

Reproductive Decision Making Role among Slum Dwellers of Dhaka City

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

February 2010

Democracywatch

7 Circuit House Road, Dhaka-1000

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 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’s 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 in 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

TABLE OF CONTENT

Chapter One

- 1.1 Introduction
- 1.2 Objectives of the study
- 1.3 Rational of the study
- 1.4 Definition of the terms used

Chapter Two

Review of Related Literature

Chapter Three

Methodology

- 3.1 Study area**
- 3.2 Study Population
- 3.3 Sample size & Sampling Method**
- 3.4 Data collection methods
- 3.5 Data Collection Procedure
- 3.6 Period of study
- 3.7 Challenges and Limitations of the study

Chapter Four

Data Analysis and Representation

Chapter Five

Recommendations

Chapter Six

References

Annexure I List of Participants

Annexure II Questionnaire

CHAPTER: ONE

1.1 INTRODUCTION:

Bangladesh is one of the most densely populated countries in the world, with over 150 million people squeezed into an area of 145,000 square-kilometers. There are nearly 920 people per square kilometer¹. With over 63 million of them (nearly half of the total population) 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 levels, Dhaka will become the second largest mega-city in the world by 2015, with a projected population of over 22 million (only Tokyo will be larger). 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 2008². The population is growing by an estimated 4.2% per year, one of the highest rates amongst Asian cities³. 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 1980s⁴. According to Far Eastern Economic Review, Dhaka will become a home of 25 million people by the year 2025⁵.

With urban population growth, the number of slums and the people who dwell in them are rapidly increasing. With an estimated 3.4 million people live in some 5000 slums of its capital city, Dhaka⁶. Dhaka is now experiencing a period of cramped population growth and slum dwellers are mainly responsible for this high growth rate. The population of Dhaka city doubles in every 11 years whereas it takes 25 years to double the population for the whole country. The population of Dhaka city is now 99, 12,908⁷, and a report expects it to swell it to 17.6 million up to 60% in the slums by the year 2010 and 25 million by the year 2025⁸; and nearly equal to the current population size of the world's second largest urban

¹ BDHS Survey 2007

² ["Statistical Pocket Book, 2008"](#), 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 Source: Bangladesh Population Census, 2001

⁸ Source: ADB Report, 1997

agglomeration, Sao Paulo, Brazil. At least 50 % of the urban population of Dhaka will be living in slums⁹. 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 poor¹⁰. 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"¹¹.

In 1990s the International Conference on Population and Development (1994), the United Nations Fourth Conference on Women (1995) and the Platform for Action (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 by 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's 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 health¹², but it will be a mistake to explain the practice of family planning methods as an indication of women's reproductive decision making power.

In Bangladesh population control has been a declared government policy since mid sixties¹³. 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 who lived in informal settlements, are almost unexplored. In Bangladesh total slum population is 5.4 million which is 35% of the aggregated population of 6 major cities-Dhaka, Chittagong, Khulna, Rajshahi, Sylhet ,Barisal¹⁴. Between 1995 and 2005 the total population living in slums of Dhaka has more than doubled¹⁵.

The informal sector in urban areas is not yet fully urbanized. Those who live in the slums are largely distressed migrants from rural areas, most of who live below the poverty line¹⁶, 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

⁹ Barkat et al., 1996

¹⁰ Khuda et al, 1994

¹¹ Jamil, Baqui, and Pajior, 1993

¹² Brydon, Lynne and Chant, Sylvia; "Women in Third World: Gender Issues in Rural and Urban Areas"; Edward Elgar Publishing Limited, England, 1993, p.190

¹³ <http://independent-bangladesh.com/news/feb/24/24022006wo.htm#A0>

¹⁴ Haque, Iffat, "Urban Slum Mapping in Bangladesh" available at <http://www.ciesin.columbia.edu>

¹⁵ Ibid

¹⁶ Haaga, 1992

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 time. Also, more than 80 % of school-aged children in Dhaka slums do not attend school. All these factors are likely to adversely affect the contraceptive behavior of those who live in the slums. These factors possibly also help to explain why urbanization has had little effect on the declining fertility in Bangladesh.

In 1994, the contraceptive prevalence rate (CPR) in slums was 40 %. This figure is much lower than the national rate in urban areas of 54%, and lower than the national rate in rural areas of 43%¹⁷. With this trend continuing, even if the family planning program achieves its targeted objectives in the rural and urban formal sectors, the national CPR may not rise enough to attain the national goal of replacement level fertility (NRR=1) by 2005. Authors of a recent national family planning strategic document suggested that, the government must devote special efforts as soon as possible to raise CPR in the slums in order to attain the national goal within the stipulated period¹⁸. 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 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 kins, 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.

¹⁷ Barkat et al, 1995

¹⁸ Barkat et al, 1996

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.

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 those deter women from accessing and 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.

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 a 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 deprivation among slum dwellers. Global slum

populations are growing at alarming rates. 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 a staggering number of 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. Because of the weak paying capacity among the slum people, even the private health care is also absent in the slums. The urban poor are forced to take alternative to unqualified health providers.

Improving access to health services to the urban poor is a challenging for a variety of reason. 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 norm 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. Because of the weak paying capacity among the urban poor, even the private health care is also absent in the slums. The urban poor are forced to take alternative to unqualified health providers.

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 affects 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 uses 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, Govt 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 hectares) of land. An average of more than three adults lives 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 houses¹⁹.

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
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 city²⁰. 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.

¹⁹ Source: 'Dhakar Paribesh', Gias Siddique, page- 47

²⁰ Ibid

Slum Dwellers:

Although the characteristics of slum vary between geographic regions, they are usually inhabited by the very poor or socially disadvantaged and these people are called slum dwellers²¹.

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-image²².

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.

²¹ Wikipedia

²² Hong & Seltzer, 1994; Petchesky, 1990; Worell & Remer, 1992

CHAPTER: TWO

REVIEW OF RELATED LITERATURE:

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 an ending mentioning 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 without saying anything.

Another publication from the same person heading "***Small Power, Little Choice***" was taken as our study material which was published on 2006 in the IDS Bulletin, Volume 37. This study 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 decreased in last ten years. Poor people came to Dhaka in last decade 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 to conceive babies y their husbands or family. Poverty ruins the treatment of their pre or post natal period. They do not have enough money to feed themselves or their children.

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 those study area does aware of the Family Planning Method. Above forty percent of the sample size suffered or suffering from various types of reproductive health related difficulties which can be very brutal to their lives.

A study entitled "***Determinant of Choices of Delivery Care in Some Urban Slums of Dhaka City***" by Iftekhar Hossain & Md. Mainul Hoque, Department of Economics, University of Dhaka, published in Pakistan Journal of Social Sciences, 3(3), 2005, page no. 469-475, found that almost seventy percent of the poor family from urban slum in Dhaka have more than five or six members and they do not show any interest in spending money on women in

pre-natal period 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%. Moreover 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 so meager. Still in the twenty first century most of the women of the slum depend on their male partners regarding reproductive decision. So that, we have taken our objectives and decided to work on Reproductive Decision Making Role among Slum Dwellers of Dhaka City.

CHAPTER: THREE

RESEARCH METHODOLOGY

3.1 Study Area:

Due to mass rural to urban migration and urbanization and incorporation of erstwhile outlying areas, growth of slums has been accelerated in Dhaka City, so that different slums selected as the study area.

3.2 Study Population:

The study Population consisted of the slum dwellers of Dhaka city.

3.3 Sample size and sampling method:

Among the slums of Dhaka city, a representative sample of nine slums was selected purposively according to access facilities. Among the slum dwellers 361 respondents selected using random sampling method to collect data, where 280 are female and 81 are male.

3.4 Data Collection Methods:

Considering the nature of variables, numbers and types of respondents and their comments quantitative procedures of data collection were applied.

Data Collection Tools:

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

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

3.5 Data collection procedure:

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. A rapport was built with the respondents. All questions were put in a conversation style. Respondents were contacted by home visits. And case study also used to understand deeply to enhance our knowledge and understanding of the culture, power relationship among couples and how these affects role expectations, child bearing and rearing practices.

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.

3.6 Period of Study: February-March, 2010

3.7 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 feel reluctant to answer the question regarding reproductive health issues.
- Some respondents do not want to say anything against husband being afraid of violence.

Second Chapter

2.1 Findings from Survey

2.1.1 Distribution of respondents according to study areas:

SI	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 nine slum has 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

2.1.2 Age of the Respondents

SI	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.

2.1.3 Educational Qualifications:

SI 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% are illiterate including 6% who can only sign their names and among male respondents 53% are illiterate which is a little less than female respondent. Percentage of female and male respondents 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.

2.1.4 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.

2.1.5 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.	<i>Thelagari</i> 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 are housewife. Among working women significant number (35%) of women are engaged as domestic workers. In addition women are engaged in small business (13%), day labor (4%), garments workers (4%), handicrafts (2%) etc.

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

Male respondents of the slum areas are occupied in economic activities which do not bring sufficient income for the family. As such, earnings of women, what ever small may be, supplements family income.

2.1.6 Number of Family Members:

SI	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:

Around 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 family members vary from six to eight. Only small number of 5 to 8 has family members nine and above.

2.1.7 Type of the Family (Female)

SI 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 are nuclear. These nuclear families probably have small number of family members. As mentioned in table 2.1.6

2.1.8 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:

Majority (74%) of female respondent's family income ranges from taka 1,001 to taka 7,000. However, majority (87%) of male respondents' family income ranges from Taka 3001 to Taka 9000. This is higher than the income range of female respondents. However, range of income of some female respondents goes up to Taka 13,000 and above. Only six female respondent's family income goes up to 13,000 and above. Among these respondents, two are housewife. That indicates that their husband or other family members are involved in some profitable business or occupation. Among the four respondents, three mentioned that their husband has small business. Only one respondent is widow with four sons. All of her sons are involve in grocery business.

2.1.9 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 respondents 11 of them got married at an early age. However, most (79%) of the men got married between the age 19 to 27.

2.1.10 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, relatives fixed their marriage without discussing with them and customary consent was taken during marriage ceremony. In case of male respondents 87% reported that their consent was taken during arrangement of marriage and in 13% cases guardians took the decisions and since they did not have any objection they did not protest.

2.1.11 Women respondents' knowledge about legal age of marriage (18 years)

SI	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 know that legal age of marriage which is 18 years and above, but because of circumstances a large number got married at an early age.

2.1.12 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 have small families of one to two children. In addition, 39% female and 36% male respondents have 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.

2.1.13 Number of son and daughter (Female):

Sl.	Number of Son			Number of Daughter		
	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%) have at least one son and out of 209, 85% have at least one daughter. (How many female respondents have both son and daughter?? How many of them want more children???)

2.1.14 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%) have at least one son and out of 64, 69% have at least one daughter. (How many male respondents have both son and daughter?? How many of them want more children???)

2.1.15 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 does not have any child.

*One female respondent is pregnant

Analysis:

Among 280 respondents, nearly half (48%) of them had first issue at the age of 12 – 17 years and another 37% had first issue at the age of 18-20 years. Similarly, 39% cases wives of male respondents had first issue at the age of 12 – 17 years and another 45% cases had first issue at 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.

2.1.16 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 husband 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 first child was their (husband) decision. Two respondents are of the opinion that it is customary that after marriage a couple will have child and were confused with the question of discussion and decision.

2.1.17. The decision of taking more than one child. (FEMALE)

SI	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.

2.1.18. The role played by husband in pregnancy period.

Female response:

SI	Role of husband	Frequency	Percentage
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:

SI	Role	Frequency	Percentage
----	------	-----------	------------

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, arranged for nutritious food, assisted in household work, took 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 the time of their pregnancy.

Among the male respondents, majority (76%) said they looked after their wives which includes supported in medical care, nutritious food, assisted in household work, took 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 took care of their wives during pregnancy, It is a positive sign that in large number of cases husbands looked after their wives during pregnancy.

2.1.19. Provision of Healthcare facilities in pregnancy period:

SI	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.

2.1.20. Persons/institutions from where health care received.

SI	Persons/institutions from where health care 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, *surjer hasi* and only 3% from traditional doctors.

Out of 81 male respondents 65 (80%) cases 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*

2.1.21. 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 takes place at home and complicated cases are taken to hospital for delivery.

2.1.22. Decision of child's birthplace

SI	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 herself or jointly with husband decided 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 61% cases decision was taken by the husband or other family members and 32% cases wife individually or jointly with husband took the decision. (Contradictory to family type which is mostly nuclear. May be people who were looking after the would be mother and husband jointly took the decision)

2.1.23. Birth attendant

SI	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. At that time she was at her place. She gave birth to her child in the house without any help of any one.

Analysis:

Among 279 female respondents, 80% were attended during delivery by unskilled midwives, untrained relatives or her. 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.

2.1.24. Incidence of abortion:

SI	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 is 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.

2.1.25. Decision for abortion (Female)

SI	Decision of abortion	Female	
		Frequency	%
1	Miscarriage	15*	40
2	Self decision	6	16
3	From husband's decision	8	22
4	Both of them together	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". Nineteen percent cases it was their own decision or jointly with their husband. 22% mentioned that the decision have been taken by their husband and 8% respondents mentioned that the decision have been taken by their family members. Others include as advised by the doctor

2.1.26. Postnatal health care of the respondents; Female/ Male respondents' wives

SI	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 surprising that so many female respondents and wives of male respondents availed postnatal care which is far above national figure which is 33%.

2.1.27. Role of husband during post natal period. (Female)

SI	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 includes supported in medical care, nutritious food, assisted in household work, took care of other children etc. Only 03 respondents reported that they had no comment.

2.1.28. State of the respondents practice on family planning

SI	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% are not practicing. On the other hand in case of male respondents majority (80%) of them does not practice family planning themselves (may be their wife use fp), Rest of them (20%) practice family planning.

2.1.29. Family planning methods used by the respondents

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 takes birth control pill. Four of them have taken IUD and only eight of them used permanent method i.e. ligation.

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

2.1.30. 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 – do not feel necessary, respondent got married twice for children, do 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 want to practice Family planning in future (6%).

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

2.1. 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.

2.1.32. Preference of decision on using family planning methods (Female)

SI	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 about husband. Around 5% mentioned about doctor or health workers. At the same time another 5% represents the category of others.

2.1.33. Do you think that the decision to practice family planning methods has been imposed on you? (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.

2.1.34. Sources of receiving family planning materials (Female)

Sl	Sources of receiving family planning materials	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 cannot rely to the materials supplied by her husband since the materials were not effective and she got pregnant.

2.1.35. 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

2.1.36. Type of side effects faced by the respondents while using family planning

No	Type of 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 devices 48% had experienced different side effects such as headache (21%), irregular period (31%), pain in the body especially abdomen (17%), dizziness (11%). Other complains includes fever, vomiting, bleeding, weakness, weight gaining, white discharge, loss of appetite etc.

2.1.37. Measures taken to reduce physical problems (Female)

SI	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. In one case husband decided to use condom.

2.1.38. Sources of collecting family planning materials

SI	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 collect family planning materials from NGO clinic, around 15% from pharmacy, around 14% from Radda (NGO), around 9% from Surjer Hashi, a big proportion around 29% from health worker, 10% from hospital, around 1% from doctor. Around 4% respondents collect materials themselves; around 3% through husband and another around 3% are other option.

2.1.39. Desire for more children in future (Female)

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 do not want to take another child in future. 25 % wants to have more children. Fifteen respondents mentioned that it depends on the husbands' decision. In case of male respondents 60% do not want to have child any more.

2.1.40. Number of children wants in future

SL	Number of children	Frequency	%	Frequency	%
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 want just one child and another 17% wanted two to three children. In case of male respondents, 50% want to have one child and 16% want to have two to three children.

2.1.41. Respondents opinion regarding necessity of women's reproductive decision making power

SI	Remarks	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 that women should be able to take reproductive decision. Another 26% think that women should not be able to take reproductive decision and the rest of the twenty eight percent have never thought about these issues. Among female respondents, majority (70%) said women should be able to take reproductive decision and 21% has never thought about it.

2.1.42. Reasons which deter women to take reproductive decision independently according to the male respondents

SI	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 play as a barrier for women to take independent decision about reproduction. Six teen percent identified economic dependency plays as a barrier for women

to take independent decision about reproduction. Six percent identified hamper of social reputation play as a barrier for women to take independent decision about reproduction. Sixteen percent identified torture of husband is a barrier for women to take independent decision about reproduction.

Twenty three percent respondents identified unhappiness in family is a barrier for women to take independent decision about reproduction. Six percent do not comment anything about it. Twenty three percent respondents identified ignorance is the barrier for women to take independent decision about reproduction. Ten percent identified prejudices is a barrier for women to take independent decision about reproduction.

2.1.43. Respondents opinion on not exercising reproductive decision making power by women

SI	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. Sixteen percent 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 nine percent 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.

2.1.44. Recommendations which encourage women to take reproductive decision

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%).
- About seventy percent people could not give any reason or they had no idea about it.
- Around 1% mentioned about surviving their child well.
- Around 9% respondents did not understand this term.

Recommendations

- 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

2.3 Case Studies

Fourteen (14) case studies of married slum dwellers were conducted to assess the change of their position in the decision making process in their reproductive health issues. It is seen that out of the 14 case studies, four of the respondents has access regarding their decision making power on their reproductive issues, eight are regarded as no access to decision making process on their reproductive issues. Other two have access to decision making but in a very narrow way. Six of the interesting cases are presented below:

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 and her parents arranged the marriage without her consent. Currently she is 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 two times. Even now, she is pregnant. She has tried to abort it several times but doctors told that it might take her to death. She had an abortion before. Another child died when it was only few days old. She practices family planning. She said, her husband does not help her in anyway during pregnancy such as visiting the clinic or meeting with the health workers regularly. He brings birth control pills for her by himself which Jarina doubts about its validity as it does not work.

She believes that, women should have the power to take reproductive decisions. But she doesn't have that power. Her husband forces her to take many more children till now. Jarina understands that, many children make too many difficulties in life. As we talked to her, we understood that she is frustrated about her pregnancy and she wants to abort her child. For many children, she cannot afford food for her children.

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 do karchupi work in 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 of 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 even when she didn't understand anything. Her 1st daughter died when she was only 2 years old, her 2nd 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 Dhonustongkar. After a few days she became pregnant and gave birth of their third daughter. This time their daughter lived in no danger. After that, Saleha gave birth of their first son and he also lived well. Then Saleha came to Dhaka and started to think about family planning. But her husband said that one son is not enough and reliable. He forced her to conceive three more babies and two of them died consequently in 16 & 17 days. Their seventh child was a girl and she lived well. Saleha Begum thought that conceiving many more children is the cause of the early death of her children.

Case Study 3

Nurjahan begum (Not her real name), 32 years old women, 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 defends her husband from gambling. Her first child was born at the age of 21 year but her child died because her husband tortured her during pregnancy. After two year she gave birth to a disable child and her husband left her. She get married again with her cousin Aslam after one year. But he also tortured her. She wanted to take family planning methods but her husband obstructs her. As a result, she gave birth to another three sons and two daughters including one disable child against her will. She mentioned that her husband look 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 husband. Now her aim to make her all children educated and self defended.

Case Study 4

Slum dweller Rezia live in Moghbazar Wireless Rail gate. 32 years Rezia is a professional cook. It was an affair marriage when she was nineteen (19) years old. Her husband marries her after the death of his first wife. This couple has one son and one daughter. Illiterate Rezia and her husband both of them earn around 7000/= (taka seven thousand only). Both of her pregnancy was unplanned. (First time she conceives on first night of wedding but second time she conceives suddenly). During prenatal period her husband has been taken care of her properly. She got health care service from "Sabuj Chata". She gave birth to both of the child in her house and her aunt -in- law was birth attendant. Both of them together have been 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 on 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 denied because she (the girl) knew that it is illegal to get marry before 18 years but Rezia was unable, she thought that her daughter becoming engage with any boyfriend. 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 taken decision for family planning and they are getting health care service from T&T service center. Rezia's 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 though Rezia was financially independent she could forbid her husband's illegal wish and after that she gave birth two healthy babies.

Case Study 5

Shahana (not her real name), a forty years aged woman living in Dhaka for last six months. Including her husband her family members are seven. Shahana is the second wife of her husband. As the first wife has no child so her husband decided to marry second time. Shahana didn't know about the first wife of her husband. She comes to know about his first wife after Shahana's first child born. She didn't take any family planning measures so she became pregnant for five times. She did not receive any nursing from her husband during her pregnancy. Her husband wanted to give their last child to another couple. But Shahana did not agree. She told that, she rather kill the child but won't give 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 is not good, 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 comes to know about family planning from the village health worker. She doesn't want child anymore. Her husband doesn't give importance to her opinion.

Case study 6:

Mohammad Subahan Ali (not his real name), thirty years old, is the youngest among three sisters and one brother. He has passed 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 other he has 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 in early age. His only son was born at BRAC clinic through normal delivery. During the time of pregnancy he took care of his wife like 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 instead of the previous method. And his wife has no problem with it. His wife has not experienced 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 capacity. 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.

Chapter Five

Recommendations

a. Service recommendations

1. Women are compelled to compromise with adverse situations because of lack of education and economic dependency. 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 adverse situations.
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 husband. So, there is scope of conducting research on parents of women, husbands and influential family members specially in-laws to reveal their perceptions and attitudes about women's reproductive decision making power.

Chapter Six

References

- Family Planning Choice Behavior of Women in Slums in Bangladesh: A Discriminant Analysis, *Mati Ur Rahman, Ph.D.*
- Barkat, A. 1997. "Population Distribution, Urbanization, and Internal Migration". In Barkat, A. and S.R. Howlader (eds). Population and Development: National Plan of Action. Dhaka: Government of Bangladesh.
- Barkat A., S. R. Howlader, M. Rahman, and M. L. Bose. 1995. Family Planning Survey in the Urban Slums in Bangladesh. National Advisory Board. Study funded by Management Sciences for Health through a grant from The William and Flora Hewlett Foundation, USA. Dhaka: University Research Corporation (Bangladesh).
- CUS. 1992. Slums in Dhaka Metropolitan Area-1991. Conducted for Urban Volunteer Program, ICDDR,B, Dhaka, Center for Urban Studies, Department of Geography, University of Dhaka, Dhaka.
- Government of Bangladesh. 1994. Bangladesh Population Census 1991: Analytical Report. Vol. 1. Dhaka: Bangladesh Bureau of Statistics, Statistics Division, Ministry of Planning.
- Haaga, E. 1992. A Case Study of the Slum Improvement Project, Bangladesh. Dhaka: UNICEF.
- Jamil, K., A.H. Baqui, and N. Pajjor. 1993. Knowledge and Practice of Contraception in Dhaka Urban Slums: A Baseline Survey. Urban FAMILY PLANNING/MCH Working Paper No. 3. Dhaka: ICDDR,B.
- Khuda, B. and A. Barkat. 1994. The Bangladesh Family Planning Program: Key Programmatic Challenges and Priority Action Areas. Prepared for the International Conference on Population and Development (ICPD), Cairo, September 1994, on behalf of National Advisory Board and Management Sciences for Health. Dhaka: University Research Corporation (Bangladesh).
- Women in Bangladesh: From Inequality to Empowerment**, Nazmunnesa Mahtab, Professor, Department of Women and Gender Studies, University of Dhaka

Women in Decision Making Process, Unnayan Padakhep, 18th Edition, Published by
Steps Towards Development