Reproductive Health Rights of Women in the Rural Areas of Meherpur District in Bangladesh

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Abstract

Background: This study evaluated the reproductive health rights, women empowerment and gender equity in a rural area of Bangladesh.

Methods: Three hundred married women of reproductive age (15-49 years) in Meherpur District, Bangladesh were interviewed using a structured questionnaire and purposing sampling techniques. The logistic regression analysis was used to determine the dominating factors affecting reproductive health rights. To fulfill the objectives of the study the two main factors, age at marriage and family planning acceptance of the respondents, were regarded as the determinants.

Results: The study results revealed that almost all the respondents were housewives (82.3%), one-third (31.0%) did not avail any modern facility, and their yearly income was very low. Moreover, about half of the women (52.7%) were very young (≤ 30 years), most of them (79.0%) had married early (<18 years) and about half of them (53.3%) had taken contraceptives based on their husbands' choice. Finally, multivariate analysis identified the relationship between the profession of the respondents, yearly income, number of family members, and the availability of modern facilities with age at marriage (Model 1). The study also identified the relationship between the age of respondents, education, occupation, yearly income, and the total number of family members with family planning acceptance (Model 2).

Conclusion: Regarding the results of this study, women's reproductive health rights, marriage after the age of 18 and family planning acceptance among couples needs to be enhanced in Mehrpur District in Bangladesh.

Keywords: Empowerment, Gender, Reproductive rights, Women.
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Background

With a population of over 160 million in only 55,100 square miles of land, Bangladesh is one of the poorest countries in the world. Nearly half of the rural households are landless and only a third of all adult population are literate. Poverty situation has remained nearly unchanged in the last two decades in rural Bangladesh. Governmental organizations (GOs) and non-government organizations (NGOs) in Bangladesh, therefore, initiated to provide economic support to the poor through micro-credit programs. The micro-credits are generally given to poor women to invest in such sectors as poultry and livestock raising, fisheries, sericulture, social forestry, etc.

In addition to the collateral-free credit for poor women, GOs and NGOs also provide a package of support services such as skill training, non-formal primary education, legal support and essential health care. These development inputs raise the poor women's social consciousness, literacy level and economic well-being. The most remarkable and visible change of this kind has been the process of integrating poor women into a financial network of savings and credit schemes. Along with credit support, group formation among poor women reduces social isolation at home, creates

scope for wider exposures and provides opportunity to financially contribute to the family (1).

Women in Bangladesh are not generally allowed to join credit programs without any resistance by their spouses in most cases. The husbands encourage their spouses to join credit groups if they have access to that money. Sharing the control of credit and income from that investment with husbands is a part of women's strategy to make their new roles acceptable to their spouses at the beginning (2). Women's bargaining power with husband gradually increases as a result of their contribution to the economic survival of the household.

The concept of reproductive health rights is rooted in the modern human rights system developed under the auspices of the United Nations. Reproductive health and rights are fundamental for sound economic development and poverty alleviation. Women around the world are divided on the question of reproductive rights and on population control. The demands for reproductive rights, the population control programs in the LACAAP (Latin American, Caribbean, African, Asian, and Pacific) countries and the development of new reproductive technologies are intertwined (3). In recent decades, most nations have come to recognize and accept the right of their citizens to reproductive health. Accordingly, they have signed treaties and accords, and endorsed the programs of conferences on population and development. Naturally Bangladesh has not remained isolated from development in these issues. Within the framework of the World Health Organization (WHO)'s definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (4). Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, and spacing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health and to make decisions concerning reproduction, free of dis-

crimination, coercion and violence (5).

Many countries have become increasingly involved in monitoring reproductive rights and use the reporting procedures for international human rights instruments that their governments have ratified. In Bangladesh, the barriers towards establishment of women's sexual and reproductive health rights are in everlasting difficulty due to malnutrition, illiteracy, and higher gender inequality. The women who are living in rural areas, especially the poor, are victims of ill-health and malnutrition, as well as ignored reproductive health rights. Women, particularly girls, are severely abused which may leave girls with long-lasting psychological problems and predispose them to risky sexual behavior later in life. After marriage, females' low status continues to limit their ability to control their own lives, including their fertility and their access to health care, and they rarely become the decision maker in the family.

Study on reproductive health rights reveals a wide range of socio-economic and demographic factors which affect women's empowerment, education and reproductive health rights. The socio-economic and demographic characteristics of people in a particular society are likely to be different from each other. These may also vary from one geographical setting to another. The reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents (6). They also include rights to help women make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.

In Bangladesh, knowledge of family planning is widespread, but its practice is limited and most of the women do not get the fulfillments of their basic reproductive rights or equal power (7). At the individual level, it particularly helps in building a base for social change.

In Bangladesh, women constitute about half of the total population of which 80% live in rural areas (8). But their status has been ranked the lowest in the world on the basis of twenty indicators related to health, marriage, children, education, employment and social equality (9). It is a well-established fact that in a patriarchal society like Bangladesh, women are ascribed a

lower status as men who have the sovereign power to control households and society as a whole, while women are often secluded in their homes (10). The World Bank (WB) study in Bangladesh highlights that women have limited role in household decision-making, limited access and control over household resources (physical and financial assets), low level of individual assets, heavy domestic workloads, restricted mobility and inadequate knowledge and skills that lead to women's greater vulnerability (11). Taking these gloomy pictures of women's situation into account, this study was undertaken.

In this study, the respondents' age below 18 years at the time of marriage has been considered violation of their reproductive health rights and it has been reserved when the respondents get free access to family planning methods and options. Therefore, the study has a greater significance and importance in policy making, which could play a key role in a country's development, especially in rural areas since women from these areas belong to the most deprived sections of society facing adverse conditions in terms of social and economic inequality, a visual majority of them being extremely poor. Considering the scenario, the main objective of this study was to investigate the status of women's reproductive health rights in rural areas through age at marriage and family planning acceptance. Hopefully, the findings of this empirical study would be very helpful to the policy makers of GOs and NGOs, as well as researchers.

Methods

The methodology of this study is an integration of qualitative and quantitative methods based on the data collected from Gangni Thana of Meherpur District, Bangladesh using a purposive sampling technique that employs focus group discussion (FGD) methods through a structured questionnaire. The data have been collected from 300 married women of reproductive age (15-49 years) who were the members of Bangladesh Rural Development Program (BRDP). The women were very poor and regularly influenced by loans given to them for growing their economic status, making them self-dependent through trainings and various programs for promoting their knowledge about reproductive health rights.

The statistical tool, logistic regression analysis was employed to investigate the effects of socioeconomic and demographic factors on age at marriage and family planning acceptance. The qualitative data were changed to quantitative data by giving suitable scores as and when necessary. The coded data were tabulated by a computer and finally they were analyzed by the computer software SPSS 16.00.

Firstly, the logistic regression model (Model 1) predicted reproductive health rights through age at marriage with categorical independent variables[1]. Lastly, another logistic regression model (Model 2) predicted reproductive health rights through family planning acceptance with categorical independent variables[2]. To perform logistic regression analysis, the dependent and independent variables have been categorized in Table 1.

Results

Socioeconomic and demographic characteristics have played important roles in the growth of knowledge about reproductive health rights. Table 2 presents the socioeconomic characteristics and Table 3 represents the demographic characteristics which would be helpful to know the real situation of reproductive health rights through age at marriage and family planning acceptance of the respondents. The multiple regression techniques were applied to explore the effects of eight key factors on women's reproductive health rights and Tables 4 and 5 represent the factors affecting reproductive health rights through age at marriage and family planning acceptance, respectively.

Socioeconomic Characteristics: Educational quailfication, occupation, yearly income and modern facilities have been considered as the socioeconomic characteristics related to reproductive health rights of the respondents. Table 2 shows that about half of the respondents (48.7%) have had the ability to sign and have had primary education, about one-third (32.3%) have had secondary and a few (8.3%) have had higher education. A small number of husbands were illiterate (13.3%) and some had higher education

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1- In Model 1, let Y = 1, if the women get opportunity to get marriage in the standard age (not <18 years), and Y = 0, otherwise.

2- For Model 2, let Y = 1, if the women have family planning acceptance, and Y = 0, otherwise.

Table 1. Categorized dependent and independent variables for logistic regression model

Variables	Categories
Dependent variables	
Age at marriage (women)	
	0 = < 18 years
	1 = ≥ 18 years
Family planning acceptance	
	0 = no
	1 = yes
Independent variables	
Current age of respondents	
	0 = < 20 years
	1 = 20-29 years
	2 = 30-39 years
	3 = 40 years and older
Educational qualification of women	
	0 = illiterate
	1 = literate
Educational qualification of husbands	
	0 = illiterate
	1 = literate
Occupation of women	
	0 = non-professional
	1 = professional
Occupation of husbands	
	0 = non-professional
	1 = professional
Total yearly income	
	0 = < 50,000 Tk[1]
	1 = ≥ 50,000 Tk
Family members	
	0 = < 3
	1 = 3-6
	2 = > 6
Modern facilities	
	0 = low
	1 = medium
	2 = high

[1] **Tk**= The Taka is the currency of Bangladesh

Table 2. Distribution of socio-economic characteristics related to reproductive health rights

Socioeconomic attributes of Category	Respondents (n=300)	
	Number	Percentage (%)
Education of respondents		
Illiterate	32	10.7
Signature and primary	146	48.7
Secondary	97	32.3
Higher	25	8.3
Education of husbands		
Illiterate	40	13.3
Signature and primary	131	43.7
Secondary	88	29.3
Higher	41	13.7
Occupation of respondents		
Housewife	247	82.3
Service holder	29	9.7
Business	16	5.3
Student	8	2.7
Occupation of husbands		
Farmer	79	26.3
Day laborer	89	29.7
Rickshaw and van puller	16	5.3
Business	61	20.3
Service holder	55	18.3
Total yearly income		
< 25000 Tk	21	7.0
25000-45000 Tk	82	27.3
45000-65000 Tk	71	23.7
65000-85000 Tk	68	22.7
> 85000 Tk	58	19.3
Modern facilities		
None	93	31.0
Electricity	20	6.7
Radio	60	20.0
Motorcycle	6	2.0
Electricity, TV and Radio	121	40.3

(13.7%). On the other hand, about half (43.7%) of the husbands had the ability to sign and had primary education while about one-third (29.3%) had secondary education. As it is observed in Table 2, most of the respondents (82.3%) were housewives that meant they were dependent on their husbands but a few were service holders (9.7%), and the rest were engaged in business (5.3%), and education (2.7%). In the case of the husbands' occupations, 26.3% of the husbands were farmers, 29.7% were day-laborers, 5.3% were rickshaw and van pullers, 20.3% were businessmen and 18.3% were service holders. Around one-third (34.3%) of the respondents' yearly income was less than 45000 Tk, and a few (19.3%) had a yearly income above 85000 Tk. In

Table 3. Distribution of demographic characteristics related to reproductive health rights

Demographic attributes of Category	Respondents (n=300)	
	Number	Percentage (%)
Current age of respondents		
< 20 years	13	4.3
20-25 years	52	17.3
25-30 years	93	31.0
30-35 years	80	26.7
35-40 years	35	11.7
40-45 years	19	6.3
> 45 years	8	2.7
The women's age at marriage		
< 18 years	237	79.0
≥ 18 years	63	21.0
The husbands' age at marriage		
< 22 years	127	42.3
≥ 22 years	173	57.7
Influential person for family planning		
Own interest	113	37.7
Husbands' interest	160	53.3
Hearing others	27	9.0
Number of children		
none	20	6.7
1 child	62	20.7
2 children	116	38.7
3 children	49	16.3
4 children	24	8.0
≥ 5 children	29	9.7
Number of family members		
≤ 3	92	30.7
4-6	171	57.0
> 6	37	12.3

the case of modern facilities, the respondents (31.0%) did not avail modern facilities except a small number of women; only 6.7% availed electricity and 15.0% only had a radio.

Demographic Characteristics: The current age of the respondents, age at marriage, influential person(s) in case of family planning, the number of children, and the number of family members were taken as the demographic variables related to reproductive health rights. From Table 3, it is observed that the respondents were very young and around one-third (31.0%) were in the highly reproductive age group (25-30 years). About half (52.7%) of the women were below 30 and most of

them (79.0%) had married early (before 18 years), though, more than half (57.7%) of their husbands' mean age at the first marriage was 22 years and above.

Family planning refers to deliberate efforts of couples or individuals to regulate fertility by delaying or spacing births or limiting the number of their children. It was seen that about half (53.3%) of the respondents' husbands were interested in taking family planning, and more than one-third (37.7%) were interested to do so. A remarkable portion of the respondents had one child (20.7%) or two children (38.7%) and a small number of women had three or more children. Around one-third (30.7%) of the women's family size was not more than three, and more than half (57.0%) had 4 to 6 family members and some lived in joint families.

Factors Affecting Reproductive Health Rights through Age at Marriage: The results of logistic regression analysis (Model 1) which depict the effects of different variables on reproductive health rights through age at marriage are presented in Table 4. It was found that the odds ratio (OR) was 0.01 (CI of OR = 0.010–0.394), for the age group 20-29 years. For the age group 30-39 years, this was 1.12 (CI of OR = 0.187–1.338), and for the age group 40 years and above that was 1.10 (CI of OR = 0.114–1.769) which implied that reproductive health rights were the poorest in the age group 20-29 years and when age increased the rights of women increased accordingly. For example, 30-39 and ≥ 40-year old women, respectively, had 1.12 and 1.10 times more rights than that of the reference age group (< 20 years).

In case of literacy, it was seen that women who were literate, the OR was 1.14 (CI of OR = 0.238–1.944), which implied that literacy had positive effects on the rights in case of their age at first marriage. In case of their husbands' education, it had a positive impact on the reproductive rights of the women (OR = 1.36, and CI of OR = 0.413–3.425).

The OR for women with a profession was .38 (CI of OR=1.370–4.899), which implies that the profession of women had positive impacts on reproductive health rights through age at marriage. The regression coefficient and odds ratio for the profession of the husbands were – 1.49 (*p* < 0.05) and 0.23 (CI of OR = 0.101–0.436) re-

Table 4. The results of logistic regression analysis for the effects of variables on reproductive health rights through age at marriage

Characteristics	Number (%)	Age at marriage (Model 1)		95% CI of OR
		Coefficient (β)	Odds ratio (OR)	
Current age of respondents				
< 20 years (RC)	13 (4.3)	----------	1.00	
20-29 years	145 (48.3)	-6.703	0.01	0.010-0.394
30-39 years	115 (38.4)	0.116	1.12	0.187-1.338
≥ 40 years	27 (9.0)	0.097	1.10	0.114-1.769
Respondents' education				
Illiterate (RC)	32 (10.7)	----------	1.00	
Literate	268 (89.3)	0.129	1.14	0.238-1.944
Education of husbands				
Illiterate (RC)	40 (13.3)	----------	1.00	
Literate	260 (86.7)	0.310	1.36	0.413-3.425
Occupation of respondents				
Non- professional (RC)	255 (85.0)	----------	1.00	
Professional	45 (15.0)	0.322	1.38	1.370-4.899
Occupation of husbands				
Non- professional (RC)	184 (61.4)	----------	1.00	
Professional	116 (38.6)	-1.490*	0.23	0.101-0.436
Total yearly income				
<50,000 Tk (RC)	178 (59.3)	----------	1.00	
≥ 50,000 Tk	122 (40.7)	0.586	1.80	0.754-1.913
Total family members				
< 3 (RC)	92 (30.7)	----------	1.00	
3-6	171 (57.0)	-0.023	0.98	0.414-1.397
>6	37 (12.3)	-0.607*	0.55	0.114-0.769
Modern facilities				
Low (RC)**	93 (31.0)	--------	1.00	
Medium	80 (26.7)	0.327	1.39	0.477-1.908
High	127 (42.3)	0.544	1.72	0.977-4.431
-2 log likelihood		255.720		
Model Chi-square		136.601		
d.f.		8		

Note: * represents the significance level at 5% (*p* < 0.05), and **RC represents the reference category

spectively, which implies that it had negative effects on women's reproductive rights through age at marriage.

In case of income, it was observed that for a yearly income of 50,000 Tk and above, the estimated regression coefficient and OR were 0.586 and 1.80 (CI of OR=0.754–1.913) respectively, which implies that it had a positive impact on reproductive rights of women than those with an income <50,000 Tk. The estimated regression coefficients for 3-6 member families was – 0.023 and for > 6-member families it was – 0.607 and the ORs for these categories were 0.98 (CI of

OR=0.414-1.397) and 0.55 (CI of OR=0.114-0.769) respectively, which imply that the number of family members below three had significant negative effects on reproductive health rights than those with 6 and above.

In the case of modern facilities, the regression coefficient and odds ratio for medium and highly modern facilities were 0.327 and 0.544; OR = 1.39 (CI of OR = 0.477–1.908) and 1.72 (CI of OR = 0.977–4.431), respectively. These results imply that both medium and highly modern facilities had positive effects on reproductive rights through age at marriage.

Table 5. Results of logistic regression analysis for the effects of variables on reproductive health rights through family planning acceptance

| Characteristics | Number (%) | Family planning acceptance (Model 2) | | 95% CI of OR |
		Coefficient (β)	Odds Ratio (OR)	
Current age of respondents				
< 20 years (RC)	13 (4.3)	------	1.00	
20-29 years	145 (48.3)	- 0.998	0.37	0.192-1.100
30-39 years	115 (38.4)	0.959*	2.61	1.594-9.743
40 years and above	27 (9.0)	0.652*	1.92	1.096-5.376
Respondents' education				
Illiterate (RC)	32 (10.7)	-----	1.00	
Literate	268 (89.3)	0.109*	1.12	1.045-1.906
Education of husbands				
Illiterate (RC)	40 (13.3)	-----	1.00	
Literate	260 (86.7)	0.112*	1.12	0.980-6.165
Occupation of respondents				
Non- professional (RC)	255 (85.0)	-----	1.00	
Professional	45 (15.0)	1.470*	4.35	1.205-3.691
Occupation of husbands				
Non- professional (RC)	184 (61.4)	------	1.00	
Professional	116 (38.6)	1.606	4.98	0.609-5.126
Total yearly income				
< 50,000 Tk (RC)	178 (59.3)	------	1.00	
50,000 Tk and above	122 (40.7)	0.557	1.74	0.284-2.252
Total family members				
< 3 (RC)	92 (30.7)	------	1.00	
3-6	171 (57.0)	0.144	1.16	0.291-2.680
6 and above	37 (12.3)	1.690*	5.42	1.735-8.768
Modern facilities				
Low (RC) **	93 (31.0)	------	1.00	
Medium	80 (26.7)	0.108	1.11	0.442-2.743
High	127 (42.3)	0.270	1.31	0.284-1.928
-2 log likelihood		195.043		
Model Chi-square		197.279		
d.f.		8		

Note: * represents the significance level at 5% ($p < 0.05$), and **RC represents the reference category

Factors Affecting Reproductive Health Rights through Family Planning Acceptance: The results of logistic regression analysis (Model 2) for the effects of variables on reproductive health rights through family planning acceptance of the respondents are presented in Table 5. From the table, it was found that the regression coefficient and OR were – 0.998 and 0.37 (CI of OR = 0.192 –1.000), respectively for the age of respondents in the range of 20-29 years, and they respectively were 0.959 ($p < 0.05$) and 2.61 (CI of OR = 1.594 –9.743) for those aged 30-39 years old, and 0.652 ($p < 0.05$) and 1.92 (CI of OR = 1.096-5.376), respectively for those aged 40 years and above. Thus early age (age 20-29 years) at marriage has negative impacts on family planning but those aged 30-39 years and 40 years and above, respectively had 2.61 times and 1.92 times family planning acceptance.

In case of the respondents' literacy, the regression coefficient and the odds ratio for literate women were 0.109 ($p < 0.05$) and 1.12 (CI of OR

= 1.045–1.906) respectively, which implies that education has significant positive effects on family planning acceptance. In Model 2, the regression coefficient and OR of literate husbands were 0.112 ($p < 0.05$) and 1.12 (CI of OR = 0.980 – 6.165) respectively, which implies that there was significant positive effects on family planning acceptance for educated husband.

The regression coefficient and odds ratio of the women's profession on family planning acceptance were 1.470 ($p < 0.05$) and 4.35 (CI of OR = 1.205–3.691) respectively, which implies that profession had significant positive impacts on family planning acceptance. The regression coefficient and OR for the profession of husbands were 1.606 and 4.98 (CI of OR = 0.609–5.126) respectively, which implies that the husbands' profession had positive impacts on family planning acceptance and of their wives' reproductive rights. The regression coefficient and OR of a yearly income of about 50,000 Tk and more were 0.557 and 1.75 (CI of OR = 0.284–2.252), respectively. This implies that the families' yearly income of 50,000 Tk and above had a significant positive impact on family planning acceptance.

In Model 2, the regression coefficient and OR for 3-6 member families were 0.144 and 1.16 (CI of OR = 0.291–2.680) respectively, and for 6 and above they are 1.690 ($p < 0.05$) and 5.41 (CI of OR = 1.735–8.768), respectively. These results imply that there existed positive impacts for both family size categories.

The estimated regression coefficient and OR for women with medium possession of modern facilities were 0.108 and 1.11 (CI of OR = 0.442–2.743) respectively, and for those with high possession of modern facilities they were 0.270 and 1.31 (CI of OR=0.284-1.928) respectively. These results imply that both for women with medium and high possession of modern facilities, there existed positive effects by those facilities on family planning acceptance and the rights.

Discussion

Reproductive health right is a condition in which reproduction is accomplished in a state of complete physical, mental and social well-being, and not merely as the absence of disease or disorders of the reproductive processes. But the overall situation is quite drastic in Bangladesh where

women's reproductive health rights are always ignored which has been depicted in this study and discussed below.

In this study, the respondents were very young and most of them had married before 18 but most of their husbands were 22 years or older. Bangladesh has one of the highest rates of child marriage in the world. More than two-thirds of adolescent girls aged 10-19 are married (12). Nearly two in five girls aged 15-17 are married, despite 18 being the legal age for marriage (13). Early female marriage has been associated with a number of poor social and physical outcomes for young women and their offspring. The study results identified that the women and their husbands who had not married early were more aware of reproductive health rights. Moreover, early marriage not only results in higher fertility rates but also results in high rates of maternal mortality and also low birth weight babies which will result in high infant mortality rates too. Consequently, high fertility and low birth weight cause poor cognitive ability of the offspring, limiting their human development, which again pushes them into more poverty.

Education is the most important variable in human resource development that especially influenced the respondents' knowledge about reproductive heath rights. Women's low literacy rate and lack of access to education are among the several causes of their low social status and their dependence on men prevailing in rural areas. The educational status of the respondents, as well as f their husbands' were not satisfactory although the purpose of education is development of carrier opportunities. Education, especially in women provides the individual with a new vision and normative orientation, better health care, better employment opportunities outside home, better knowledge of access to family planning methods. Literate women can more easily demand and protect their rights in order to change and improve their situation. The fact that women are less educated than men is largely due to ancient traditions and common mentality. It is essential to improve the literacy skills of women which have a beneficial impact on their socio-economic condition (14). Educational qualification of husbands plays a very important role in their attitude towards their wives regarding reproductive health rights. For growing positive reproductive attitudes

among couples, educational qualification of husbands is a more important factor than that of their wives. Generally, it is observed that when a husband is educated; he may share his feelings, attitudes, and behavior with his wife more freely. In this study, the respondents and their husbands who were literate were more aware of their reproductive health rights. Similar results were found in the case of occupation. Empowerment of women is an essential precondition for the elimination of world poverty and upholding of human rights (15). When women earn money, they become independent, try to get equal power and expect less violence from their husbands and, consequently, establish reproductive health rights.

Similarly, occupation of women is an important attribute related to this study. A large majority of the respondents were completely dependent on their husbands' money, clothes, and food since they were not employed. The overall economic status and family income of the respondents was not satisfactory and their yearly income was very low although they regularly took loans from BRDP to develop their economic status. Nevertheless, the relationship between poverty and reproductive health in Bangladesh is closely intertwined. It is evident that poor access to reproductive health facilities is not simply a health disadvantage but an economic and social disadvantage as well. Because of low income and lack of a secure income in women, they get married at an early age (between 16-19 years) and almost immediately become adolescent mothers.

In case of family planning, the concept of male involvement in family planning is broad in nature. The study results identified that men and women did not necessarily have similar fertility attitudes and goals. It is important that cultural, demographic, social and economic factors play an important role in shaping marriages in society, as well as family planning (16). The study results ensured that the respondents were less considered to take family planning options and in this way their reproductive health rights, as well as their basic rights were violated continuously. Family planning acceptance has the greatest effects on the total number of family members. In those families who had more family members the reproductive health rights were less considered due to economic limitations and the mentality among their family members. Thus, family planning acceptance had played an important role and for this the respondents had a limited number of children.

Possession of modern facilities is a very important issue for a society, and a society with enough modern facilities is more developed and people enjoy their reproductive health rights. The facilities which make a new man and are intended to be different from traditional styles are known modern facilities such as TV, radio, etc. Mass media such as radio and television can create awareness about issues affecting the daily life, family planning programs, poverty alleviation programs, gender issues, human rights issues, etc. Consequently, modern facilities had played a vital role to ensure the reproductive health rights of the respondents.

Conclusion

The study concludes that age at marriage and family planning acceptance have the potential to enhance women's reproductive health rights. Based on the empirical results of the study, the level of women's reproductive health rights was not satisfactory at the household level. In contrast, the traditional beliefs, attitudes and practices of the studied population are deeply entrenched in the women's lives and they hinder their reproductive health rights. To move forward, some concrete steps need to be undertaken by the major intervening agencies, namely GOs, NGOs, women's organizations and other stakeholders (private initiatives, civil society, etc.) aiming at stimulating the process of women's reproductive health rights. Interventions should be in the nature of legislative processes, planning, programming or structural steps to provide greater opportunities for the sustainable development of women at all levels and to reduce discriminatory practices against women, as well as all types of gender-based stereotypes.

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