(The study is conducted by the 13th batch participants of Gender and Governance Training Program of Democracywatch)

# Reproductive Decision Making Role among Slum Dwellers of Dhaka City

Democracywatch

15 Eskaton Garden Road, Dhaka-1000

**Published by:**
Democracywatch
15 Eskaton Garden Road
Ramna
Dhaka-1000

**First Edition 2014**



**Printed by:**
Democracywatch
15 Eskaton Garden Road
Ramna
Dhaka-1000

# Preface

Democracywatch, a trust and a registered NGO was established in 1995 with the aim of strengthening Democracy in Bangladesh. We ventured out to achieve this through creating awareness of democratic process, values, human rights and good governance and thereby foster democratic culture. These are to be implemented through education, training of youth especially women, concluding research, increase capacity of democratic institutions and advocacy. Democracywatch trained around 25000 youths sofar in “Life skills” and “Lifestyle” course on basic skills for developing as a confident, aware and competent human being ready to contribute as leaders towards ushering in a better society.

Democracywatch developed a special gender and governance training to add its leadership program. Awareness of gender issues is one of the main themes of training the youths of tomorrow. So an innovative training program called Gender and Governance Training Program (GGTP) and later named as Gender and Governance Sensitization Program (GGSP) was introduced in 2005 funded by CIDA. After two terms of funding by CIDA the Royal Danish Embassy, the Program for Asian Project (PAP) gave us the necessary support. Young public university graduates both male and female came forward to undertake this innovative and purposeful training program. Our rich pool of resource persons includes renowned academics and researchers on gender, politics, sociology and law. These immensely enriched trainings attracted well attributed women and men. The training period was only four months. It was highly regarded as it incorporated some additional components which are not readily found in other short courses i.e. research on gender issues and internship with reputable development and economic organizations. Both of these gave the participants of the course practical knowledge and hand on experience. This inculcated in many of the participants being well placed in renowned international and national NGOs and also engaged in big corporate. We feel elated that the course has been successful in creating female and male leaders in our society within such a short time.

We are proud to present the research reports that each batch has produced. These researchers are rather empirical with small sample size, as it had to be finished within the course period on a shoestring budget. These studies need to have a sympathetic view by its readers. Nevertheless topics selected often created a lot of interest among the stakeholders and academics when they were presented by the students at our seminars. Hope this study is useful to some in their own work and in giving an insight on women’s plight in our society.

To end I thank Mrs. Taherunnesa Abdullah, Magsaysay Award Winner, Prof. Salahuddin M. Aminuzzaman, Prof. A.S.M Atiqur Rahman of Dhaka University, Mr. Saiful Islam our Monitoring and Evaluation Team Leader and the gender unit for helping the students in completing the reports of these researchers. The students would have been at a loss without their all out support.

I congratulate and thank all the participants for their hard work and willingness to learn about importance of gender in all spheres of the society and contribute in achieving it.

Last but not the least my deepest gratitude to our donors Norad, CIDA, PAP and Royal Danish Embassy for their support.

Taleya Rehman

Founder Executive Director

Democracywatch

# Acknowledgement

We, the participants of the 13th batch of the "Gender and Governance Sensitization Program" of Democracywatch conducted the research titled –"**Reproductive Decision Making Role among the Slum Dwellers**" as part of our training program. In doing this research we received guidance and support from many people, without which this research would not have been possible. As such we would like to thank a number of people for their contribution to this research work. First of all we would like to thank Mrs. Taleya Rehman for always being so enthusiastic about our research and taking time out of her busy schedule to guide us in different stages of research. We thank Mrs. Tahrunnesa Abdullah for her precious advice and guidance. We express our sincere gratitude to **Prof. A. S. M. Atiqur Rahman,** Institute of Social Welfare and Research, **University of Dhaka** for acquainting us with basic research methods. It is due to his excellent teaching on the theoretical aspects of social research that we felt comfortable in undertaking this field of research. We would like to convey our special thanks to Ms. Mansura Akhter, Ms. Anupama Anam and Ms. Syeda Nazneen Jahan for their continuous guidance and suggestions at every stage of the research. Thanks to all the respondents for their time and sharing with us valuable knowledge and experience on the study subject.

**Participants of the 13th Batch**
Gender and Governance Training Program
Democracywatch
February 2010

# Table of Contents

# Summary

Bangladesh is one of the most densely populated countries in the world, with over 160 million people squeezed into an area of 145,000 square-kilometers. The average per capita income is just $440 per year and the income disparity between rich and poor is wide. The country's urban population continues to expand rapidly. Already, over 30 per cent of Bangladeshis live in urban areas.

The congestion of living space, unhealthy environment and lack of health services make the urban poor vulnerable to health risk. Maternal and child morbidity in slums could easily have been reduced by providing basic health services and improving access to water supply and sanitation services.

One of the most common health hazards of Bangladeshi women is reproductive health problems which is indicated by the high maternal mortality rate (4.0 per 1000 live births). Fertility control like most other family decisions is not always an individual affair but involves co-operation, discussion and joint decision making among couples. The existing nature of relationship among the couples affects the decision on family size. The status of women in the family in particular and society in general is important especially to influence marital decisions. The way women interact with kith and kin, neighbors, peers, and community leaders, health professionals etc. exercise influence in shaping women's decision style. Fertility decisions at a given time depend to a large extent on current situations within the family. Each birth may, therefore, be influenced by a different set of motivational, cultural and family conditions.

The study on "Reproductive Decision Making Role among Slum Dwellers of Dhaka City" was undertaken with the objective to know about the present status, powers and autonomy of women of slum dwellers regarding reproductive decision making. Both the qualitative and quantitative approaches were used to conduct the study including literature review, sample survey and non-participant observation. Sample survey was carried out among the slum dwellers at different places in Dhaka, namely Moghbazar Rail Gate, Vashantek - Mirpur, Rajbari -Shia Masjid, Baoniabadh- Mirpur. Among the slum dwellers 361 respondents were selected using random sampling method to collect data, of them 280 are female and 81 are male.

**Major findings from the study**

Half of the respondents are illiterate and there is not much difference in education level of male and female respondents. The respondents in general have small number of family members ranging from five and below.

A significant number of women respondents are engaged in different types of economic activities along with male respondents. Generally, male respondent's family income is higher than the income range of female respondents. Altough, range of income of some female respondents is higher than the male respondents. However, male respondents' income is insufficient for the family. As such, earnings of female respondents, what ever small may be, supplement family income.

Though slum dwellers know that legal age of marriage is 18 years and above, child marriage is very much prevalent among the female respondents and early marriage is common for the

male. Practice of taking consent of girls and boys during arrangement of marriage in the slum area have been initiated in the recent time but still in most of the cases, guardians, and relatives take decision about their marriage without discussing with them. Only customary consent is taken during marriage ceremony.

These respondents are conscious of having small families. Women living in slums generally have their first child at a very early age as their marriage age is average 13/14.

It is encouraging to find that husbands provided various support to their wives during pregnancy, such as medical care, providing nutritious food, assisting in household work, taking care of other children etc. It is a positive sign that in large number of cases husbands looked after their wives during pregnancy. However, there are cases where husbands were indifferent and did not take care of their wives during pregnancy. Many female respondents and wives of male respondents availed postnatal care which is very surprising and encouraging.

Slum women received healthcare services from various healthcare institutions such as services of health workers, NGO clinics, hospitals, community clinic (*surjer hasi)* and traditional doctors. Slum women also availed pre-natal care from recognized health care services. Generally, normal child birth takes place at home and complicated cases are taken to hospital for delivery. Usually these decisions are taken by the husband and wife as they live in a nuclear family, but if any other family members were looking after the mother to be often decided the birthplace of the new born. Unskilled midwives, untrained relatives attend the pregnant women of the slums during delivery.

Women among the slum dwellers usually practice family planning method rather than men. They use birth control injection, birth control pill, IUD, permanent method i.e. ligation etc.

Female respondents who do not practice family planning mentioned various reasons such as ignorance about family planning, resistance of husband, religious prejudice, absence of husband, physical problem, methods used by husband etc. Male respondents did not practice family planning because their wives practiced family planning which is the most common phenomena. Other reasons for not practicing family planning according to the male respondents were ignorance about family planning, religious prejudice, desire for more children etc.

Since women generally stay at home, they have access to information delivered at home from health workers, relatives, friends, neighbors, TV, Radio and newspaper etc. In case of male also source of information is mainly from health workers, relatives, friends, neighbors, TV, Radio and news paper. Since men go out they also have access to information from community functions, posters and bill boards, NGO clinics and hospitals. Since family planning is still considered an issue not to be discussed in public, information delivered at home is more effective. Role of health workers and relatives/ friends/neighbors is prominent in getting Family Planning information. Role of health workers is also prominent in supply of family planning materials. NGO clinic including '*Surjer Hashi'* plays important role in this sector.

As side effect of practicing family planning the respondents mentioned various physical problems such as headache, irregular period, pain in the body especially abdomen, dizziness, fever, vomiting, bleeding, weakness, weight gaining, white discharge, loss of appetite etc. In case of side effects they took advice from doctors/health workers/NGO clinic

and took medicine. They collect family planning materials from NGO clinic, pharmacy, Radda MCH Center (NGO), Surjer Hashi. A big proportion collects materials from, health worker, hospital and doctor. They do not want to take more children in future.

Women living in slums want to take reproductive decision by themselves. Illiteracy, lack of understanding in marital life, economic dependency, social stigma, torture by husband, unhappiness in family, ignorance, prejudices etc are some of the barriers which prevent women from taking independent decision about reproduction.

# CHAPTER: ONE

## 1.1 Introduction:

Bangladesh is one of the most densely populated countries in the world, with over 160 million people squeezed into an area of 145,000 square-kilometers. There are nearly 920 people per square kilometer[1] of which over 63 million of them struggling below the national poverty line (less than one dollar a day). The average per capita income is just $440 per year. Although income poverty has fallen over the past decade, from 58 per cent of the population to 49 per cent, the income disparity between rich and poor has widened. The country's urban population continues to expand rapidly. Already, over 30 per cent of Bangladeshis live in urban areas. If it continues to grow at current level, Dhaka will become the second largest mega-city in the world by 2015, with a projected population of over 22 million. The population of Dhaka city (areas under the jurisdiction of the Dhaka city corporation) stands at approximately 7.0 million. The city, in combination with localities forming the wider metropolitan area, is home to an estimated 12.8 million as of 2008[2]. The city population is growing by an estimated 4.2% per year, one of the highest rates amongst Asian cities[3]. The continuing growth reflects ongoing migration from rural areas to the Dhaka urban region, which accounted for 60% of the city's growth in the 1960s and 1970s. More recently, the city's population has also grown with the expansion of city boundaries, a process that added more than a million people to the city in the 1980s[4]. According to Far Eastern Economic Review, Dhaka will become a home of 25 million people by the year 2025[5].

With urban population growth, the number of slums and the people who dwell there are rapidly increasing. With an estimated 3.4 million people living in some 5000 slums of its capital city, Dhaka[6], Dhaka is now experiencing a rapid population growth and slum dwellers are mainly responsible for this. The population of Dhaka city doubles in every 11 years whereas it takes 25 years to double the population in the whole country. Bangladesh's high rate of growth of slums and population living in slums has serious economic, social, and public health consequences. Although the government has a structured health and family planning service delivery system for the rural poor, it does not have any comparable infrastructure for the urban poor[7]. Nongovernmental organizations (NGOs) are the primary service providers for the urban poor population. However, some studies report that "NGO services are often selective, less than optimum, and their coverage is incomplete"[8].

[1] BDHS Survey 2007
[2] "Statistical Pocket Book, 2009", Bangladesh Bureau of Statistics
[3] McGee, Terry (2006-09-27). "Urbanization Takes on New Dimensions in Asia's Population Giants" Population Reference Bureau.
[4] Ibid
[5] Planet of Slums by Mike Davis
[6] Islam N. Slums of Bangladesh Mapping and Census *Center for Urban Studies,* 2005.
[7] Khuda et al, 1994
[8] Jamil, Baqui, and Paijor, 1993

Those who live in the slums are largely distressed migrants from rural areas, most of who live below the poverty line[9]and maintain the outlook and values of their rural heritage. They do not have sufficient access to education, employment, and health facilities of the formal sector to attain any higher standard of living.

One of the most common health hazards of Bangladeshi women are the reproductive health problems which are indicated by the high maternal mortality rate (2.16 per 1000 live births). Fertility control like most other family decisions is not always an individual affair but involves co-operation, discussion and joint decision making among couples. The nature of relationship existing among the couples affects the decision on family size. The status of women in the family in particular and society in general is important in the decision authority in the marital dyad. The way women interact with kin, neighbors, peers, and community leader, health professionals etc. are significant extramarital influences in shaping the decision style. Fertility decisions at a given time depend to a large extent on current situations within the family. Each birth may therefore be influenced by a different set of motivational, cultural and family conditions.

Since family planning services are usually centered on women, it is required to find that whether they can take reproductive decisions without their husbands consent. In other words, the social context of sexual and reproductive decision-making should be well explored. Towards this end, it is vital that we have objective insight into the personal, household and social factors influencing fertility regulating behavior of individuals and couples and on the basis of this suggest possible solution for problems of gender inequality, women empowerment and low fertility rate in the slum areas of Dhaka city. This work invariably leads to new research questions and agenda that can enhance our knowledge and understanding of the culture, power relationship among couples and how these affect role expectations, child bearing and rearing practices.

## 1.2 Objectives of the study:

The objectives of the study are to

1. To know about the present status, powers and autonomy of women of slum dwellers regarding reproductive decision making.

2. To find out their knowledge regarding reproductive health issues

3. To determine the influence of socio economic background of the slum dwellers in reproductive decision making.

4. To find out the causes that deter women from exercising decision making power.

5. To identify the way to remove the obstacles in the way of women's decision making power and to ensure the right to freedom of choice.

[9] Haaga, 1992

## 1.3 Rationale of the study:

The growth rate of urban population is almost double than that of the rural population. People living in slums experience a staggering number of human rights violations. They are routinely denied their right to adequate housing, safe water, sanitation and drainage, electricity, health and education, and face the constant threat of police and gang violence, and forced eviction. Slum residents pay disproportionately high rents because rent control legislation is rarely imposed in areas considered by the authorities to be “un regularized”. Access to justice is denied because of discrimination and residents have no say in the upgrading of homes or services. The absence of health facilities and schools within many slums severely restricts access to health care and education. Malnutrition and child mortality rates in slums often match rural areas.

A great number of barriers for women are related in social values, customs, belief and assumption about the nature of women and her capability; Males are generally referred to as the head of the home. These socially determined roles in the household always have significant effect on reproductive decision making. The social pressure to conform to the social elements determining gender relationship is strong and deviation often carries a sanction especially for women.

Slum dwellers are usually excluded from decision making processes that impact on their lives and rarely enjoy full legal protection. The lack of security of residence and widespread forced evictions sustain and deepen poverty and deprivation among slum dwellers. Global slum populations are growing at an alarming rate. Disinvestment in rural areas, conflict, natural, disasters, climate change, forced evictions and corporate land grabbing continue to force people to migrate to cities where affordable housing is scarce.

The growth rate of urban population is almost double than that of the rural population. People living in slums experience gross human rights violations. This study will help to know about the present reproductive decision making situation of slum dwellers. The absence of health facilities and schools within many slums severely restricts access to health care and education. Malnutrition and child mortality rates in slums often match rural areas. Women are particularly vulnerable in slums, where lack of facilities place them at greater risk of sexual assault and harassment and where the reporting of domestic violence is often not treated seriously by police. Property law also frequently discriminates against women.

Health facilities are not adequate for the slum dwellers. As a result of this acute shortage of health facilities most slum dwellers are either entirely left out of health services or receive very poor quality health care. The slum people are unable to pay for the private health care. The urban poor are forced to take the alternative and go for unqualified health providers.

Improving access to health services to the urban poor is challenging for a variety of reasons. Urban health infrastructure in most cities is inadequate to meet the demands of large sections of the urban poor. Currently there is one Urban Health Centre for every 230,000 persons as against the goal of one centre for every 50,000 population. As a result of this acute shortage of health facilities most slum dwellers are either entirely left out of health services or receive very poor quality health care.

Since family planning services are usually centered on women, it is required to find that whether they can take reproductive decisions without their husbands consent as the

traditional head of the home or not. So it is necessary to reshape the decision-making environment in a way that would undermine the coercive patriarchal systems and creates conditions favorable to female autonomy, late marriages and smaller family size. In other words, the social context of sexual and reproductive decision-making should be well explored. Towards this end, it is vital that we have objective insight into the personal, household and social factors influencing fertility regulating behavior of individuals and couples and on the basis of this suggest possible solution for problems of gender inequality, women empowerment and low fertility rate in the slum areas of Dhaka city. This work invariably leads to new research questions and agenda that can enhance our knowledge and understanding of the culture, power relationship among couples and how these affect role expectations, child bearing and rearing practices.

This study will also help us to understand government health delivery system in slums, treatment seeking behavior for various reproductive morbidities (Gynecological, Obstetric and Contraceptive Morbidity) and discuss various homemade remedies women use and treatment seeking behavior is often influenced by a large number of factors apart from knowledge and awareness.

## 1.4 Definition of the concepts and terms:

Slum:

The slums have defined as a run-down area of a city characterized by substandard housing and squalor, a densely populated temporary residential house built lawfully or unlawfully having no water supply, sanitation facilities or electricity supply. Most of these are one-roomed dwellings and extremely over-crowded defined by the *United Nations agency UN-HABITAT*. *The World Bank*, in a survey report that was conducted in collaboration with the Housing and Settlement Directorate, government of Bangladesh and Centre for Urban Studies, defined a slum as a residential area where more than three hundred people live in one acre (0.405 hectors) of land. An average of more than three adults live in a single room. 46 percent of these houses are one-roomed and the average size is 120 square feet. Ventilation, drinking water, electricity and sewerage facilities are absent in these houses[10].

Slums can be divided into three groups

1. Unauthorized occupation of government or semi-government lands
2. Living in thatched houses made of papers, polythene, tin etc, built on unauthorized vacant land near railway lines or on the footpath or by side of the main roads.
3. Living in unauthorised private lands.

Again In a study by the Centre for Urban Studies et al. 2006, slums were defined as residential areas characterized by the following conditions:

1. Predominantly poor housing
2. Very high population density and room crowding
3. Very poor environmental services, particularly water and sanitation facilities
4. Very low socioeconomic status for the majority of residents

[10] Source: 'Dhakar Paribesh', Gias Siddique, page- 47

5. Lack of security of tenure

At present 1.5 million people live in slums within two or two and half miles radius of the city[11]. The living conditions of these slums are inhuman. There are no water supplies for drinking, bathing or cooking. Most of the dwellers have to spend daily Tk. 10-15 on average for buying water, which is unaffordable for many. Apart from this, there are few sanitation facilities. In the majority of slums, up to 20 - 100 families use one toilet and only on payment. The slum dwellers are also deprived of primary health care facilities. There is no medical centre for them. The child death rate is unusually high, more than 15 per cent. Most of the children suffer from malnutrition.

Slum Dwellers:

Although the characteristics of slum vary between geographic regions, they are usually inhabited by the very poor or socially disadvantaged and displaced people who are called slum Dwellers.

Reproductive decision making:

The processes involved when women make decisions regarding reproductive behavior and how the decisions made or the decision-making processes affect women's self-image and their relationships with significant others--spouse, children (in case of both wanted and unwanted pregnancy) and members of the extended family is called Reproductive Decision Making. The impact on self image is an important concern since empowerment of women occurs when they have a more positive self-image[12].

In this study, the decisions of taking child, choosing family planning methods, knowledge about family planning methods, number of children, role of the spouse during pregnancy period, problems faced for using contraceptive, health care facilities in postnatal and prenatal period, decisions of marriage are considered as indicators of productive decision making.

For this study we define Reproductive decision making to somewhat similar to that of the "Platform for Action"- the freedom and ability of couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain a safe and standard sexual and reproductive health.

## 1.5 Research Methodology

### 1.5.1 Study Area:

Among the slums of Dhaka city, a representative sample of nine slums were selected purposively according to access facilities.These are Segunbahgicha, Moghbazar Rail gate, Khilgaon Bahgicha, Moga's , Gulbagh, Vashantek , Mirpur, Paikpara, Ahmedabad, Mirpur, Baoniabadh , Mirpur, Shukkur Mian's, Baitul Aman, Shaymoli and Rajbari , Shia Masjid, Shaymoli.

[11] Ibid.

[12] Hong & Seltzer, 1994; Petchesky,1990; Worell & Remer, 1992

### 1.5.2 Study Population:

The study Population consisted of the slum dwellers of Dhaka city. A total of 361 respondents selected using random sampling method to collect data, where 280 are female and 81 are male.

### 1.5.3 Data Collection Methods and Tools:

Considering the nature of study both qualitative and quantitative approaches were used to conduct the study including literature review, sample survey and non-participant observation.

Two types of data collection methods were used to conduct this study. These are:

- **Semi-structured interview schedule**
- **Case Study**

The study was conducted on urban slum women and men to know about their knowledge regarding reproductive health issues and to determine the influence of socio economic background of the slum dwellers in reproductive decision making.

A semi structured interview schedule was formulated for data collection. Rapport was built with the respondents. All questions were put in a conversation style. Respondents were contacted by home visits. Fourteen (14) case studies of married slum dwellers were taken to assess the opinion and status of respondents in the decision making process on their reproductive health issues. Six of theseing cases are presented in the report.

### 1.5.4 Data Analysis

To analyze the data, collected information was classified in the light of objectives set forth for the study. The classified data was coded, tabulated and percent calculated for the same. The results were presented and discussed along with tables and graphs in numbers and percentages.

## 1.6 Period of Study: February-March, 2010

## 1.7 Limitations of the study:

- As resources and manpower allocated for the proposed research was very limited, the data collection was limited only within 361 respondents of slum dwellers of Dhaka city.
- Some respondents were reluctant to answer the question on reproductive health issues.
- Some respondents did not want to say anything against their husbands on being afraid of violence.

# CHAPTER: TWO

## Review of Related Literature

The International Conference on Population and Development (1994), the United Nations' Fourth World Conference on Women (1995) and the Platform for Action (PFA 1995) advocated integrated approach towards health service, family planning and reproductive health problems of women. Considering the reality of a male dominated society where women have less opportunity to exercise power in reproductive decisions, the PFA focused on women's health, including physical, mental, maternal and reproductive health and linked these with empowerment of women and the attainment of gender equality. According to the Beijing Declaration (1995) "the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment." It is true that population control programs have a long history, relative to the concept of reproductive rights, to work under the banner to improve the maternal and child health[13], but practice of family planning may not indicate women's reproductive decision making power.

In Bangladesh population control has been a declared government policy since mid sixties[14]. On the other hand in the early eighties women groups in western industrialized countries first coined the term reproductive rights. In countries like Bangladesh the use of the term reproductive right is very recent and thus the perception and practices of urban middle class are dominant in this discourse. But the practices, perspectives and perception of a large segment of population who lived in informal settlements, are almost unexplored.

Those who live in the slums are largely distressed migrants from rural areas, most of who live below the poverty line[15]and maintain the outlook and values of their rural heritage. They do not have sufficient access to education, employment, and health facilities of the formal sector to attain any higher standard of living. As Haaga has observed, the health and nutritional status of the urban poor is even worse than that of the rural poor. Infant and maternal mortality rates are higher than the national rates, and around one-third of the people in the slum communities are thought to be ill at any given time. Also, more than 80 % of school-aged children in Dhaka slums do not attend school. All these factors are likely to affect adversely contraceptive behavior of those who live in the slums.

Authors of a recent national family planning strategic document suggested that, the government must devote special efforts as soon as possible to raise Contraceptive Prevalence Rate (CPR) in the slums in order to attain the national goal within the stipulated period[16]. However, very little is currently known about reproductive behavior and family planning in the urban slums.

Decision making capacity of a human being is one of those criteria which distinguish her/him from other species. Since it is related to intellectual ability to make the right choice and take responsibilities, recognizing the right of women to exercise decision making power also recognizes women as complete human being. But it is a historical fact that, women face

[13] Brydon, Lynne and Chant, Sylvia; "Women in Third World: Gender Issues in Rural and Urban Areas"; Edward Elgar Publishing Limited, England, 1993, p.190
[14] http://independent-bangladesh.com/news/feb/24/24022006wo.htm#A0
[15] Haaga, 1992
[16] Barkat et al, 1996

much more challenges in accessing the decision making power just because of their sexual difference.

One of the most common health hazards of Bangladeshi women are the reproductive health problems which are indicated by the high maternal mortality rate (4.0 per 1000 live births). Fertility control like most other family decisions is not always an individual affair but involves co-operation, discussion and joint decision making among couples. The nature of relationship existing among the couples affects the decision on family size. The status of women in the family in particular and society in general is important in the decision authority in the marital dyad. The way women interact with kin, neighbors, peers, and community leader, health professionals etc. are significant extramarital influences in shaping the decision style. Fertility decisions at a given time depend to a large extent on current situations within the family. Each birth may therefore be influenced by a different set of motivational, cultural and family conditions.

A great number of barriers (for women) are rooted in social values, customs, beliefs and assumption about the nature of a woman and her capability. Males are generally referred to as the head of the home. These socially determined roles in the household have a significant effect on decision-making that will determine ability to take advantage of opportunities that will then affect the educational, occupational, social and health-related status of members of the household along gender line. The social pressure to conform to the social elements determining gender relationship is strong and deviation often carries a sanction, especially for women.

The congestion of living space, unhealthy environment and lack of health services make the urban poor vulnerable to health risk. Maternal and child health morbidities in slum communities which could have been easily prevented by providing basic health services and improving access to water supply and sanitation services.

A study conducted by Mrs. Sabina Faiz Rashid, Assistant Professor of Brac University on ***Emerging Changes in Reproductive Behavior among Married Adolescent Girls in an Urban Slum in Dhaka, Bangladesh***, published in Reproductive Health Matters, Volume 14, pages 151-159, dated May'06. This study came to conclusion that, most of the women slum dwellers does not have power to take reproductive decisions independently, either they depend on their husband or they are forced to obey their husband.

Another publication by the same author titled "***Small Power, Little Choice***" published on 2006 in the IDS Bulletin, Volume 37 found that, poor or extreme poor women from rural or urban area do not have any sexual security and they cannot practice their sexual rights. Thus, they are becoming valueless in reproductive decision making role and turning into wooden dolls of their male partners.

Another study by Mrs. Sabina Faiz Rashid titled *"**Worried Lives: Gender & Reproductive Health for Adolescent Women in a Slum in Dhaka, Bangladesh**"* in 2003-04 reveals that, reproductive health situation among slum dwellers of Dhaka ditoriated in last ten years. Poor people from rural areas came to Dhaka in last decade and settled mainly in slum areas. Because of their poverty and unawareness, reproductive health situation has worsened. Several case study and in depth interviews have made our view clear on the decision making role of women among slum dwellers. Most of the women depend on their husband and cannot take their own decision by themselves. Sometimes, they are forced by their

husbands or family to conceive babies. Poverty prevents them from receiving pre or post natal care.

Another cross sectional study on *"**Unmet Need of Contraceptives among Eligible Couples of Urban Slum Dwellers in Dhaka**"* conducted by Dr. Shamsun Nahar, Associate Professor, National Institute of Preventive and Social Medicine, Mohakhali, Dhaka & Farhana Amin, Plan International, Bangladesh, published on Ibrahim Medical College Journal 2009, 3(1): pages 24-28. A total of 265 married women of reproductive age from Kamrangir Char of Dhaka were taken as the sample of this study. This study found that, almost half of the poor women in the study area are practicing various Family Planning Methods. Among them 40% suffered or suffering from various types of reproductive health related problems.

A study entitled *"**Determinant of Choices of Delivery Care in Some Urban Slums of Dhaka City**"* found that almost seventy percent of the poor family from urban slums in Dhaka do not show any interest in spending money on women during pre-natal or post natal period due to their poverty. The study also reveals that for a woman with a family size less than 5, the hospital utilization rate for delivery purposes is 14% and as the family size increases, the home delivery incidents increase. We found more information from this study such as Information & choice of delivery, reliance on traditional system, social taboo and belief, access to Family Planning are also responsible for making reproductive decisions.

From the findings of these studies, it is clear that the condition of reproductive decision making role among slum dwellers of Dhaka City is almost nonexistent. Still in the twenty first century most of the women of the slum depend on their male partners regarding taking reproductive decision. The objective of this study is to find out the decision making role of women of slum dwellers of Dhaka city.

# CHAPTER: THREE

## Findings from Survey

### 3.1 Distribution of respondents according to study areas:

| Sl | Study areas ( Slums) | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Moghbazar Rail gate | 68 | 24 | 21 | 26 |
| 2 | Vashantek , Mirpur | 44 | 16 | 18 | 22 |
| 3 | Rajbari , Shia Masjid, Shaymoli | 38 | 14 | 16 | 20 |
| 4 | Baoniabadh , Mirpur | 35 | 12 | 09 | 11 |
| 5 | Segunbahgicha | 28 | 10 | 04 | 05 |
| 6 | Moga's , Gulbagh | 23 | 8 | 03 | 04 |
| 7 | Khilgaon Bahgicha | 19 | 7 | 03 | 04 |
| 8 | Shukkur Mian's, Baitul Aman, Shaymoli | 16 | 6 | 05 | 06 |
| 9 | Paikpara, Ahmedabad, Mirpur | 9 | 3 | 02 | 02 |
| **Total** | | **280** | **100** | **81** | **100** |

**Analysis:**

A total of nine slums have been selected as study area from where 280 female respondents and 81 male respondents were selected for interview. Distribution of respondents according to slums is presented in table 2. Sixty six percent female respondents and 79% male respondents selected from slum areas of Moghbazar Rail gate, Vashantek - Mirpur, Rajbari - Shia Masjid, Baoniabadh- Mirpur

### 3.2 Age of the Respondents:

| Sl | Age Limit | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | 16-20 | 82 | 11 | 04 | 5 |
| 2 | 21-25 | 70 | 25 | 10 | 12 |
| 3 | 26-30 | 46 | 29 | 21 | 26 |
| 4 | 31-35 | 31 | 17 | 16 | 20 |
| 5 | 36-40 | 31 | 11 | 11 | 14 |
| 6 | 41-45 | 9 | 03 | 05 | 06 |
| 7 | 45+ | 11 | 04 | 14 | 17 |
| **Total** | | **280** | **100** | **81** | **100** |

**Analysis:**

Female respondents are mostly (71%) in the age group 21 to 35, where as 83% of the male respondents age varies between 26 and 45 plus.

### 3.3 Educational Qualifications:

| Sl No. | Educational Qualification | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Illiterate | 143 | 51 | 40 | 49 |
| | Only sign name | 18 | 06 | 03 | 04 |
| 2 | Primary | 82 | 29 | 23 | 28 |
| 3 | Junior secondary | 26 | 09 | 07 | 09 |
| 5 | Secondary | 5 | 02 | 07 | 09 |
| 6 | Higher secondary | 1 | 01 | 01 | 01 |
| 7 | No information | 5 | 02 | -- | -- |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Among female respondents 57% were illiterate including 6% who could only sign their names and among male respondents 53% were illiterate which is less than female respondents. Percentage of female and male respondents who completed primary and junior secondary level education is more or less same that is 38% and 37%. There is some difference among female (3%) and male respondent (10%) who have completed secondary and higher secondary level of education. This shows there is not much difference in education level of male and female in slum areas.

**3.4 Marital Status:**

| Sl. | Marital status | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | frequency | % |
| 1 | Married | 233 | 82 | 79 | 98 |
| 2 | Separation | 10 | 04 | -- | -- |
| 3 | Abandoned | 22 | 08 | -- | -- |
| 4 | Widow/Widower | 15 | 05 | 2 | 2 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Majority (82%) of the female as well as male ((98%) respondents are married. Among female respondents there are 12% who are separated or abandoned and 5% are widow.

**3.5 Occupations**

**Female Respondents:**

| Sl | Occupation | Frequency | % |
|---|---|---|---|
| 1 | House wife | 114 | 41 |
| 2 | Domestic worker | 92 | 33 |
| 3 | Small business | 36 | 13 |
| 4 | Day laborer | 11 | 04 |
| 5 | Garments worker | 10 | 04 |
| 6 | Cook | 06 | 02 |
| 7 | Handicrafts | 06 | 02 |
| 8 | Others | 05 | 01 |
| **Total** | | **280** | **100** |

**Male Respondents:**

| SL | Occupation | Frequency | (%) |
|---|---|---|---|
| 1. | Small Business | 18 | 23 |
| 2. | Fish Business | 03 | 04 |
| 3. | Day labor | 19 | 24 |
| 4. | Garments Worker | 02 | 02 |
| 5. | Rickshaw puller | 23 | 28 |
| 6. | *Thelagari* driver | 03 | 04 |
| 7. | CNG Driver | 03 | 04 |
| 8. | Van Driver | 01 | 01 |
| 9. | Cook | 02 | 02 |
| 10. | Tailor | 01 | 01 |
| 11. | Unemployed | 04 | 05 |
| 12. | Job | 02 | 02 |
| | **Total** | **81** | **100** |

**Analysis:**

Among female respondents 41% respondents were housewives. Among working women significant number (35%) of women were engaged as domestic workers. In addition women were engaged in small business (13%), day labor (4%), garments workers (4%), handicrafts (2%) etc.

Among male respondents 37% were drivers of different type of transports such as CNG, rickshaw, cart and van. Twenty seven percent were engaged in small business and another 24% day laborers. In addition, there were two garment workers, one tailor and one cook. Five of the respondents were unemployed.

Male respondents of the slum areas were occupied in economic activities which did not bring sufficient income for the family. As such, earnings of women, however small may be, supplement the family income.

**3.6 Number of Family Members:**

| Sl | Number Family Members | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | 5 and below | 199 | 71 | 58 | 73 |
| 2 | 6-8 | 73 | 26 | 18 | 22 |
| 3 | 9 and above | 08 | 03 | 05 | 05 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

About three fourth of the respondents, both male and female, number of family members ranges from 5 and below. Similarly, around one fourth respondents, both male and female, mentioned that number of their family members varied from six to eight. Only a small number of 5 to 8 respondents have family members nine and above.

**3.7 Type of Family:**

| Sl No. | Family Type | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Nuclear | 219 | 78 | 68 | 84 |
| 2 | Joint | 61 | 22 | 13 | 16 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Majority of the families of both male (84%) and female (78%) respondents were nuclear families. These families had small number of members. As mentioned in table 2.1.6

**3.8 Family Income:**

| Sl. | Family income | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | 1001 – 3000 | 70 | 25 | 7 | 09 |
| 2 | 3001 – 5000 | 70 | 25 | 31 | 38 |
| 3 | 5001 – 7000 | 69 | 24 | 30 | 37 |
| 4 | 7001 – 9000 | 25 | 09 | 10 | 12 |
| 5 | 9001 – 11000 | 11 | 04 | 13 | 04 |
| 6 | 11001 – 13000 | 02 | 01 | -- | -- |
| 7 | 13000 + | 06 | 02 | | |
| 8 | No info | 27 | 10 | -- | -- |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Family income of three fourth of female respondents ranged from taka 1,001 to taka 7,000 and 87% of male respondents' ranged from Taka 3001 to Taka 9000. However, range of income of six female respondents goes up to Taka 13,000 and above. Among these respondents, two were housewives. That indicates that their husband or other family members were involved in some profitable business or occupation. Among remaining four respondents, three mentioned that their husbands have small business. Only one respondent was a widow with four sons. All of her sons were involved in grocery business.

**3.9 Age of Marriage (female):**

| Sl. | Age of marriage | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | frequency | % |
| 1 | 10 – 12 | 46 | 16 | -- | -- |
| 2 | 13 – 15 | 106 | 38 | 01 | 01 |
| 3 | 16 – 18 | 86 | 31 | 10 | 12 |
| 4 | 19 – 21 | 38 | 13 | 22 | 28 |
| 5 | 22 – 24 | 01 | 01 | 22 | 28 |
| 6 | 25 – 27 | 03 | 01 | 19 | 23 |
| 7. | 28-30 | -- | -- | 06 | 07 |
| 8 | 30+ | -- | -- | 01 | 01 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Child marriage was very much prevalent among the female respondents. Eighty five percent of the female respondents got married on or before 18 years and below. Even among male

respondents11 of them got married at an early age. However, most (79%) of the men got married between the age 19 to 27.

**Case Study: 2**

39 years old Saleha Begum (Not her real name) lives in Vasantek Slum, Mirpur. Her husband who was a taxi driver died two years ago. Saleha supplies water in shops and did 'karchupi' work on sari. Her monthly income is about taka 3000. She has a family of eight members.

Saleha Begum was married when she was 7 years old. She gave birth to seven children but now only 3 of them are alive. As she said, she was about 13-14 years old when her first son was born. She conceived her first child when she didn't understand anything. Her first daughter died when she was only 2 years old, her second daughter was born only one year after the death of first one. But she also died in 11 days. Saleha thought they died because of Titenus. After a few days she became pregnant and gave birth to their third daughter .This time their daughter lived. After that, Saleha gave birth to their first son and he also lived. Then Saleha came to Dhaka and started to think about family planning. But her husband said that one son is not enough to depend on. He forced her to conceive three more babies and two of them died within 16 -17 days. Their seventh child was a girl and she lived. Saleha Begum thought that conceiving many children was the cause of early deaths of her children.

### 3.10 Consent of Marriage:

| Sl. | Consent of marriage | Female | | Male | |
|---|---|---|---|---|---|
| | | frequency | % | frequency | % |
| 1 | Yes | 151 | 54 | 70 | 87 |
| 2 | No | 47 | 17 | 06 | 07 |
| 3 | Guardian | 68 | 24 | 05 | 06 |
| 4 | Other* | 12 | 04 | -- | -- |
| 5 | No comments | 02 | 01 | -- | -- |
| | | **280** | **100** | **81** | **100** |

*(Others included elder brother, uncle, relatives.)

**Analysis:**

More than half (54%) of the female respondents mentioned that their consent was taken during negotiation of the marriage. Forty five percent respondents mentioned that their guardians and relatives arranged their marriage without discussing with them and only the customary consent was taken during marriage ceremony. In case of male respondents 87% reported that their consent was taken during the arrangement of marriage and in 13% cases guardians took the decisions and since they did not have any objection they did not protest.

**Case Study 3**

Nurjahan begum (Not her real name), a 32 years old woman, was married with Mohammad Halim at the age of 18 reluctantly. She migrated to Vasantek slum, Dhaka from the flood affected area of Jamalpur. Her husband is daily labor and she is a domestic worker. Her monthly income is 2500tk. Her husband often tortures her because she often prevents her husband from gambling. Her first child was born at the age of 21 years but her child died because her husband tortured her during pregnancy. After two years she gave birth to a disabled child and her husband left her. She got married again with her cousin Aslam after one year. But he also tortured her. She wanted to take family planning methods but her husband prevented her. As a result, she gave birth to another three sons and two daughters including one disabled child against her will. She mentioned that her husband looked after her sometime during her pregnancy periods. Due to her husband's unwillingness she took family planning methods only for three months. She thinks that it is very important for every woman to take decision regarding reproductive issues. From her own experience, she said that female can take decision on reproductive issue only if they are educated and earn more than their husbands. Now her aim to is get all her children educated and become self sufficient.

### 3.11 Women Respondents' Knowledge about Legal Age of Marriage (18 years)

| Sl | Knowledge about legal age of marriage (18 years) | Frequency | Percentages (%) |
|---|---|---|---|
| 1 | Yes | 238 | 85 |
| 2 | No | 42 | 15 |
| | **Total** | **280** | **100** |

**Analysis:**

Although majority (85%) of the respondents mentioned that they knew that legal age of marriage is 18 years and above, but because of circumstances a large number got married at an early age.

### 3.12 Number of Children:

| Sl. | No. of children | Female | | Male | |
|---|---|---|---|---|---|
| | | frequency | % | frequency | % |
| 1 | 0 | 04 | 01 | -- | -- |
| 2 | 1 – 2 | 142 | 51 | 40 | 49 |
| 3 | 3 – 4 | 108 | 39 | 29 | 36 |
| 4 | 5 – 6 | 22 | 08 | 10 | 13 |
| 5 | 7 – 8 | 04 | 01 | - | - |
| 6 | 9 – 10 | -- | -- | 2 | 2 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Around half of the female (51%) and male (49%) respondents had small families of one to two children. In addition, 39% female and 36% male respondents had three to four children.

This shows that these respondents are conscious of having small families which is contradictory to general notion that slum dwellers have large families.

**3.13 Number of Son and Daughter (Female):**

| **Sl.** | **Number of Son** | | | **Number of Daughter** | | |
|---|---|---|---|---|---|---|
| 1 | Number | Frequency | Percent | Number | frequency | Percent |
| 2 | 1 – 2 | 192 | 86 | 1 – 2 | 177 | 85 |
| 3 | 3 – 4 | 29 | 13 | 3 – 4 | 27 | 13 |
| 4 | 5 – 8 | 02 | 01 | 5 – 6 | 05 | 02 |
| | **Total** | **223** | **100** | **Total** | **209** | **100** |

**Analysis:**

Among 280 female respondents 223 (86%) had at least one son and out of 209, 85% had at least one daughter.

**3.14 Number of Son & Daughter (Male)**

| **Sl No.** | **Son** | **Frequency** | **Percentage** | **Daughter** | **Frequency** | **Percentage** |
|---|---|---|---|---|---|---|
| 1 | 1-2 | 55 | 81 | 1-2 | 44 | 69 |
| 2 | 3-4 | 11 | 16 | 3-4 | 14 | 22 |
| 3 | 5-6 | 2 | 3 | 5-6 | 6 | 9 |
| | **Total** | **68** | **100** | **Total** | **64** | **100** |

**Analysis:**

Among 68 male respondents 55 (81%) had at least one son and out of 64, 69% had at least one daughter.

**3.15 Age of having First Child (female)**

| **Sl.** | **Age of having first child** | **Female** | | **Male** | |
|---|---|---|---|---|---|
| | | **frequency** | **%** | **frequency** | **%** |
| 1 | 12 – 14 | 34 | 12 | 7 | 9 |
| 2 | 15 – 17 | 100 | 36 | 24 | 30 |
| 3 | 18 – 20 | 102 | 37 | 36 | 45 |
| 4 | 21 – 23 | 34 | 12 | 9 | 11 |
| 5 | 24 – 26 | 06 | 02 | 4 | 5 |
| 6 | 27 – 29 | 03 | 01 | -- | -- |
| | **Total** | **279*** | | **80*** | **100** |

*One male respondent did not have any child.

*One female respondent was pregnant

**Analysis:**

Among 280 respondents, nearly half (48%) of them had first issue within the age of 12 – 17 years and another 37% had first issue within the age of 18-20 years. Similarly, 39% cases wives of male respondents had first issue by the age of 12 – 17 years and another 45% cases had first issue by the age of 18-20 years. These findings coincide with their marriage age. Eighty five percent of female respondents were married at an early age.

**3.16 Decision to have 1st Child:**

**Female Respondents:**

| Sl No. | Whose decision | Frequency | Percentage |
|---|---|---|---|
| 1 | Both | 161 | 58 |
| 2 | Husband | 59 | 21 |
| 3 | Without planning | 27 | 10 |
| 4 | Herself | 18 | 06 |
| 5 | Family | 11 | 04 |
| 6 | Others | 4 | 01 |
| | **Total** | **280** | **100** |

**Analysis:**

Two third (64%) of the respondents mentioned that respondents themselves along with their husbands decided to have children. Twenty six percent reported that their decision was influenced by their husband and family members.

**Male Respondents:**

| Sl | Decision | Frequency | Percentage |
|---|---|---|---|
| 1 | Both | 53 | 66 |
| 2 | Self | 22 | 27 |
| 3 | Didn't Understand | 2 | 3 |
| 4 | Wife | 1 | 1 |
| 5 | Family Decision | 1 | 1 |
| 6 | Others | 1 | 1 |
| **Total** | | **81** | **100** |

**Analysis:**

Two third (66%) of the respondents' mentioned that decision of having first child was taken by both husband and wife together. Twenty seven percent respondents mentioned that decision of having the first child was their (husband) decision. Two respondents were of the opinion that it is customary that after marriage a couple will have a child and were confused with the question of discussion and decision making.

**3.17 The Decision of Taking More than One Child.**

| Sl | Whose decision | Frequency | Percentage |
|---|---|---|---|
| 1 | Both | 124 | 44 |
| 2 | Husband | 62 | 22 |
| 3 | Without planning | 36 | 13 |
| 4 | Herself | 24 | 09 |
| 5 | Family | 22 | 08 |
| 6 | Others | 12 | 04 |
| | **Total** | **280** | **100** |

**Analysis:** Nearly half (53%) of the respondents mentioned that respondents themselves along with their husband decided to have more than one child. 22% respondents reported that taking more than one child was their husband's decision.

Findings of above tables 2.1.16 and 2.1.17 indicate that women are gradually taking part in reproductive decision making.

### 3.18. The Role Played by Husband in Pregnancy Period.

**Female Response:**

| Sl | Role of husband | Frequency | % |
|---|---|---|---|
| 1 | Indifferent | 101 | 34 |
| 2 | Looked after the wife by supporting medical care, nutritious food, assisting in household work, taking care of other children etc | 181 | 60 |
| 3 | Took some care | 13 | 04 |
| 4 | No comment | 5 | 02 |
| | **Total (*multiple response)** | **300** | **100** |

**Male response:**

| Sl | Role | Frequency | % |
|---|---|---|---|
| 1 | Did not play any role | 19 | 24 |
| 2 | Looked after the wife by supporting medical care, nutritious food, assisting in household work, taking care of other children etc | 77 | 76 |
| **Total (*multiple response)** | | **96** | **100** |

**Analysis:**

It is encouraging to find that 60% cases husbands provided various support to their wives during pregnancy, such as medical care, providing nutritious food, assistance in household work, taking care of other children etc. Another 13 respondents mentioned that their husbands took some care. One third (36%) of the respondents reported that their husbands were indifferent during their pregnancy.

Among the male respondents, majority (76%) said they looked after their wives which include support in medical care, having nutritious food, assists in household work, taking care of other children etc. Only 19 respondents reported that they did not pay attention during their wife's pregnancy period.

Although, there are cases where husbands were indifferent and did not take care of their wives during pregnancy, it is a positive sign that in large number of cases husbands looked after their wives during pregnancy.

**Case Study 4**

Slum dweller Rezia (Not her real name), lived in Moghbazar Wireless Rail gate. 32 years Rezia is a professional cook. It was a love marriage when she was nineteen (19) years old. Her husband married her after the death of his first wife. This couple had one son and one daughter. Illiterate Rezia and her husband both of them earn around 7000/= (taka seven thousand only). Both of her pregnancies were unplanned. (First time she conceived on first night of wedding but second time she conceived suddenly). During prenatal period her husband had taken care of her properly. She got health care service from "Sabuj Chata". She gave birth to both of the children in her house and her aunt -in- law was the birth attendant. Both of them together have taken the decision for third baby but during prenatal period she became very sick and was admitted to Dhaka Medical College. She saw a dead body in the medical college. She was so afraid to see the dead body that she lost all of her amniotic fluid. As a result she lost her third baby. She wanted to arrange marriage for her only daughter who was only 15 years old, but the girl opposed because she knew that it was illegal to get married before 18 years. She heard about family planning method from her neighbor and she is also taking birth control injection. Though first time she had heavy bleeding but after taking medicine from the doctor she got well. Husband and wife both of them together have been taking decision about family planning and they are getting health care service from T&T service center. Rezia told that it is necessary to be financially independent. It makes women self-sufficient to take any kind of reproductive decision in favor of their opinion. She informed that when she was pregnant both the time her husband tried to abort her baby but Rezia resisted. She was financially independent and could turn down her husband's illegal wish. After that she gave birth to two healthy babies.

### 3.19. Provision of Healthcare Facilities during Pregnancy Period:

| Sl | Healthcare in pregnancy period | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Yes | 183 | 65 | 60 | 74 |
| 2 | No | 97 | 35 | 21 | 26 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Around two third (65%) of the female respondents mentioned that they were provided healthcare facilities during pregnancy period and 74% male respondents said that their wives received medical care as and when needed.

**3.20. Persons/Institutions from where Healthcare Received.**

| Sl | Persons/institutions from where healthcare received. | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Health worker | 58 | 27 | 25 | 38 |
| 2 | NGO clinic | 56 | 26 | 21 | 32 |
| 3 | Hospital | 48 | 23 | 9 | 14 |
| 4 | Surjer hasi | 26 | 12 | 6 | 9 |
| 5 | Local /traditional doctor | 5 | 03 | 1 | 2 |
| 6 | Others | 20 | 09 | 3 | 5 |
| | **Total** | **213** | **100** | **65** | **100** |

**Analysis:**

Among 280 female respondents, 213 (76%) women mentioned that they have received healthcare services from various healthcare institutions. Most (88%) of them avail services of health workers, NGO clinic, hospital, community clinic (*surjer hasi)* and only 3% from traditional doctors.

Out of 81 male respondents 65 (80%) said their wives received health care from various health institutions during pregnancy. As mentioned by female respondents, wives of male respondents mostly (84%) availed services of health workers, NGO clinic, hospital, and *surjer hasi.*

**Case Study 5**

Shahana (not her real name), a forty year old woman living in Dhaka for six months. Her family had seven members. Shahana was the second wife of her husband. As the first wife had no children so her husband decided to marry second time. Shahana didn't know about the first wife of her husband. She came to know about his first wife after Shahana's first child was born. She didn't take any family planning measures so she became pregnant for the fifth time. She did not receive any support from her husband during her pregnancy. Her husband wanted to give away their last child to another couple. But Shahana did not agree. She told him that, she would rather kill the child than give it to anyone .That is why she wanted to poison her own child. But her other kids did not let her to do so. She struggled very hard to raise her children. Her husband's behavior was not acceptable, he married third time. Shahana has no idea about reproductive health service. When she was pregnant she didn't take any vaccination and also after giving birth she didn't get any health care.

Now she has come to know about family planning from the village health worker. She doesn't want children anymore. Her husband doesn't care for her opinion.

### 3.21. Birth Place of the Children:

| Serial | Birthplace of child | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | At home | 244 | 84 | 70 | 85 |
| 2 | At hospital | 41 | 14 | 11 | 13 |
| 3 | Others | 5 | 2 | 02 | 02 |
| | **Total (*multiple response)** | **290** | **100** | **83** | **100** |

**Analysis:**

Although most of the female respondents and wives of male respondents availed pre-natal care from recognized health care services, majority of both male (85%) and female (84%) respondents mentioned that their children were born at their home; their mother's place or relatives place. Only 52 cases reported that they went to hospital for delivery. Generally, normal delivery took place at home and complicated cases were taken to hospital for delivery.

### 3.22 Decision of Child's Birthplace:

| Sl | Whose decision | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Family | 86 | 31 | 14 | 17 |
| 2 | Husband | 84 | 30 | 35 | 44 |
| 3 | Wife | 74 | 26 | 2 | 02 |
| 4 | Both husband & wife | 32 | 11 | 24 | 30 |
| 5 | Others | 4 | 02 | 6 | 07 |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

37% female respondents reported that they themselves or jointly with their husbands took the decision about the birthplace of their children. Around two third (61%) of the respondents reported that husband and family members decided the birthplace. Similarly, in case of male respondents in 61% cases, decision was taken by the husbands or other family members and in 32% cases wife individually or jointly with their husbands took the decision.

### 3.23. Birth Attendant:

| Sl | Birth attendant | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Unskilled midwife | 145 | 52 | 44 | 56 |
| 2 | Relatives | 63 | 23 | 17 | 22 |
| 3 | Health assistant | 10 | 04 | 05 | 06 |
| 4 | Trained T.B.A | 46 | 16 | 10 | 13 |
| 5 | Others* | 15 | 05 | 02 | 03 |
| | | **279** | **100** | **78** | **100** |

*Others also mean herself and relatives. By "herself" means – One respondent named Sakhina Khatun, lived in Baunia Badh Slum. She mentioned that at her labor time there was no one to help her, not even her husband or relative or neighbor. She gave birth to her child in the house without any help from any one.

**Analysis:**

Among 279 female respondents, 80% were attended during delivery by unskilled midwives, untrained relatives. 20% respondents' were attended by health assistant and trained T.B.As. Similarly, wives of the male respondents were also in majority cases (78%) attended by unskilled midwives and relatives during delivery.

**3.24 Incidence of Abortion:**

| Sl | Incidence of abortion | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Yes | 37 | 13 | 15 | 19 |
| 2 | No | 242 | 87 | 66 | 81 |
| | **Total** | **279*** | **100** | **81** | **100** |

N.B: 1. One respondent was carrying baby who was not counted in the total number of female respondents.

**Analysis:**

Among 279 female respondents, 13% mentioned that they had abortion of the child and in case of male respondents 19% male respondents' wives had abortion.

**3.25. Decision for Abortion (Female)**

| Sl | Decision of abortion | Female | |
|---|---|---|---|
| | | Frequency | % |
| 1 | Miscarriage | 15* | 40 |
| 2 | Self decision | 6 | 16 |
| 3 | Husband's decision | 8 | 22 |
| 4 | Joint decision | 1 | 03 |
| 5 | Family members | 3 | 08 |
| 6 | Others | 4 | 11 |
| | **Total** | **37** | **100** |

* one respondent had abortion due to physical torture by her husband

**Analysis:**

Among 37 female respondents, 40% respondents mentioned that they had miscarriage. According to them it was like "Batash laga" (Evil wind). Nineteen percent cases it was their own decision or jointly with their husband. 22% mentioned that the decision was taken by their husband and 8% respondents mentioned that the decision was taken by their family members. Others include on advise of the doctor

**3.26. Postnatal Healthcare of the Respondents; Female/ Male Respondents' Wives:**

| Sl | Postnatal health care | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | %) | Frequency | % |
| **1** | Yes | 174 | 62 | 69 | **85** |
| **2** | No | 106 | 38 | 12 | **15** |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Nearly two third (62%) of the female respondents and 85% of the male respondents mentioned that their wives availed postnatal care. It is notable that so many female

respondents and wives of male respondents availed postnatal care which is far above the national figure of 33%.

### 3.27. Role of Husband during Post- natal Period. (Female)

| Sl | Role of Husband | Frequency | Percentage |
|---|---|---|---|
| 1 | Satisfactory | 170 | 98 |
| 2 | Had no comment | 03 | 2 |
| | **Total** | **173** | **100** |

**Analysis:**

Total 173 respondents' reported about their husband's role during post natal period. Most (98%)of them reported that their husband's role was satisfactory which included support in medical care, providing nutritious food, assistance in household work, taking care of other children etc. Only 03 respondents did not make any comment.

### 3.28. State of the Respondents Practice on Family Planning

| Sl | State of family planning practice | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Yes | 170 | 61 | 16 | 20 |
| 2 | No | 101 | 36 | 65 | 80 |
| 3 | Followed before | 9 | 04 | -- | -- |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Around two third (65%) respondents mentioned that they have been practicing family planning or practiced before and 36% were not practicing. On the other hand in case of male respondents majority (80%) of them did not practice family planning themselves (may be their wives used fp), Rest of them (20%) practiced family planning.

### 3.29. Family Planning Methods Used by the Respondent :

**Female**

| SL | Family Planning Methods* | Frequency | Percentage |
|---|---|---|---|
| 1 | Pill | 84 | 41 |
| 2 | Birth control injection | 107 | 53 |
| 3 | Ligation | 8 | 4 |
| 8 | IUD | 4 | 2 |
| | **Total** | **203** | **100** |

* Multiple responses

**Male**

| SL | Name of materials | Frequency | Percentage |
|---|---|---|---|
| 3 | Permanent | 03 | 19 |
| 6 | Temporary | 13 | 81 |
| | **Total** | **16** | **100** |

**Analysis:**

Among 179 female respondents, some of them used more than one method. 53% used birth control injection which is followed by 41% who took birth control pill. Four of them had taken IUD and only eight of them used permanent method i.e. ligation.

Among 16 male respondents, 81% adopted temporary methods and 19% took the permanent method. i.e. vasectomy.

### 3.30. Reason Behind Not Using Family Planning Methods :

| Sl | Reasons behind not using family planning | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Ignorance/ No idea | 10 | 14 | 3 | 5 |
| 2 | Resistance of husband | 16 | 23 | | |
| 3 | Religious prejudice | 16 | 23 | 3 | 5 |
| 4 | Methods are used by husband /wife | 4 | 6 | 47 | 72 |
| 5 | Husband absent | 14 | 20 | - | - |
| 6 | Physical problem | 6 | 8 | - | - |
| | No plan to adopt FP | - | | 4 | 6 |
| | Want more children | - | | 2 | 3 |
| 7 | Want to use in future | 4 | 6 | | |
| | Others* | - | | 6* | 9 |
| 9 | No response | 21 | | | |
| | **Total** | **91** | **100** | **65** | **100** |

*Others – did not feel necessary, respondent got married twice for children, did not believe in these methods, boy child expectancy, it will decrease the value of masculinity

**Analysis:**

Female respondents reported various reasons for not practicing family planning. These are ignorance about family planning (14%), resistance of husband (23%), religious prejudice (23%), absence of husband (20%), physical problem (8%), methods used by husband (6%) etc. However, four respondents said that they wanted to practice family planning in future (6%).

In most (72%) cases the male respondents reported that they were not practicing family planning, usually their wives practiced family planning, which is most common phenomena. Other reasons for not practicing family planning according to the male respondents were ignorance about family planning (5%); religious prejudice (5%), want more children (3%), others (9%). A very interesting finding came out from the study is that only among the male respondents six percents said that they had no plan to adopt family planning.

### 3.31. Sources of Receiving Information About Family Planning:

| SL | Sources of info on FP* | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Newspaper | 2 | 1 | - | - |
| 2 | TV | 38 | 14 | 17 | 21 |
| 3 | Radio | 5 | 2 | 04 | 05 |
| 4 | Relatives/friends/neighbors | 129 | 46 | 29 | 36 |
| 5 | Health worker | 167 | 60 | 49 | 60 |
| 6 | Poster/ billboard | 7 | 2 | 04 | 05 |
| 7 | Community functions | 2 | 1 | 01 | 01 |
| 8 | NGO Clinic (Marie Stopes) | - | - | 03 | 04 |
| 9 | Hospitals | - | - | 01 | 01 |
| 10 | No info | | | 05 | 06 |
| 11 | Others | 13 | 5 | | |
| | Total | 363 | | 113 | |

* *Multiple responses.*

**Analysis:**

Since women generally stay at home, they have access to information delivered at home such as health workers (60%), relative, friend, neighbor (46%) and TV, Radio and news paper ((17%). In case of male also source of information is mainly health workers (60%), relatives/friends/neighbors (36%) and TV, Radio (26%). Since men go out they also have access to information from community functions, posters and bill boards, NGO clinics and hospitals. Since family planning is still considered an issue not to be consulted in public, source of information delivered at home is more effective. Role of health workers and relatives/ friends/neighbors is prominent in getting Family Planning information.

**3.32. Preference of Decision on Using Family Planning Methods (Female)**

| Sl | Decision | Frequency | Percentage |
|---|---|---|---|
| **1** | Own | 74 | 35 |
| **2** | Husband | 33 | 16 |
| **3** | Both husband and wife | 81 | 39 |
| **4** | Doctor/ health worker | 10 | 5 |
| **5** | Others | 11 | 5 |
| | Total | 209 | |

**Analysis:**

More than one third (39%) of the respondents mentioned that they are using current family planning method by mutual understanding. 35% said that the decision was their own and 16% mentioned as their husbands. Around 5% mentioned that the decisions were made by the doctors or health workers. At the same time another 5% represented in the category of others.

**Case Study 1**

32 years old Jarina (not her real name) lives in 22, Shukkur Mia's Slum in Adabor, Shyamoly, Dhaka. She is a housewife with no educational background. She got married when she was only 13 years of age and her parents arranged the marriage without her consent. Currently she has a nuclear family with her husband, 4 daughters and the only son. As we understood, almost all her family decisions have been imposed upon her by her husband. Their first 3 children were born by their joint decision. But in spite of taking birth control pills regularly, she conceived twice. She was pregnant at the time of this study. She tried to abort it several times but doctors told that it might cause death. She had an abortion before. Another child died when it was only few days old. She practiced family planning. She said, her husband did not help her in anyway during pregnancy such as visiting the clinic or meeting with the health workers regularly. He brought birth control pills for her but Jarina doubts about its validity as it did not work.

She believed that, women should have the power to take reproductive decisions. But she doesn't have that power. Her husband forced her to take many more children. Jarina understands that, many children make too many problems in life. As we talked to her, we understood that she was frustrated about her pregnancy and she wanted to abort her child. She could not afford to provide food for all.

### 3.33. Whether Decision to Practice Family Planning Methods has been imposed? (Female)

| Sl | Whether methods are imposed | Frequency | Percentage |
|---|---|---|---|
| **1** | Yes | 36 | 16 |
| **2** | No | 189 | 84 |
| | Total | 225 | 100 |

**Analysis:**

Majority (84%) has taken the decision voluntarily. On the other hand 16% mentioned that the decision had been imposed on them.

### 3.34. Sources of Family Planning Related Support (Female)

| Sl | Sources of family planning support | Frequency | Percentage |
|---|---|---|---|
| 1 | Hospital | 16 | 9 |
| 2 | Health worker | 118 | 66 |
| 3 | Surjer hashi/Sobuj chata | 24 | 13 |
| 4 | NGO clinic | 33 | 18 |
| 5 | Medical college | 2 | 1 |
| 6 | Others | 24 | 13 |
| | **Total** | **217** | |

**Analysis:**

Role of health workers is also prominent in supply of materials. Two third of the total respondents (66%) received family planning materials from health workers.31% from NGO clinic including '*Surjer Hashi'*. Lastly 13% has reported that they received materials from other sources such as relatives, husbands, and pharmacies. One woman mentioned that she could not rely on the materials supplied by her husband since the materials were not effective and she got pregnant.

### 3.35. Respondents Opinion on Side Effects of Family Planning Methods

| Sl | Physical problem | Frequency | Percentage |
|---|---|---|---|
| 1 | Yes | 98 | 48 |
| 2 | No | 106 | 52 |
| **Total** | | **204** | **100** |

### 3.36. Side Effects Faced by the Respondents while using Family Planning

| No | Side effects | Frequency | Percentage |
|---|---|---|---|
| **1** | Headache | 21 | 21 |
| **2** | Fever | 2 | 02 |
| **3** | Abdomen pain | 3 | 3 |
| **4** | Irregular period | 30 | 31 |
| **5** | Pain in body | 14 | 14 |
| **6** | Dizziness | 11 | 11 |
| **7** | Vomiting | 7 | 7 |
| **8** | Bleeding | 7 | 7 |
| **9** | Weakness | 8 | 8 |
| **10** | Weight gaining | 6 | 6 |
| **11** | White discharge | 2 | 2 |
| **12** | Loss of appetite | 2 | 2 |
| **13** | Eye problem. | 2 | 2 |
| | **Total** | **115** | |

**Analysis:**

Out of total respondents using various family planning devises 48% had experienced different side effects such as headache (21%), irregular period (31%), body ache especially in abdomen (17%), dizziness (11%). Other complained of fever, vomiting, bleeding, weakness, weight gaining, white discharge, loss of appetite etc.

### 3.37. Measures Taken to Reduce Physical Problems (Female)

| Sl | Measures taken by the respondents | Frequency | Percentage |
|---|---|---|---|
| 1 | Take medicine | 09 | 09 |
| 2 | Went to doctor or health worker | 16 | 16 |
| 3 | Don't take any measure | 33 | 34 |
| 4 | NGO/Clinic | 03 | 03 |
| 5 | Stop using measures | 06 | 06 |
| 6 | Take rest | 01 | 01 |
| 7 | Husband uses condom | 01 | 01 |
| 8 | Put water and oil on their head | 01 | 01 |
| 9 | Eat tamarind or sour | 04 | 04 |
| | **Total** | **74** | |

**Analysis:**

Out of total respondents 33% did not take any measures and 28% took advice from doctors/health workers/NGO clinic and took medicine. Only in one case husband decided to use condom.

### 3.38. Sources of Collecting Family Planning Materials

| Sl | Sources of collecting FP | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Own | 7 | 4 | 4 | 5 |
| 2 | NGO Clinic | 36 | 21 | 8 | 10 |
| 3 | Pharmacy | 26 | 15 | | |
| 4 | Radda | 24 | 14 | | |
| 5 | Surjer hasi | 15 | 09 | 10 | 12 |
| 6 | health worker | 49 | 29 | 38 | 47 |
| 7 | Hospital | 17 | 10 | 5 | 07 |
| 8 | Others | 5 | 03 | | |
| 9 | Husband | 5 | 03 | | |
| 10 | Doctor | 2 | 01 | | |
| 11 | Medical College | | | 2 | 02 |
| 12 | Marie Stopes | | | 7 | 9 |
| 13 | No Info | | | 11 | 14 |
| | **Total** | **186** | | **85** | |

**Analysis:**

Around 21% reported that they collected family planning materials from NGO clinic, around 15% from pharmacy, around 14% from Radda MCH Center (NGO), around 9% from 'Surjer Hashi', a big proportion around 29% from health worker, 10% from hospital, around 1% from doctor. Around 4% respondents collected materials themselves; around 3% through husbands and another around 3% acquired through other options.

### 3.39. Desire for More Children in Future

| No | Desire for more children | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Yes | 69 | 25 | 32 | 40 |
| 2 | NO | 174 | 62 | 49 | 60 |
| 4 | Desire of their husband. | 15 | 5 | -- | -- |
| 6 | No comment | 22 | 8 | -- | -- |
| | **Total** | **280** | **100** | **81** | **100** |

**Analysis:**

Majority (62%) of the respondents mentioned that they did not want to take another child in future. 25 % wanted to have more children. Fifteen respondents mentioned that it depends on the husbands' decision. In the case of male respondents 60% did not want to have any more children.

### 3.40. Desire for Number of Children

| SL | Number of children | Frequency Female | % | Frequency Male | % |
|---|---|---|---|---|---|
| 1 | 1 | 56 | 82 | 16 | 50 |
| 2 | 2 | 10 | 14 | 11 | 34 |
| 3 | 3 | 2 | 03 | 01 | 03 |
| 4 | No plan yet | 1 | 01 | 04 | 13 |
| | **Total** | **69** | **100** | **32** | **100** |

**Analysis:**

Majority (82%) of the female respondents mentioned they wanted just one child and another 17% wanted two to three children. In case of male respondents, 50% wanted to have one child and 16% wanted to have two to three children.

### 3.41. Opinion Regarding Necessity of Women's Reproductive Decision Making Power

| Sl | Necessity of Women's Reproductive Decision Making Power | Male | | Female | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Yes | 37 | 46 | 190 | 70 |
| 2 | No | 21 | 26 | 16 | 06 |
| 3 | Never thought about it | 23 | 28 | 58 | 21 |
| | Others | | | 1 | 01 |
| | No response | | | 5 | 02 |
| | **Total** | **81** | **100** | **270** | **100** |

**Analysis:**

Out of 81 male respondents around half (46%) of the respondents thought that women should be able to take reproductive decision. Another 26% thought that women should not take reproductive decision and the rest 28% never thought about these issues. Among female respondents, majority (70%) said women should be able to take reproductive decision and 21% had never thought about it.

**3.42. Reasons which Prevent Women to Take Reproductive Decision Independently (male respondents):**

| Sl | Reasons behind women's deter condition | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Illiteracy | 46 | 12 | 11 | 30 |
| 2 | Lack of husband's cooperation | 97 | 25 | 08 | 22 |
| 3 | Economic dependency | 66 | 17 | 06 | 16 |
| 4 | Social dishonor | | | 02 | 06 |
| 5 | Husband's torture | | | 05 | 16 |
| 6 | Unhappiness in family | | | 07 | 23 |
| 7 | No comments | | | 02 | 06 |
| 8 | Unconsciousness | | | 07 | 23 |
| 9 | Superstition | | | 03 | 10 |
| 10 | Others | | | | |
| 11 | want for children | 4 | 01 | | |
| 12 | Ignorance | 19 | 05 | | |
| 13 | Religious prejudices | 5 | 01 | | |
| 14 | To avoid family conflict | 45 | 12 | | |
| 15 | Lack of knowledge and information on reproductive issues | 4 | 01 | | |
| 16 | No knowledge of what decision making means | 35 | 09 | | |
| 17 | Social dogma that women should not take decision | 31 | 08 | | |
| 18 | women are considered weaker sex | 5 | 01 | | |
| 19 | Interference from powerful relatives | 1 | 01 | | |
| 20 | No response | 23 | | | |
| | **Total** | **381** | | **51** | |

**Analysis:**

Among eighty one male respondents thirty percent identified illiteracy as a barrier for women to take independent decision about reproduction. Twenty two percent identified lack of understanding in marital life was a barrier for women to take independent decision about reproduction. Sixteen percent identified economic dependencies was a barrier for women to take independent decision about reproduction. Six percent identified social stigma as a barrier for women to take independent decision about reproduction. Sixteen percent identified torture of husband as a barrier for women in taking independent decision.

Twenty three percent respondents identified unhappiness in family was a barrier for women in taking independent decision about reproduction. Six percent did not comment. Twenty three percent respondents identified ignorance as the barrier for women in taking independent decision. Ten percent identified prejudices as a barrier for women in taking independent decision about reproduction.

### 3.43. Respondents Opinion on not Exercising Reproductive Decision Making Power by Women

| Sl | Reasons | Female | | Male | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Illiteracy, ignorance and lack of information on reproductive issues for which cannot take decision | 81 | 21 | 18 | 35 |
| 2 | Dominance of husband and Economic dependency | 163 | 43 | 19 | 37 |
| 3 | Pressure of Social Customs to have children and to avoid family conflict | 61 | 16 | 09 | 18 |
| 4 | Religious Prejudices | 05 | 01 | 03 | 06 |
| 5 | Society undermines women's decision | 11 | 03 | - | - |
| 6 | Influence of relatives | 02 | 01 | - | - |
| 7 | Did not understand the concept of decision making | 35 | 09 | - | - |
| 8 | No response | 23 | 06 | 02 | 04 |
| | **Total** | **381** | **100** | **51** | **100** |

**Analysis:**

Among female respondents dominance of husband and economic dependency was identified as a significant cause (43%) for women for not taking decision regarding reproductive issues independently which is followed by Illiteracy and ignorance and lack of information (21%) on reproductive issues for which women cannot take decision. 16% of the respondents mentioned pressure of social customs to have children and to avoid family conflict as a cause which affects women's inability to take decision and 9% did not understand the concept of decision making.

Similarly, male respondents identified dominance of husband and economic dependency (37%), Illiteracy and ignorance and lack of information (35%), and Pressure of Social customs to have children and to avoid family conflict (18%) as major causes which affect women's inability to take decision.

### 3.44. Recommendations to Encourage Women to take Reproductive Decisions (Male respondents):

**Analysis:**

Male respondents have some recommendations regarding women's reproductive decision making role. Such as-

- Economic solvency (38%) can help women to take their reproductive decision independently.
- Education (43%)
- Social cooperation (3%),
- Family cooperation (22%),
- Husbands cooperation (19%).
- Access to information (20%)
- About seventy percent people could not give any reason or they had no idea about it.

**Case study 6:**

Mohammad Subahan Ali (not his real name), thirty years old, is the youngest among three sisters and one brother .He has studied up to class eight and now he is living in Vashantekh slum (no 2). He got two rooms in that slum as his paternal property of which one is now used by him and the other has been rented out. He is a contractor and from this his monthly income is 6000 taka.

When he was 26 years he got married and at that time his wife was 21 years old. During the time of first issue his wife was 24 years old. It was the doctors of BRAC who advised the couple not to take child at early age. His only son was born at BRAC clinic through normal delivery. During the time of pregnancy he took care of his wife, supported in the daily household activities, took her to the clinic etc. And as the postnatal care he brought his sister to assist his wife and provided necessary medicines and diet for her.

After his marriage he used condom as a family planning method but now he emphasizes on pill for his wife. And his wife had no problem with it. His wife did not experience any incident of miscarriage. In case of issues related to reproductive health they get advice and support from the doctors of BRAC clinic.

To him it is necessary for women to have the reproductive decision making right. To him self dependence, education and access to information are the prerequisites for it. At the same time he believes that lack of education, absence of interaction and communication as well as dependency prevents women to take reproductive decisions independently.

**Recommendations from Female Respondents to Facilitate Reproductive Decision Making Capacity:**

- Women's economic solvency
- Women's education
- Women's awareness about their reproductive right
- Women's increased decision making power
- Change in the attitude of the husband, family and society to accept equity and equality of women and men,
- Survival of children should be ensured.

# CHAPTER: FOUR

## Recommendations

### a. Service recommandations

**1.** Women are compelled to compromise with adverse situations because of lack of education and economic independence. Therefore the state can take steps to provide adequate mass education for women as well as employment opportunities so that if the need arises women can take necessary reproductive decisions instead of compromising with their husbands'/families' decisions.

**2.** In fear of domestic violence or being victims of domestic violence, women sometimes refrain from making any decisions. Thereby, it is important to enact specific legal provisions to address domestic violence.

**3.** Government and Non-government organizations can provide more information and support (if necessary) to women regarding their reproductive health, health related problems, family planning etc. so that they can become more aware about their rights.

**4.** The media can play a constructive role in raising consciousness among both men and women about the necessity of exercising women's decision making power especially on reproductive health issues.

**5.** Government, non government organizations and media can advocate for importance and necessity of reproductive issues and family planning. They can encourage male population to follow family planning methods.

### b. Study recommendations

**1.** The research is conducted on small sample and of particular study area (Slum).This type of research could also be conducted on other women of different strata of society, educational backgrounds, economic status and of various professions to know their status regarding reproductive decision making power.

**2.** For any woman the opportunity of getting "access to" and continuing "exercise of" reproductive decision making power, largely depends on the will and views of their husbands. So, there is a scope of conducting research on parents of women, husbands and influential family members specially in-laws to know their perceptions and attitudes about women's reproductive decision making power.

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# Annex 1

**Participant's Name**

1.Vaskar Bhadury

2.Esmat Ara

3.Bimalendu kishore Paul

4.Mohammad Jamal Hossain

5.Sarwar Kamal

6.Rayhan Kawsar

7.Anando Mostofa

8.S.M Sumaiya Zabeen

9.Md Rokon Uddin

10.Mohammad Hasnaine Aftab

11.Arju Nasrin Pony

12.Razia Sultana

13.Tashnuva Sharmin

14.Sanjida Sarmin

15.Md. Ashik Ahmed Jony

16.Md. Ansaruddin Masel

17.Sultan Khan

18. Afroza Sharmin Tamanna

19.Omar Sharif

20.Mostofa Kamal

21.Sadia Afrin