



**RURAL-URBAN DIFFERENTIALS OF GENDER INEQUALITY AND
REPRODUCTIVE HEALTH AMONG MARRIED WOMEN IN
SOUTHWESTERN BANGLADESH**

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Abstract: The present study aims at determining the effect of gender inequality on the reproductive health of married women in two villages within the district of Satkhira and two municipal wards of Khulna City Corporation in Bangladesh. The study was conducted on married women by using questionnaire technique, case study and observation methods. Data were collected by the interviewers from October 2007 to January 2008. The relationships between gender inequalities and reproductive health were analyzed, focusing on some specific factors that affect the extent of reproductive health problems among the married women in both urban and rural areas. The findings of this study suggest the fact that the majority of the women in study area are not only aware about the concept of gender inequality but also their ignorant about their own sexual and reproductive rights, and as such they have very limited control over their own physical bodies. Because traditional beliefs have kept them under the shadow of their fathers and husbands and due to the effect of gender inequality they are deprived of getting basic reproductive health rights. The overall objective of this study was to identify the relationship between gender inequalities and reproductive health and to seek a modest attempt to find out the factors that affect the state of reproductive health of married women in both urban and rural areas of Bangladesh.

Keywords: Gender inequality, reproductive health, violence against women, early marriage

Introduction

The afflicted world in which we live is characterized by deeply unequal sharing of the burden of adversities between women and men. Gender inequality exists in most parts of the world, from Japan to Morocco, from Uzbekistan to the United States of America. However, inequality between women and men can take very many different forms. Indeed, gender inequality is not one homogeneous phenomenon, but a collection of disparate and interlinked problems (Sen, 2001).

International instruments and national documents now recognize reproductive rights and nations are committed to ensure and promote reproductive health and rights of every individual of their people. The International Conference on Population and Development (ICPD), held in Cairo in 1994, called upon all nations to take measures to ensure reproductive health and rights and empower women to realize their rights (United Nations, 1995). Reproductive health and rights “refer to the right of the couples and individuals to decide freely and responsibly the number,

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spacing and timing of their children, and have the information, education and the means to do so, and the right 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 (United Nations, 1995).

There is dearth of researches directly related to the issue of reproductive health and rights in Bangladesh; perhaps, because of the sensitivity of the problems. Though access to and use of effective, user-friendly methods to regulate fertility is an important aspect of reproductive health rights, Akhter (1996) was critical of what she calls ‘reproductive technologies’ i.e., contraceptive devices, because of their ‘sexist, eugenic, racist nature’. She was also concerned with the adverse effects of contraceptive methods on women’s reproductive health. However, no adequate empirical evidence was given; neither did the author suggest any alternative to the problems of population and contraceptive methods as well. Akhter (1995) identified critical facts about Norplant, a contraceptive device, introduced in Bangladesh in the 1980s. The author found that it had many side-effects (e.g., bleeding) and a provider-controlled method. Akhter (1995) notes that though Norplant was publicized in mass media as ‘wonderful invention of modern Science’, and it did not have any side-effects, but, in fact, such propaganda was found to be false, misleading and baseless. Begum (1999) argued that population control policy in Bangladesh adversely affect women’s health as a result of the use of banned/harmful contraceptives imported from developed countries. Begum (1991) found that illegally induced abortion is related to maternal mortality and morbidity, and husbands tend to force women to undergo abortions.

In order to realize their reproductive rights, individuals and couples should have access to affordable, effective, easy-to-use methods of contraceptive methods and the required information to make choices about their reproductive lives.

Women in Bangladesh enjoy a low status in society and hardly work outside their home. They do not have the freedom to decide how many children they want, when to have them, whether they can use contraception or terminate a pregnancy, etc. The ideology of motherhood is quite often a central matter in the patriarchal structure of society. Motherhood is sometimes forced by depriving young women of adequate contraceptive information. Due to traditional customs and norms, an adolescent girl in Bangladesh is forced into getting early marriage. Early sexual experience, combined with a lack of information and services, increase the risks of unwanted and premature pregnancy. Gender discrimination in patriarchal structure is deeply rooted in Bangladesh society and culture. Although religion is a very powerful institution in controlling the community, it has influenced women's lives negatively. Family is such an important institution where gender roles are most specified and ingrained. The man is considered the head of the household. The son preference which is prevalent in Bangladesh leads to discrimination of girls in health, nutrition, education and other opportunities. According to the social custom of Bangladesh, the son controls most property and other productive resources, which are inherited usually from fathers by sons. While the girl child is considered a liability, the son is expected to maintain the generation of the family and provide an old age security for his parents. Lack of economic independence lessens women’s control over productive and reproductive lives. Cultural and religious considerations are stronger and systematic barriers in attaining reproductive health and rights (Islam, 2001).

Gender inequality in the form of discrimination against women may be considered as one of the pressing factor in reproductive health issues in Bangladesh. Gender-based violence including battering, sexual abuse of female children, dowry related violence, marital rape and so on 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).

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Moreover, women's greater vulnerability and poverty could have horrible affect on reproductive health for not meeting their health need. In most cases, the rural women work as farm hands and mostly they are under-paid in terms of longer working hours than their male counterparts. Thus, the rural women remain in a whirlpool of hunger, exploitation and ultimate health hazards (Siddiquee, 1997).

On the basis of the above background, this study has tried to explore how married women experience their reproductive health and exercise reproductive rights. It has also looked at how gender inequalities at the household, family and community levels affect women's reproductive health.

Methods and Materials

The study was conducted by using an appropriate survey research design. Data were collected through structured interview technique by means of a well-formulated questionnaire from Ward no 24 and 25 of Khulna City and two villages of Tala thana under Satkhira district named Sujansaha and Ghona. A sample of 200 women (one hundred from rural and one hundred from urban area) was selected following a purposive sampling procedure. The data were also gathered from both primary and secondary sources to improve the rationality of the study and to test the hypothesis. The purpose of the study was fully explained to the respondents. The questionnaire was administered to them after their well informed consent. After collection, data were put into computer data analysis software called Statistical Package for Social Sciences (SPSS). Data were post-coded and processed by using the software. Data were also checked for accuracy and consistency. Data analysis was done by means of percentages and Chi-square and these were compared in order to find out the differences across a host of variables such as, local (rural – urban), age, and so on. Proportional percentage and Chi-Square test was primarily followed in order to make the study an appropriate and logical one in quantitative form.

Results

Reproductive Health: Household Dimensions and Gender: The gender inequality tends to begin at the family. Family is considered the primary organ of socialisation and after the birth of a baby family members usually show the way how a new- born baby will lead his/ her life.

Age at First Marriage of the Respondents: The study reveals that 63 percent of the respondents of the said urban area and 75 percent respondents of the above mentioned rural area got married within the age limit of 10-17 years; while 34 percent respondents of urban area and 25 percent respondents of rural area got married within the age limit of 18-25 years (Table 1). The study reveals that the incident of early marriage happened more frequently in the rural area than the urban area. The data presented in Table 1 also shows that women were married off below the legal age of 18 years for women in Bangladesh. Interestingly enough the marriage age increases as the percentages of women in each age range decrease and vice versa.

Table 1. Distribution of the respondents by age at marriage (Field survey, 2007-08)

Age in Years	Urban		Rural		Total	
	No	%	No	%	No	%
10-17	63	63.0	75	75.0	138	69.0
18-25	34	34.0	25	25.0	59	29.5
26-33	2	2.0	0	0.0	2	1.0
34-41	1	1.0	0	0.0	1	0.5
Total	100	100.0	100	100.0	200	100.0

Decision-Making Regarding Marriage: The study found that parents played a dominant role in the case of taking decisions regarding marriage. Almost 76 percent decisions of marriage were made by the parents while only 11.5 percent respondents were able to take their own decision. In urban-rural context, it was evident that the influence of parents for marriage was more prevalent in rural area (90 percent) than in the urban area (62 percent). This study also shows that urban respondents (20 percent) were more privileged than the rural respondents (3 percent) in terms of taking decision of their marriage.

Age at Marriage and Number of Pregnancy: There exists a close relationship between total number of pregnancy and overall reproductive health of women. Table 2 shows that 42 percent women belonging to the age group 10-17 had two pregnancies and the highest 69.5 percent women in the age group 18-25 had on one pregnancy. Interestingly, around 13 to 14 percent women in the age group 10-17 years had three to four pregnancies. This data suggests women's lack of access to contraceptives and information about them and also they have poor reproductive health caused by multiple pregnancies at younger ages (below 18 years) which are very risky and often may lead to maternal mortality and infant or child mortality as well. It is also noticeable that the calculated value of Chi-Square is 54.391, at 15 degree of freedom, which is greater than the table value (24.996) at .05 level of significance. Thus the result of Chi-Square indicates that early marriage leads to the higher number of pregnancy after marriage.

Table 2. Distribution of the respondent's age at marriage by number of pregnancy after marriage (Field survey, 2007-08)

Age at marriage	Number of Pregnancy after Marriage						Total
	0	1	2	3	4	5 or more	
10-17	5 3.6%	26 18.8%	58 42.0%	19 13.8%	18 13.0%	12 8.7%	138 100.0%
18-25	1 1.7%	41 69.5%	11 18.6%	3 5.1%	3 5.1%	0 .0%	59 100.0%
26-33	0 0%	0 0%	2 100.0%	0 .0%	0 .0%	0 .0%	2 100.0%
34-41	0 0%	0 0%	1 100.0%	0 .0%	0 .0%	0 .0%	1 100.0%
Total	6 3.0%	67 33.5%	72 36.0%	22 11.0%	21 10.5%	12 6.0%	200 100.0%
Chi-Square=54.391 D.F=15		Level of significance 5		Tabulated value=24.996		Asymp. Sig=.000	

Decision-Making Regarding Pregnancy and Childbirth: The study reveals that the decision of husbands (40.7 percent) was predominant than the respondent's own decision (6.9 percent) in terms of conceiving children. However, as the table 3 shows, in 39.7 percent of cases, decisions with regard to conceiving child was taken by both husband and wife and unwanted pregnancy happened in case of almost 10 percent of the respondents, which is higher among rural women (19 percent) than among urban women (11.7 percent). It is evident that husbands played a dominant role regarding conception of child in both urban (36.8 percent) and rural area (44.6 percent).

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Table 3. Distribution of the respondents regarding decision for conceiving child (Field survey, 2007-08)

Decision Maker	Urban		Rural		Total	
	No	%	No	%	No	Total %
Husband	35	36.8	42	44.6	77	40.7
Own	8	8.4	5	5.3	13	6.9
Both Husband and Wife	39	41.0	36	38.4	75	39.7
Mother in law	2	2.1	3	3.2	5	2.6
Unwanted Pregnancy	11	11.7	8	8.5	19	10.1
Total	95	100.0	94	100.0	189	100.0

Birth Attendants: It was evident that 68.35 percent of the births were handled by the traditional birth attendants (locally called Dais); followed by 22.7 percent by doctors and 8.95 percent births were dealt with by nurses. In rural areas, most of the births (85.1 percent) were handled by the traditional birth attendants than in the urban area (51.6 percent). Poverty and lack of medical facilities were the main reasons for taking delivery care from midwife (Dai) or from quacks.

Use of Birth Control Methods: This study found that 62.5 percent of the respondents used birth control method while 37.5 percent of the respondents did not use any birth control methods. The study revealed that the use of birth control methods was more frequent in urban area (65 percent) than in the rural area.

Decision for Using Birth Control Method: Table 4 shows that husbands (26.0 percent) played a dominant role in taking decision for using birth control methods. Besides this, both husbands and wives took decision in 24.5 percent of the cases while 37.5 respondents reported that they didn't use any birth control methods. It is also evident that the use of birth control method was higher in urban area than in the rural area.

Table 4. Distribution of the respondents regarding decision for using birth control methods

Decision Makers	Urban		Rural		Total	
	No	%	No	%	No	%
Husband	27	27.0	25	25.0	52	26.0
Own	5	5.0	3	3.0	8	4.0
Family Planner	6	6.0	6	6.0	12	6.0
Other	4	4.0	0	0.0	4	2.0
Both husband and wife	23	23.0	26	26.0	49	24.5
No Use	35	35.0	40	40.0	75	37.5
Total	100	100.0	100	100.0	200	100.0

Problems Due to the Use of Birth Control Methods: Women faced several problems due to use of birth control methods. About 33.5 percent of the respondents viewed that the use of birth control methods created health problems for them while 29.5 percent of the respondents reported that they did not face any problems due to the use of birth control methods and the question was

not applicable to 37 percent of the respondents because they did not use any birth control methods at all. The commonly faced problems by the respondents for using birth control were vomiting, mal-fitness, high temperature in body, fever, headache etc.

Problems Due to Giving First Birth of a Female Child: This study found that 29 percent of the respondents faced problems due to giving first birth of a female child by their husbands and other members of the family while 34 percent of the respondents did not face any problems and the question was not applicable to 37 percent of the respondents because their first child was a boy. In terms of rural and urban differences the study reveals that urban respondents (33 percent) had to face more problems than the rural area (25 percent). It is a general conception that urban people are more conscious than the rural people but in the case of the birth of female child, urban women faced greater problems than the rural counterparts.

Types of Problems Faced by the Respondents: The study reveals that 29 percent of the respondents had to face problem due to giving birth of a female child, among them 79.2 percent of the respondents were mentally harassed, followed by physical torture (18.1 percent) and other 2.7 percent. Comparing the data by rural-urban differences, it becomes evident that incidence of physical torture was higher in urban area (20.0 percent) than in the rural area (15.6 percent).

Immunization at Pregnancy: Immunization is an important aspect of physical wellbeing of a pregnant woman because it helps to protect her from some diseases and an immunized mother has always a better chance of giving birth of a healthy baby. Most of the respondents (96.5 percent) viewed that they were immunized during their pregnancy and only 3.5 percent of respondents were not immunized.

Taking of Extra Food during Pregnancy: If the pregnant women do not get the opportunity to take extra food during pregnancy then it creates health problems for them. More than half of the total respondents (51 percent) viewed that they did not have the capacity to take extra food during pregnancy while 49 percent respondents were able to take extra food during pregnancy.

Regular Household Activities during Pregnancy: Most of the respondents (76.5 percent) reported that they had to perform regular household activities during pregnancy. In the rural area, it was found that most of them (93 percent) had to engage in regular household activities while only 7 percent respondents of the rural area were able to keep themselves free from household work during pregnancy. However, 40 percent of urban women reported that they were able to keep themselves free from household activities during pregnancies.

Decision-Making Power of the Respondents and Household Dynamics: The respondents of study area had a low level of decision making power at the household levels. Only 41.5 percent of the respondents said that they exercised the decision making power in their family affairs and almost 50.5 of the respondents did not have decision-making power over the household dynamics. In case of rural areas, only 32 percent of the respondents exercised decision making power while in urban area the figure was 51.0 percent. This indicates that urban women are better off than their rural counterparts in terms of exercising decision-making power in the household affairs.

Health Facilities during Illness: During illness most of the respondents did not get the proper health facility in time. The study shows that only 42 percent of the respondents got medical facilities during their illness and 58 percent of the respondents did not have that opportunity. It is evident that urban women (65.0 percent) got greater health facilities than the rural women (52.0 percent) during their illness.

Health Problems for More Children or Short Birth-Spacing: About 22.5 percent of the respondents had faced physical problems for conceiving more children or having short space between two or more births. Almost 47 percent of the respondents did not face this type of problem and the question was not applicable to 30.5 percent of the respondents. In rural area, 27 percent of the respondents had faced this problem and in urban area the figure was only 18

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percent. This indicates that rural women tend to have less space between two or more births than their urban counterparts.

Causes of Abortion: Table 5 presented below shows that about 22 percent of the respondents viewed that they had to recourse to abortion after pregnancy. The said table reveals that 43.2 percent of total pregnancies were destroyed due to physical problems. About 34 percent of respondents thought that they had to recourse to abortion due to conception of a female child and 22.7 percent of the respondents viewed that their husband forced them to undergo abortion. The study reveals that in rural area physical problem (73.7 percent) was the predominant factor for abortion while conception of a female child (52.0 percent) was the main cause of abortion in urban area.

Table 5. Distribution of the respondents in terms of abortion (Field survey, 2007-08)

Causes of Abortion	Urban		Rural		Total	
	No.	%	No.	%	No.	%
Physical Problem	5	20.0	14	73.7	19	43.2
Conceiving of Female Child	13	52.0	2	10.5	15	34.1
Forced by Husband	7	28.0	3	15.8	10	22.7
Total	25	100.0	19	100.0	44	100.0

Discussion

The findings of this study suggests the fact that the majority of the women of study area, based on sample investigation, are not aware of the concept of gender inequality and reproductive rights and health, because traditional patriarchal norms, customs and beliefs kept them under the profound influence of their fathers and husbands. Most of the respondents were married off before the age of 18 and only a small percentage were married in matured age. In case of decisions regarding marriage, most of the respondents had no choice since in the decision of marriage parents played a dominant role. In case of decisions regarding having children, respondents had a limited role. In most cases respondent's husbands took the decisions and even unwanted pregnancies occurred in some cases. Normal deliveries happened in most cases than the caesarian deliveries. Data also reveal that percentage of caesarian deliveries were higher in urban area than in the rural area. The birth of a baby is an important phase of the reproductive cycle of the pregnant women. Data also reveal that that almost 72 percent births occurred at home and majority of the births were handled by the traditional birth attendants (locally called Dais).

Birth control methods seem to have an adverse effect on the reproductive health of women. More than half of the total respondents used birth control methods and most of the technique were applied to the women, which created health hazard for them. Women had little choice over the use of birth control methods. In some cases, they were both mentally and physically tortured by their husbands as well as other members of the family due to giving birth of a female child.

Most of the women did not use sanitation pad. In rural area the women had little knowledge about sanitation pad. Pregnancy period is a critical phase of the life of married women and in this period if they do not get proper facility, then it creates health hazards for them. Most of the respondents confirmed that they were immunized in their pregnancy and this is a positive aspect of reproductive health but almost half of the total respondents reported that they did not take extra food during their pregnancy period. Majority of the respondents had to perform their regular household activities during their pregnancy period. In this case, rural women suffered more than the urban women and due to gender inequality the affected women were forced to do regular

household work. Required health services from health personnel during pregnancy are an important factor of reproductive health and in the study area; about half of the respondents did not get required health services during their pregnancy period.

The study reveals that the respondents had faced physical problems for conception of more children or getting limited time space between births. Safe abortion is an important aspect of reproductive health and in the study areas a good number of respondents had to resort to abortion after pregnancies and in most cases, they were forced by their husband and conceiving female child was one of the main reasons for abortion. As the women had no control over decision-making process at household levels, they were forced to comply with the insistence of their husbands.

The level of knowledge about gender inequality is still lower among the women of study area and the discriminatory attitude against women is rooted in the family structure. The facts of gender inequality—the restrictions placed on women's choices, opportunities and participation—have direct and often serious consequences for women's health and education, and also for their social and economic participation. Almost half of the total respondents had no decision-making power over household affairs. This indicates the ultimate nature and extent of gender inequality. During their illness they did not get the proper health facility in time. In the study areas, most of the respondents did not get the medical facilities during their illness. The above-mentioned circumstances indicate the manifest effect of gender inequality on the reproductive health of married women.

Conclusion

The facts of gender inequality—the restrictions placed on women's choices, opportunities and participation—have direct and often serious consequences for women's reproductive health. The findings of this study suggest the fact that the majority of the women of study area, based on sample investigation, are not aware of the concept of gender inequality because of traditional beliefs that kept them in the shadow of their fathers and husbands. From the analysis of data it is evident that the gender inequality has a direct effect on the reproductive health of the women of study area. They have no control over the household affairs as well as their own body. Women usually do not have the decision-making power in regard to their marriage, conception, childbirth, the use of contraceptive methods and so on. Both urban and rural women, though in disproportions, are married before they become mature enough and reach the legal marital age of 18 years. As a result, they become pregnant at an early age and this creates health hazards for them. Birth control techniques are generally used to limit fertility often without the consent of women. Even a good proportion of women had faced physical and mental torture due to giving birth of a first female child. In their pregnancy periods, most of the women did not get adequate rest and extra food as a result of which they had to confront chronic health hazards. A larger portion of respondents do not get medical facilities during illnesses. It is astounding fact that due to conception of a girl child quite a good number of respondents were forced by their husbands to do abortion. In order to improve this pitiable state of affairs, some realistic steps are required to be initiated not only by the major agencies, such as GO and NGOs but also by the women themselves. Efforts, therefore, need to be made to address the women reproductive health concerns and create awareness about gender inequalities, with particular reference to household affairs and wider society.

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