Reproductive Rights and Decision-Making : A Comparative Study in Rural and Urban Bangladesh

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Abstract

Though the process of human reproduction is an age-old phenomenon and has been going on since antiquity, concern over reproductive right and health is relatively recent one. International instruments and national documents now recognise reproductive rights and nations are committed to ensure and promote reproductive rights of every individual of its people. A host of genetic, economic, hereditary, biological, cultural and social factors affect people's reproductive health status and the prospects of promoting reproductive rights. Researches in the area of reproductive rights seem to be narrowly focused on contraceptive acceptance and use and fertility reduction. This paper focuses on the predominant socio-economic factors that shape people's, especially women's, reproductive rights and health status. In so doing, this paper aims at bridging the gaps between in reproductive health and rights research in Bangladesh and public policy-making.

Introduction

From time immemorial, human beings have produced the kind of its own to survive on this earth. In fact, no animal can live without producing its own kind- a process called reproduction. Apart from productive activities that sustain life on earth by transforming the material environment, human beings must continue producing its biological entities. "The reproductive activity of human species is therefore one of the fundamental premises of history." (Akter 1996:58). Though the process of human reproduction is an age-old phenomenon, concern over reproductive rights and health agenda is a recent one. Until very recently, the issue of reproduction did not get much attention. It is only after the 1994 United Nations International Conference on Population and Development (ICPD) that counties, policy planners, researchers, development agencies have become concerned with the reproductive rights and health agenda. The ICPD was a landmark event in the history of women's rights and population and development planning.

In the commonest sense of the term reproductive rights means the right of an individual over one's reproductive power or the power to control one's own body without coercion, use of force and so on. It means people should have the right to decide freely their reproductive activities, have control over their own bodies and regulate their fertility. Reproductive right is a right of each individual and couple irrespective of sex. The world community at ICPD, attended by about 11000

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registered participants from 180 countries, reached a global consensus and signed a global document called Programme of Action (poA) which reflects the commitment of global community to take appropriate measures at national level to promote reproductive rights.

The United Nations definition of reproductive rights is as follows :

"Reproductive rights refer to the right of the couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and have the information, education and the means to do so, and the tight to attain the highest standard of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion and violence" (United Nations, 1995). The right to reproductive health now includes the concept that individuals have the right to attain highest standard of sexual and reproductive choices free from coercion (ibid).

Individuals and couples reproductive rights can be affected by a host of biological, genetic, socio-economic and cultural factors. This study focused on only social factors. For Instance, a woman's reproductive health can be severely affected by unwanted pregnancies, even if it is not going to kill her direcelty or impair her physically and even if she can give birth to live baby and with no physical handicap (UN 1996:203). According to WHO's global estimate, more than half a million women die each year because of complications related to pregnancy and childbirth. All but 4000 of these deaths take place in developing countries (ibid, 203). Maternal mortality accounts for 1.3 per cent of all deaths in developing counries. (ibid, 204). There are 170 million children in poor countries who are underweight and over 3 million of them die each year as a result (WHO:2002).

It appears from the above statistics that the situation of reproductive rights is very dismal in developing and underdeveloped countries because of their lower level of development vis-a-vis developed nations. It would be worthwhile, therefore, to understand the problems of reproductive rights promotion from Bangladesh perspectives and the factors that affect reproductive health and enjoyment of rights for appropriate policy interventions. This paper is an attempt to make a comparative study of reproductive rights status of women in rural and urban Bangladesh. This paper has been prepared based on the research undertaken by the author as requirement of his MSS course "Advanced Research Monograph" in the Department of Sociology, University of Dhaka in 2003.

Objectives of the study

The broad objective of the paper is to understand socio-economic factors that shape the rural and urban women's enjoyment of reproductive rights in Bangladesh from a comparative point of view. Accordingly, the specific objectives are to :

- Explore social factors affecting reproductive rights status in rural and urban Bangladesh from a comparative point of view.
- Understand the decision-making process of couples related to reproduction.

- Put forward recommendations to create a social system where individuals can enjoy reproductive rights as enshrined in international instruments.
- Understand the linkages among multiple population and development issues (e.g., population control programmes) and reproductive rights.

Methodology of the Study

Social survey method was used to collect data for this study. A sample of 80 women was purposively drawn from Dhaka City areas and another sample of 80 women from two villages Mondakini and Forhadabad under Hathazari police station in Chittagong. Data were collected directly from primary sources. All women were married and in their reproductive ages (15-49). A questionnaire, which contained structured and open questions, was given to them to fill in. In case of women who could not read or write, data collectors helped them to fill in the questionnaires. The objective of the research was clearly explained to the respondents and they were assured that identity will be kept secret in an effort to elicit responses. Only female data collectors were used to obtain reliable data, ensure privacy and to have maximum responses possible. Some data were collected from secondary sources. Data were compiled, edited, checked for accuracy and consistency, and analyzed using statistical tools.

Rationale of the Study

A survey of reproductive health research in Bangladesh makes it clear to us that researches in this area have ignored the issues of reproductive rights. Previous research works have focused primary on demographic aspects of population including failure or success of family planning in Bangladesh, but tended to keep reproductive health and rights problems virtually untouched. These researchers have concentrated on assessing the impacts of particular family planning programmes and/or the program gaps and so on. In contrast to the moat of the previous research works, this study takes a right cantered approach in dealing with the issues of reproductive health problems and reproductive rights violations with a particular focus on structctural social differences between urban and rural Bangladesh.

Limitations

As is the case in almost all social science researches, the author encountered some problems in conducting the research on which the paper is based.

- Time and resource were limited for the study preventing from working with larger sample.
- Some sensitive questions could not be avoided because of the objective of the study.
- Some respondents refused to fill in the questionnaire as it contained some apparently sensitive questions.
- Some apparently sensitive questions might have produced discomforts for the respondents.

Socio-demographic Characteristics of the Respondents

All the respondents selected for the study were married women with at least one children in an effort to obtain from them all the relevant information required to fill in the questionnaire, considering the socio-cultural conditions of the study areas. Exactly 50 per cent of the respondents were urbanites and the same proportion was from rural areas. Age of the respondents ranged from 15 to 49 and the highest percentage of concentration (27.5 per cent) was found in the age category 25-29 with 37.5% of urban, in contrast to 17.5% rural respondents. However, taken separately, highest concentration of rural respondents (31.25%) fell in the age category 20-24 compared with 14.75 urban respondents. 92.5% respondents were Muslims and only 7.5% Hindus and respondents from other religious community were not found. The study revealed that 77.5% of the rural respondents were unpaid household labour while, in contrast, 62.5% were found in this category for urban respondents. Urban respondents tended to be engaged in some formal jobs in offices (15%). In all, majority of the respondents were found to have no income of their own and again, highest percentage of urban women (37.5) had an income between 5000 to 9999 Taka, whereas highest concentration of the rural (61.26 %) of the rural respondents had income in the lower income category at below Taka 4999.

Review of Literature

There is dearth of researches directly related to the reproductive rights issue in Bangladesh, perhaps, because of the sensitivity and newness of the concept. Akter (1996) was critical of what she calls 'reproductive technologies' i.e., contraceptive devices, because of their 'sexist, eugenic, racist' nature. She attacked the Western notion of population control that holds the view that children are burden of family to the Third World poor families. She was also concerned with the adverse effects of contraception. However, no adequate empirical evidence was given. Akter (1995) explored critical acts about Norplant, a contraceptive device, promoted in Bangladesh in the 1980s. The author found that it had many side-effects (e.g., bleeding). Begum (1999) argued population control policy in Bangladesh adversely affect women's health as consequence of use of banned/armful contraceptives imported from developed countries. Begum et al. (1991) found that illegally induced abortion is related to maternal mortality and morbidity, and husbands tend to force women undergo abortions. Amin and Hossain (2003) observed that religious orthodoxies in Bangladesh pose challenges in furthering reproductive rights in Bangladesh. They mentioned a group of Christian (led by Vatican) and Muslim fundamentalists attempted at ICPD to restrain and elaborate the reproductive rights. A study by Choudhury et. al. (1997) revealed that people have misconceptions about the causes and prevention of STDs including AIDS. Goodburn and Gazi (1994) found that peoples' health beliefs influence their therapeutic practices. People believe most illnesses during pregnancy and childbirth are caused by interventions of evil spirits - bhut and certain food habits. It should, however, be noted here that the studies are narrowly focused on contraceptive and demographic aspects of Bangladesh and do not address the

wider issue of reproductive rights. "Most demographic research on fertility and family planning has been narrowly focused on contraceptive acceptance and use and on fertility reduction." (Germain 1992).

The findings of the study have been presented in two separate Sections. Section A deals with Reproductive Rights which is again subdivided into its component parts such as Number, Timing and Spacing of Children, Reproductive Rights and Contraception, Access to Reproductive Information and Health Care Services, Child Survival, Violence Against Women and Reproductive Rights and so on. On the other hand, Section B entitled Reproductive Decision-Making focuses on decision-making process related to number, timing, spacing and contraceptive use and the like.

Section A: Reproductive Rights

There have been, over centuries, debates on the relationships between population and development. The issue of population problem was given extensive treatment by Malthus when in 1798 he wrote the famous but controversial treatise on population "Essays on the principles of Population". Malthus's population doctrine had generated much debates in the subsequent decades. Malthus held that human bedings have passion to reproduce and that is inborn. He found a disproportionate relationship between population growth and food supply. Malthus's thesis generated considerable debates in the area of population and development. However, until the UN population conferences, particularly ICPD in 1994, the issue of reproductive rights did not enter in the population and development discourses.

The agenda of human reproduction did not get much currency until the 1994 International Conference on Population and Development in Cairo, Egypt. The Cairo Conference saw intensified debates as regards the relationships between population and development. The Conference, attended by a host of academics, heads of the governments from around the world, policy makers, researchers and NGO representatives put the issue of reproductive rights on the development agenda. Dr. Nafis Sadik termed the conference a 'quantum leap' towards emancipation of women and realisation of reproductive rights of all people irrespective of sex.

One of the key aspects of the said ICPD was that it set the stage for rights cantered approach to deal with the problems of population control or to solve the problems of population growth. In other words, the issue of reproduction and reproductive health was viewed from rights perspective rather than from merely a narrow health issue in the wake of increasing widespread orientation and recognition of rights-based approach to development.

The most significant outcome of the conference was the Programme of Action which includes a wide range of policy measures and guidelines with regard to relationships between population and reproductive rights.

The ICPD conference put the empowerment of women on population agenda and contended that through empowering woman it was possible to reduce fertility and thus check population growth in the world.

The government of Bangladesh responded very positively and immediately after the conference to the recommendations of the ICPD document. The government has expressed its commitment to take measures to realise the reproductive rights of each individual and women.

It is particularly difficult for women to exercise heir reproductive rights in traditional patriarchal societies as there are wide gaps between men and women. It should be made clear that Bangladesh being a patriarchal society undervalues women and they are always put in subordinate positions in every aspect of their lives-in family, community and state levels. Except for a few exceptions, it should be said that women in Bangladesh tend to play traditional gender roles in the household, family and community. They live all though their life cycles, under control of men-during childhood under father, during youth under husband and during old age under son. In Bangladesh a wide range of social, economic and cultural factors are at work that impede the realisation of reproductive rights in the country. First and foremost, there is dearth of awareness about the reproductive rights among men and women for whom it meant. Women in Bangladesh are married off at earlier ages without their consent in most cases and subsequently after marriage they bear children. But they cannot decide themselves the number, timing and spacing of childbirth, neither can they promote sexuality without fear and/or coercion because of patriarchal dominations and attitudes.

However, this cannot be treated as an overarching observation as some changes are taking place in our society. With increasing number of women entering higher education, empowerment of rural women as a consequence of rural development endeavors and greater participation in employment, women are being aware of their rights and so traditional patriarchal attitudes, at least to some extent, are undergoing changes. But reproductive rights and health situations of the country is undoubtedly deplorable. This statement can be supported by some facts related to reproductive rights and health situations of the country. Now we would like to highlight some of major findings of the study:

Number, Timing and Spacing of Children

UN consensus documents recognised the rights of all couples and individuals to decide freely and responsibly the number, timing and spacing of childbirth.

Age at First Marriage: Age at first marriage is an important factor affecting women's reproductive rights as marriage is highly valued in Bangladesh, particularly for women. Women in general and rural women in particular are married of early, particularly in the late twenties. An unmarried woman is stigmatised and seen by family as a burden. Marriage in Bangladesh patriarchal society gives the socially approved means to enter in sexual intercourse and bear children. It can be argued that a good number of maternal deaths can be attributable to early marriage resulting from pregnancy complications and physical preparedness for child bearing.

Table 1: Respondents' Age at First Marriage

Age at First Marriage	Urban		Rural		Total	
	N*	Per cent	N	Per cent	N	Per cent
15-19	24	30	39	48.75	63	39.37
20-24	48	60	27	46.25	85	53.13
25-29	8	10	4	5	12	7.5
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source: Field Survey, 2003

N* = No. of respondents

Table 1 shows that rural women tend to be married off earlier than urban counterparts because of the formers' low education level, employment status and lower level of decision-making power. Early marriage is a matter of great concern as early married women may run the higher risks of maternal deaths than those married at a time when risks are reduced, particularly after 20.

Age at First Childbirth: There is a societal pressure in Bangladesh to give birth to children, especially male one, after marriage as male children are presumed to be 'Bongsher Bati' (light of the family). Early marriage is, therefore, likely to follow by early childbirths. Early marriage and consequent early pregnancy and childbirth are highly risky causing deaths either to the mother or child, or both.

Table 2: Respondents' Age at First Childbirth

Age (Years)	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
15-19	13	16.25	28	35	41	25.62
20-24	55	86.75	50	62.5	105	65.63
25-29	12	15	2	2.5	14	8.75
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source: Field Survey, 2003

It is noticeable from table 2 that rural women tend to have children at earlier ages than their urban counterpart, putting them at greater risks of maternal mortality and morbidity. About 90 per cent of the respondents said that one should bear first child after 20 years of age. But, as the table 2 reveals, 35 per cent of rural women as against only 16.25 per cent urban bore children before 20.

Number of Children: If women do not have access to means and the required information about it, it is probable that they would not be able to regulate their fertility. Rural respondent women was found to have, on average 3.14 children in contrast to only 2.1 children for urban, with standard deviation of 2 in both cases. Lower-use of contraception, lower education, demand for child labour in rural economy, son preference and lack of access to reproductive rights information accounted for this contrasts. Around 19 per cent rural respondents in comparison

to 12.5 percent urban said that they have more children than they wanted. In all, slightly less than 16 per cent women were found to have more children than their desire. Inability to fix desired family size, which result from unwanted pregnancy, lack of access to contraception and reproductive information is a violation of reproductive rights.

Birth-Spacing: The ICPD PoA provides that men and women should be able to give adequate space between two childbirths as too frequent and closely-spaced births cause heavy dent on the mother's health resulting in birth related complications.

Table 3: Duration of Time Spent Between First and Second Childbirth

Duration (years)	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
1	1	3.28	4	5.48	6	4.48
2	16	26.24	22	30.14	38	28.37
3	20	32.78	29	39.73	49	36.55
4	11	18.03	12	16.42	23	17.17
5	6	9.83	3	4.12	9	6.72
6	2	3.28	2	2.73	4	2.98
7	1	1.64	1	1.37	2	1.49
8	1	1.64	0	0	1	· 0.75
9	1	1.64	0	0	1	0.75
10	1	1.64	0	0	1	0.75
Total	**61**	**100**	**73**	**100**	**160**	**100**

Source: Field Survey, 2003

It can be gleaned from table 3 that as the number of years increases, percentage of urban and rural respondents decreases, disproportionately.

It is also noticeable that urban women tend to give more space between two births. Son preference, presumption of rural couple's children (males) as source of agricultural labour and age-old security, unfavorable attitude towards female babies, who are seen as burden to family, may be at work.

In addition to this, the study found that around 16 per cent respondents reported some problems for not giving adequate space between first and second child birth. The problems include lack of adequate childcare, weaknesses, loss of weight and so on.

Reproductive Rights and Contraceptive

Though access to effective, affordable, easy-to-use methods of contraception is an important aspect of reproductive rights, use of contraception may itself constitute violation of reproductive rights. Contraceptive devices developed and marketed by multinationals are imported in poor countries like Bangladesh to control population growth, as population is seen as a major problem to the development of the countries. Second Five Year Plan declared population number one problem

of Bangladesh. Still, governments and NGOs follows a depopulating strategy aimed at augmenting the Contraceptive Prevalence Rate (CPR), reducing the Total Fertility Rate (TFR) and controlling the population growth. Women are targets of population policy in developing countries. For instance, China's "One Child Per Couple" population policy is more restrictive and destructive to the promotion of reproductive rights. Women with one child is forcibly sterilized by government health officials/workers in China.

This study found that use of male method i.e., condom is much lower (17 per cent) for both rural and urban cases than use of female methods. It also found 60 per cent of rural and 67 per cent of urban respondents had followed contraceptive methods.

Furthermore, it revealed that exactly 28.36 per cent urban respondents in contrast to 25 per cent rural faced problems as a result of use of contraception. The regional differences in the experience of side-effects are put in the table below:

Table 4: Side-Effects of Contraception as Reported by the Respondents

Nature of Side-Effects*	Urban		Rural		Total	
	N = 19	Per cent	N = 15	Per cent	N	Per cent
Headache	8	42.11	9	60	17	50
Weakness	3	15.79	5	33.13	8	23.53
Infertility	3	15.79	2	13.33	5	14.70
Bleeding	3	15.79	1	6.67	4	11.76
Black spot face	2	10.53	0	0	2	5.88
Pain	0	0	3	20	3	8.82
Total	**19**	**100**	**20**	**133.33**	**39**	**114.69**

Source: Field Survey, 2003

* Responses in more than one category were found for rural. So total of percentages is more than 100.

It is evident from the table 4 that despite lower percentage of rural women experienced side-effects than their urban counterparts, the former are more likely to report multiple problems. It is also notable that higher percentage of rural respondents experienced headache (60 per cent) and weakness (33.13 per cent) and pain (20 per cent), the corresponding figure for urban respondents being 42.11 per cent, 15.79 per cent and 0 pre cent. On the other hand, higher percentage of urban respondents suffered from bleeding (15.79 per cent) than rural counterpart (6.67 per cent).

Health Check Up Prior to Contraceptive Use: In order to reduce effects of side-effects and to suit contraceptive, one needs to go for health check-ups prior to use of contraception. The study found that around 67 per cent urban in comparison to 75 per cent rural respondents did not undergo health check-ups prior to contraceptive use.

It should therefore be concluded that though access to contraceptive method paves the way to enjoyment of reproductive rights by regulating fertility and enabling

individuals and couples to have desired family size, contraceptive methods in most cases constitute violation of reproductive rights affecting women's health causing side-effects.

Access to Reproductive Health Care Services

Social factors and peoples' health beliefs tend to affect their reproductive health and access to health care services. People in low income brackets and low education level are less likely to have access to reproductive health services. Again, certain health beliefs affect reproductive health care seeking. To give an example, people believe that if a woman eat too much during pregnancy, the would be baby will be too fat causing difficulty during pregnancy.

Medical Examination During Pregnancy: Medical examination during pregnancy is crucial for proper treatment, diagnosis, counseling and safe motherhood. The study found out that 66.25 rural women in contrast to only 31.25 urban did not go for medical examinations during last pregnancy. These differences represent rural women's lower capacity of service use, relatively poor communication system in rural areas, sense of privacy or shame, social barriers to go to doctors who are predominantly men and economic insolvency etc.

Place of Delivery: Place of delivery is used in this study as an important indicator of access to reproductive health services. The study revealed wide disparity between urban and rural respondents in terms of place of delivery as is shown in the following table:

Table 5: Place of Delivery of Last Childbirth

Place of delivery	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
Home	12	15	55	67.75	67	41.87
Hospital	30	37.5	20	25	50	31.25
Clinic	38	47.5	5	6.25	43	26.88
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source: Field Survey, 2003

Table 5 clearly shows that overall 41.87 per cent deliveries took place in home usually by trained or untrained Traditional Birth Attendants (TBAs) but it is notable that the percentage for rural is much higher at nearly 69 per cent in contrast to only 15 per cent for urban. As the respondents said economic hardship was the major reasons for both types of home deliveries. The other reasons found by the study were in order of importance poor communication systemic in-laws' inhibition, lack of knowledge about obstetric care and the belief that safe delivery was possible at home.

Baby Blues: The study found that 30 per cent of rural in contrast to 27.5 per cent rural suffered some form of problems. Nature of the problems are summarized in the following table:

Table 6 : Baby Blues Faced by Respondents After Last Childbirth

Baby Blues	Urban		Rural		Total	
	N = 22	Per cent	N = 24	Per cent	N = 46	Per cent
Numbness	8	36.36	10	41.67	18	39.13
Fear	7	31.81	8	33.33	15	32.60
Anxiety	4	18.18	6	25	10	21.73
Loss of Appetite	3	13.63	5	20.83	8	17.39
Lack of interest in sex	12	54.54	8	33.33	20	43.47
Total	**34**	**154.52**	**37**	**145.16**	**71**	**154.34**

Source: Field Survey, 2003

The break-down of data in Table 6 shows that a higher percentage of rural women suffered from multiple problems called baby blues than their urban counterpart in all reported categories except in the last category. It should be noted that baby blues are not uncommon after childbirth and counselling may be a good option to overcome the problems.

Child Survival

Child survival is closely linked to number, timing, birth spacing and to the reproductive health of the mothers. Early late, numerous and closely spaced pregnancies are major contributors to high infant child mortality and morbidity especially where health care facilities are scarce. Section B of ICPD PoA recommends to reduce the disparity in mortality rates between and within the developed and developing countries. (UN 1995). The PoA also recommended actions to health and nutritional status of infants and children and to promote breast-feeding as a child survival strategy. We used child survival as a proxy indicator of enjoyment of reproductive rights.

Table 7 : Mortality and Breast Feeding Data

Indicator	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
Stillbirth	3	3.75	5	6.25	8	5
Infant death	2	2.5	6	7.5	8	5
Under-five Deaths	5	6.25	7	8.75	12	7.5
No Breast Feeding	2	2.5	0	0	2	1.25

Source : Field Survey, 2003

It is noticeable from table 8 that urban respondents are at favorable position in terms of all child survival indicators except breast feeding Table shows that exactly 2.5 per cent reported that they did not breast fed because of inadequacy of milk. The higher percentage of stillbirth, under-five deaths and infant deaths for rural compared with urban respondents, perhaps, resulted from lower nutrition level, lower access to health care services and balanced diet, lower income level, too frequent deliveries, early conception and so on.

Information and Education about Reproductive Rights and Health

One of the central aspects of reproductive rights is that individuals and / or couples should have access to enough education and information with regard to reproductive health care services, pregnancy. safe sex, contraception and so on and so forth Restricting people from this information constitutes violation of human rights. Discussion of sex is a taboo in Bangladesh (Akter 1996) and sex education is not incorporated in school and college curriculum.

Knowledge about he Term 'Reproductive Rights' : The study found that 82.5 per cent of rural respondents in contrast to a much lower 60 per cent of their ruban counterparts did not ever hear the terms reproductive rights from sources ranging from electronic, print media or any friend or relative, limited access to media of communication being the main reason for the contrast. It is observable that media in Bangladesh campaign to reduce family size and women are the targets of the ads and contraception.

Information about Side-Effects of Contraception. The study also found that while 56.25 per cent of urban women thought that they were not given information about side-effects of contraception, the corresponding figure for their rural counterparts is much higher at 72.5 per cent. In all, slightly more than 59 per cent of the total women did not have information about side-effects of contraception.

Information about the Causes of AIDS : the AIDS pandemic is a major concern in both developed and developing countries of the world. Developing countries are at greater risks of AIDS than the developed worlds. As of mid 1993, about four-fifths of all persons ever infected with HIV lived in developing countries and the number of cases are rising most rapidly among women (UN 1995). Though Bangladesh is a low prevalence country, it is categorized as high risk one and given the socio-economic organisation of society, women are at greater risks of infection.

Though 40 per cent of rural respondents in contrast to 82.5 per cent urban respondents said that they knew the causes of AIDS, an analysis of the responses led us to conclude that both type of the respondents have misconception about the causes of AIDS. The following table shows the responses:

Table 8 : Respondents' Given Causes of AIDS

Causes*	Urban		Rural	
	N = 58	Per cent	N = 32	Per cent
Illicit sex	**36**	**62.07**	**18**	**56.25**
sex with AIDS Infected people	12	20.68	2	6.25
Non-Use of condom	8	13.79	6	18.5
Indulgence in Sex	0	0	3	9.39
Lack of Awareness	0	0	3	9.38
Taking Unexamined Blood	3	5.17	2	6.25
Use of Unexamined Syringe	3	5.17	2	6.25
Violation of Religious Norms	0	0	7	21.88
Total	**62**	**106.90**	**43**	**136.14**

Source : Field Survey. 2003

* Multiple responses were found in a single category.

As the table 8 shows the predominant cause given by both types of respondents is illicit sex rather than unsafe sex. For some rural respondents (21.88 per cent) violation of religious codes may cause AIDS. The causes of violence are therefore linked with value judgements of the respondents and in cases not scientific. No response in "Violation of religious norms is a reflection of decreased influence of religion in urban life.

Respondent's Knowledge about Most Effective Methods of Contraception : Some researches (Akter 1996, for example) in the area of population studies has documented severe side-effects of contraception on women's reproductive health in the country, but failed to suggest any alternatives. Therefore the author felt the need to learn from those who make use of contraception. The study found that in contrast to 39 per cent urban respondents, only 20 percent rural reported that they knew about the most effective methods of contraception.

Table 9 : Methods with Least Side-Effects

Methods with Least Side-Effects	Urban		Rural		Total	
	N = 28	Per cent	N =18	Per cent	N = 46	Per cent
Condom	16	57.14	10	55.56	26	56.52
Pill	12	42.86	6	33.33	18	39.13
Safe Period	0	0	2	11.11	2	4.35
Total	**28**	**100**	**18**	**100**	**46**	**100**

Source : Field Survey, 2003

The study revealed that, taken together, highest per cent of the respondents (56. 52 per sent) thought condom to be the method with least side-effects. Rural urban differences were found to be negligible in this respect.

Violence Against Women and Reproductive Rights

Violence against women (VAW) is widespread and take multiple forms such as beating, use of abusive words. rape including marital rape, mental torture, threat of violence and so on. However most of the cases of VAW go unreported and even unrecognized. ICPD PoA states that women should go safely all through their reproductive cycles and make reproductive choices free of coercion and violence. Violence during pregnancy and/or post-partum constitutes violation of women's reproductive rights. It is very difficult to collect reliable data on VAW. The nature of violence is shown in the following table.

Table 10 : Nature of Violence Faced by Respondents During Last Pregnancy

Nature of Violence*	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
Mental Torture	2	33.33	1	10	4	21.05
Physical Beating	3	22.22	6	60	8	42.11
Threat of Violence /Verbal abuse	5	55.55	6	60	11	57.89
Total	**10**	**111.10**	**13**	**130**	**23**	**121.05**

Source : Field Survey. 2003

* Multiple responses were found.

This study did not find any significant difference in the percentage of women experiencing of violence during pregnancy between urban and rural respondents. Table 10 shows that while 11.25 urban respondent women faced some forms of violence, the corresponding figure for rural is slightly higher at 12.5 percent. However, break-down of data by rural urban difference shows that percentage of physical violence in comparison to mental torture is higher in rural than in urban settings and vice versa.

Section B: Reproductive Decision-Making

One of the most important aspects of reproductive rights is who take decisions with regard to reproductive behavior and functions. In order to promote reproductive rights, individuals should have power to take reproductive decisions without coercion or force or violence. That is, they should decide of their own who they marry, whether they bear children, when they bear children and how many, what methods they chose to regulate fertility and so on.

One of the major objectives of ICPD Programme of Action was "to promote adequate development of responsible sexuality that permits relations of equity and mutual respect between the genders" (UN 1995:14).

Since policymaking related to family planning and health is predominantly male exercises, these policies tend to be gender-blind and do not address the specific needs and health implications of women.

Reproductive Decision-Making with Regard to Whether Women Bear Children: As has been noted earlier in this paper, there is a social pressure on women to give birth to children especially males. We took an effort to understand reproductive decision-making at the family or community level in rural and urban study areas from a comparative point of view.

Table 11 : Persons Taking Decisions Regarding Whether Women Bear Children

Decision Makers	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Per cent
Self	22	27.5	6	7.5	28	17.5
Partner	12	15	25	31.25	37	23.12
Both	46	57.5	45	56.25	91	56.88
Elderly Family Members	0	0	4	5	4	2.5
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source: Field Survey, 2003

Table 11 reveals that higher percentage of urban women than rural take decisions in consultations with their partners regarding if they bear children. However, the percentage of women taking decisions on their own in remarkably low among both urban and rural respondents. In cases of rural women, decisions are somewhat influenced by elderly people, the percentage of urban respondents in this category is down to zero resulting from increasing nuclear family and individualism in urban lives.

Reproductive Decision-Making with Regard to Timing of Bearing Children: As closely spaced births cause complication and sometimes even deaths to respective women, ICPD Provided that individuals should have choice to decide freely and responsibly the timing of their childbirth. This study revealed women's subordination and incapability to decide the timing when they bear children.

Table 12 : Persons Taking Decisions Regarding Timing of Bearing Children During Last Childbirth

Decision Makers	Urban		Rural		Total	
	N	per cent	N	Per cent	N	Per cent
Self	15	18.75	15	18.75	30	18.75
Partner	21	26.25	27	33.75	48	30
Both	44	55	31	38.75	75	46.87
Elderly Family Members	0	0	7	8.75	7	4.38
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source : Field Survey, 2003

Table 12 shows that highest concentration of responses in both partner categories suggests that reproductive decisions are mostly mutually agreed and is a positive sign. However, rural respondents lag behind in deciding the timing of children as more than 31 per cent of rural in contrast to 15 per cent urban respondents reported that decisions were taken by partners alone.

Reproductive Decision-Making with Regard to Number of Children Born: Because of women's subordinate position in patriarchal social structure in Bangladesh, and lack of access to contraception adequate reproductive information, and long-standing social values related to childbirth and population policies and programs affect their decision-making power as far as fertility regulation is concerned.

Table 13 : Persons Taking Decisions Regarding Number of Children Born

Decision Makers	Urban		Rural		Total	
	N	Per cent	N	Per cent	N	Percent.
Self	12	15	4	5	16	10
Partner	20	25	33	41.25	53	33.13
Both	48	60	37	46.25	85	53.13
Elderly Family Members	0	0	6	7.5	6	3.75
Total	**80**	**100**	**80**	**100**	**160**	**100**

Source : Field Survey, 2003

It is noticeable from table 13 that percentages of women taking decisions on their own are remarkably low among both urban and rural respondents. It is encouraging to note that higher percentage of urban and rural women took mutual decisions with regard to number of children. This represents rural women's subordinate position in male-dominated society.

Decision-Making With Regard to Contraceptive Use : The decision to use contraceptives by women is not taken by them per se. These are taken by male policymakers, health workers and husbands. Health workers allure poor women to adopt family planning (FP) in exchange of money or a piece of cloth (Akter 1996).

Much like the same way it is assumed that decisions with regard to birth spacing, reproductive service utilization and contraceptive use and so on are taken and rural women are at unfavorable position compared with urban counterparts.

Recommendations

Policy Shift: Promotion of reproductive rights and empowerment of women through enhancing decision-making capacity should be the core components of national population and health policy. The goals of population policy can be achieved through ensuring reproductive rights. Women or gender experts, women rights activists can be involved in population and health related policy-making.

Bridging the Gap: Rural-urban gap in enjoyment of reproductive rights should be bridged through empowerment of rural and poor women. National-level policy-making should take due cognizance of rural-urban differences in reproductive practices and decision-making. There is need for disaggregated data generation with regard to reproductive health status and rights to facilitate policy-making and design intervention measures.

Men Do Matter : Reproductive health programmes tend to overlook the requirement and involvement of men to a large extent. Men in Bangladesh despite having positive attitude towards family planning are unable to adopt it because of lack of method choice and male providers. In matters of reproductive health decision-making they are mostly ignorant about protection of themselves and their wives. Male methods of contraception should be promoted as it lessens the side-effects. more important, it reduces the risks of HIV/AIDS and other STDs. Thailand's "100 Per Cent Condom Use" campaign can be considered as an example.

Management of Side-effects : Merely access to contraception is not all. Management of side-effects, providing information about it and so on are also important for enjoyment of reproductive rights.

Empowering Women: Appropriate policy measures should be taken to enhance their capacity through education, employment and information so that they can take reproductive decisions that affect their lives.

Monitoring Progress : National Committee on ICPD should closely monitor gains in reproductive rights situation and report for public education and scrutiny. Civil society organizations (CSOs), women's rights bodies, human rights organizations and NGOs too should play their due role in this process and take appropriate measures.

Awareness Raising through Designing BCC : Appropriate behavior change communication (BCC) programmes should be designed to raise awareness about reproductive rights and mass media should play their due role in this regard.

Education: There is an urgent need for integrating sex and reproductive rights eduction in the curriculum of upper secondary school and onwards to promote awareness about and respect for reproductive rights.

Conclusion

It can therefore be concluded that a multiplicity of factors ranging from age at first marriage and childbirth, son preference, access to education, access to media and reproductive information, gender, level of awareness about reproductive rights, use of contraception, religion to patriarchal attitudes affect reproductive rights and health status. Except a few exceptions, rural women are at unfavorable situation to promote reproductive rights because of low educational attainment, media use, economic insolvency and ignorance about rights and most importantly, patriarchal

attitudes.[2] Rural women's needs should be given special attention. It should also be remembered that it is not enough for men and women to have access to some forms of contraceptive methods for the enjoyment of reproductive rights, what is more important is that they should have access to accessible, effective, affordable, easily manageable contraceptives methods and information about those methods.

This study gives empirical proof to the facts about the affects of contraception stated by Akter, and Begum and verifies finding of Choudhury et al. The study, however, could find any proof to suggest that people believe in supernatural powers like Bhut affecting reproductive health as found in Goodburn and Gazi and attitudes towards reproductive behavior are changing. Traditional beliefs associated with reproductive behavior are also undergoing changes, as reflected in the growing consciousness (though some times mistaken) about the causes and effects of HIV/AIDS.

Governmental and NGO programs designed to promote reproductive rights will not only meet the obligations of the GoB at ICPD, but also contribute a lot to attain MDG goals such as reducing mortality and empowerment of women. Appropriate policies and programs should be designed so that men and women can enjoy reproductive rights. Promotion of reproductive rights should be the integral part of population policy marking a shift from current depopulating policy goals to a more human, people centered, gender-sensitive population policy.

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[2] Official data on all indicators for reproductive rights and health is not adequate in Bangladesh. Data for only some indicators were found. Please see Annexure attached herewith which also reflects the rural-urban differences in almost all reproductive rights and health related indicators.

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Annexure

Rural-Urbans Differentials in Reproductive Health Related Statistics in Bangladesh

Indicator/Year	Urban	Rural	National
TFR per women, 1998	2.24	3.0	2.98
Gross Reproduction Rate (GRR), 1998	1.08	1.62	1.48
Net Reproduction Rate (NRR), 1998	1.06	1.43	1.31
Infant Mortality Rate, 1998	47	66	57
Life Expectancy at Birth	62.5	59.9	60.6
Contraceptive Prevalence Rate 2002	60.1	51.7	53.4
Use of Nurse/Doctor as Birth Attendant, 2001, Per cent	43.3	14.9	22.2
Neo-natal Morality Rate, 2002	24	39	36
Post Neo-natal Mortality Rate, 2002	13	18	17
Maternal Mortality Rate, 2002	2.04	3.40	3.15
Pregnancy Related Deaths, 2002, per cent	2.30	3.07	2.96
Abortion Related Deaths, 2002, per cent	0.73	0.61	0.63
Per cent of Home Deliveries, 2001	74.7	93.6	87.4

Source : BBS Statistical Yearbook of Bangladesh, 2002, 23 ed.