA. (1994)
- Development of "National Plan of Action."(1997)
- Preparation of document entitled "Strategic Directions for the Bangladesh National Family Planning Program: 1995-2005." (1996)
- Development of "Health and Population Sector Strategy" (HPSS) and Health Population Sector Program (HPSS). (1996)
- Development of National Policy on HIV/AIDS and STD related issues. (1996)

- Establishing the "National Council for Women's Development" chaired by the Prime Minister.
- Development of "National Integrated Population and Health Program" (NIPHP) (1996)
- Formation of "National Population Policy Committee" chaired by the Prime Minister.
- Formation of the "National Population Policy Committee" chaired by the Minister of Health and Family Welfare.
- Formation of the "National Health Policy Committee" chaired by the Minister of Health and Family Welfare.
- Formation of "High Level Committee" (HLC) chaired by the Minister of Health and Family Welfare.
- Formulation and approval of "National Food and Nutrition Policy". (1998)
- Formation of National Reproductive Health Strategy. (1997)
- Formation of government-NGO Consultative Council. (1995)
- Formation of National Women Development Policy. (1997)
- Five Year Plans of Bangladesh (Fourth and Fifth) (Begum 2003:123)

6.2.h Problems of Implementation of Reproductive Rights and Health Care in Bangladesh:

Bangladesh has been implementing family planning programs since mid-sixties to control the increasing population. Over the years, she has achieved significant success in the field of population control. Major problems of implementing reproductive rights health in Bangladesh are following:

Abortion and Harmful Practices: The abortion policy of a country is the product of socio-economic, political and religious context in which it is embedded. However Islamic law has an important influence on abortion law in Bangladesh. In Bangladesh abortion is considered as unlawful in many circumstances, but performing an abortion to save of women is permitted. Menstrual Regulation (MR) has been accepted as a legitimate health and family planning measure. It follows from the above discussion that legal structure of

the country is not favorable to the exercise of reproductive rights of women rather it violates women's fundamental human rights including reproductive rights.

Infertility and Sub-fecundity: The problem of infertility is not only a biological problem, it is a social problem as well since due to prevalence If stereotypical, gendered ideas that a women is held responsible for not being able to produce a child, in most cases male ones. Thus lack of diagnosis and treatment for infertility constitute a violation of women's and men's reproductive rights.

Incentives for Family Planning: The Government has introduced incentive system to motivate couple's for adopting permanent methods of family planning. If a woman undergoes ligation, she gets more money than a man.

Lack of Decision-Making Power and Reproductive Choice: Participation of women in taking decisions regarding reproductive health is one of the most important indicators of women's reproductive rights. The higher the decision making power of women, the higher the enjoyment of reproductive rights. However, over the years, women's socio-economic conditions have changed significantly with their increasing participation in gainful employment and greater access to the labor market.

Social Norms and Values: Bangladesh is still largely a tradition-bound society with certain set of norms and cultural values. These norms and values prevent women from exercising their reproductive rights. In this society husband takes the decision in all matters including having the number of children and use or non use of contraceptives. On the other hand, cultural value of son preference hampers women's reproductive health to fulfill patriarchal society's desire to have at least one male child.

Mass Media: Mass media in Bangladesh plays a vital role in disseminating information about contraception and various other health services. In fact, the advertisement never tells about the side-effects of the methods.

Early Marriage: Though the legal age at marriage of women is 18 years, many women are married off much earlier, affecting their reproductive and sexual health. Early pregnancies followed by early marriage contribute to extremely high mortality rate in Bangladesh.

6.2.i Role of NGOs in Promoting Reproductive Health

Chapter 25 of ICPD Program of Action stated that the primary objective of this chapter is to promote an effective partnership between governments, non-governmental organizations, local community groups and private sectors in discussion and decision design, implementation, coordination, monitoring and evaluation of programs relating to population (UN 1995).

NGOs in Bangladesh have been extending support and services to the poor at the grassroots level since the seventies. The non-government organizations involved in reproductive health research in Bangladesh are as follows: The Bangladesh Rural Advancement Committee (BRAC), The Gonoshashthya Kendro (GK), Radda Barnen, BAVS, Concerned Women for Family planning, CARE, BIRPERHT, ICDDR-B etc.

These organizations mostly conduct researches related to their own areas of interest and population they serve.

Role of ICDDR, B: The fundamental mission of the Centre is to develop and disseminate solutions to major health and population and population problems facing the world, with emphasis on simple and cost-effective methods of prevention and control. The Center has gradually acquired reproductive health portfolio with the following unique attributes:

- Long history of conducting pioneering research in areas of population dynamics and family planning.

- Key role in raising the contraceptive use rate among women of reproductive age in Bangladesh.
- Rural family planning interventions in Matlab which provide a modes for maternal and child health, and family planning programs throughout the world.
- Matlab International Training Center which hosts visitors and conferences and conduct a variety of courses, including reproductive health. Family Planning Research Project (FHRP) that works in collaboration with the Government of Bangladesh implementing strategies developed at the Center to improve family planning, reduce population growth and promote safe motherhood.
- Integrate family planning and child health program improving child survival as well as lowering fertility rate. (ICDDR,B 2002:26)

During 2001 the Centre's reproductive health program's continued to address issues relating to reproductive health research. The program has been conducting research in critical and priority areas of health in various parts of Bangladesh. It also focuses on safe motherhood interventions as a means in reducing maternal mortality and morbidity.

Role of BRAC: BRAC's present health program has evolved from a series of lessons learned over the years in providing basic health care services at grassroots level. Essential Health Care (EHC) is a package of BRAC which delivered primarily through the Shastho Shebika's or health volunteer. Components of EHC include water and sanitation, family planning, immunization, pregnancy related care, basic curative care.

Role of CARE-BANGLADESH: The strategies areas for CARE's health and population programming in 2000 were:

- Hygiene behavior change-both rural and urban
- Water and sanitation –both urban and rural
- HIV prevention-high risk groups

- Immunization-rural including remote areas
- Reproductive health-rural
- Women's empowerment-both urban and rural

The NGOs have either strengthened the existing health care system or have developed institutional structures and mechanism to ensure effective delivery of health services and family planning services through other established centers at the community level.

CHAPTER SEVEN

GENERAL CHARACTERISTICS OF THE RESPONDENTS

Table 7.1: Age of the Respondents

Age Category	Frequency	Percentage
15-19	26	4.8
20-24	105	19.4
25-29	221	40.8
30-34	84	15.5
35-39	63	11.6
40-44	34	6.3
45-49	9	1.7
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.1 illustrates that age of the respondents are between 15 to 49 years which have been divided into 7 clusters with 5 years of interval. 5 per cent of the respondents are between 15 to 19 years of age. 19 percent of the respondents are between 20 to 24 years. Majority of the respondents belong to age limit between 25 to 29 years. 16 percent respondents are between 30 to 34 years and 12 percent is between 35 to 39 years. Only 6 percent of the respondents are between 40 to 44 years. At the higher age group of 45 to 49 years of age two percent only.

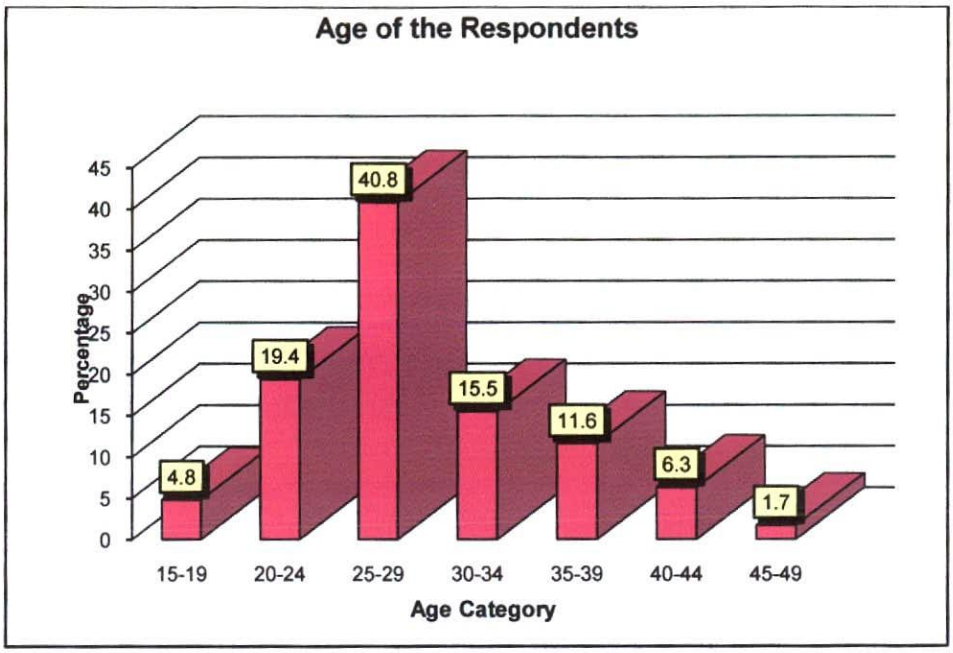


Table 7.2: Household size

Household Size	Frequency	Percentage
Three	94	17.3
Four	155	28.6
Five	156	28.8
Six	57	10.5
Seven	31	5.7
Eight	22	4.1
Nine and above	27	5.0
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.2 shows that among the respondents there are six types of household based on members observed in the study area. 17 percent respondents belong to three categories, 29 percent to four categories, and five categories respectively. 11 percent respondents fall into Seven-member family. Household with eight members and above is 5 percent. Majority of the respondents belong to 4 and 5 members family.

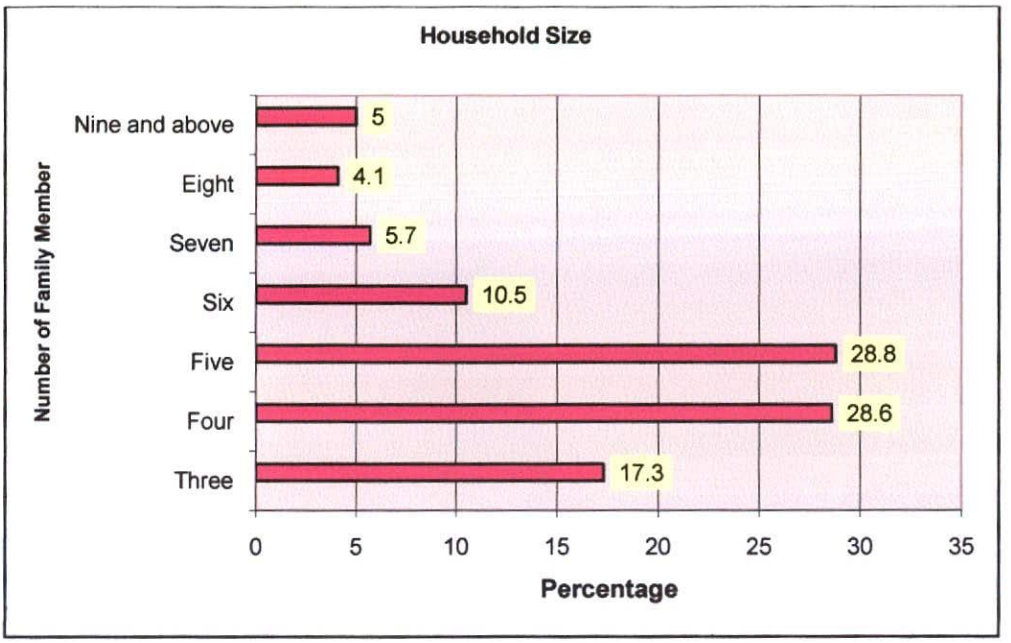


Table 7.3: Occupation of the respondents

Frequency	Frequency	Percentage
Garment worker	272	50.2
Day laborer	30	5.5
Nurse	4	0.7
Doctor	3	0.6
Lawyer	2	0.4
Lecturer	1	0.2
NGO worker	21	3.9
Small entrepreneur	170	31.4
Engineer	1	0.2
School teacher	11	2.0
Banker	2	0.4
Shop keeper	7	1.3
Health worker	6	1.1
Farmer	12	2.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.3 presents many types of occupation prevailing across the study area. 50 percent respondents are garment workers. Only 6 percent respondents are day laborers because they have not got other opportunities to go outside for earning. Nurse, doctor, lawyer and lecturer are hardly found among the respondents. NGO workers are only 4 percent but 31 percent are small entrepreneur because NGOs have contributed much to make them capable of taking entrepreneurship. Very small percentage of the respondents have the profession of school teacher, shopkeeper and farmer among the respondents.

Table 7.4: Occupation of the Respondents' Husband

Occupation	Frequency	Frequency
Rickshaw puller	42	7.7
Day laborer	114	21.0
Manager	95	17.5
Govt. employee	52	9.6
School Teacher	20	3.7
Migrant workers	90	16.6
Driver	30	5.5
Supervisor	22	4.1
Farmer	24	4.4
Businessman	53	9.8
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.4 shows that the majority (21 percent) of the respondent's husbands are day-laborer. 8 percent's are Rickshaw puller, 18 percent's are manager, 10 percent government employee. 4 percent are School teacher, supervisor and farmer. 17 percent of the respondents' husbands are migrant workers. Only 10 percent of the respondents' husbands are business man.

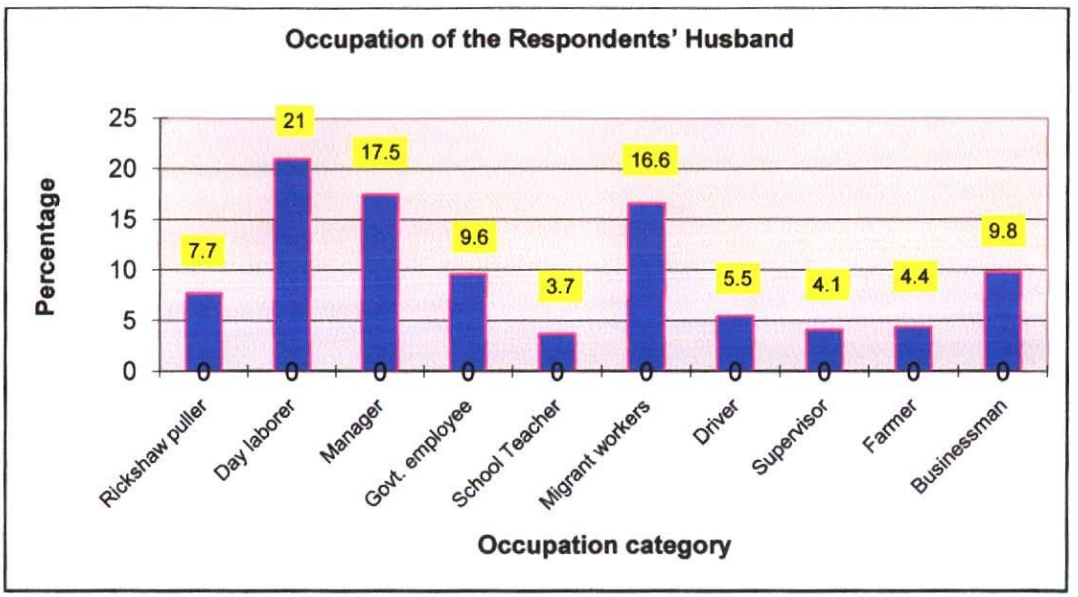


Table 7.5: Level of education

Educational Level	Frequency	Percentage
Illiterate	65	12.0
Primary	107	19.7
SSC	128	23.6
HSC	172	31.7
Honors	54	10.0
Master's	16	3.0
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.5 shows educational qualifications of the respondents. 12 percent of the respondents are illiterate. 20 percent had been enrolled in primary school. At SSC and HSC level, the rates are 24 and 32 percent respectively. Though a number of the respondents had honours level education but only very few had masters level education.

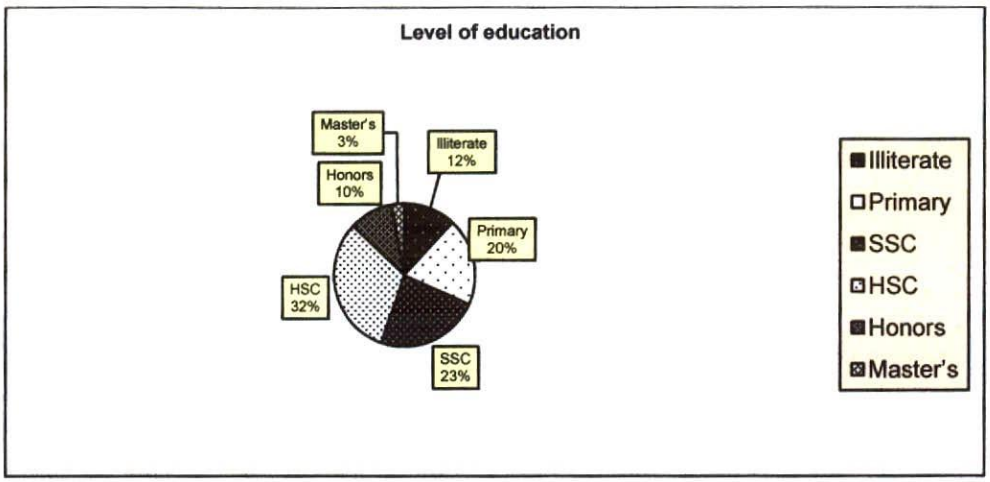


Table 7.6: Religion of the Respondents

Educational Level	Frequency	Percentage
Islam	504	93.0
Hinduism	20	3.7
Buddhism	11	2.0
Christianity	7	1.3
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.6 shows the religious status of the respondents. As Bangladesh is a Muslim country, the majority of the respondents are Muslim, which was 93 percent. 4 percent are Hindus, 2 percent are Buddhist and 1 percent is Christian.

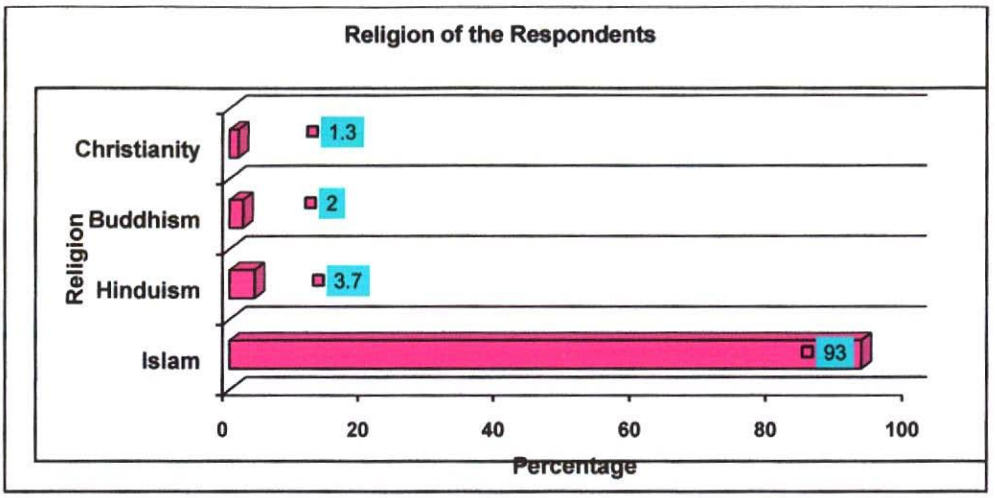


Table 7.7: Total Income of the Respondents per month

Income Category	Frequency	Percentage
0-3999	160	29.5
4000-6999	103	19.0
7000-9999	132	24.4
10000-12999	27	5.0
13000-15999	20	3.7
16000-25000	60	11.1
25000-50000	40	7.4
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.7 presents income status of the respondents. 30 percent of the respondent's income is limited to Taka 0-3999 which represents majority of the respondents. 19 percent falls in the income group of Taka 4000 to 6999. 24 percent are in Taka 7000 to 9999 level. 5 percent are among Taka 10000-12999. 4 percent are from Taka 13000 to 15999. 11 percent are from Taka 16000 to 25000. 7 percent's income is above Taka 25000.

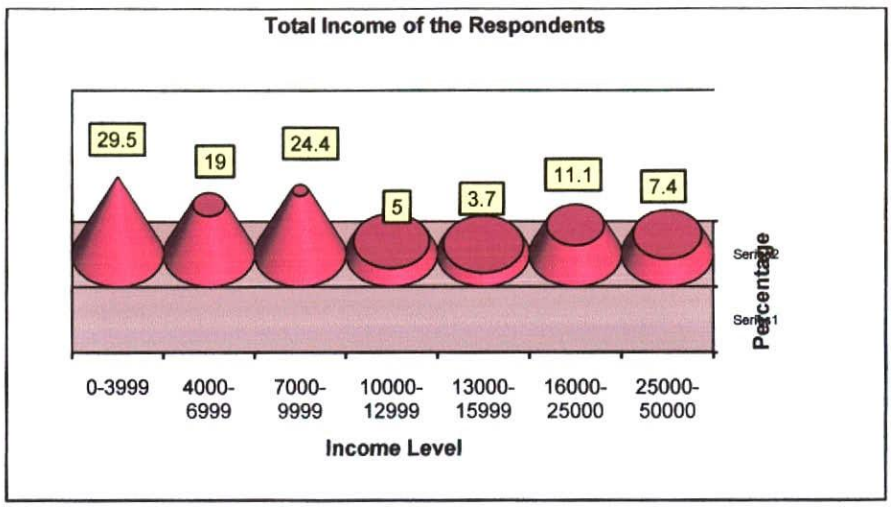


Table 7.8: Total Income of the Household

Income Category	Frequency	Percentage
4000-6999	202	37.3
7000-9999	30	5.5
10000-12999	80	14.8
13000-15999	102	18.8
16000-25000	72	13.3
25000-50000	30	5.5
50000+	26	4.8
Total	**542**	**100.0**

Source: Field Work, 2007-08

Out of 542 respondents 37 percent respondents' household income level is between Taka 4000-6999, which is the highest number of the respondents depicted in the table 8. Only 6 percent respondents belong to Taka 7000-9999 and Taka 25000-50000 respectively. 15 respondents are under Taka 10000-12999 and 19 percent to Taka 13000-15999. 13 percent respondent's income is in between Taka 16000-25000 which is very high in the table. Only 5 percent respondents' income is above Taka 50000.

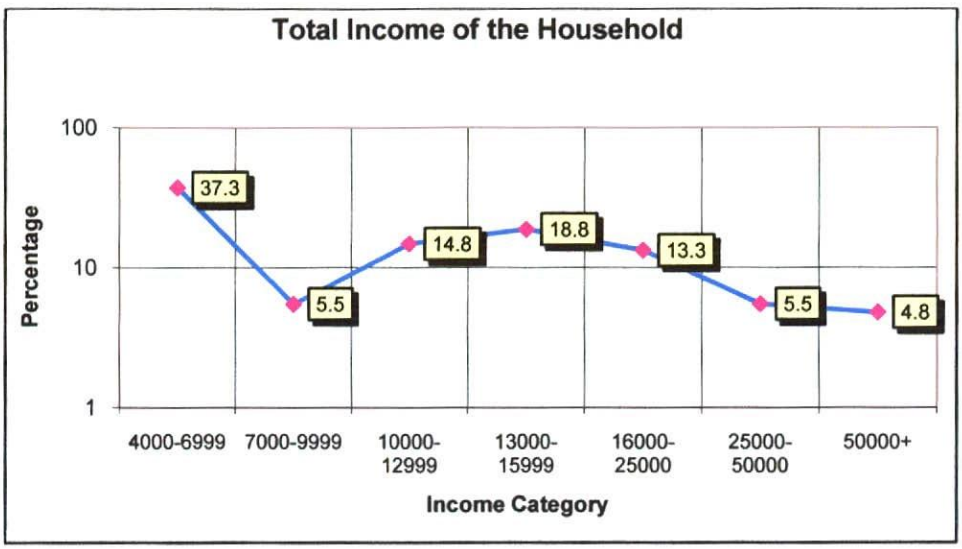


Table 7.9: Total Income of the Respondents' Husband

Income Category	Frequency	Percentage
0-3999	108	19.9
4000-6999	114	21.0
7000-9999	60	11.1
10000-12999	66	12.2
13000-15999	53	9.8
16000-25000	59	10.9
25000-50000	63	11.6
50000+	19	3.5
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.9 illustrates that 20 percent respondents' husband's income are in 0-3999; 21 percent respondents' husband's income are in 4000-6999; 11 percent respondents' husband's income are in 7000-9999; 12 percent are in 10000-12999; 10 percent are in 13000-159999; 11 percent are in 16000-25000; 12 percent are in 25000-50000 and 6 percent are in above 500000.

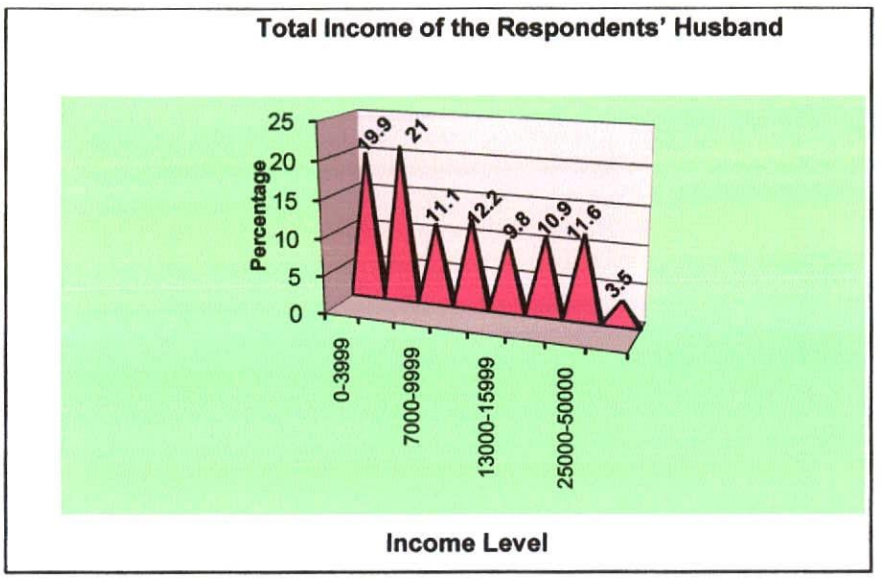


Table 7.10: Total Expenditure of the Respondents per month

Income Category	Frequency	Percentage
0-3999	324	59.8
4000-6999	134	24.7
7000-9999	57	10.5
10000-12999	27	5.0
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.10 above shows that 60 percent respondents' expenditure are within Tk. 4000 and only 5 percent respondents' expenditure is Taka 10000-12999.

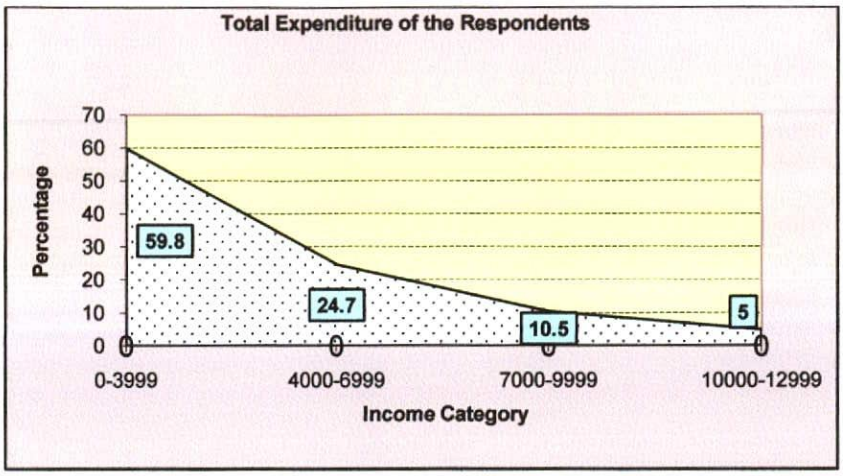


Table 7.11: Total Expenditure of the Household per month

Income Category	Frequency	Percentage
4000-6999	190	35.1
7000-9999	42	7.7
10000-12999	38	7.0
13000-15999	68	12.5
16000-25000	85	15.7
25000-50000	105	19.4
50000+	14	2.6
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.11 demonstrates that 35 percent of the respondents' household expenditure is between Tk. 4000-6999; 8 percent respondents' household expenditure is Taka 7000-9999; 7 percent respondents' household expenditure is Taka 10000-12999; 13 percent respondents' household expenditure is Taka 13000-15999; 16 respondents' household expenditure is Taka 13000-159999; 11 percent respondents' household expenditure is Taka 16000-25000; 12 percent respondents' household expenditure is Taka 25000-50000 and only 6 percent respondents' household expenditure is above Taka 500000.

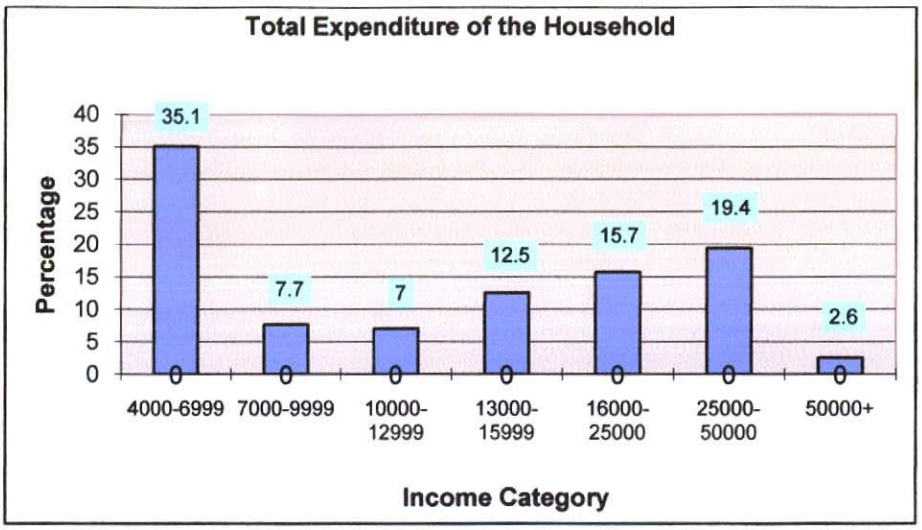


Table 7.12: Total Expenditure of Her Husband

Income Category	Frequency	Percentage
0-3999	281	51.8
4000-6999	157	29.0
7000-9999	39	7.2
10000-12999	65	12.0
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.12 shows that 52 percent respondents' husband's expenditure is between Tk. 0-3999; 29 percent respondents' husband's expenditure is Taka 4000-6999; 7 percent respondents' husband's expenditure Taka 7000-9999 and 12 percent respondents' husband's expenditure is Taka 10000-12999.

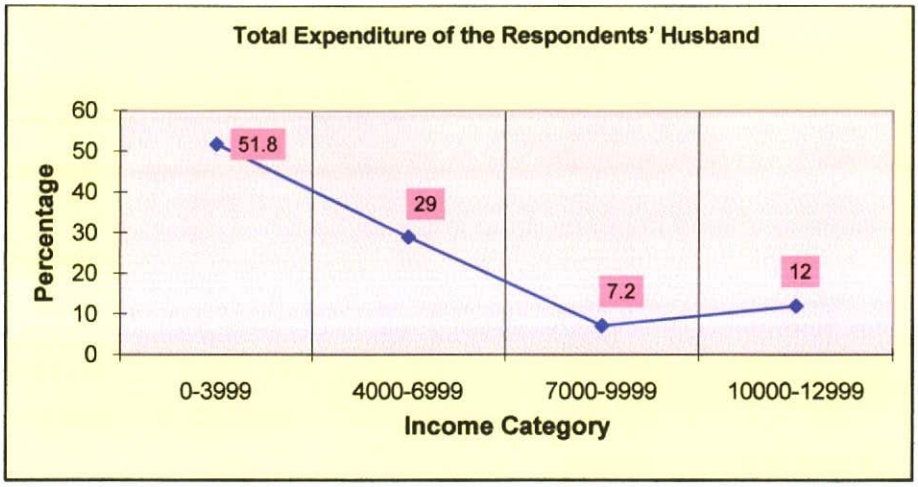
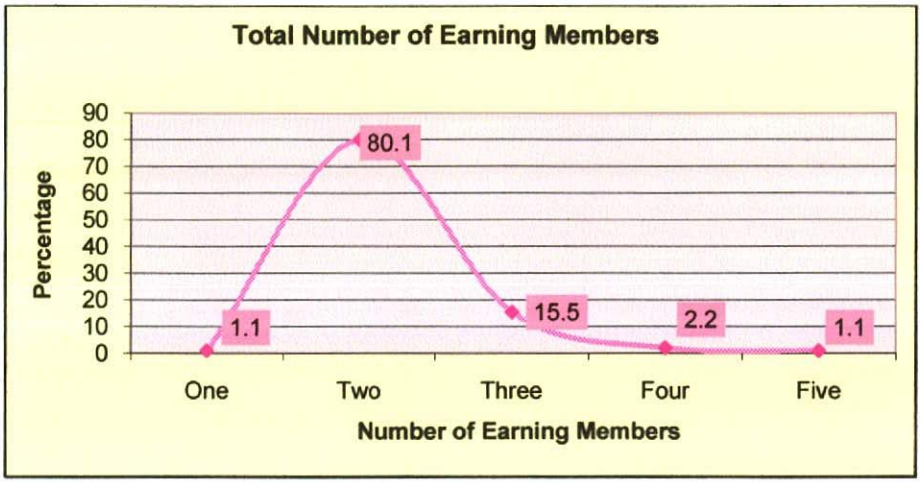


Table 7.13: Total Number of Earning Members

Earning Members	Frequency	Percentage
One	6	1.1
Two	434	80.1
Three	84	15.5
Four	12	2.2
Five	6	1.1
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 7.13 indicates that only 1 percent of the respondents' have single earning member. But the 80 respondents' earning members are two. 16 percent family has three earning members and interestingly there are even five and six earning members in a joint or extended family.



CHAPTER EIGHT

FINDINGS OF THE QUANTITATIVE STUDY

Table 8.1: Age at First Marriage

Age Category	Frequency	Percentage
10-14	78	14.4
15-19	232	42.8
20-24	159	29.3
25-29	63	11.6
30-34	10	1.8
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.1 shows age at first marriage of the respondents based on 5 categories with 5 intervals. Those who are in 1o to 14 years of age is 14 percent, 15 to 19 are 43 percent, and 25-29 are 12 percent and those who are in 30 to 34 is 2 percent. It is apparent from the table that 43 percent of respondents got married with the age of 15-19. That means early marriage is prevalent in the study area among the respondents.

Table 8.2: Age at Second Marriage

Age	Frequency	Percentage
10-14	6	1.1
15-19	54	10.0
20-24	30	5.5
25-29	20	3.7
30-34	25	4.6
Total	135	24.9
System	407	75.1
Total	**542**	**100.0**

Source: Field Work, 2007-08

Second marriage is also seen among the respondents. In this respect age limit has been divided in to 5 categories based on 5 years interval. Those who have got second marriage between 10 to 14 years are 1 percent, 15 -19 are 10 percent, 20-24 are 6 percent, 25-29 are 4 percent and 30-35 are 5 percent

Table 8.3: Marriage Pattern

Marriage Pattern	Frequency	Percentage
Personal choice	185	34.1
Arrange	357	65.9
Total	**542**	**100**

Source: Field Work, 2007-08

In our country, arrange marriage is very common and that revealed in this study as well. 66 percent of the respondents had arranged marriage and 34 percent had their marriage by their choice.

Table 8.4: Idea about Reproductive Rights

Ideas about Reproductive rights	Frequency	Percentage
Yes	404	74.5
No	138	25.5
Total	**542**	**100.0**

Source: Field Work, 2007-08

In answering to a question of the idea of reproductive rights 75 percent of the respondents replied positively and 26 percent do not know because they have not been made aware of their rights by any organizations.

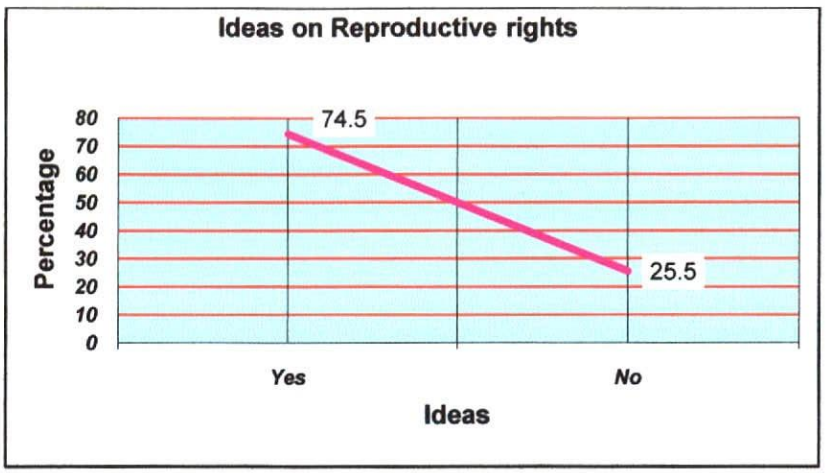


Table 8.5: Decision about having children

Decision about having children	Frequency	Percentage
Yes	194	35.8
No	348	64.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.5 shows that at the time of having child, 36 percent of respondent's opinions were take into consideration and 64 percent of the respondents could not take their own decisions because the society is patriarchal and women are completely dependent on their husband's decision.

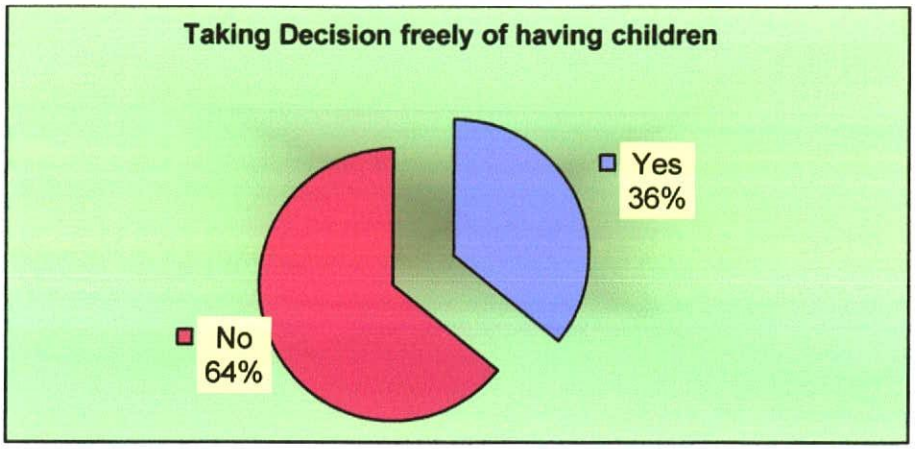


Table 8.6: Decision about number of children

Decision about number of many children	Frequency	Percentage
Self	195	36.0
Husband	232	42.8
Both	97	17.9
Mothter-in-law	18	3.3
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.6 shows that in taking decisions of how many children they will get, 36 percent respondent says that they themselves decided. 43 percent said that their husband took decision and 18 percent thought that both husband and wife took joint decision. But 3 percent said that their mother-in law took the decision.

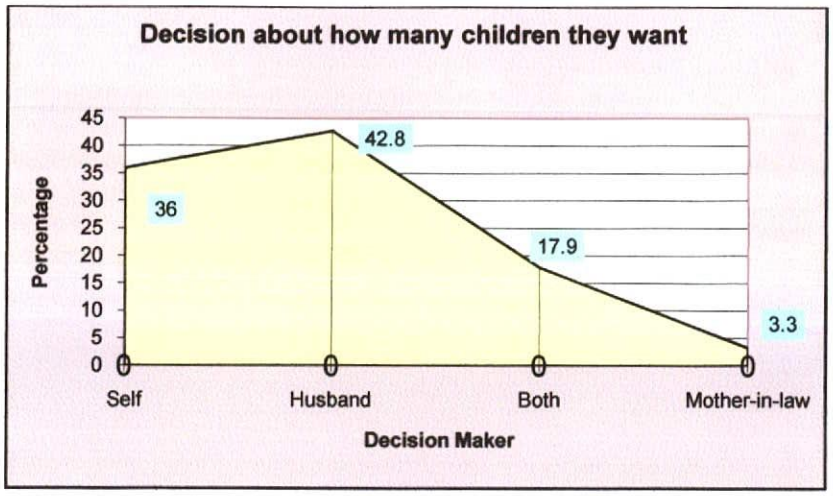


Table 8.7: Decision of timing to become pregnant

Decision of timing to become pregnant	Frequency	Percentage
Yes	183	33.8
No	359	66.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

In taking decision about timing of pregnancy 34 percent said that they took decision by themselves. 66 percent did not take decision on their own. They had to follow their husbands' decision.

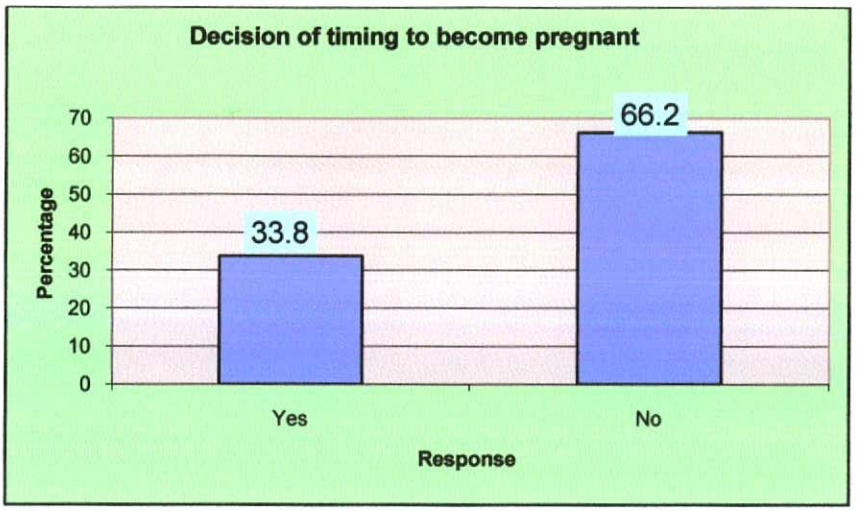


Table 8.8: Decision about the gap or space?

Decision about the gap or space	Frequency	Percentage
Self	155	28.6
Husband	248	45.8
Both	114	21.0
Mother-in-law	16	3.0
Doctor	9	1.7
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.8 shows taking decision about the gap or space of having children. It is observed from the table that women themselves who took decision themselves are 29 percent. 46 percent of the respondents said that their husband took the decision for them. In this respect, 21 percent respondents took decision jointly. In some cases it is found that Mother-in-law's also took the decision though it is very small, only 3 percent. Almost nobody took Doctor's decision about this issue.

Table 8.9: Violence for denying husband's decision

Violence occurred for denying husband's decision	Frequency	Percentage
Yes	93	17.2
No	449	82.8
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.9 shows the incident of violence due to denial of husband's decision. 17 percent stated that they had to face violence for the denial but 83 percent did not face any violence due to the denial of husband's decision to take child.

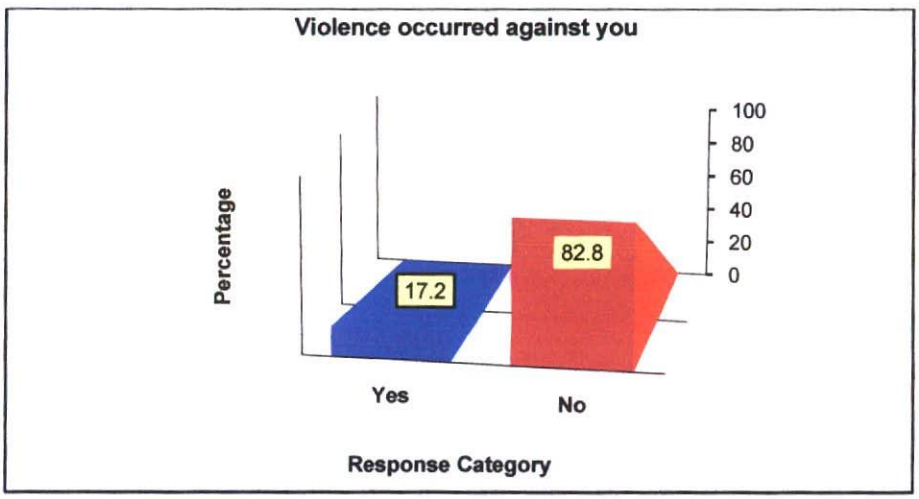


Table 8.10: Types of Violence

Types of Violence	Frequency	Percentage
Physical abuse	39	41.9
Mental torturing	40	43.0
Sexual assault	14	15.1
Total	**93**	**100.0**

Source: Field Work, 2007-08

Those who have said yes have pointed out three types of violence such as physical abuse, mental torturing and sexual assault. 42 percent respondent said

that they have been physically abused by their husbands. 43 percent claim that they had been victim of mental torturing and 15 percent were sexually assaulted.

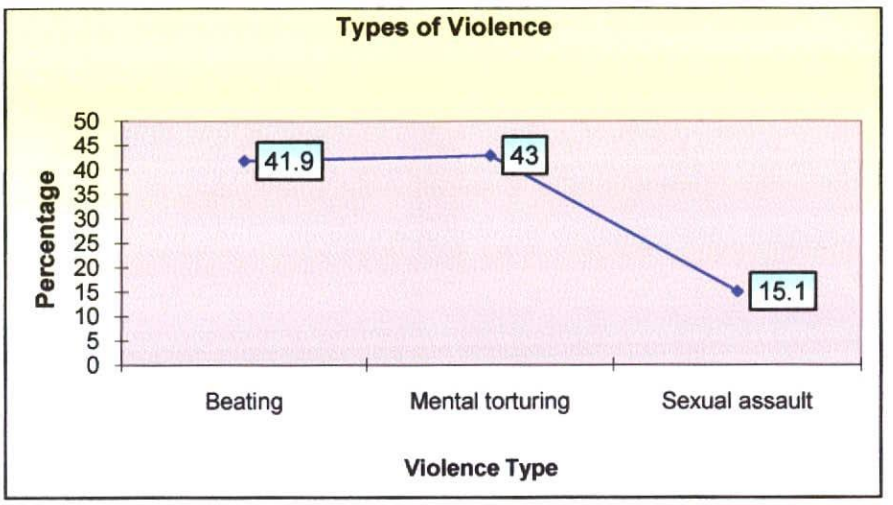


Table 8.11: Right to protest against husband

Right to protest against husband	Frequency	Percentage
Yes	233	43.0
No	309	57.0
Total	**542**	**100.0**

Source: Field Work, 2007-08

43 percent respondents said that they have right to protest against husband's decision but 57 percent of the respondents are not in a position to protest because they are totally dependent on their husband's income.

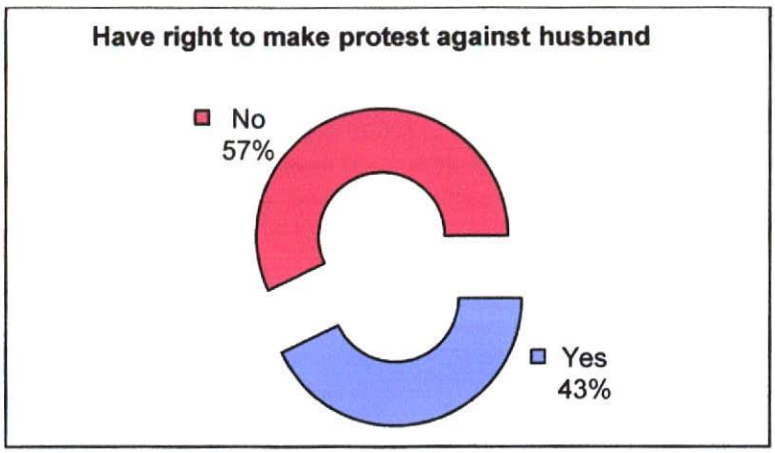


Table 8.12: Coercion of having sex

Coercion of having sex	Frequency	Percentage
Yes	165	30.4
No	377	69.6
Total	**542**	**100.0**

Source: Field Work, 2007-08

In this question of coercion for having sex 30 percent respondents have confessed that they had been coerced .On the other hand, 70 percent had not been coerced.

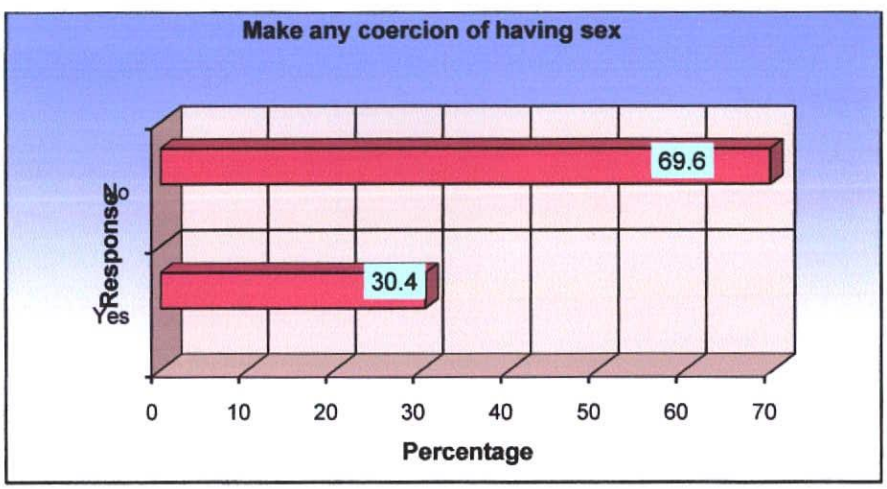


Table 8.13: Priority for having sex

Priority for having sex	Frequency	Percentage
Self	114	21.0
Husband	345	63.7
Both	83	15.3
Total	**542**	**100.0**

Source: Field Work, 2007-08

This was a very difficult question to get an answer. In spite of that 21 percent respondents claimed that they enjoyed much priority during the sex. 64 percent said that their husband enjoy much priority. Only 15 percent expressed that both of them enjoyed equal priority during sex.

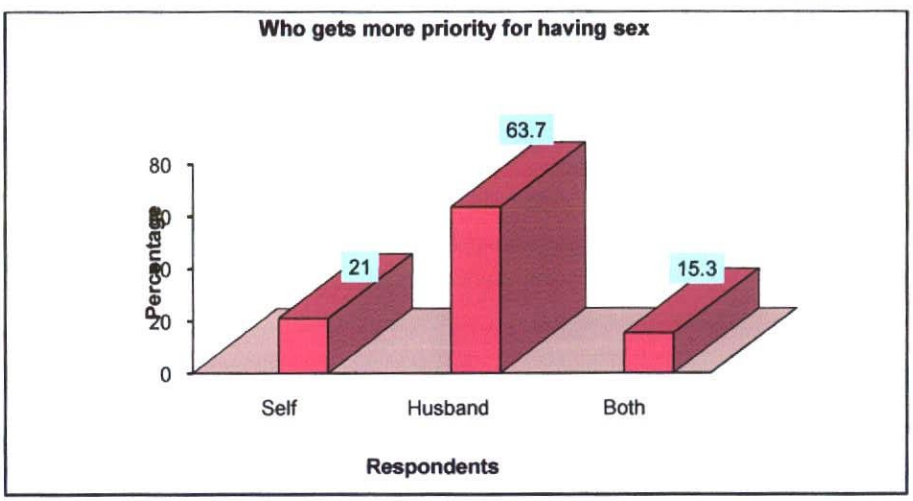


Table 8.14: Mutual understanding of having sex lives

Mutual understanding of having sex lives	Frequency	Percentage
Yes	369	68.1
No	173	31.9
Total	**542**	**100.0**

Source: Field Work, 2007-08

61 percent of respondents said that there exist mutual understanding for having sex but 32 percent disagreed at this question.

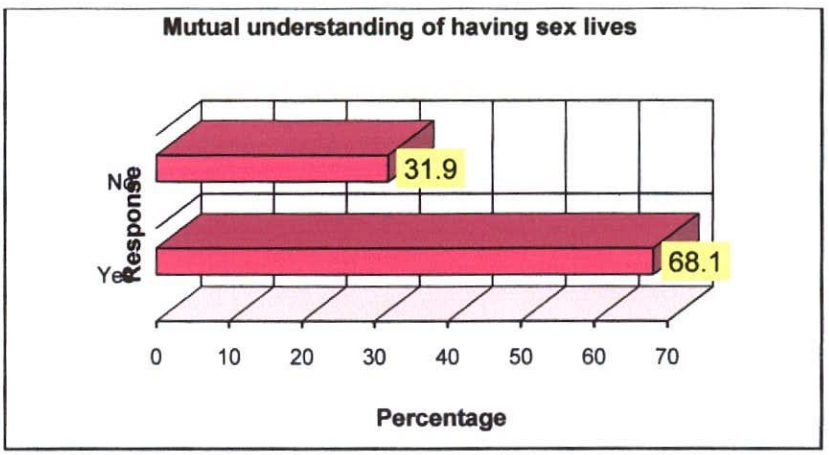


Table 8.15: Experience of having abortion

Experience of having abortion	Frequency	Percentage
Yes	185	34.1
No	357	65.9
Total	**542**	**100.0**

Source: Field Work, 2007-08

34 percent of the respondents said that they have the experience of having abortion but 66 percent of the respondents had no experience of having abortion.

Table 8.16: Decision about abortion

Decision about abortion	Frequency	Percentage
Self	36	19.5
Husband	105	56.8
Father-in-law	6	3.2
Mother-in-law	17	9.2
Both	21	11.4
Total	**185**	**100.0**

Source: Field Work, 2007-08

From the table 8.16, it appears that the decision of having abortion mainly comes from husband. 20 percent took decision by themselves. 57 percent said that their husbands decided whether abortion can be done. In this case mother –in-law rather than father-in-law plays much more role. Only 11 percent of the respondents claim that both husband and wife took decision.

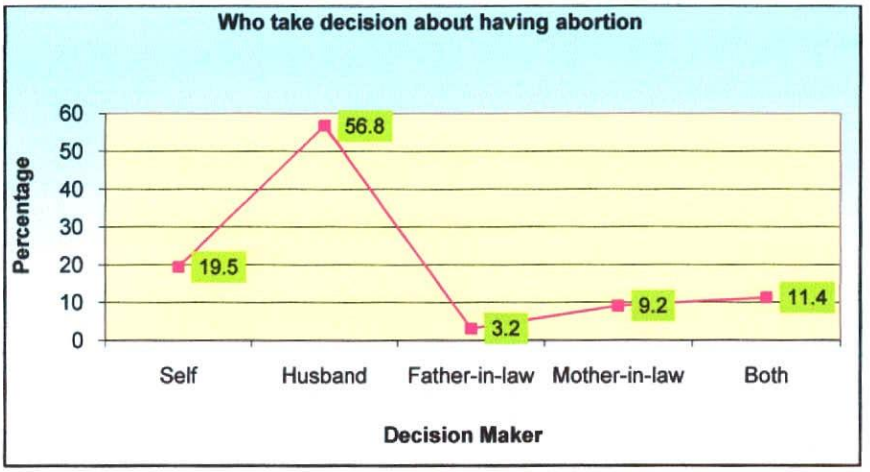


Table 8.17: Get respect from husband?

Get respect from husband	Frequency	Percentage
Yes	270	49.8
No	222	41.0
Sometimes	50	9.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

In response to a question to get respect/honor from their husband 50 percent respondents informed that they get respect from their husband. But 42 percent stated that they do not get respect.

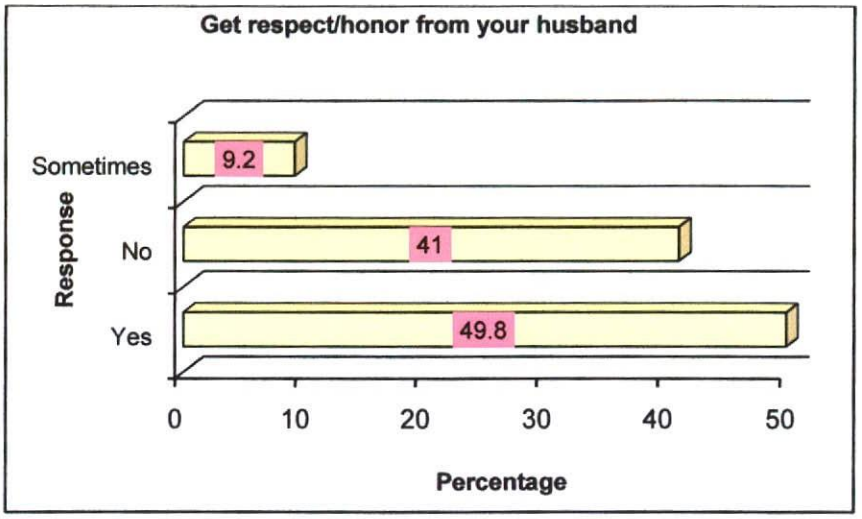


Table 8.18: Follow reproductive belief

Follow reproductive belief	Frequency	Percentage
Yes	353	65.1
No	189	34.9
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.18 presents religious bindings about reproductive issues. It is observed from the table that 65 percent of the respondents followed religious bindings because religion has been associated with their lives from the very infancy. 35 percent respondents do not think that religion influences their lives about reproductive issues.

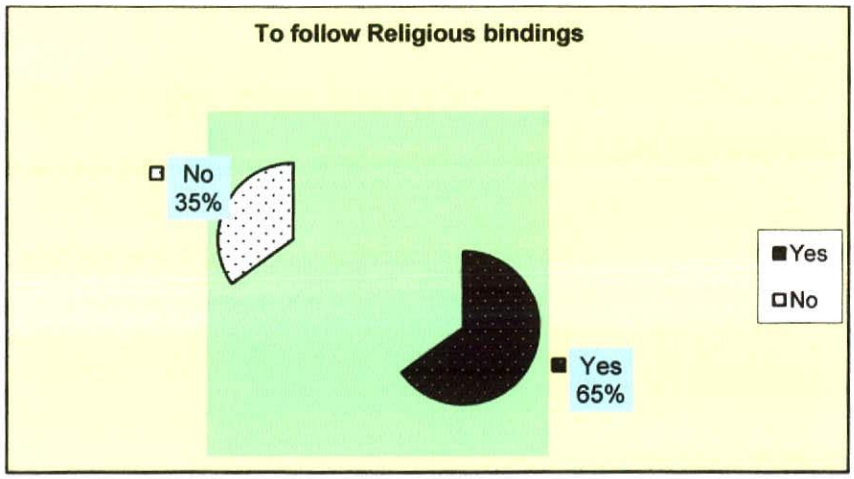


Table 8.19: Idea about reproductive health?

Idea about reproductive health	Frequency	Percentage
Yes	355	65.5
No	187	34.5
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.19 shows that most of the respondents have been aware of reproductive health because many governmental and non-governmental organizations have taken different steps to make people aware of reproductive rights. 66 percent of the respondents know about it and 35 percent of the respondents do not have any idea about their reproductive health in spite of so many campaigns.

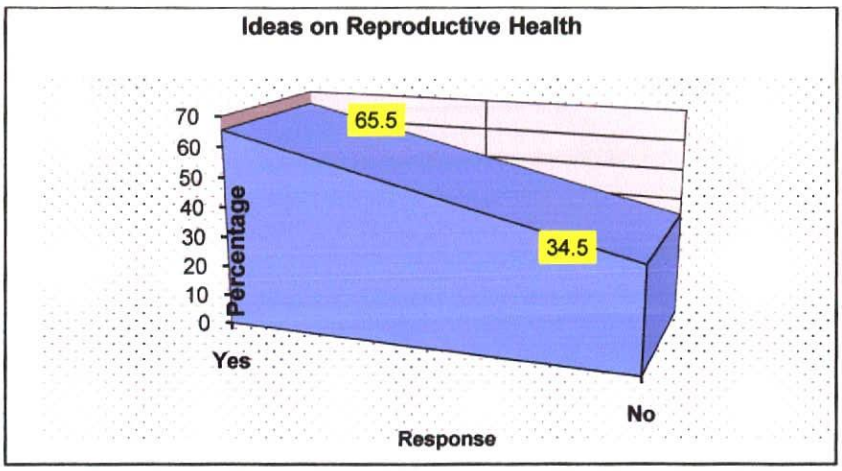


Table 8.20 Idea about family planning

Idea about family planning	Frequency	Percentage
Yes	524	96.7
No	18	3.3
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.20 shows that 97 percent of the respondents are aware of family planning services through media and due to many steps taken by GO and NGOs. Only 3 percent respondents have not been aware of family planning yet.

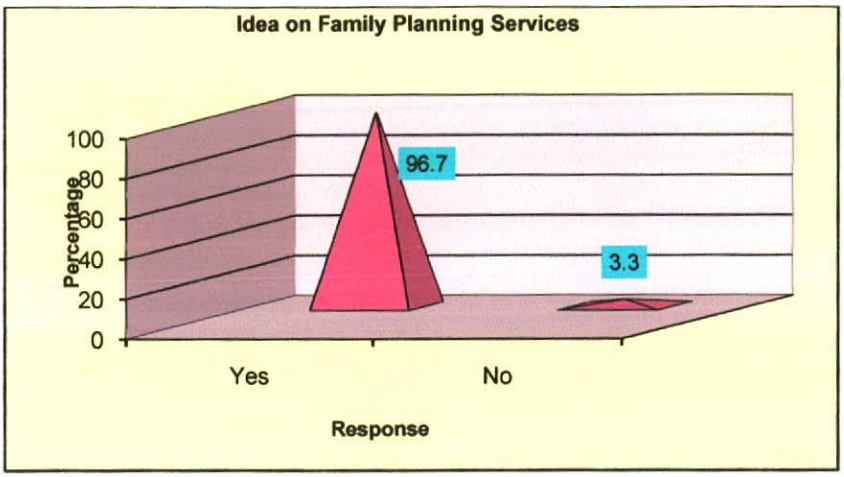


Table 8.21: Source of information about reproductive health

Source of information about reproductive health	Frequency	Percentage
Health worker	198	36.5
Doctor	101	18.6
Nurse	32	5.9
Kabiraj	18	3.3
Fakir	12	2.2
Relatives	18	3.3
Mass media	163	30.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.21 presents the sources of information about reproductive health. 37 percent respondents received information from health workers. 19 percent respondents have got information from doctor, 6 percent from nurse and 3 percent from kabiraj. Fakirs have also played a significant role in giving information to the village people. In this respect mass media have come forward and 30 percent respondents have been aware of reproductive health by seeing different sources of reproductive health.

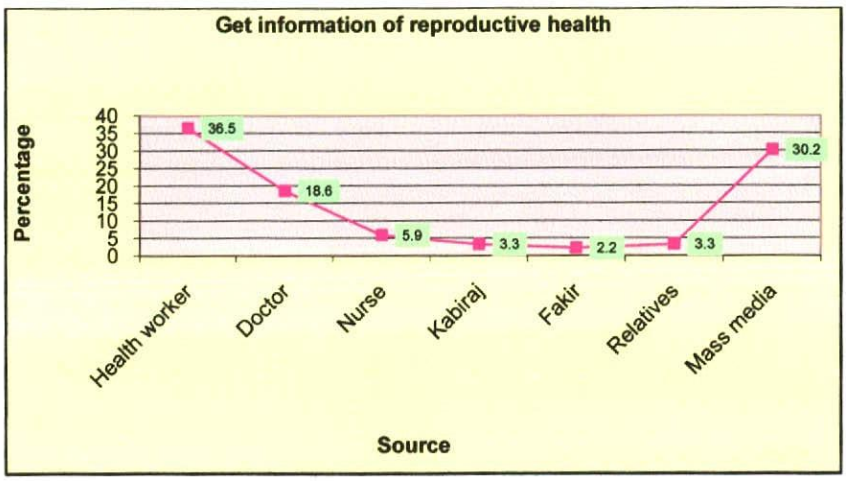


Table 8.22: Co-operation from husband during pregnancy

Sufficient co-operation during pregnancy	Frequency	Percentage
Yes	395	72.9
No	147	27.1
Total	**542**	**100.0**

Source: Field Work, 2007-08

The table 8.22 above indicates that 73 percent respondents get sufficient co-operation during pregnancy. But 27 percent respondents did not get sufficient co-operation during pregnancy because they are either low paid or not good looking or unable to give dowry during marriage.

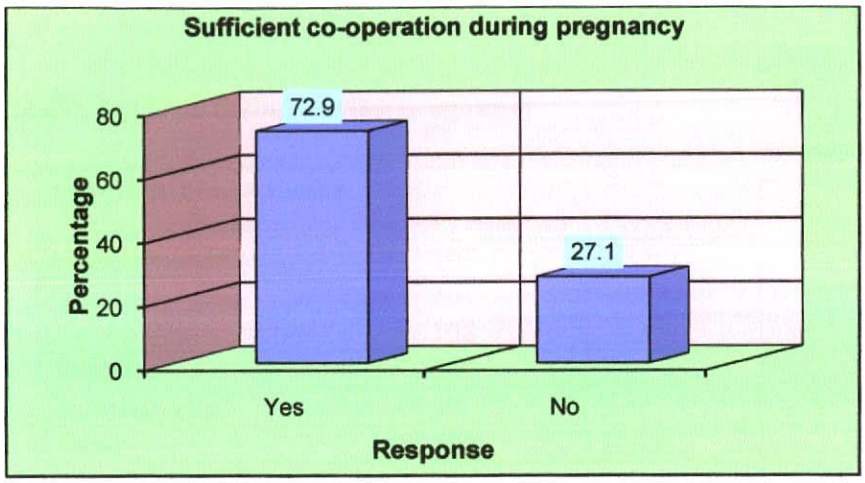


Table 8.23: Health care during Pregnancy

Enough food and healthcare during Pregnancy	Frequency	Percentage
Yes	362	66.8
No	180	33.2
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.23 shows that most of the respondents are very poor. They do not get food two times a day. It is rather a luxury for them to take extra food during pregnancy. In spite of that it is observed from the table that 67 percent respondents get enough food but 33 percent do not.

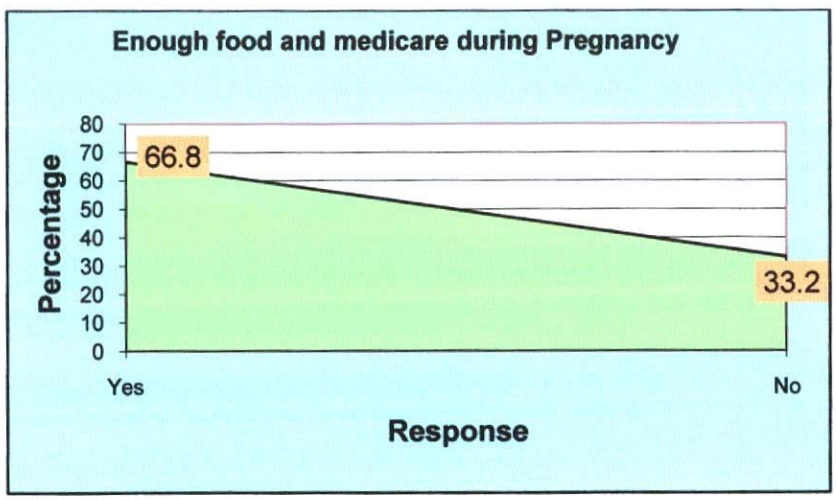


Table 8.24: Health problem facing during pregnancy

Health problem facing during pregnancy	Frequency	Percentage
Fever frequently	109	20.1
Vomiting	167	30.8
No problem	198	36.5
Jaundice	38	7.0
Stomach pain	30	5.5
Total	**180**	**100.0**

Source: Field Work, 2007-08

Table 8.24 shows that most of the respondents have suffered from many diseases. 20 percent of the respondents said that they suffered from fever frequently. 30 percent suffered vomiting. 37 percent did not face any problems. 7 percent from jaundice and 6 percent from stomach ache.

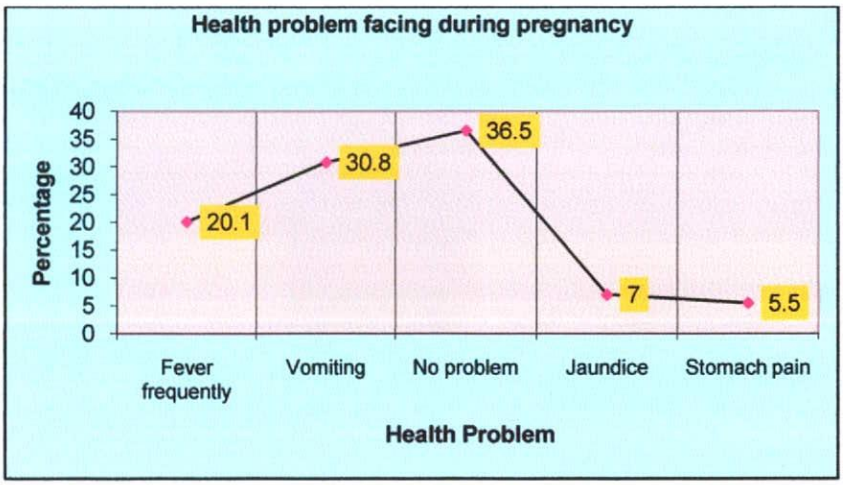


Table 8.25: Decision about contraceptives

Decision about contraceptives	Frequency	Percentage
Self	113	20.8
Husband	224	41.3
Both	205	37.9
Total	542	100.0

Source: Field Work, 2007-08

38 percent respondents say that they choose contraceptives by their own. On the other hand 41 percent said that it depends almost on the will of their husband. Out of the total respondents 38 percent acknowledged that both played important role in taking decision about using contraceptives.

Table 8.26: Types of contraceptives

Types of contraceptives	Frequency	Percentage
Condom	102	26.5
Pill	229	59.5
Injection	54	14.0
Total	385	100.0

Source: Field Work, 2007-08

Among the respondents three types of contraceptive are found. These are Pill, Condom, and injection. It is observed from the table that 27 percent respondents take condom, 60 percent take pill and 14 percent respondents take injection.

Table 8.27: Idea about sexually transmitted diseases (STD)

Idea about sexually transmitted diseases	Frequency	Percentage
Yes	433	79.9
No	109	20.1
Total	**542**	**100.0**

Source: Field Work, 2007-08

Table 8.27 shows that people are lot more aware about sexually transmitted disease through mass media and many GOs and NGOs. As a result 80 percent respondents of the

respondents are aware of this fatal disease but 20 percent have been reluctant about this disease, who consider that AIDS is the result of sin.

Table 8.28: Types of STD

Types of STD	Frequency	Percentage
Syphilis	56	12.9
HIV/Aids	305	70.4
Vaginitis	7	1.6
Gonorrhea	30	6.9
Pelvic Inflammatory Disease	17	3.9
Genital Warts	6	1.4
Hepatitis C Virus	12	2.8
Total	**433**	**100.0**

Source: Field Work, 2007-08

Table 8.28 presents a picture of sexual diseases with which people are generally affected. Syphilis, AIDS and Gonorrhea are worth mentioning. In the study area we have found that 13 percent respondents are aware of Syphilis, 70 percent have heard the name of HIV/AIDs. BUT only 2 and I percent are aware of vaginitis and genital warts which are very fatal to women. The information about Pelvic Inflammatory Disease and Hepatitis c Virus have reached to the respondents.

Statistical Test of the Hypotheses

Chi-square Test

Table 8.30 gives the summary of the significant association found at chi-value, shows factors that are significantly associated with the items of reproductive rights and reproductive health. It is found that the selected dependent variables are significantly related to selected demographic and socio-economic variables like age, education, occupation (own), occupation (husband), income (own) and income (husband). Given the predominance of nominal level of measurement, the chi-square test is preferred for measuring the association. Many associations between independent variables and dependent variables are found significant at α=.01 and α=.05 levels of significance.

It shows that income (own), education, occupation (own) and income (husband) are the key correlates of this study in terms of number of items significantly related. Next in importance is occupation (husband) followed by age that appears to be least influential variables.

Table 8.29 Chi-Square Values of Selected Variables

Dependent Variables	Age	Education	Occupation (Own)	Occupation (husband)	Income (Own)	Income (Husband)
First marriage	X^2=1.828 df=1;α=.01	X^2=4.064 df=11;α=.01	-	X^2=2.442 df=7;α=.01	X^2=2.010 df=3;α=.01	X^2= 7.237 df=7;α=.05
Second marriage	-	X^2=1.131 df=3;α=.01	X^2= 7.237 df=7;α=.05	X^2=4.558 df=7;α=.01	X^2=4.558 df=7;α=.01	X^2=7.589 df=11;α=.01
Arrange marriage	-	-	X^2=1.191 df=3;α=.01	-	X^2= 7.237 df=7;α=.05	X^2=6.293 df=5;α=.01
Personal choice	X^2=2.569 df=1;α=.01	X^2=6.437 df=11;α=.01	X^2=1.131 df=3;α=.01	X^2= 7.237 df=7;α=.05	X^2= 45.292 df=35;α=.01	-
Knowing Reproductive rights	X^2=2.569 df=1;α=.01	X^2=6.437 df=11;α=.01	X^2=1.131 df=3;α=.01	X^2= 7.237 df=7;α=.05	X^2= 45.292 df=35;α=.01	X^2=2.569 df=1;α=.01
Decision freely of having children	-	X^2= 7.237 df=7;α=.05	X^2=1.744 df=3;α=.05	X^2=5.727 df=7;α=.01	X^2= 7.237 df=7;α=.05	X^2= 7.237 df=7;α=.05
Decision about number of children	-	X^2=11.821 df=11;α=.01	X^2= 7.237 df=7;α=.05	-	X^2= 7.237 df=7;α=.05	X^2= 7.237 df=7;α=.05
Decision of timing to become pregnant	X^2= 7.237 df=7;α=.05	X^2=7.589 df=11;α=.01	X^2= 7.237 df=7;α=.05	X^2= 7.237 df=7;α=.05	X^2=41.081 df=35;α=.05	X^2=2.010 df=3;α=.01
Decision about the gap or space	-	X^2= 7.457 df=13;α=.01	X^2=2.010 df=3;α=.01	X^2=2.010 df=3;α=.01	X^2=2.010 df=3;α=.01	X^2= 46.462 df=35;α=.05
Violence against you for denying husband's decision	$X^2$2.889 df=1;α=.01	-	X^2=10.670 df=3;α=.01	X^2=2.010 df=3;α=.01	X^2=34.463 df=35;α=.01	-
Have right to make protest against husband	X^2=5.509 df=1;α=.01	X^2=2.010 df=3;α=.01	X^2=2.614 df=3;α=.01	-	X^2=45.807 df=35;α=.01	X^2=8.266 df=13;α=.05
Make coercion of having sex	-	X^2=6.902 df=11;α=.01	X^2=2.010 df=3;α=.01	X^2=11.150 df=7;α=.05	X^2=2.010 df=3;α=.01	X^2=5.661 df=13;α=.01
Priority for having sex	X^2=15.709 df=11;α=.01	X^2= 46.462 df=35;α=.05	X^2=2.226 df=3;α=.01	X^2=2.676 df=7;α=.01	X^2=29.362 df=35;α=.01	X^2= 46.462 df=35;α=.05
Mutual understanding of having sex lives	X^2= 1.726 df=1;α=.05	X^2= 46.462 df=35;α=.05	X^2= 46.462 df=35;α=.05	-	X^2= 46.462 df=35;α=.05	-
Any experience of having abortion	-	X^2= 46.462 df=35;α=.05	-	X^2=13.348 df=7;α=.01	X^2= 46.462 df=35;α=.05	-
Taking decision about having abortion	-	X^2=2.612 df=3;α=.01	X^2= 46.462 df=35;α=.05	-	X^2=3.657 df=5;α=.01	X^2= 46.462 df=35;α=.05
Get respect/honor from your husband	X^2= 46.462 df=35;α=.05	X^2= 46.462 df=35;α=.05	X^2=2.280 df=3;α=.01	-	X^2= 46.462 df=35;α=.05	X^2=36.478 df=35;α=.01

Dependent Variables	Age	Education	Occupation (Own)	Occupation (husband)	Income (Own)	Income (Husband)
Religious bindings about reproductive issues	-	X^2=13.823 df=11;α=.01	-	X^2=5.410 df=7;α=.01	X^2 = 46.462 df=29;α=.05	X^2=17.301 df=14;α=.01
Making violence by religious issues against you	X^2=2.706 df=1;α=.01	X^2 = 46.462 df=35;α=.05	X^2=2.226 df=3;α=.01	-	X^2 = 46.462 df=35;α=.05	X^2=1.417 df=;1=.01
Knowing reproductive health	X^2 = 46.462 df=31;α=.05	X^2=13.823 df=11;α=.01	X^2=1.254 df=3;α=.01	X^2=13.849 df=11;α=.01	X^2=40.024 df=35;α=.05	X^2=25.658 df=11;α=.01
Knowing family planning services	-	X^2=14.846 df=11;α=.01	X^2=13.823 df=6;α=.01	X^2 = 46.462 df=31;α=.05	X^2 = 46.462 df=31;α=.05	-X^2=16.478 df=35;α=.01
Getting information of reproductive health	-	X^2 = 46.462 df=31;α=.05	-	X^2 = 46.462 df=31;α=.05	X^2=38.623 df=35;α=.01	X^2=2.226 df=3;α=.5
Co-operation during pregnancy from your husband	X^2 = 1.563 df=3;α=.05	X^2=12.798 df=11;α=.01	X^2=1.858 df=3;α=.01	X^2=6.465 df=7;α=.05	X^2=36.478 df=35;α=.01	X^2 = 1.563 df=3;α=.05
Co-operation from other members during pregnancy	-	- X^2 = 1.563 df=3;α=.01	X^2 = 1.563 df=3;α=.05	X^2 = 1.563 df=3;α=.01	X^2 = 2.015 df=3;α=.05	X^2 = 38.603 df=35;α=.01
Enough food and medicare during pregnancy	-	X^2=10.554 df=11;α=.01	X^2 = 1.563 df=3;α=.05	X^2=2.626 df=7;α=.05	X^2 = 1.563 df=3;α=.01	X^2=36.412 df=33;α=.01
Violence occurred during pregnancy	-	X^2=1.858 df=3;α=.01	X^2=1.858 df=3;α=.01	X^2 = 2.492 df=7;α=.01	X^2 = 35.044 df=35;α=.01	X^2=18.192 df=13;α=.05
Health problem facing during pregnancy	X^2=1.785 df=1;α=.01	X^2 = 38.603 df=35;α=.01	X^2 = 38.603 df=35;α=.01	X^2=6.886 df=7;α=.05	X^2=39.987 df=35;α=.01	X^2 = 38.603 df=35;α=.01
Places of delivery of the last baby	-	X^2 = 38.603 df=35;α=.01	X^2 = 2.093 df=3;α=.01	-	X^2 = 46.462 df=32;α=.05	X^2=13.192 df=13;α=.01
Using contraceptives	X^2=1.604 df=1;α=.01	X^2=7.881 df=11;α=.05	X^2 = 31.523 df=32;α=.01	X^2 = 38.603 df=35;α=.01	X^2 = 38.603 df=35;α=.01	X^2=20.011 df=13;α=.01
Awareness of STD	-	X^2 = 46.462 df=35;α=.05	X^2=2.226 df=3;α=.01	X^2=2.706 df=1;α=.01	X^2 = 46.462 df=35;α=.05	X^2=1.417 df=;1=.01

Table 8.29 above shows that

1. **Age** is significantly related to 14 dependent variables as- first marriage, personal choice , knowing reproductive rights, decision of timing to become pregnant, violence against you for denying husband's decision, have right to make protest against husband, priority for having sex, mutual understanding of having sex lives, get respect/honor from your husband, making violence by religious issues against you, knowing reproductive health, co-operation during pregnancy from your husband, health problem facing during pregnancy and using contraceptives.

2. **Education** is significantly related to 28 dependent variables as-first marriage, second marriage, personal choice , knowing Reproductive rights, decision freely of having children, decision about number of children, decision of timing to become pregnant, decision about the gap or space, have right to make protest against husband, make coercion of having sex, priority for having sex, mutual understanding of having sex lives, any experience of having abortion, taking decision about having abortion, get respect/honor from your husband, religious bindings about reproductive issues, making violence by religious issues against you, knowing reproductive health, knowing family planning services, getting information of reproductive health, co-operation during pregnancy from your husband, co-operation from other members during pregnancy, enough food and medicare during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, places of delivery of the last baby, using contraceptives , awareness of STD

3. **Occupation** (own) is significantly related to 26 dependent variables as- second marriage, arrange marriage, personal choice, knowing reproductive rights, decision freely of having children, decision about number of children, decision of timing to become pregnant, decision about the gap or space, violence against you for denying husband's decision, have right to make protest against husband, make coercion of having sex, priority for having sex, mutual understanding of having sex lives, taking decision about having abortion, get respect/honor from your husband, making violence by religious issues against you, knowing reproductive health, knowing family planning services, co-operation during pregnancy from your husband, co-operation from other members during pregnancy, enough food and medicare during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, places of delivery of the last baby, using contraceptives, awareness of STD.

4. **Occupation** (husband) is significantly related to 22 dependent variables as- first marriage, second marriage, personal choice, knowing reproductive rights, decision freely of having children, decision of timing to become pregnant, decision about the gap or space, violence against you for denying husband's decision, make coercion of having sex, priority for having sex, any experience of having abortion, religious bindings about reproductive issues, knowing reproductive health, knowing family planning services, getting information of reproductive health, co-operation during pregnancy from your husband, co-operation from other members during pregnancy, enough food and medicare during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, using contraceptives, awareness of STD.

5. **Income** (own) is significantly related to 30 dependent variables as- first marriage, second marriage, arrange marriage, personal choice, knowing reproductive rights, decision freely of having children, decision about number of children, decision of timing to become pregnant, decision about the gap or space, violence against you for denying husband's decision, have right to make protest against husband, make coercion of having sex, priority for having sex, mutual understanding of having sex lives, any experience of having abortion, taking decision about having abortion, get respect/honor from your husband, religious bindings about reproductive issues, making violence by religious issues against you, knowing reproductive health, knowing family planning services, getting information of reproductive health, co-operation during pregnancy from your husband, co-operation from other members during pregnancy, enough food and medicare during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, places of delivery of the last baby, using contraceptives, awareness of STD.

6.Income (husband) is significantly related to 26 dependent variables as- first marriage, second marriage, arrange marriage, knowing reproductive rights,

decision freely of having children, decision about number of children, decision of timing to become pregnant, decision about the gap or space, have right to make protest against husband, make coercion of having sex, priority for having sex, taking decision about having abortion, get respect/honor from your husband, religious bindings about reproductive issues, making violence by religious issues against you, knowing reproductive health, knowing family planning services, getting information of reproductive health, co-operation during pregnancy from your husband, co-operation from other members during pregnancy, enough food and medicare during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, places of delivery of the last baby, using contraceptives, awareness of STD.

8.2.b Pearson's Correlation

Summary of Pearson's Correlation on Selected Variables by-

Table 8.30 Selected Socio-Demographic Variables

Dependent Variables	Independent Variables				
	Income (Own)	Income (Husband)	Education	Occupation (Own)	Occupation (husband)
Second marriage	0.192**	0.242**	0.140**	0.128**	0.142**
Arrange marriage	0.185**	0.111**	0.134*	0.121**	0.463**
Personal choice	0.199**	-	-	0.155**	0.177**
Knowing Reproductive rights	0.285**	0.104**	0.127**	0.192*	0.288**
Decision freely of having children	0.146**	0.104**	0.242**	0.255**	0.2 34**
Decision about number of children	0.199**	0.185**	0.092**	0.085**	0.185**
Violence against you for denying husband's decision	0.215**	0.111**	-	121**	0.163**
Have right to make protest against husband	0.219**	0.085**	0.122**	0.146**	0.133**
Priority for having sex	0.142**	0.104*	0.142*	0.185**	0.134*

Taking decision about having abortion	0.175**	0.142**	0.140**	0.121**	0.142*
Get respect/honor from your husband	0.113**	0.111**	0.132*	0.126**	0.263**
Knowing reproductive health	0.136**	0.104**	0.144**	0.258	0.124*
Knowing family planning services	0.289**	0.085**	0.192**	0.188**	0.195**
Co-operation during pregnancy from your husband	0.285**	0.088**	0.240**	0.132**	0.188*
Enough food and healthcare during pregnancy	0.399**	0.085**	0.122**	0.146*	0.131**
Violence occurred during pregnancy	0.185**	0.104**	0.127**	0.142**	0.455**
Health problem facing during pregnancy	0.185**	0.104*	0.162**	-	0.234*
Places of delivery of the last baby	0.299**	0.085**	-	0.185**	0.235**
Awareness of STD	0.185**	-	0.181**	0.144**	0.242**
** α=.01 and * α=.05					

Table 8.30 above shows that-

1. **Respondents' income** are significantly related to all dependent variables of reproductive rights and health at the level of α=.01. Income has comparatively a strong coefficient with second marriage (r=0.192; α=.01), arrange marriage (r=0.185; α=.01), Personal choice (r=0.199; α=.01), knowing reproductive rights (r=0.285; α=.01), decision freely of having children (r=0.146; α=.01), decision about number of children (r=0.199; α=.01), violence against you for denying husband's decision (r=0.215; α=.01), have right to make protest against husband (r=0.219; α=.01), priority for having sex (r=0.142; α=.01), taking decision about having abortion (r=0.175; α=.01), get respect/honor from your husband (r=0.113; α=.01), knowing reproductive health (r=0.136; α=.01), knowing family planning services (r=0.289; α=.01), co-operation during pregnancy from your husband (r=0.285; α=.01), enough healthcare during pregnancy (r=0.399; α=.01), violence

occurred during pregnancy (r=0.185; α=.01), health problem facing during pregnancy (r=0.185; α=.01), places of delivery of the last baby (r=0.299 α=.01), awareness of STD (r=0.185; α=.01).

2. **Respondents' husband's income** are significantly related to all dependent variables of reproductive rights and health at the level of α=.01and α=.05 . Income has comparatively a strong coefficient with second marriage (r=0.242; α=.01), arrange marriage (r=0.111; α=.01), knowing reproductive rights (r=0.104; α=.01), decision freely of having children (r=0.104; α=.01), decision about number of children (r=0.185; α=.01), violence against you for denying husband's decision (r=0.111; α=.01), have right to make protest against husband (r=0.085; α=.01), priority for having sex (r=0.104; α=.05), taking decision about having abortion (r=0.142; α=.01), get respect/honor from your husband (r=0.111; α=.01), knowing reproductive health (r=0.104; α=.01), knowing family planning services (r=0.085; α=.01), co-operation during pregnancy from your husband (r=0.088; α=.01), enough healthcare during pregnancy (r=0.085; α=.01), violence occurred during pregnancy (r=0.104; α=.01), health problem facing during pregnancy (r=0.104; α=.05), places of delivery of the last baby (r=0.085 α=.01).
3. **Respondents' education** are significantly related to all dependent variables of reproductive rights and health at the level of α=.01 and α=.05. Education has comparatively a strong coefficient with second marriage (r=0.140; α=.01), arrange marriage (r=0.134; α=.01), knowing reproductive rights (r=0.127; α=.01), decision freely of having children (r=0.242; α=.01), decision about number of children (r=0.092; α=.01), have right to make protest against husband (r=0.122; α=.01), priority for having sex (r=0.142; α=.05), taking decision about having abortion (r=0.140; α=.01), get respect/honor from your husband (r=0.132; α=.05), knowing reproductive health (r=0.144; α=.01), knowing family planning services (r=0.192; α=.01), co-operation during pregnancy from your husband (r=0.240; α=.01), enough healthcare during pregnancy (r=0.122; α=.01), violence occurred during pregnancy (r=0.127; α=.01), health problem facing during pregnancy (r=0.162; α=.01), awareness of STD (r=0.181; α=.01).
4. **Respondents' occupation** are significantly related to all dependent variables of

reproductive rights and health at the level of α=.01 and α=.05. Occupation has comparatively a strong coefficient with second marriage (r=0.128; α=.01), arrange marriage (r=0.121; α=.01), Personal choice (r=0.155; α=.01), knowing reproductive rights (r=0.192; α=.05), decision freely of having children (r=0.255; α=.01), decision about number of children (r=0.085; α=.01), violence against you for denying husband's decision (r=0.121; α=.01), have right to make protest against husband (r=0.146; α=.01), priority for having sex (r=0.185; α=.01), taking decision about having abortion (r=0.121; α=.01), get respect/honor from your husband (r=0.126; α=.01), knowing reproductive health (r=0.258; α=.01), knowing family planning services (r=0.188; α=.01), co-operation during pregnancy from your husband (r=0.132; α=.01), enough healthcare during pregnancy (r=0.146; α=.05), violence occurred during pregnancy (r=0.142; α=.01), places of delivery of the last baby (r=0.185 α=.01), awareness of STD (r=0.144; α=.01).

5. **Respondents' husband's occupation** are significantly related to all dependent variables of reproductive rights and health at the level of α=.01 and α=.05. Occupation has comparatively a strong coefficient with second marriage (r=0.142; α=.01), arrange marriage (r=0.463; α=.01), Personal choice (r=0.177; α=.01), knowing reproductive rights (r=0.288; α=.01), decision freely of having children (r=0.234; α=.01), decision about number of children (r=0.185; α=.01), violence against you for denying husband's decision (r=0.163; α=.01), have right to make protest against husband (r=0.133; α=.01), priority for having sex (r=0.134; α=.05), taking decision about having abortion (r=0.142; α=.05), get respect/honor from your husband (r=0.263; α=.01), knowing reproductive health (r=0.124; α=.05), knowing family planning services (r=0.195; α=.01), co-operation during pregnancy from your husband (r=0.188; α=.05), enough healthcare during pregnancy (r=0.131; α=.01), violence occurred during pregnancy (r=0.455; α=.01), health problem facing during pregnancy (r=0.234; α=.05), places of delivery of the last baby (r=0.235 α=.01), awareness of STD (r=0.242; α=.01).

CHAPTER NINE

Findings of the Qualitative Study

Presentation of Case Study

In this study the qualitative findings has been divided into two major parts describing as income group and non-income group women and the impact of income on their decision-making power in the family particularly in case of reproductive matters. 15 case studies have been discussed in order to examine the relationship between income and reproductive rights both in rural and urban women in our society. The following table summarizes the categorization of women both in rural and urban settings in respect of which our case studies were carried out.

	Income	Non-income	Total
Urban	3	5	8
Rural	3	4	7
Total	6	9	15

In-depth Interview -1

Name	:	Ruba
Status	:	Non-income
Age	:	38
Home District	:	Dhaka
Present Address	:	Dhanmondi
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	26
Type of Marriage	:	Arranged
Education	:	M.A
Perception about RR	:	High Level Perception
RH	:	Conscious
FP	:	Media
STD	:	AIDS
RB	:	Never went out after evening during pregnancy
Use of Contraceptives	:	Pills, condom
Number of Child	:	2 boys
Husband's :		
Occupation	:	Banker
Income	:	150,000
Expenditure	:	100,000
Family Type	:	Nuclear
Family Members	:	Nuclear
Decision Making Power	:	Yes

Ruba, aged 38, is a post graduate from Dhaka University. She got married at the age of 26 and have 2 children aged 10 and 8 respectively. She was married while studying in Masters. Had a dream of working as a professional person but after marriage her dream could not be materialized. This is partly due to her pre-occupation in raising

children. Although children are grown up now, she still could not develop the courage to look for a job as the responsibilities of taking the children to school in the morning, and to the art school in the evening and taking them out on a regular basis lies with her.

Ruba's husband is a banker. He earns handsome salary in the region of Taka 100,000 per month with free car. They live in their own flat. They belong to affluent class of the society. Ruba spends around Taka 40 to 50 thousand per month.

Ruba had arranged marriage. However, she has been enjoying peaceful and serene family life. She is very happy with the level of understanding with her husband. Although her husband does not impose his views on her she never thought of doing anything against his will. She gives utmost importance to his views.

She gives preference to her husband's decision in almost all decision regarding family life. She has some idea about reproductive rights but she takes all decision in consultation with her husband for instance how many children will they take, what would be the age gap between the children.

Ruba got pregnant immediately after her marriage. The dicision to take child so soon was her own. She was no in favour of adopting family planning at the beginning of her marriage. Ruba was advised by her mother not to take any family planning measures during the initial period of her marriage. She was afraid that if contraceptives are used during the initial period, it may lead to difficulties in taking child later. Her husband had no objection to her decision. It transpired that he too wanted this.

During pregnancy, she received cooperation from her husband and she was never subjected to any sexual intercourse against her will. Their sex life can be described as "responsible" one. She never imagined that her husband will be abusing her in any manner let alone regarding sexual matters.

Ruba has a good working knowledge about reproductive health. She undergoes regular health check-up. During pregnancy she went to see doctors regularly. Both of her children were given birth in hospital. Now- a- days she takes pill and has decided

not to take any child any more. This is her personal decision. She has decided to look for job now.

When she was asked if her decision making power would have had any impact had she earning money as a working women, her reply was that she is taking her decision without having any earning of her own. She does not think that her earning capacity would have any difference in her power to take decision now. In response to the question, if she has the power to take decision then why her husband is not using contraceptive she informed that he too used condoms for a while and may use again in future.

Ruba gets Taka 5000 as her purse money for her own expenditure. She buys things of her choice with the money. Sometimes, she spends her allocated money for family expenditure or buys gifts for her husband or children. Why is she looking for a job? According to her, she is bored now without having a job. Ruba thinks that it is important to have own earning because it helps to develop self-respect and gain self-confidence and the status of family is also upgraded.

In-depth Interview - 2

Name	:	Shila
Status	:	Non-income
Age	:	32
Home District	:	Jessore
Present Address	:	Dhanmondi
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	24
Type of Marriage	:	Arrange
Education	:	B.A.
Perception about RR	:	Fairly clear
RH	:	Strong awareness
FP	:	Through media
STD	:	AIDS
RB	:	Not going out in the evening, not watching horror movies, tying hair after evening
Use of Contraceptives	:	Pill and condom
Number of Child	:	2 girls
Husband's Occupation	:	Businessman
Income		5,00,000
Expenditure		3,00,000
Family Type	:	Nuclear
Family Members	:	4
Decision Making Power	:	Yes

Shila, 32 years of age, had an arranged marriage about 8 years back with an established businessman. She had education up to graduation level. After her marriage she couldn't pursue her M.A. due to lack of interest in studying and too much interest in leading family life. Her life is surrounded with her husband and two kids. She is very much happy with it and she has no intention to do anything else.

Shila lives in an extended family with her in-laws which include parents, brother and his family. Total member of family is 9. Shila's paternal family is also an extended family as such she found no problem after getting married. The relationship with her husband is that of a traditional husband-wife. Shila is very much obedient to her husband.

During the first year of their marriage Shila used to take pills. After that her husband used condom. But Shila frequently takes pills. According to her, continuously using any method for a long time is not good for health. Besides when they go out for travel she takes pills because it is easier to maintain.

Their total income is around 5,00,000 per month and expenditure is nearly 3,00,000 per month. They lead a very luxurious life where establishment of reproductive right should be obvious. Shila can take part in all most all the matters related to her family life. At the same time she depends on her husband's opinion in taking any decisions. She has no complain about her husband regarding reproductive matters. Her husband took good care of her during her pregnancy. She had to follow various superstitions during her pregnancies like not going out in the evening, tying hair after evening, not watching any horror movies etc. She did not feel any problem following these rituals.

Rearing her children is more important than earning money at this moment. She does not think independent income would bring her more honor and respect. It is, however, not certain whether she would have thought about her status in the same manner had she been earning her own income.

In-depth Interview-3

Name	:	Shahida
Status	:	Non-income
Age	:	40
Home District	:	Chittagong
Present Address	:	Kalabagan
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	19
Type of Marriage	:	Arrange
Education	:	S.S.C
Perception about RR	:	Not clear
RH	:	Very much concerned
FP	:	Media
STD	:	AIDS
RB	:	Wearing tabiz, dinking holy water
Use of Contraceptives	:	Condom
Number of Child	:	3 (2 girls and one boy)
Husband's Occupation	:	Businessman
Income	:	60,000
Expenditure		40,000
Family Type		Nuclear
Family Members	:	5
Decision Making Power	:	No

Shahida, aged 40 years, mother of three children and now lives in her husband's own house. She was married at the age of 20. For the first 15 years she lived with her in-laws. Shahida's family consists of 5 members. Her husband is a businessman, who earns around 50,000 per month and her monthly expenditure is around 40,000.

Shahida's eldest daughter is 19, the second daughter is 15 and the only son is 13. All of them are busy with their study and friends. It was an arranged marriage. At the beginning of her marriage she wished to continue her study further. But due to various circumstances she could not turn her wish into reality.

Understanding with her husband is good but they are completely different in their views. Shahida is extrovert, she loves to travel, love to mingle with people and loves to maintain close contacts with relatives. She also loves to watch movie and shopping. But her husband is completely reverse. He is a religious person. He wants her wife to stay at home and take care of children only. He does not like to go out and very stubborn in nature. But as their children are grown up now their relationship is in good shape.

Shahida is completely dependent on her husband in the context of decision making process about family life, sexual life and children's future. She has no clear idea about reproductive right. It was not her wish to take three children. But due to her husband's desire for a son she had to take the third child. As her husband is a religious person she had to follow many religious rituals during her pregnancy period specially for the third issue like wearing "tabiz' and drinking 'holy water'.

In response to the question, whether her husband respects her or not- she remained silent for a while and then replied that her husband is a very stubborn person. If she obeys him completely he is very kind to her but if she does not comply with his commands he gets very angry. But Shahida's husband earned respect from her with regard to his rather attitude stand on use of contraceptive. Her husband never forced her to take pills or injections. On the contrary, he uses condoms.

Shahida is very much conscious about Reproductive Health. She visits her physicians regularly. As the children are grown up Shahida feels bored and wants to do something. But she does not know what and how she can do. She is not getting any inspiration from her husband in this respect. Shahida beliefs that if she is engaged in

work she can pass her time more productively and can participate in family matters more effectively. Another thing strikes her that is her child's view about her. They want their mom to be smarter. It is her belief that she will get more respect and love from her children if she is involved herself in income-generating activities. She strongly believes that if she acquires income generating capacity it will enhance her standing in her family and most importantly she will earn respect from her children.

In-depth Interview-4

Name	:	Neela
Status	:	Non-income
Age	:	38
Home District	:	Tangail
Present Address	:	Gulshan
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	19
Type of Marriage	:	Personal choice
Education	:	M.S.S.
Perception about RR	:	Strong perception
RH	:	Strong
FP	:	Media
STD	:	AIDS, CYPHILIS
RB	:	Does not believe
Use of Contraceptives	:	No method at present
Number of Child	:	2 girls
Husband's Occupation	:	Businessman
Income		
Expenditure		Nominal
		30,000
Family Type	:	Nuclear
Family Members	:	4
Decision Making Power	:	Yes

Neela got married against her parent's wish at the age of 19. Although she got married at a tender age, she continued her education and completed Masters from Dhaka University. However, her husband merely completed his higher secondary. Now she has two daughters. The elder one is about 16 and the younger one is 5 years of age. Her husband is a businessman. They had a very happy family life during the first six

years of their marriage. Persistent deterioration of her husband's business condition has taken its toll in worsening her family relationship.

Though their monthly expenditure is around 60,000 but her husband barely manages the expenditure for food, which is not more than 20% of their monthly expenditure. Neela has to manage the rest of the monthly expenditure. Neela works really hard to make her decent living and doing more than one job to secure a middle-class life style. At times she takes financial support from her parents.

She is very much concerned about her reproductive right and always shared the matter with her husband. She had no wish to take second child after such a long gap. In fact, it was an accident. Initially her husband did not take any method. She took pills and injections. But now-a-days the sexual intercourse with her husband is rare so she is not taking any pill or injection.

Due to this condition Neela is very much worried about her children's future. Though she is an M.A. in Political Science she never thought of doing service. Now the situation has compelled her to think otherwise. She feels that it is too late for her to manage a decent job. Now she is earning her living by providing private tutorship.

Neela strongly believes that if she can manage a respectable job it will strengthen her position both in personal and family life. She will get honor from her husband also and she can help him to overcome his inferiority complex.

In-depth Interview- 5

Name	:	Jhumka
Status	:	Non-income
Age	:	30
Home District	:	Shirajgonj
Present Address	:	Shantinagar
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	20
Type of Marriage	:	Personal choice
Education	:	B.A. (Hons.)
Perception about RR	:	Very much concerned
RH		Very much concerned
FP		Media
STD		AIDS, Syphilis
RB		Do not follow
Use of Contraceptives		Condom
Number of Child		2 (1 boy and 1 girl)
Husband's Occupation		Physician
Income		
Expenditure		200,000
		100,000
Family Type		Nuclear
Family Members		4
Decision Making Power		Yes

Jhumka, 30 years of age, is an honors graduate from Dhaka University. She got married at the age of 20 when she was in her 2nd year honors. Now she is mother of two kids, a boy of 9 years and a girl of 5 years. Jhumka was teaching in an English Medium school before marriage. She was continuing her job after her marriage but had to leave the job when she realized that her son is autistic. Ever since diagnosis of his son being autistic, she has devoted all her time for the care of the child.

Her husband is a busy physician. He earns more than 2,00,000 per month. It was a love marriage but both the families had tacit consent to their relationship. Their younger girl is now aged 5 years and studying in kg-1 at an English medium school. There is a special private tutor for the boy as he is not in mainstream school. Their monthly expenditure is relatively high due to the special condition of their child, which now ranges around Taka 1,00,000 per month.

Their family life is very simple and smooth. The first baby was a result of an accident. They had no intention of taking child so early. But the second one was a planned decision. At the early stage of their marriage, she used to take pills but she has stopped taking pills for quite some time. Now her husband uses condom. In this case her husband is very cooperative and flexible. He never forces her to do anything.

She can take all the decisions in her family. She consults with her husband and in some cases her opinion gets more priority. She has a plan to do a job after her boy would be in good condition. Her husband has no problem with it. He inspired her to do so.

Jhumka wants to take another child but it was her husband's decision not to take another child keeping in mind about her boy as they have to spend more time and energy for the boy.

As a physician's wife she is well versed about reproductive right. She visits doctor's regularly. In this matter her husband's help is immense. Now-a-days her husband is very busy so she has to look after everything. She doesn't know when she can get a job. She believes that a job would refresh her mind. She also believes that keeping herself busy in work would help her to keep away ill feelings. So relationship between husband-wife will be smoother.

In-depth Interview-6

Name	:	Rubina
Status	:	Income
Age	:	38
Home District	:	Dhaka
Present Address	:	Rampura
Occupation	:	NGO Service
Income	:	30,000
Age at Marriage	:	28
Type of Marriage	:	Personal choice
Education	:	M.S.S.
Perception about RR	:	Concerned
RH	:	Concerned
FP	:	Media
STD	:	AIDS, GONORRHEA
RB	:	Take tabiz during pregnancy
Use of Contraceptives	:	Pill
Number of Child	:	2 girls
Husband's Occupation	:	Service holder
	:	70,000
Income	:	50,000
Expenditure		
Family Type	:	Nuclear
Family Members	:	4
Decision Making Power	:	Yes

Rubina comes from upper class family and she got married with her own choice at the age of 29. She lives with her in–laws, including her husbands parents and sister and two daughters. She has completed her M.S.S. in Sociology from Dhaka University and now working in a reputed N.G.O. Her husband works in a multinational company. Both of them earn more than 1, 00,000 per month.

They live in their own house, which is a five storied building owned by her father-in-law. They own a car. Rubina earns 30,000 taka per month and she can save half of that. She mainly spends her money to buy her personal stuff. She spends a substantial part of her income buying gifts on the occasions of various social events like marriage, birthday, festival etc.

From the very beginning Rubina's in-laws did not take her so easily as they wanted a better bride for their son. But now they are very much happy for her. Over the time, she was able to earn respect from her in-laws and now they maintain a healthy relationship.

She is very much happy with her sexual life. Her husband never forced her to do sex or take pills or injections. But, according to her, as he is a short tempered person Rubina had to be cautious all the time. Her husband did not want her to take pills as it makes her ill. Rubina does not want to take any more kid and her husband has accepted her decision. She can participate in all family matters. Her father-in-law takes advices from her in many matters. She has a very strong position in her family.

According to her, a woman must involve in a job because it will get her not only money but also respect and honor from every member of the family. But at the same time she believes that every women need to be cautious in her family life.

In-depth Interview- 7

Name	:	Masuma
Status	:	Income
Age	:	20
Home District	:	Rangpur
Present Address	:	Pagar, Tongi
Occupation	:	Garment worker
Income	:	3400
Age at Marriage	:	19
Type of Marriage	:	Arranged
Education	:	Class five
Perception about RR	:	Strong perception
RH	:	Strong perception
FP	:	Office
STD	:	AIDS
RB	:	None
Use of Contraceptives	:	Pill
Number of Child	:	None
Husband's Occupation	:	Fertilizer business
Income	:	10,000
Expenditure	:	4,000
Family Type	:	Joint
Family Members	:	Joint
Decision Making Power	:	Yes

Masuma, aged 20, is a garments worker in a factory located in Gazipur. She came to Dhaka about 7 years ago with the objective of working in garments factory. She has been working in this particular factory for about 4 years. Her monthly salary is now Taka 3400 per month.

Masuma has lost her father at an early. She came to Dhaka with her mother and two other sisters. Her sisters too are working in garment factories around Gazipur. They live in a rented house near their factory.

She got married about a year back through family arrangement. Her husband is from Rangpur, where he has fertilizer business and earns about Taka 10,000 per month. Masuma's husband stays with her half of the month and the remaining days he stays in Rangpur. Masuma has not taken any child yet. Masuma's husband will take him to Rangpur within next one year. Her husband is constructing new house in Rangpur. Once the construction is completed, they will set up their family in new environment. Because of this uncertainty about setting up home they are unable to take any child at this stage. It is expected that immediately after moving into new house they will take child.

Masuma's husband pays her Taka 1000 per month for her expenditure. They have consensual sexual intercourse, but she gives preference to her husband's desire. Her observation about this is that "he stays half of the month out of home, therefore, I obey his wishes and try to satisfy his demands". Her husband does not compel her in any manner. She is not using any pill. Her husband has been using condom.

Apart from sexual matters, she usually speaks against her husband's opinion. For example, she has told her husband that she will take only one child. Her view about this is that with the earnings they make if they can raise one child properly, that will be sufficient. Why take more children?

Although she studied till class five, she is determined to keep her family small. At the same time, she thinks her job is very important for her. She saves around Taka 2000 per month. Since she lives very close of her factory, there is no transport cost and moreover she does not spend any money unnecessarily. She is quite conscious about her health as well. She did not appear to have any idea about sexually transmitted diseases. She has heard about AIDS in T.V. She has also learned about family planning from T.V. and her acquaintance. Her husband respects her a lot and does not try to impose his opinion on her.

In-depth Interview- 8

Name	:	Ramiza
Status	:	Income
Age	:	22
Home District	:	Rangpur
Present Address	:	Pagar, Tongi.
Occupation	:	Garment worker
Income	:	3500
Age at Marriage	:	19
Type of Marriage	:	Love
Education	:	Class six
Perception about RR	:	Never heard
RH	:	Heard from field worker
FP	:	Media
STD	:	AIDS
RB	:	No time to follow
Use of Contraceptives	:	Pills, injections
Number of Child	:	1 boy
Husband's Occupation	:	Garment worker
Income	:	1200
Expenditure	:	4000
Family Type	:	Joint
Family Members	:	7
Decision Making Power	:	No

Ramiza, aged 22, is a garments worker at a factory located in Tongi. She earns Taka 3500 per month. She married her co-worker, who earns Taka 1200 per month. Both of them have a baby boy. There are seven members in her family, out of which four members, her father-in-law and brother-in-law, are working and earning their livelihood as garment workers.

Ramiza studied till class six at her village in Rangpur district. Since her arrival in Dhaka, it has been about one year that she is working in this garment factory in Tongi.

She met her husband at this factory and fallen in love. Although her marriage was not a settled marriage, both her family members and in-laws are in good term with each other and have been maintaining cordial family relationship.

Although all the adult members of the family are working, their total earning is meager due to the fact that her in-laws earn very little. As the guardian of the family all the earning members deposit their money with her father-in-law. Ramiza keeps Taka 1000 to meet her personal expenditure. Her mother-in-law looks after the baby when she is at her work.

Since her marriage she went to Rangpur two to three times. Her mother too visited her in Tongi once. Ramiza's joint family is not solvent at all. They hardly make their living from the earnings of their occupation as garment workers.

Both Ramiza and her husband decided not to take child immediately after their marriage, but accidentally the child was born within the first year of their marriage. Both of them decided not to take second child. In response to the question why she does not want to take any more child, her reply was that it will not be possible to "up bring" the child if they take more than one child.

Any decision regarding family matters are taken together. The decision not to take any more children is a joint decision. However, she gives preference to her husband's decision. Regarding sexual intercourse, she gives preference to her husband's decision and it is her husband who takes decision as to when they will have sexual intercourse. In this respect, Ramiza's view is that "it is my duty to obey my husbands desire". She gives priority to her husband's decision even during her menstrual cycle. She takes pill at the dictation of her husband. When it was put to her that why her husband does not take any preventive step, it was a surprise to her. The fact that her husband can also take birth control measure did not occur to her. Ramiza's husband is very kind to her and does not resort to violence.

It is noteworthy that Ramiza earn more than her husband. Despite this, she obeys her husband and abide by her husband's decision. Absence of violence is not uncommon in such a situation.

During her pregnancy, Ramiza could not follow the traditional rituals due to her work. She had to work till 8 months of her pregnancy. The fact that her husband also

working in the same factory acted to her advantage, particularly traveling to and from her workplace. The fact that her mother-in-law looks after the baby demonstrate that she plays an important role in the family.

Ramiza's percept about Sexually Transmitted Dieses is confined to AIDS. However, she thinks that only "bad people" get AIDS. She learned about family planning from media. Besides, a good number of Health Workers also visit her factory. She also learned a lot about family planning methods from them. Apart form taking pills, she also learned about taking injection from her workplace. She lacks clear idea about Reproductive Health. She did not encounter any serious problem during her pregnancy and she gave birth to her child at home.

The story of Ramiza reveals that although she is not the master of her body, she enjoys a certain level of participation in the decision making process so far as it relates to giving birth to child. However, when it comes to any decision regarding sexual intercourse, she appears to be powerless but she lacks awareness about her right over her own body. This may be attributable to her lack of education.

In-depth Interview- 9

Name	:	Helena
Status	:	Non-income
Age	:	25
Home District	:	Manikganj
Present Address	:	Madhabpur village
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	16
Type of Marriage	:	Arranged
Education	:	Class five
Perception about RR	:	Aware about it
RH	:	Used to visit health center regularly
FP	:	Health-worker, neighbor
STD	:	AIDS
RB	:	Wearing tabiz
Use of Contraceptives	:	Pill
Number of Child	:	3 (2 girls and 1 boy)
Husband's Occupation	:	Living Abroad
Income	:	60,000
Expenditure	:	25,000
Family Type	:	Joint
Family Members	:	7
Decision Making Power	:	Yes

Helena got married when she was only 16. Now she is 25 and already mother of three children and expecting another one. Her husband lives abroad coming home every year for one month. She had to leave school when she was in class five. Total number of family is 7 including her husband.

Though she did not learn too much but she manages the whole family very nicely. Her husband earns 60,000 taka per month and sends home 25,000 taka. Helena saves 5,000 taka from that money. She has two Deposit Pension Schemes as well. Her kids are going to school and madrasha as well.

Their house is well furnished with tv, freeze, cd player, ceiling fan etc. She misses her husband and at the same time feels proud of her husband's living abroad. She takes pill when her husband comes to home. Helena is well aware about reproductive right and according to her, she has that right. The decision of taking fourth child is hers and she wanted a boy as two of her kids are girls.

She is aware about reproductive health as well. She used to visit health center, located near her home, regularly. Her mother in law took good care of her during her pregnancy. Mother in law took the charge of the family including looking after the children when she was sick. She got all the support from her family.

She believes both money and mentality are big factors for being happy. They are happy because they have sufficient money and they have commitment to each other. Besides, she thinks education is also very important element to maintain good life. She also wants to be involved in income generating activities once the children are grown up. Her husband is aware of this decision and he has no objection to her such a decision.

In-depth Interview-10

Name	:	Minu
Status	:	Non-income
Age	:	16
Home District	:	Manikganj
Present Address	:	Madhavpur village
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	13
Type of Marriage	:	Arrange
Education	:	Class five
Perception about RR	:	No idea
RH	:	Go sometimes
FP	:	Neighbour
STD	:	No idea
RB	:	Didn't have fish and go outside alone
Use of Contraceptives	:	Pill
Number of Child	:	1 girl
Husband's Occupation	:	Living abroad
Income	:	40,000
Expenditure	:	15,000
Family Type	:	Extended
Family Members	:	15
Decision Making Power	:	No

Minu got married at the age of 13 when her menstrual regulation did not even start. She was a teenage girl of class seven and wanted to continue her study. But as her father is very poor and she is the first child amongst her five sisters her father had no alternative.

Minu is now a member of extended family consisting of 15 members. Her husband lives in Singapore for 3 years and earns 40,000 per month. He sends nearly 15,000 taka per month to his father to meet the family expenditure. From that she gets 3000

taka for her and her only daughter. This money is enough for her and she is happy with the amount.

Her husband is the youngest son of this family. Minu got to do a lot of work here with other sisters in law. One of her school friend is currently working as health worker. She feels inspired to see her and wants to do the same job. She has already talked with her husband about the issue. Her husband has no problem with it but he advised her to take the permission from his father. Minu's father in law is very dogmatic and traditional person. Minu has no courage to face him.

According to Minu, her husband is very sensible in sexual life. He never tortured or forced her. He took good care of her wife and surprisingly he was expecting a baby girl. After hearing the news he distributed sweets to neighbors which is very rare. Minu has decided to take another child after one year. She takes the decision alone and her husband had no objection on it.

She can never share her feeling with anybody in her husband's family. She is just waiting of her husband to return from abroad. The question of reproductive right and reproductive health is meaningless to her. She has no freedom to express her desire here. That is why she is eagerly waiting for her husband's return. In this case money or independent earning is not the main issue.

In-depth Interview-11

Name	:	Kajol
Status	:	Non-income
Age	:	35
Home District	:	Gazipur
Present Address	:	Madhabpur village
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	18
Type of Marriage	:	Arranged
Education	:	Uneducated
Perception about RR	:	No idea
RH	:	Go sometimes
FP	:	Neighbor
STD	:	No idea
RB	:	Used to visit Fakirbari
Use of Contraceptives	:	Pill
Number of Child	:	3 (2 girls and 1 boy)
Husband's Occupation	:	Cow trader
Income	:	30,000
Expenditure	:	15,000
Family Type	:	Nuclear
Family Members	:	5
Decision Making Power	:	No

Kajol, very straight forward and smart lady, a mother of three children at the age of 35. She is uneducated and her husband is a cow trader who earns more than 30,000 taka per month. As both of them is illiterate their main aim is to educate their children. Her elder daughter is 16, the younger daughter is 10 and the youngest boy is only 4.

They have a nice tin-shed house with a large yard in front of the house. Their family expenditure is not more than 10,000. They are leading a very healthy life. Kajol gave birth to her their first child after 4 years of her marriage. She did not take anything as she wanted baby. Now, she is taking pills but not regularly because her husband has to stay in town for his profession often.

Her husband is very much rude in sexual life. He dose not want to use condom and have sex whenever he wants. If Kajol is not fit for having sex he does not care. He has a practice to go to red light area also. Kajol does not mind. In her language "generally men's are of this type". She believes it will be all right after some time. She keeps herself busy with her children and try to give them her best.

Kajol does not understand the term reproductive right but she is very much conscious about her position in the family. Though her husband is a stubborn person but never disagrees with her decision. Kajol loves her husband because he always takes her to doctor whenever needed. When her husband returns from town she makes good dishes. Children get happy to see their father. Her happiness lies to see this.

She feels bad sometimes for her husband's misdeeds but never revolts. Because it will bring worst situation in her family. According to her, women who revolt are alone and she doesn't want to live alone. That is why compromise is her way of leading life.

In-depth Interview-12

Name	:	Khaleda
Status	:	Non-income
Age	:	20
Home District	:	Gazipur
Present Address	:	Madhavpur village
Occupation	:	Housewife
Income	:	None
Age at Marriage	:	17
Type of Marriage	:	Arrange
Education	:	Class nine
Perception about RR	:	No clear idea
RH	:	Went to Health Center after miscarriage
FP	:	Neighbor
STD	:	No idea
RB		Didn't follow
Use of Contraceptives		Pill
Number of Child	:	None
Husband's Occupation	:	Living abroad
Income	:	40,000
Expenditure	:	10,000
Family Type		Joint
Family Members		5
Decision Making Power	:	Yes

At the age of 17, Khaleda got married in a rich family. Her husband is an electrician and earns 40,000 taka per month. He lives in middle- east and comes once in every year. She lives with her mother in law, sister and brother in law. She has no child and had miscarriage of her first child at her father's home. Though her husband did not scold her for that but her mother in law was very much upset with her and her family.

She gets 5,000 taka for her personal convenience. From that money she saves 2,000 taka. Their total family expenditure is around 10,000 taka which also comes from her husband. However, all money is spend by her mother in law.

Though she did not finish her S.S.C but she is very intelligent. Her idea about reproductive right is that small family means happy family and one child is enough for happiness. She has already decided with her husband about the next child.

She loves her husband very much because he is very caring to her and respects her decision about family matters. Her husband never tortured her. In this case she has a special view and that is- if women are smart and clever husbands will never get away with the abuse of their wife.

As her husband lives abroad she is not using any method right now. Generally she used to take pills and she did not feel any problem taking that. Besides she thinks that she should take the method not her husband. Though she has no clear idea about reproductive health but she used to go to the health clinic regularly as she had miscarriage. Basically from there she has learnt about the contraceptive methods.

She had no idea about Sexually Transmitted Diseases. But after going to the health clinic and watching advertisements she knows about AIDS. She also came to know that condom is the best method against STD's. She believes that education brings power of taking decision. She can take decision but not that much because of her lack of education.

In-depth Interview-13

Name	:	Aparna
Status	:	Income
Age	:	35
Home District	:	Manikganj
Present Address	:	Madhabpur village, Manikganj
Occupation	:	Health Worker
Income	:	1,500
Age at Marriage	:	18
Type of Marriage	:	Arranged
Education	:	S.S.C
Perception about RR	:	Well known
RH		Well known
FP		Office
STD		AIDS, CYPHILIS, GONORRHOEA
RB		Not to eat citron and fish , not to go alone at night
Use of Contraceptives		Pill
Number of Child		3 (2 girls and1 boy)
Husband's Occupation	:	Farmer
Income	:	100,000 (annually)
Expenditur	:	60,000
Family Type	:	Nuclear
Family Members	:	5
Decision Making Power	:	Yes

Aparna, 35, is a health worker in Gramee Health Centre. She is doing this job for the last two years. Her salary is 1,500 taka per month. Her husband is a farmer and he earns almost 1,00,000 yearly. She has three kids, two girls and one boy. Aparna got married when she was only 18. Now her elder girl is 16 and the rest are 14 and 11.

Aparna did her S.S.C. and she has keen interest in studying. She wants her children to be well-educated. She promised herself and convinced her husband about the need of good education for their children. Before H.S.C. she would not let her girls get married. She believes education creates the awareness about the reality.

She is very much concerned about reproductive right and reproductive health. It was her decision as to how many children they would take and what would be time gap between each child. Her husband never opposes her decision but in one matter she couldn't make him understand, that is, using condoms. As pill does not suit her body she used to take injections.

She got enough care during her pregnancies. She had to follow many traditional rituals like not to have citron (jambura) and water melon, not to go out alone at night, not to have fish etc. She did not mind following these rules as she considered them as blessings. She has completed a training in Dhaka about reproductive rights and health. Now she is exercising her knowledge over the other women.

Aparna is loved by her husband and her mother –in-law as well who lives with them. She thinks it was possible because of her smartness which she gained from her job. She firmly believes that every woman should do something apart from taking care of her family. It will increase her importance in family and she can take part in the decision making process.

In-depth Interview-14

Name	:	Hameeda
Status	:	Income
Age	:	26
Home District	:	Working
Present Address	:	Rural
Occupation	:	Health Worker
Income	:	3400
Age at Marriage	:	16
Type of Marriage	:	Arranged
Education	:	S.S.C.
Perception about RR	:	Very much concerned
RH	:	Professionally she knows it
FP	:	Well known
STD	:	AIDS. CYPHILIS
RB	:	Doesn't believe
Use of Contraceptives	:	Emergency Contraceptive Pills (ECP)
Number of Child	:	1 boy
Husband's Occupation	:	Tailor
Income		
Expenditure	:	15,000
	:	5,000
Family Type	:	Nuclear
Family Members	:	4
Decision Making Power	:	Yes

Hameeda, aged 26, has been working in Grameen Kalyan as a Health Worker since last four years at a Medical Centre in Madhabpur village, Manikganj. She studied till SSC and now earns Taka 3400 per month. Her husband is a tailor and owns a tailoring shop at Mohalkhali, Dhaka. Her husband earns Taka 15,000 per month. Hameeda was married at the age of 16 and she has got one child aged 9 years, who lives with his

mother. Hamida lives with her parents and sister. Her father is a farmer and also owns a grocery shop at the local bazaar.

Hameeda's husband pays her Taka 4000 per month for family expenditure. She saves Taka 1500 per month from her own salary. She borrowed Taka 10,000 from Grameen Bank and invested the money in herd trading. She earns taka 1000 per month from her investment after payment of service charge to Grameen Bank.

Hameeda did not adopt any preventive measures after her marriage. She wanted to take child and moreover she had no particular view about taking contraceptive. Her husband too did not tell her anything about it. Consequently she became pregnant within a short period of her marriage. Hameeda started taking pills after 40 days of giving birth to her child. In response to the question, despite being a health worker and aware of risk involved in taking pills for long time why is she taking pills, she stated that she requested her husband several times to use condom but without any success as he was not inclined to use this method of family planning.

Hameeda has recently learned that her husband got a second wife but, considering her son's future, she decided not to do anything about it. She thinks that if she takes any action against her husband, he will not give money to her and may even divorce her, which will create problems in raising her child as it is not possible to support the education and upbringing of the child with her earning alone. Now Hameeda's husband wants to take second child but she does not want to take any child. Her decision not to take child is prompted from the fact that her husband has taken a second wife. However, she has not disclosed this decision to her husband. Her husband visits her once a month. Instead of taking pills throughout the month, Hameeda now started using Emergency Contraceptive Pills (ECP), which helps her in preventing pregnancy.

She thinks that she is able to take this firm decision not to take any child because of her own earnings. She will continue her life with her husband but leads her life according to her own opinion. There is no doubt about that she gets this spirit from her service.

In-depth Interview-15

Name	:	Parul
Status	:	Income
Age	:	28
Home District	:	Manikganj
Present Address	:	Madhavpur village
Occupation	:	Health worker
Income	:	3400
Age at Marriage	:	18
Type of Marriage	:	Arranged
Education	:	Class eight
Perception about RR	:	Concerned
RH	:	Concerned
FP	:	Office
STD	:	AIDS
RB	:	Didn't follow
Use of Contraceptives	:	Natural method,condom
Number of Child	:	2 girls
Husband's Occupation	:	Primary School Teacher
Income	:	3000
Family Type	:	Nuclear
Family Members	:	4
Decision Making Power	:	Yes

Parul, aged 28, is a Health Worker, employed in Grameen Health Centre at Madhabpur Village, Shingair, Manikganj. Her husband is a school teacher at a local primary school. She earns Taka 3400 per month and her husband's earning is Taka 3000 per month.

Parul has been married for 10 years. They have 2 children aged 7 and 4. Parul lives with her in-laws at her husband's ancestral home. She has a clear idea about family

planning and different options available in the market. No doubt her profession as a health worker has played the vital role in creating the awareness.

At the initial stage of her marriage life, she used to take contraceptive pills in consultation with her husband. She is not taking pills anymore. She is aware of the health danger involved in taking pills for long time. Parul was able to make her husband understand about the health risk. Now Parul and her husband using "natural" method to prevent unwanted pregnancy. When she was requested to explain it further, her reply was that "one week before and after menstrual cycle we do not use anything because there is risk of pregnancy during this time". In response to the question, how safe this method of contraception is, she informed that they have been using this method since last three years. However, Parul informed that at times, her husband uses condom. Apart from the "safe period" her husband uses condom.

All decision of the family are taken in consultation with each other. Parul thinks that her husband gives sufficient importance to her views about family. Parul also thinks that she commands respect from her husband as well. Despite the fact that both of their children are girls, they still do not want to take any more child. Because, it is not possible to raise more than 2 children with their current income. Parul strongly believes that her income and employment have made her more aware about her rights and standing and she has earned respect from her husband because of that.

CHAPTER TEN

Analysis of the Findings

10.1 Quantitative Findings

The present study stands on 542 married females who were drawn from urban (272 females) and rural (270 females) areas for the quantitative part. These people encapsulate their stipulation of income and reproductive issues from their own background which attracted me to find out the comeback of these. I asked them 53 questions to know, and to explore as well as examine, the real experience of different background people in the question to ascertain objectives and testable hypothesis. The findings of this study are divided into three parts-

(a) socio-economic profile of the respondents and

(b) core areas of interest i.e. the proper application of objectives and

(c) test of hypothesis by chi-square and correlation.

(a) Socio-economic profile

1. For socio-economic variables the study illustrated that the age of the respondents start from 15 to 49 years, which have been divided into 7 clusters with 5 years of interval. Those who are between 15 to 19 years of age is 5 percent. 19 percent of the respondents are in between 20-24 years. Majority of the respondents belong to the age limit of 25 to 29, which is 41 percent and the age group between 45 to 49 years are very few as demography suggests. The majority (57 percent) of the respondents belong to four and five membership family.
2. At table 7.3 we find many types of occupation prevailing across the study area where 50 percent respondents are garment workers and 19 percent are laborers, nurse, doctor, lawyer, lecturer, NGO workers, teacher, shopkeeper and farmer; but 31 percent are small entrepreneur. Occupation of the respondents' husband shows that major portion of them are day laborer and migrant workers (21 percent and 17 percent respectively). Since the number of

garment workers and small entrepreneurs are 81 percent, it was no surprise that the overwhelming majority of the respondents' educational level is SSC or bellow SSC level.

3. For this study, respondent's income structure is very important. 73 percent of the respondent's income is limited to Tk.10000 and only 26 percent respondents' income is over Tk.10000. This income configuration shows the connection between occupational compositions. On the basis of this income the respondents' expenditure is delineated, which is : 60 percent of the respondents' expenditure is Tk. 4000, 35 percent of the respondents' expenditure is Tk.10000 and only 5 percent of respondents' expenditure is above Taka 10000.

4. From the respondents' profile it was found that 43 percent people got marred between the ages of 15-19 and 29 percent of them were between the ages of 20-24 years. This marital composition indicates the early marriage due to number of intervening factors including lower status of profession or lower education and poverty. Along with this, 25 percent of the respondents got married for the second time because of divorce and due to husband's death. Here, in my study area I found two types of marriage arrangement– namely marriage through personal choice and the other one is arranged marriage. Among the respondents 66 percent had the arranged marriage and 34 percent got married with the person of their choice.

5. 93 percent of the respondents are Muslim.

(b) Core findings against objectives

1. In answering a question on the idea (table 8.4) of reproductive rights about 74 percent of the respondents replied positively and 26 percent did not know because they have not been made aware of their rights by any medium or organizations. Table 8.5 shows that 64 percent of the respondents are not in a position to take a decision about this issue whereas only 36 percent of the respondents could take the decision because our society is patriarchal and

women are largely compelled to obey their husband's decision. So in this study, in most cases, it is found that women's own income is not an influential factor to take decision about them or, to be empowered in the context of reproductive issues.

2. Table 8.6 shows that 36 percent of the respondents think they themselves can take decisions about the number of children they want to take but 43 percent respondents said that their husband took decision and 18 percent respondents said that both husband and wife took the decision. However, other respondents (3 percent) replied that their mother-in law took the decision.

3. In taking decision of when they would become pregnant, 34 percent respondents said that they took decision by themselves. However 66 percent of the respondents could not take decision. Moreover, they had to respect their husbands decision.

4. Table 8.9 shows that 17 percent of respondents claimed that violence occurred against them for denying their husband's decision. Table 8.10 shows that these violence include physical abuse (42 percent), mental torturing (43 percent) and sexual assault (15 percent).

5. 43 percent of the respondents said that they exercise their right to protest against husband's decision but 57 percent are not in a position to exercise this right because, unwillingly, they are depended on their husband as such their husband dominate over them. In response to the question as to whether they were subjected to any coercion for having sex against their will by the husband 30 percent respondents replied in the affirmative.

6. 21 percent of the respondents claimed that they enjoy priority for having sex and 64 percent said that their husband enjoy much priority for having sex. But 32 percent respondents disagreed that there exist mutual understanding of having sex. However, 57 percent of the respondents said that their husband decide whether abortion can be done or not.

7. Though it is observed that women depend on their husband's opinion in every sector, but in this study (see table 8.14) the number of mutual understanding of having sex lives is 68 percent. Obviously it is an outcome of women's awareness about their reproductive rights.

8. In response to a question whether they receive respect/honor from their husband, 50 percent of the respondents informed that they get respect from their husband. The study also presents religious compliance about reproductive issues. It is observed that 29 percent of the respondents follow religious bindings because they had to follow it to satisfy their husband and in laws. But 43 percent did it at their own decision.

9. Table 8.18 presents that 65 percent of the respondents follow religious and cultural belief on reproductive issues. 35 percent respondents do not think that religion does influence their lives about reproductive issues.

10. Table 8.19 shows that 65.5 percent of the respondents are aware of reproductive health. This was possible because of both governmental and non-governmental initiatives taken about the issue throughout the country especially in rural areas. In spite of so many initiatives 34.5 percent still have no idea about reproductive health.

11. 97 percent of the respondents are aware of family planning services and when they were asked about the source of information, media (30%) and health worker (36%) came out to be the prevailing source of information. In table 8.23, it is observed that 67 percent of the respondents get health care. This is not because they can afford it rather they get the health facilities from the health center located in their village.

12. 41 percent of the respondents confirmed that their husband takes the decision of using contraceptives. Though 20.8 percent of the respondents said that they decide about the contraceptives but the hidden truth is, they take this decision on their husband's consent. Husband's influence or domination can easily be determined by analyzing table 8.26. Almost 60 percent of the respondents use

pill and 14 percent use injection. That means, 74 percent of the respondents use contraceptives. On the other hand, it is only 26 percent for men.

13. Most of the respondents (80%) are aware about Sexually Transmitted Diseases. In that case, AIDS is known to 70 percent of the respondent. This is, no doubt, due to various media campaign about the issue. But fact remains that though majority know the tern AIDS but very few know the actual meaning of it and reason for this.

14. Only 82 percent of the respondents replied that violence was not inflicted on them by their husband or otherwise due to "non-compliance" with orthodox religious belief on reproductive rights and reproductive health which can be said a sign of empowerment.

15. This study found that the medium income women received sufficient co-operation during their pregnancy from their husband but women who are low paid or unable to give dowry during marriage did not get sufficient cooperation from their husband.

16. It is observed from the findings that 67 percent of the respondents had enough food at the time of pregnancy that show a positive sign for women though it should have been cent- percent. This study found many reasons for occurrence of violence during pregnancy such as low income, unable to give dowry. But the percentage of this violence is only 17.

17. 38 percent of the respondents said that they can choose contraceptives by their own for the purpose of having sex that is also a significant finding of this study. This study also brings into being that people are much more aware sexually transmitted disease through mass media and numerous GOs and NGOs campaign, confirming that 80 per cent of them learned about this through media.

(c) Test of hypothesis by chi-square and correlation.

C.1 Hypothesis test by Chi-square

The summary of the significant association found at chi-value- shows factors that are significantly associated with the items of reproductive rights and reproductive health. It is found that the selected dependent variables are significantly related to selected demographic and socio-economic variables like age, education, occupation (own), occupation (husband), income (own) and income (husband). Given the predominance of nominal level of measurement, the chi-square test is preferred for measuring the association. Many associations between independent variables and dependent variables are found significant at α=.01 and α=.05 levels of significance. It further shows that income (own), education, occupation (own) and income (husband) are the key correlates of this study in terms of number of items significantly related. Next is occupation (husband) followed by age that appears to be least influential variable.

C.2 Hypothesis test by Correlation

This study found 19 dependent variables that have significant co-efficient correlation with 5 independent variables. The independent variables (of Pearson co-relation) are- own income, husband's income, education, own occupation and husband's occupation. But the dependent variables are- Second marriage, arrange marriage, marriage with personal choice, knowing Reproductive rights, decision freely of having children, decision about number of children, violence against you for denying husband's decision, have right to make protest against husband, priority for having sex, taking decision about having abortion, get respect/honor from your husband, knowing reproductive health, knowing family planning services, co-operation during pregnancy from your husband, enough health care during pregnancy, violence occurred during pregnancy, health problem facing during pregnancy, places of delivery of the last baby, awareness of STD.

10.2 Analysis of the Qualitative Findings

Having an exploring knowledge of qualitative data, 15 in-depth interviews have been analyzed where different types of situations and views have emerged. Almost all the cases are very much proverbial about reproductive rights and reproductive health.

Predominantly, in urban areas both income and non-income group women are well aware of these issues.

Urban Income Group Women:

Ramiza, Masuma and Rubina, all of them believe that their income help them to take part in family matters. As-

1. Ramiza, a garments worker, thinks that she enjoys a certain level of participation in the decision making process.
2. Similarly, Masuma thinks that her husband respects her and does not try to impose his opinion on her due to the fact that she is earning, albeit small.
3. According to Rubina, an NGO worker- said that she is able to take any firm decision because of her own earnings. At the same time she believes that all women should have own source of earning- may it be from job or any other independent profession. This economic power will create a standing of its own.

About all these women, one interesting common feature is that, despite the fact, they have a position in their family and able to take part in decision making process, but when it comes to give preference amongst husband and wife, almost all of them incorrigible that they give preference to their husband's opinion.

Urban non-income group women:

The majority of them comes from relatively wealthy and educated family as such they have a sound knowledge about reproductive rights and reproductive health. However, they do not believe that reproductive rights will be established if they start earning or take up a profession. For instance-

1. Ruba thinks that although she is not earning, as she has no job, she can still take part in decision making process. At the same time, she also believes that income generating capacity helps to boost self confidence.

2. Jhumka believes that every woman should have her own world and a suitable job can help to create that better. She also believes that a job can strengthen the relationship between wife and husband.

3. To Shahida, earning is not merely about reproductive rights, it also helps to gain respect from children as well. On the other hand, Shela thinks raising children is the most important means to earn respect from the family.

Rural Income Group Women:

For this categories of women, earning is merely about gaining the ability to participate in the decision making process. It is lot more than that. It is rather about securing livelihood as the money that they are very important contribution for their families. As-

1. Aparna thinks that every woman should be involved in income generating work; this will help to gain importance in the family.
2. Parul, a health worker, also thinks that her job made her aware of her rights and her husband gives importance to her opinion because of her job.
3. Hamida, also a health worker, does not want to take any more children. She thinks that she is able to take this decision because of her job.

Rural Non-income Group Women:

The picture is somewhat different in this category. A common feature about this group of women is that almost all of them got married at their teens and wholly depended on their husbands. For instance-

1. Minu, a woman from Madhabpur, cannot share her thoughts and feelings with anyone let alone taking decision.
2. Khaleda, also from Madhabpur, thinks that if a woman is intelligent it is not difficult to make the husband listen to her. However, she thinks that having education is more important than having income.
3. Helena thinks that having money is very important and it can solve all the problems.
4. According to Kajol, life is all about compromise. Without this a woman cannot survive in this society.

The empirical study of urban and rural working and non-working women reveals certain common phenomena which indicate the following:

1. All categories of women have a fair idea about reproductive health. Almost all of them learned about reproductive health from electronic and print media.
2. All of them are aware of family planning. However, in most cases, the women from urban area learned about family planning through media and the women from rural areas learned from health workers.
3. Regardless of background of the women, almost everyone observed various religious and traditional rituals involving reproductive belief.
4. Everyone was aware of AIDS. However, knowledge about the means of spreading and the difference between HIV and AIDS does not seem to be at the same level.
5. Regarding the status of women, almost everyone give preference to their husband's opinion and views.

A number of differences also emerged from the study. These include:

1. All the rural women (both income and non-income group) invariably used pills and injection as contraceptives for family planning. Those who are not using pills and injections have restored to "natural" method for family planning.
2. On the other hand, urban women are flexible in adopted different means of family planning including usage of condom.
3. Rural non-income group tend to get married at an early age and prone to taking more children than the urban categories of women categories of women.

During my interview, I found a strong co-relation between income and reproductive rights, especially in the case of urban respondents. However, between these two variables there are some intervening variables which played important role in enhancing perceptions about reproductive health and reproductive rights. These

variables are education, poverty, husband's cooperation and self determination. Given that every woman showed deference to their husband's opinion, domestic violence did not appear to have surfaced in developing the concept of reproductive rights. Urban women appeared to be more conscious about the importance of having consensual sex as opposed to male dominated masochistic sexual life. To rural women, treating them as sexual object did not appear to be inconsistent with the social fabric. They have taken for granted that men are like that. One woman even accepted the fact that her husband will go to other women while living in town.

Role of media in creating a sound perception about reproductive right and reproductive health, obviously, have played important role. At times, it felt that media was the driving force behind creating awareness. It would appear that media gives more importance to reproductive health than rights. The direct result of this disproportionate importance is that women too have developed more awareness towards reproductive health than reproductive rights.

CHAPTER ELEVEN

COMPARATIVE ANALYSIS AND CONCLUSION

11.1 Comparative Analysis

To examine the last, and of course very crucial, objective of my study I made a comparison of the findings between urban and rural issues relating to income and its impact on reproductive issues.

Indicators for Comparison	**Urban**	**Rural**
Area	Tongi, Gazipur	Singair, Manikgonj
Sample Unit of Area	Sharp Knitting and Buying garment factory, Pagar	Madhabpur village
Sample Unit	Women Garments Workers	Women who have own income
Population size	992	905
Sample Size	272	270
Methodology	Multi-stage Stratified Sampling, Random Sampling	Purposive sampling, Systematic sampling
Respondents' Profile		
1. Age	65 percent over 20 years old	35 percent over 20 years old
2. Household size	Average HH size is 3	Average HH size is 5
3. Occupation of the respondents	Cent percent Garment worker	More than 70 percent small entrepreneur

4. Occupation of the Respondents' Husband	More than 90 percent are day laborer, rickshaw puller and low paid manager	More than 70 Migrant worker, businessman and farmer
5. Level of education	30 percent above SSC level	70 percent above SSC level
6. Total Income of the Respondents	Average Tk. 4000	Average Tk. 7000
7. Total Expenditure of the Respondents	Average Tk. 3000	Average Tk. 2500
8. Total Number of Earning Members	Average 2	Average 3
9. Age at First Marriage	More than 80 percent women married between 16-20 years age	More than 60 percent women married between 14-19 years age
10. Marriage Pattern	Love marriage – about 65 percent	Love marriage – about 35 percent
Reproductive issues (Quantitative Part)		
	Percentage	**Percentage**
Know about reproductive rights	66	44
Decision take freely of having children	52	48
Decision about number of children	46	54
Decision of timing to become pregnant	49	51
Decision about the gap or space	56	44
Violence against you for denying husband's decision	41	
Have right to make protest against husband	60	40

Make coercion of having sex by husband	58	42
Priority of you for having sex	67	43
Mutual understanding of having sex lives	42	58
Taking decision about having abortion	71	29
Get respect/honor from your husband	47	53
Making violence by religious issues against you	63	37
Know about reproductive health	51	49
Know about family planning services	52	48
Co-operation during pregnancy from your husband	38	62
Co-operation from other members during pregnancy	43	57
Enough food and healthcare during pregnancy	48	52
Violence occurred during pregnancy	55	45
Health problem facing during pregnancy	54	46
Using contraceptives	56	44
Awareness of STD	62	38
(Qualitative Part)		
Observed Group		
Ramiza	She enjoys a certain level of participation in the decision making process.	-

Masuma	She thinks that her husband respects her and does not try to impose his opinion on her due to the fact that she is earning, albeit small.	-
Rubina	She is able to take any firm decision because of her own earnings.	-
Aparna	-	Should be involved in income generating work; this will help to gain importance in the family.
Hameeda	-	she is able to take this decision because of her job
Parul	-	Job made her aware about reproductive rights
Controlled Group		
Minu	-	She cannot share her thoughts with anyone let alone taking decision
Khaleda	-	She thinks that having education is more important than having income to take decision

Kajol	-	According to Kajol, life is all about compromise.
Helena	-	Helena thinks money can solve all the problems
Ruba	Without having job she can still take part in decision making process	-
Shila	She doesn't think that independent income would bring to her more honor	-
Shahida	She thinks that own income capability get more respect deriving from her children	-
Neela	She strongly belief job bring an enduring position both in personal and family life	-
Jhumka	She thinks that income generating activities make smooth relation between husband and wife and also create an entertaining life.	-

In this Study all the respondents are married women. The total sample size of this Study is 572 for qualitative part (272 for urban and 270 for rural) and 15 for quantitative part (8 for urban and 7 for rural). Tongi has been chosen as an urban area and Manikganj as the rural area. From these areas Sharp Knitting and Buying Factory has been taken as urban sample unit and Madhabpur village has been taken as rural

sample unit. In urban case Multistage stratified sampling and random sampling have been used. On the other hand, for rural case purposive and systematic sampling have been used.

Comparative analysis between rural and urban areas for quantitative part:

65 percent of the respondent's age is over 20 years of age in urban area and it is 35 percent for the rural area. Average household size is 3 for urban and 5 for rural areas respectively. All the respondents of the urban side are garment workers and more than 70 percent of the rural respondents are small entrepreneurs. 30 percent of the respondent's educational level in urban area is above SSC whereas it is 70 percent for rural area. The average income of the respondents in urban sector is 4000 whereas 7000 is for rural sector. Earning member of the rural family is 3 and 2 is for the urban family. One interesting thing has shown in this study that is, urban respondents got married at an early age than the rural respondents, who prefer personal choice than arranged marriage.

Awareness about Reproductive rights is seen in both sectors but it is more in the urban area. 66 percent of the urban respondents know about the issue whereas for the rural sector the number is 44 percent. In case of taking decision about the number of children and decision about the gap or space and about having abortion the percentage of urban respondents are much higher than the rural respondents. 60 percent of urban respondents had exercised their right to make protest against husband's decision whereas 40 percent of the rural respondents exercised that right. This is due to husband's low income in urban area. In this study most of the garment factory workers' husbands earn very little so they are depended on their wife's support. This is one of the reasons why the rate of violence is also lower amongst the urban working women.

Both Reproductive health and Family Planning are very well known issues in urban and rural sectors. The percentage of contraceptive use is higher among urban respondents than rural ones. Everybody knows what is AIDS. This is due to media in urban sector and health worker in rural sector. Though the respondents are not very educated but almost everybody knows about their rights especially reproductive rights. In the garment sector, the respondents did not hesitate to answer personal questions about their sexual life and even in Madhabpur village women did not feel

shy to answer deeply personal questions. This proves that they consider the issue, reproductive rights, as a major aspect of their lives. But a major difference has been demonstrated between rural and urban respondents. Urban women practice their rights more than rural respondents. On the other hand, a significant similarity has been observed. That is faithfulness and obedience towards husband.

Comparative analysis between rural and urban areas for qualitative part:

The size of the qualitative sample is 15. Out of that, there are two groups: observed group and control group. All non-income group respondents are called controlled group. After summarizing all the in-depth interviews it is found that there are similarities and dissimilarities between rural and urban respondents, as well as, income and non-income group respondents.

From observed group, all the respondents agreed with the statement that there is a deep connection between income and reproductive rights. All of them think that their income has given them the decision-making power and they can enjoy a certain level of participation in the decision making process. They also think being involved in a job makes a woman important in her family and above all it generated the awareness about reproductive rights with the intervention of other matters like media, health worker etc.

From controlled group the situation is different especially in urban area. Some respondents from this group differ with the statement that women's income directly affects their decision-making power in their reproductive life. According to them, women can still take part in decision- making process without involving in income-earning activities. But, some of them agree that own income capability allows a woman to earn more respect from husband as well as from children and it creates better understanding between husband and wife. This is the scenario of the urban respondents who are well-educated. However, the rural non-income respondents strongly believe that income greatly affects their reproductive rights. Thus they think there is a positive relation between these two variables. At the same time they feel that education, compromise and support from family are also very essential with regard to this relationship.

11.2 Conclusion

Reproductive rights do not necessarily mean reducing fertility but a person's right to decide about the number of children. In this study an attempt has been made to understand the relationship between women's income and reproductive rights. In doing so, I have tried to portray a real picture of the status of Bangladeshi women in different sectors. From that picture it would appear that the life of a woman in this society is surrounded by patriarchal norms and values. I have tried to sketch the phenomenon from Sociological perspective both in rural and urban settings.

The samples have been drawn from both rural and urban area through multiple sampling techniques. The main purpose of the study was to see the relation between women's income and reproductive rights. Therefore, the specific purposes of the study were to (a) explore the demographic and socio-economic characteristics of working women in general and non-working women in particular, (b) examine the relationship between income and non-income group women and their state of reproductive rights, (c) explore the nature of change in income pattern and its impact on reproductive rights, (d) illustrate the comparison between rural and urban settings in terms of the above objectives.

In short the findings of the study demonstrate that both urban and rural respondents are aware about reproductive rights, reproductive health, family planning, sexually transmitted diseases and contraceptives. Strong co-relation has been found between income and reproductive rights in case of urban women. They appeared to be more cautious about the importance of having consensual sex as opposed to male dominated sexual life. To rural women, treating them as sexual object did not appear to be inconsistent with the social structure they perceived. Awareness about reproductive right is more in urban side. In case of taking decision about the number of children and decision about the gap or space and having abortion, the percentage of urban respondents are much higher than the rural respondents. In this study most of the garment workers' husband earn very little so they have to depend on their wife's support. This income generating status of women plays a vital role in reducing incident of domestic violence. Female garments workers almost invariably agreed that they enjoy a higher standing in their family than those women who are not employed or not earning for their family. Since financial contribution and economic power is

directly translated in the creation of the standing in the family, other peripheral social issues also gain deeper footing in favour of working women, having a greater level of awareness and consequent standing vis a vis reproductive rights is therefore is necessary corollary. That's why the rate of violence is lower.

Another common feature in both urban and rural women appeared to be the dependence on husband's decision. Regardless of the level of financial contribution by working women in the family, in some cases even wife is earning more than the husband, the husband appeared to have enjoyed upper footing in terms of decision making power. In some cases, even if working women expressed her opinion, she still subjects her opinion to that of her husband. This feature of dominance is not confined to reproductive rights. It pervades every aspects of family life. This is due to the patriarchal social structure of our society. The literature review also showed this picture.

Another aspect of this study suggests that although the strong connection between income and reproductive rights have not occurred especially for rural women, there is some rays of hope. In rural areas women's income is related to the basic needs like food, fuel and shelter. They have to manage their needs with their income. In such a situation, the question about exercising reproductive rights appeared to be remote. If they were to appreciate the importance of exercise of reproductive rights, rudimentary level of financial contribution by rural working women needs to be upgraded. If rural working women's financial contribution or standing is enhanced, it appeared that their awareness level and demand for exercise of reproductive rights are strengthened. This feature is demonstrated by some of the rural working women's interview, those who have greater level of contribution in the family had higher level of awareness and decision making power including the decision on reproductive rights. Poverty had played an important intervening variable in this case. Which also demonstrates the interlink between these two aspects i.e. reproductive rights and poverty.

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Appendix One: Interview Schedule

Women's Income and Reproductive Rights: A Sociological Study in Rural and Urban Settings in Bangladesh

(The collected information will be used only for

the purpose of research and secrecy will be strongly maintained.)

(All respondents are married women)

[Section---A]
Socio-demographic Indicators

Address (urban/rural):

1. Age: (exact): .....

2. Household Size:

Two	1	Five	4	Eight	7
Three	2	Six	5	Nine	8/+
Four	3	Seven	6		

3. Occupation of the Respondent:.....

4. Occupation of her Husband: .....

5. Level of Education:

Illiterate	1	HSC	4
Primary	2	Bachelor's	5
SSC	3	Master's	6

6. Religion of the Respondent: Islam [1] Hinduism [2]
Budhism [3] Christianity [4]

7. Total Income of the Respondent (monthly): Tk.....

8. Total Income of the Household (monthly): Tk.....

9. Total Income of her Husband (monthly): Tk.....

10. Total Expenditure of the Respondent (monthly): Tk.....

11. Total Expenditure of the Household (monthly): Tk.....

12. Total Expenditure of her Husband (monthly): Tk.....

13.Total Number of Earning Members of the Household: .....

[Section---B]
Reproductive Rights

14. Age at first marriage: .....

15. Age at second marriage (if any): .....

16. Your marriage is/are personal choice/arrange? ..... Personal choice/arrange

17. What do you mean by the reproductive rights?.....

.....

.....

.....

.....

18. Can you take the decision freely of having children?.....yes / no

19. Who will take the decision about how many children you want?....self / husband / others (specify).....

20. Can you take the decision of timing to become pregnant?....yes / no

21. If no .....why ?.....

22. Who decides about the gap or space of taking children between one child to another?

self / husband / others (specify).....

23. Have any kind of violence occured against you for denying your husband's decision on reproductive issue? .....yes / no

24. If yes.....(specify the pattern of violence).....

25. Do you have right to make protest against your husband regarding any kind of discrimination to you? yes / no

26. Does your husband make any coercion of having sex at any time (without your consent)?....yes / no

27. Whose intention/opinion gets more priority in most cases for having sex?

self / husband

28. Do you have any mutual understanding of having safe and responsible sex lives?

yes / no

29. Do you have any experience of having abortion? yes / no

30. If yes……who will take the decision about abortion? self / husband / others

31. Do you get respect/honor from your husband?… yes / no

32. Do you follow the religious bindings about reproductive issues? yes / no

33. If yes….who follow it…self / husband / both you and husband / others……..

34. Do you think that by following the religious issues your husband making violence/coercion/discrimination against you? ……yes / no

35. if yes…. specify the pattern of violence/coercion/discrimination……..

……

[Section---C]
Reproductive Health

36. What do you mean by reproductive health?……

……
….

37. Do you know about family planning services?…….yes / no

38. From where you get all information about reproductive health?……

.....

.....

39. Do you get sufficient co-operation from your husband during pregnancy? yes / no

40. Do you get sufficient co-operation from other members of the family during pregnancy? ..... yes / no

41. Do you get enough food and medicare during your pregnancy? ..... yes / no

42. If no.....why?.....

.....

...

43. Any violence occurred during pregnancy?.....yes / no

44. If yes ....why?.....

.....

45. What type of health problem facing during pregnancy? .....

46. Where did the delivery of the last baby take place? (specify).....

47. Who take the decision regarding the use or non-use of contraceptives?.....

self / husband / both

48. Do you use contraceptives for protecting pregnancy ?.... .yes / no

49. If yes...(specify the type of using contraceptives) .....

50. If no.....why ? (specify the causes).....

.....

51. Are you aware of sexually transmitted diseases (STD)....,..... yes / no

52. If yes ..what are that.....

53. If no...why.....

.....Thank You.....

Appendix Two: Check List for In-depth Interview

Name	:
Status	:
Age	:
Home District	:
Present Address	:
Occupation	:
Income	:
Age at Marriage	:
Type of Marriage	:
Education	:
Perception about RR	:
RH	:
FP	:
STD	:
RB	:
Use of Contraceptives	:
Number of Child	:
Husband's Occupation	:
Income	
Expenditure	:
	:
Family Type	:
Family Members	:
Decision Making Power	:

.....Thank You.....

Appendix Three: Photograph