



SOME DIFFERENTIALS OF REPRODUCTIVE HEALTH OF THE MARRIED WOMEN IN BANGLADESH

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Abstract: Gender inequality is rampant at every sphere of the society in Bangladesh. It influences the reproductive health of the married women in Bangladesh. The main focus of this article is to find out the differentials of the reproductive health in gender perspective of married women in Bangladesh. Data were collected from 100 urban and 100 rural women. Findings show that married women of Bangladesh are not aware of their own sexual and reproductive rights, and they have very limited control over their own bodies. Personal opinion of the women with regard to birth control and family planning seems irrelevant in decision-making where they play a passive role to fulfill their husbands' wishes. Only 8.5 percent of the women took part in decision regarding conception followed by 22.5 percent of the women used contraceptives by their own choices. The urban rural differentials of the reproductive health status of the women found remarkable. 78.5 percent of the women had to marry at the age of below 18 years and 79.5 percent of them were married by the decision of their parents. Although family members were involved in the decision to have a child, nobody found involved in providing pre-natal care to the expectant mother. Moreover, 76.5 percent of the women had to perform regular household activities during their pregnancy.

Keywords: Reproductive health, violence against women, gender consciousness, urban- rural difference, family planning

Introduction

Gender inequality in the form of discrimination against women has been identified as one of the prime reproductive health issues in Bangladesh. Gender-based violence including battering, sexual abuse of female children, dowry related violence, marital rape and so on that result in or is likely to result in physical, sexual or psychological harm or suffering to women in Bangladesh. In rural Bangladesh, a married woman's risk of experiencing domestic violence is associated with her individual autonomy, as well as the autonomy of women within her community (Koenig *et al.*, 2003). Based on World's Women Population Report (2000), UNFPA stated, 47 percent of the women in Bangladesh testify to having ever been physically assaulted by a male partner. This report and the fact that Bangladesh rank second in a list of 12 countries with a high rate of Violence Against Women (VAW) caused a great deal of media attention. A recent study revealed the rank ordering of different types of VAW, with verbal abuse being the most prevalent and alarming one; the second most widely occurring violence is battery, while dowry-related violence is third (Barkat and Ahmed, 2001). Inadequate reproductive health care for women results in high rates of unwanted pregnancy, unsafe abortion, and preventable death and injury as a result of

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pregnancy and childbirth. Progress in family planning has been impressive with contraceptive prevalence rate (CPR) among married women aged 10– 49 having risen from 7 percent in 1975 to 49 percent in 1997 (Mitra *et al.*, 1997). However, the maternal mortality rate still remains high at 380 maternal deaths per 100,000 live births, depending on the estimation technique used (UNDP, 2006).

In Bangladesh society, women are facing widespread discrimination in all spheres of their life. They have no controlling power over the social and economic world and due to the lack of control over decision-making process, they are forced to involve in child marriage, unwanted sexual relations, unwanted pregnancies and restricted access to family planning information and contraceptives. They also face unsafe abortion or injuries sustained during a legal abortion after an unwanted pregnancy. A study on safe motherhood programme in Bangladesh assessed that women’s low status in society, poor quality of maternity care services, lack of trained providers, low uptake of services by women, as well as infrastructure and administrative difficulties-all contribute to the high rate of maternal deaths (Haque *et al.*, 1997). Women are treated as unequal and they do not have access to proper human rights due to social stigma, cultural norms, and lack of social consciousness and by this social construction, they do not get proper nutrition in health sector, which basically hampers their reproductive health. In these circumstances, the main objective of the present study was to identify the effects of gender inequalities, including in social, economic, health and political spheres, on reproductive health.

Methods and Materials

The study was conducted with the survey research design. Data were collected from urban and rural areas of Khulna division of Bangladesh since November 2007 to February 2008. A sample of 200 married women aged 15-34 years was selected purposively. Among 200 women, 100 were from the urban area and the rest of 100 were from the rural area. Data were collected through personal interview based on a questionnaire that contained both open ended and close-ended items. Five trained interviewers collected the data from the field and finally the data were processed and analyzed according to the objective of the study.

Results

Age of the respondents: Age is an important factor of reproductive health of the women. Table 1 shows 13 percent urban and 16 percent rural women belonged to the age group of 15-19 years. 30 percent urban and 24 percent rural women respondents belonged to the age group of 20-24. Again 36 percent urban and 31 percent rural women respondents belonged to the age group of 25-29 followed by 21 percent urban and 29 percent rural women respondents belonged to the age group of 30-34.

Table 1. Age of the respondents

| Age (in Years) | | | |
|----------------|------------------|------------------|------------------|
| 15-19 | 13.0 | 16.0 | 14.5 |
| 20-24 | 30.0 | 24.0 | 27.0 |
| 25-29 | 36.0 | 31.0 | 33.5 |
| 30-34 | 21.0 | 29.0 | 25.0 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Education of the respondents: Education is very much influential social context of the reproductive health of the women. Table 2 shows that 27 percent of urban and 36 percent of rural women were illiterate followed by 26 percent of urban and 34 percent of rural women enrolled in

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primary education. Again, 38 percent urban and 30 percent rural women enrolled in secondary education. Only 9 percent of urban women acquired higher education.

Table 2. Level of education of the respondents

| Level of Education | Urban Women (%) | Rural Women (%) | Total (%) |
|--------------------|------------------|------------------|------------------|
| Illiterate | 27.0 | 36.0 | 31.5 |
| Primary (I-V) | 26.0 | 34.0 | 30.0 |
| Secondary (VI-XII) | 38.0 | 30.0 | 34.0 |
| Higher | 9.0 | 0.0 | 4.5 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Age at first marriage of the respondents: Marital age is a vital factor of reproductive health status of the women. Table 3 reveals that 69 percent of urban women and 88 percent of rural women got married at the age group of up to 18 years. In addition, 31 percent urban women and 12 percent of rural women got married at the age group of 18+ years. From the above discussion, it can be generalized that the rural women are married at a very young age, i.e. early marriage is more prevailing at rural area than urban area in Bangladesh.

Table 3. Marital age of the respondents

| Age (in Years) | Urban Women (%) | Rural Women (%) | Total (%) |
|----------------|------------------|------------------|------------------|
| Up to 18 | 69.0 | 88.0 | 78.5 |
| 18+ | 31.0 | 12.0 | 21.5 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Decision making regarding marriage: Participation of women in decision-making process denotes the empowerment of women. Table 4 presents that 62 percent of the marriage decisions were made by the parents in urban area compared to 97 percent in rural area. On the other hand, 20 percent of urban women themselves took decision of their marriage compared to 3 percent in rural women. This may be the reflection of the freedom of urban women.

Table 4. Decisions making regarding marriage of the respondents

| Decision Maker | Urban Women (%) | Rural Women (%) | Total (%) |
|----------------------|------------------|------------------|------------------|
| Parents | 62.0 | 97.0 | 79.5 |
| Self | 20.0 | 3.0 | 11.5 |
| Other Family Members | 18.0 | 0.0 | 9.0 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Sources of reproductive knowledge: Women should have the knowledge about their reproductive health to obtain sound reproductive health. But findings indicate that 64 percent had no source to know about the reproductive health. In addition, the respondents who had the reproductive

knowledge got it from the persons who had only basic ideas of this issue. Table 5 shows that in the urban area 21 percent of the women gained reproductive knowledge from mother, 4 percent from religious books, 10 percent from their neighbor and 29 percent had no knowledge about reproductive health at all. The remaining 8 percent were informed from clinic, 24 percent from health worker and only 4 percent from media. On the other hand, in rural area only 5 percent gained reproductive knowledge from mother, 6 percent from educational institution, 4 percent from neighbor, and 38 percent from health worker. Mainly the lack of education, lack of sufficient number of health workers, lack of consciousness and poverty of women are responsible for the little knowledge regarding reproductive health.

Table 5. Sources of reproductive knowledge of the women

| Sources of Reproductive Knowledge | Urban Women (%) | Rural Women (%) | Total (%) |
|-----------------------------------|------------------|------------------|------------------|
| Mother | 21.0 | 5.0 | 13.0 |
| Religious Books | 4.0 | 6.0 | 5.0 |
| Neighbor | 10.0 | 12.0 | 11.0 |
| Educational Institutions | 0.0 | 4.0 | 2.0 |
| Clinic | 8.0 | 0.0 | 4.0 |
| Health Worker | 24.0 | 38.0 | 31.0 |
| Media | 4.0 | 0.0 | 2.0 |
| No Knowledge | 29.0 | 35.0 | 32.0 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Living children: Table 6 shows that 7 percent in urban and 6 percent in rural women had no child. 43 percent in urban and 33 percent in rural women had one child whereas 34 percent in urban and 41 percent in rural women had two children. The mean of the children indicates that rural women possessed higher fertility rate (TFR) than urban women in Bangladesh.

Table 6. Living children of the respondents

| Number of Children | Urban Women (%) | Rural Women (%) | Total (%) |
|--------------------|------------------|------------------|------------------|
| 0 | 7.0 | 6.0 | 6.5 |
| 1 | 43.0 | 33.0 | 38.0 |
| 2 | 34.0 | 41.0 | 37.5 |
| 3 | 11.0 | 10.0 | 10.5 |
| 4 | 2.0 | 8.0 | 5.0 |
| 5 | 3.0 | 2.0 | 2.5 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |
| | Mean=1.67 | Mean=1.87 | Mean=1.77 |

Violence against women: Violence is a key component of affecting the reproductive health. The following Figure 1 shows that in the urban area 20 percent of the women were physically tortured compared to 12 percent in rural area. 28 percent in the urban area and 16 percent in the rural area of the women were mentally tortured.

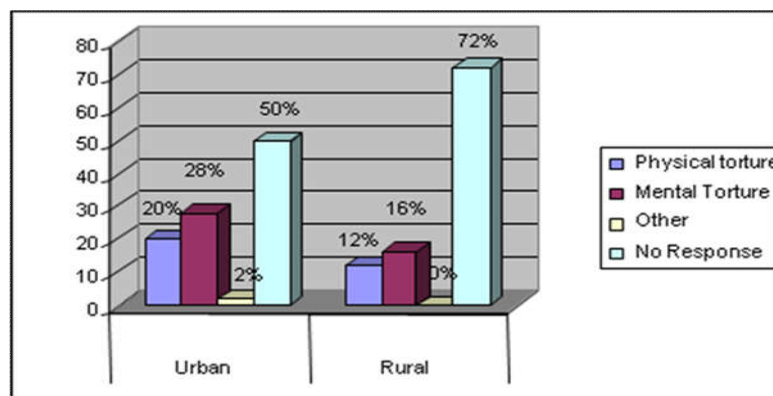


Fig. 1. Distribution of respondents by violence experienced

Participation in regular household activities during pregnancy: It was observed that in the urban area 60 percent respondents had to work during pregnancy compared to 93 percent in rural area. In the urban area 40 percent women did not engage in daily activities during pregnancy. On the other hand, only 7 percent in rural women were able to keep themselves free from household activities during pregnancy.

Table 7. Participation in regular household activities during pregnancy

| Participation | Urban Women (%) | Rural Women (%) | Total (%) |
|---------------|------------------|------------------|------------------|
| Yes | 60.0 | 93.0 | 76.5 |
| No | 40.0 | 7.0 | 23.5 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=200) |

Number of pregnancy and age at marriage: Table 8 shows the relation between age at marriage and number of pregnancy. Here the value of Chi-square indicates that there is a significant relationship between number of pregnancy and early age at marriage at .05 percent level of significance.

Table 8. Relationships between age at marriage and number of pregnancy

| Age at Marriage (Years) | | Number of Pregnancy after Marriage | | | | | | Total |
|---------------------------|-------|------------------------------------|-------|-------|-------|------|------|--------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| 10-17 | Count | 32 | 59 | 25 | 21 | 14 | 6 | 157 |
| | % | 20.4% | 37.6% | 15.9% | 13.4% | 8.9% | 3.8% | 100.0% |
| 18-25 | Count | 23 | 13 | 3 | 4 | 0 | 0 | 43 |
| | % | 53.5% | 30.2% | 7.0% | 9.3% | .0% | .0% | 100.0% |
| Total | Count | 55 | 72 | 28 | 25 | 14 | 6 | 200 |
| | % | 27.5% | 36.0% | 14.0% | 12.5% | 7.0% | 3.0% | 100.0% |
| Pearson Chi-Square=21.815 | | Level of significance .05 | | | | | | |

Decision regarding conception and place of delivery: Table 9 reveals that 20 percent decisions of conception were made by the husbands of the respondents. The women respondents themselves made only 8.5 percent decisions of conception. Both husband and wife took decisions in the case of 47 percent. Table 9 also reveals that 64 percent deliveries were performed at home and the rest 36 percent of the deliveries were performed in hospitals and clinics. The value of Chi-square indicates that there is a significant relationship between decision-making regarding conception and place of delivery at .05 percent level of significance.

Table 9. Conception decision makers and place of delivery

| Decision maker | | Place of delivery | | | Total |
|--------------------------|-------|---------------------------|----------|--------|--------|
| | | Home | Hospital | Clinic | |
| Husband | Count | 25 | 15 | 0 | 40 |
| | % | 62.5% | 37.5% | .0% | 100.0% |
| Own | Count | 11 | 6 | 0 | 17 |
| | % | 64.7% | 35.3% | .0% | 100.0% |
| Both | Count | 58 | 21 | 15 | 94 |
| | % | 61.7% | 22.3% | 16.0% | 100.0% |
| Mother in Law | Count | 19 | 3 | 2 | 24 |
| | % | 79.2% | 12.5% | 8.3% | 100.0% |
| Other Family Members | Count | 2 | 4 | 3 | 9 |
| | % | 22.2% | 44.4% | 33.3% | 100.0% |
| Unwanted Pregnancy | Count | 13 | 3 | 0 | 16 |
| | % | 81.3% | 18.8% | .0% | 100.0% |
| Total | Count | 128 | 52 | 20 | 200 |
| | % | 64.0% | 26.0% | 10.0% | 100.0% |
| Pearson Chi-Square=26.02 | | Level of significance .05 | | | |

Birth attendants: Fig. 2 indicates that in the urban area 49 percent delivery was performed by *dhai* (untrained traditional birth attendants) compared to 80 percent in the rural area. Another set of data shows that 34 percent delivery was performed by Doctor in the urban areas whereas only 9 percent by Doctor in the rural area. In Addition the nurse conducted only 12 percent of the deliveries in the urban area compared to 5 percent in the rural area. However, it may be said that most of the deliveries in the rural area are performed by *dhai* that creates more postpartum complications of the women in Bangladesh.

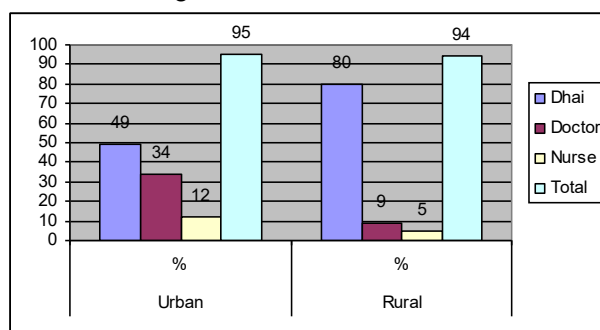


Fig. 2. Birth attendants of the respondents

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Contraception decision maker and problems faced by the women: Table 10 shows that 38 women faced problem when they used birth control methods prescribed by their husbands. And 25 women faced problems when they took the decision by own. The value of Chi-square indicates that there is a significant relationship between the contraception decision maker and problems faced by the women.

Table 10. Decision makers of contraception and problems faced by the women

| Decision maker | | Whether faced problem | | |
|---------------------------|-------|---------------------------|-------|--------|
| | | Yes | No | Total |
| Husband | Count | 38 | 47 | 85 |
| | % | 44.7% | 55.3% | 100.0% |
| Own | Count | 25 | 20 | 45 |
| | % | 55.6% | 44.4% | 100.0% |
| Family planner | Count | 25 | 5 | 30 |
| | % | 83.3% | 16.7% | 100.0% |
| Mother in Law | Count | 6 | 9 | 15 |
| | % | 40.0% | 60.0% | 100.0% |
| Other (Dispensary) | Count | 5 | 16 | 21 |
| | % | 23.8% | 76.2% | 100.0% |
| Both | Count | 1 | 3 | 4 |
| | % | 25.0% | 75.0% | 100.0% |
| Total | Count | 100 | 100 | 200 |
| | % | 50.0% | 50.0% | 100.0% |
| Pearson Chi-Square=22.204 | | Level of significance .05 | | |

Menstruation Management: Table 11 presents that 43 percent women used sanitary napkin in the urban area whereas only 26 percent in the rural area. In addition, 71 percent women did not use sanitary napkin in the rural area whereas 55 percent in the urban area. As a result, some diseases related to reproductive health might be seen among the women.

Table 11. Use of sanitary napkin by the women

| Response categories | Urban women (%) | Rural women (%) | Total (%) |
|---------------------|------------------|------------------|------------------|
| Yes | 43.0 | 26.0 | 34.5 |
| No | 55.0 | 71.0 | 63.0 |
| No Response | 2.0 | 3.0 | 2.5 |
| Total | 100.0 (N=100) | 100.0 (N=100) | 100.0 (N=100) |

Discussion

Gender inequality is tremendously affecting the reproductive health conditions of the women and thus every sphere of the reproductive life of women is being hazardous. The adolescent stage of women is considered the development stage of women body as at this stage the biological organs of human body grow to keep the body fit. So, if anybody is married at early age, the development

process of biological organs will be hampered. The government of Bangladesh, taking the situation of adolescent stage under considering, has prohibited marriage of female prior to 18 years. This age is legalized in favor of government to minimize the maternal mortality, physically challenged and mentally retarded childbirth, malnutrition, genital mutation and so on. But the early marriage is mostly (78.5 percent) celebrated in Bangladesh. It is worthwhile to note that these teen-age mothers are mostly illiterate and physically unfit to bear a child. They are the victims of pregnancy related complexities, who even embrace fateful death following an early childbirth. Obviously, they are more vulnerable to various diseases than their male counterparts (BIDS, 1997).

Another important issue of gender inequality is related with the decision making of female marriage. In our country it is observed that majority of the marriages are arranged by family where parents or elder brothers take decision about the marriage and choose bridegroom. For this reason, spousal violence and other chaos are rampant among them that might take immediate death toll on women causing suicide.

Education is called the prime mover of civilization and human development. But low educational rate of women hampers this development by increasing the number of children. The study shows the illiterate and primary level completed women had more children than literate women. Although equal opportunity of education of men and women is delineated as a fundamental state policy of Bangladesh, the educational status for women is truncated, particularly for girls. The gender gap in enrollment in primary as well as secondary levels of education has, however, been dropping fast due to the concerted efforts of the government of Bangladesh; it is implementing stipend program for girls at secondary level of education.

Rural women could not disengage her from the daily activities in spite of having more joint family in that area. She was induced to perform the daily activities. Even in many respects, more or less it was observed in both educated and non-educated family, if women failed to perform her job due to illness or other causes, she was beaten and kept under psychological pressure. In the urban area, 40 percent women, did not engage themselves with any work compared to 7 percent in rural area during pregnancy. Women suffer from various diseases that had great impact on the reproductive health of women due to the involvement of daily household activities.

Decision regarding conception and place of delivery are very vital issues for reproductive health. Wife hardly takes the decision regarding conception and place of delivery. Most of the decision regarding conception comes from the husband or husband's mother. They also decide where the child will be delivered, regardless the expected mother's conditions. The study showed maximum delivery (64%) had been done at home with high risks. In maximum cases, in rural area, decision makers with their conventional thinking did not send the expected mother to the hospital or clinic to be delivered. As a result, maternal mortality rate, and genital mutilations and so on are still remaining high that always call on reproductive health risks.

Usually at the time of delivery the untrained traditional birth attendant (*dhai*) apply force to bring out the baby leading to the death of the child and the mother. In quantitative terms three-fourth of all births in Bangladesh are carried out by the *dhai*, the untrained traditional birth attendant. The extensive use of the *dhai* in the home delivery in rural Bangladesh has significantly increased the vulnerability of the life of the pregnant women. The major drawback of a *dhai* is her low educational background, lack of medical knowledge and skill and the dependence on unsafe traditional instrument, which put the life of the pregnant women at serious risk. The nature of the complication as mentioned below further shows that it is hardly possible to handle the problems at the home level or by untrained person. For example, the complication like blurry vision, high blood pressure, prolonged labor, obstructed labor, eclampsia, retained placenta, mal-presentation cannot be dealt with by an untrained person (NIPORT, 2003).

The victim of the home delivery in terms of different physical injuries is the pregnant woman. If the injury is called a piece of violence one may ask who the perpetrator is. That there is no perpetrator in the visible sense does not weaken the claim of violence voiced in this paper. It is a 'passive' violence because of the rather apparent absence of a perpetrator. One may also call it self-inflicted violence if the emphasis is on the refusal of the pregnant women to visit a qualified doctor. However, the indifference of the pregnant women to visit a qualified doctor and instead depending on the folk attendants is an outcome of the social indifference that began during the childhood of a girl. Discrimination is the basis of indifference to women in our society that affect their reproductive health.

It is common that with the consent of husband, women mostly adopt family planning devices. Most of the respondents take oral pill according to their husband's decision. During field investigation, women reported that contraceptive pill did not suit their body. Some women suffered from nausea and some women became horribly obese. Moreover, the technical possibility of choosing an oral contraceptive or in vitro fertilization is only a small aspect of reproductive freedom. For some women, motherhood remains their only chance of creativity, while economic and social circumstances compel others to relinquish motherhood altogether (Stanworth, 1994).

Menstruation management is an important issue for women's reproductive health. But findings indicate that a significant portion of the women used rags instead of sanitary napkins during menstruation. They also did not dry these rags in an open air or sunlight due to the negative values imposed on it. As a result, germs or bacteria could grow out of these damp rags. In many cases respondents never used or seen a sanitary napkin. Bangladesh Rural Advancement Committee (BRAC) showed that 80 percent girls used pieces of old rags as pads during menstruation, while others did not use anything. Sixty percent used rags that were wet or had not been dried in a hygienic fashion (Ali *et al.*, 1997). Ninety-nine percent of the girls in the urban slum study associated menstruation with being unclean or impure (Ahmed, 1991). The consequences of not maintaining hygiene during menstruation resulted hazards on reproductive health such as becoming sick, itching, or ulceration of genitals.

Conclusion

Reproductive health of the women is affected by gender-based inequality. At every sphere in the patriarchal society of Bangladesh women are being affected in such a way that hampers their reproductive health. They get married at a very young age and are forced to conceive with their unprepared body. They have no right to take the decision of marriage, bearing child, place of delivery, and have no control over their body. Women rarely took decision regarding these issues. Early marriage and child bearing are associated with education. The low level of education of young women results in a lower use of reproductive health services. Physical and sexual violence are predominant among the women in Bangladesh. Sexual abuse, especially forced sex, can cause physical and mental trauma. Participation in the daily activities during pregnancy and lack of gender consciousness create immediate and long-term impact on their reproductive health. It is notable that three-fourth of all births are being carried out by the untrained traditional birth attendants that create the vulnerability of the life of the pregnant women in Bangladesh. The impact of gender inequality on the reproductive health is found more in the rural area compared to urban area. The male domination is pervasive in the rural Bangladesh due to low education, lack of consciousness, and the involvement of women in unpaid household activities.

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