

## Adolescent Fertility in Bangladesh

Md. Mahabub-ul-Anwar

Department of Population Sciences, University of Dhaka, Dhaka-1000, Bangladesh

---

**Abstract:** The consistent high rate of adolescent fertility in Bangladesh is an issue of concern to policy planners, researchers and government because of serious negative social, economic and health consequences associated with early fertility. Besides, early marriage leads to the beginning of fertility at an early age, which eventually increases the risk of mortality and morbidity for both mother and child. The specific objective of this paper is to examine the trends of fertility of adolescent and contraceptive practices among them. The study is based on nationally representative demographic and health survey. Data shows that the total fertility rate has dramatically declined but adolescent fertility is high, which accounts one-third of the total fertility rate. Culturally marriage initiates the beginnings of fertility where outside marriage, fertility is prohibited and age at first marriage is very low here. Though there is a law of minimum age at marriage for females for 18 years, more than three fourth (78 percent) women marry before that age. The mean age at first marriage and birth are 15 and 15.6 years respectively. With successful efforts of GO and NGOs, contraceptive knowledge is universal here, but the use of contraceptive method among adolescent is low (37.8 percent) and the topic is not always discussed between husband and wife.

**Key words:** Adolescent, fertility, contraceptive practice

---

### Introduction

In the past few years, the issue of adolescent pregnancy has been increasingly perceived as a social problem (Sharma, 2003). It has emerged as an issue of increasing concern throughout the developed and developing world. Following the International Conference on Population and Development (ICPD) in Cairo in 1994, much concern has been expressed about the importance of the life-cycle stage of adolescence, the powerfully formative time of transition to adulthood. What happens to the individual during this period shapes how they will live their adult lives, in the reproductive arena as well as in the social and economic realm, which will determine their future life as well as their countries (UNFPA, 2003).

Adolescence in general is a complex phase and often not well understood by the adolescents themselves and adults. Today's adolescents are becoming a major target group of various life threatening health problems. Of all these problems, reproductive and sexual health problems are getting more attention mainly because majority of adolescents from all over the world are facing consequences of early, unprotected and unplanned sexual activities and child bearing. Adolescent often lack basic reproductive health information, skills in negotiating sexual relationships, and access to affordable, confidential reproductive health services. A number of factors are responsible for this situation. They mainly decrease in age at menarche, gradual increase in age at marriage, change in socio-cultural values brought about by globalization, urbanization, migration, and widespread availability and use of mass media (Bongaarts, 1996).

Adolescent pregnancy involves a great cost to society and has significant ramifications at personal, societal, and global levels. For the individual woman, childbearing at an early age can shape and alter her entire life. From the perspective of communities and governments, adolescent pregnancy and childbearing have a strong and unwelcome association with low levels of educational achievement for young women, which in turn may have a negative impact on their position in and potential contribution to society (UN, 1995). Globally, the rates of population growth are more rapid when women have their first child before they are in their twenties (Manzur, 1997; Senderowitz and Paxman, 1985).

Today as the world witnesses the entry of the largest ever generation of adolescents, and their present condition will determine the tomorrows world and their pregnancy has a negative relationship with their future, all the countries should pay a complete attention in this issue. In Bangladesh, adolescents constitute one-fourth of the total population (Mitra *et al.*, 2001), despite an impressive demographic achievement of declining fertility from 6.3 in 1975 to 3.3 in 2000. This large group is at risk for a wide variety of reproductive health problems. Reproductive health knowledge among the adolescents in Bangladesh is very low (Haider *et al.*, 1997). The majority has no idea about the changes associated with puberty (e.g. menstruation or wet dream until they experience them and their knowledge of symptoms, transmission and prevention of STIs and HIV/AIDS is inadequate (ICDDR, 1999). As a consequence, adolescents may not know how to protect themselves from unsafe sexual encounters. Lack of access to adolescent-friendly services or poor access to health services and economic constraints make the problem more complex in Bangladesh.

The adolescent population will continue to grow in the near future at a higher rate than the overall population growth due to population momentum effect (Islam, 2000). This poses a major challenge to the government,

stretching limited resources in order to try to meet the increasing reproductive health, educational and economic needs of adolescents.

Bangladesh has the highest rate of adolescent childbearing among the Asian countries; the country's characteristics in this regard are similar to Sub-Saharan African countries (Singh, 1998). According to Bangladesh Demographic and Health survey (BDHS) 1999-2000, 30 percent of all those in the age group 15-19 were mothers and another 5 percent were pregnant with their first child. This indicates that more than one third of the adolescents (35 percent) started childbearing by age 19. The annual age-specific fertility rate for adolescents aged 15-19 is 144 births per thousand women, which accounts 22 percent of the overall TFR. Teenage parenthood is higher among rural and illiterate girls. It has been observed that the proportional contribution of the adolescent fertility to overall fertility has increased overtime. The maternal mortality and infant and child mortality rates are higher for adolescent mothers. More than half of the married adolescents are illiterate. In this paper the trends of adolescent fertility is examined. In view of negative health, social and economic consequences of childbearing, it is important have a clear understanding of the fertility behavior of adolescence in order to design interventions to improve the situation.

### Objective of the Study

The objectives of the study are:

- \* to examine the levels and trends of adolescent childbearing in Bangladesh
- \* to observe the contraceptives practices among them.

The findings of the study may have important policy implications for further reducing fertility and improve the state of the adolescent.

**Methodology and Sources of Data:** The study is based on secondary data. Data is drawn from the Bangladesh Demographic and Health Survey (BDHS) 1999-2000 (Mitra *et al.*, 2001). Although the 1999-2000 BDHS was not designed especially for surveying adolescents, it did collect information through a nationally representative sample of 10,544 ever married females aged 10-49 years among whom 1514 are aged 15-19 years, which gives a greater opportunity to study various aspects of adolescent fertility.

In this paper, only the adolescent aged 15-19 years were considered to study adolescent fertility so that the results could be compared with the result from other studies of respondents aged 15-49 years. Only simple tabular method is applied in this study.

**Concept of Adolescent:** Generally, the transition from childhood to adulthood is known as adolescence \_ the most critical stage in the life cycle. The word "adolescence" is Latin in origin, derived from the verb "adolescere", which means, "to grow into adulthood". Adolescence has been defined and classified in many ways with the most common classification being made according to physical and psychological development as well as by age. It is a distinct and dynamic phase of development in the life of an individual that encompasses physical and emotional stages of transition from childhood to adulthood. This is a period of rapid growth and involves the development of secondary sexual characteristics and the start of sexual and reproductive health activity. Adolescence is also referred to as a period of emotional turbulence where adolescents seek to develop their own identity and achieve independence from their parents and guardians. It is a phase where adolescents encounter physical and emotional changes and often too shy or find it difficult to discuss the related issues with anyone. Sexual activities begin at this phase in one's life. Adolescence is therefore a critical phase in every person's life where sustaining a high level of reproductive and sexual health is vital if one's future aspiration is to attain a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. Incidentally, the World Health Organization defines adolescence as the period between 10 and 19 years of age (WHO, 1995). In this study only age group 15-19 are considered as adolescent so that it could be comparable with other studies.

Factors related to defining adolescence include:

- age group between 10 to 19 years (WHO)
- encompasses physical and emotional stages of transition from childhood to adulthood
- a period of rapid growth involving the development of secondary sexual characteristics
- also refers to as a period of emotional turbulence other associated with seeking to develop one's own identity and to achieving independence from

**Present Situation of the Adolescent:** The overall situation of adolescent in Bangladesh cannot be denoted as "satisfactory" both in terms of program efforts and actual performance (MOHFW, 1999). Some of the major issues pertaining to the adolescent fertility situation are presented in Table 1 and discussed below:

- About 50 percent of the female adolescents are illiterate.
- 89.8 percent of the adolescents are unemployed.
- About 36.2 percent have no access to mass media.

## Mahabub-ul-Anwar: Adolescent fertility in Bangladesh

- The mean age at first marriage is 15.0 years.
- The adolescent fertility rate is one of the highest in the world with 144 births per 1000 women aged 15-19 years.
- The mean number of children ever born for the adolescent group (age 15-19 years in the survey) was 0.71. The proportion of surviving children was lowest in this age group.
- About 34.7 percent of adolescent women have begun childbearing – 29.8 percent are already mothers and another 4.9 percent are pregnant with their first child.
- Family planning practice is less pronounced among adolescent women. Contraceptive use rate among the adolescent (married) women (aged 15-19 years) is 37.8 percent compared to the national rate of about 53.8 percent.
- Unmet need for family planning is highest among the adolescent women, compared to the national average of 15.3 percent. Among adolescent aged 15-19, the unmet need for family planning is 20.0 percent.
- One-fourth (24.6%) of births to adolescent women in Bangladesh can be considered as unplanned (mistimed and unwanted).
- Spousal communications regarding family planning and associated issues are very limited among adolescent couples. About 49.6 percent of adolescent women had not talked to their husband about Family Planning (FP) in the 3 months preceding the BDHS survey.
- Mortality rates – neonatal, post neonatal, infant, child, and under-five – all are higher for children of adolescent mothers.

**Table 1: Fertility situation of female adolescent in Bangladesh – some selected indicators (1999-2000)**

Sr. No	Indicator(s)	Situation
<b>A. Social and Economic</b>		
1.	Illiteracy (% illiterate: 10-19 years female)	50
2.	% Unemployment	89.8
3.	% Having no access to mass-media	36.2
<b>B. Fertility and Regulation</b>		
4.	Mean age at first marriage (in years)	15.0
5.	Current fertility (births per 1000 women)	144
6.	Children ever born	0.71
7.	Adolescent pregnancy (% who have begun childbearing)	34.7
8.	Contraceptive prevalence rate (%)	37.8
9.	Never discussed FP with husband (%)	49.6
10.	Unmet need for FP (%)	20.0
11.	Last birth wanted later (%)	24.6
<b>C. Infant and Child Mortality</b>		
12.	Neonatal mortality	72.0
13.	Post neonatal mortality	31.4
14.	Infant mortality	103.4
15.	Child mortality	29.2
16.	Under five mortality	129.5

Source: Bangladesh Demographic and Health Survey 1999-2000.

**Fertility Trends in Bangladesh:** Bangladesh has experienced a dramatic decline in fertility levels from 6.3 to 3.3 children within 25 years from 1975 to 2000. Table 2 presents the age specific fertility rates (ASFRs) for 15-49 age groups at various periods between 1975 to 2000. The table indicates a decline of 48 percent in TFR, a decline of 1.9 percent per year. The pace of decline was steeper during the late 1980s to early 1990s, and since then it has remained almost constant.

The analysis of the fertility rates by age cohort shows that starting from 1975 to 1993-1994, fertility declined steadily in 1993-1994 in all age groups with the exception of age group 15-19. The age-specific fertility rates in 1999-2000 also shows decline in all age groups since 1993-1994, except ages 15-19 and 25-29 (Table 2). The decline is steeper among women aged 35 and above. The tendency of adolescent fertility is increasing. In comparison with 1975 to 1999-2000, it increased about 32.1 percent, whereas the rate is decreasing in all age groups. The decreasing rate is higher in the older age groups, the more the years in age groups the more the decreasing rate. This indicates that there is a shift in fertility towards younger age groups in recent years and fertility has declined substantially among older age groups.

## Mahabub-ul-Anwar: Adolescent fertility in Bangladesh

**Adolescent Pregnancy and Motherhood:** Table 3 shows the percentage of teenagers aged 15-19 who are mothers or pregnant with their first child, according to various background characteristics. Thirty percent of teenage women in Bangladesh are mothers, and another 5 percent are pregnant with their first child. Thus, 35 percent of teenage women have begun childbearing. There has been slight decline in this proportion since the 1996-1997 BDHS survey, which indicated that 36 percent of women aged 15-19 had begun childbearing (31 percent had delivered a child and 5 percent were pregnant with their first child) (Mitra *et al.*, 1997).

There is a close relationship between age and childbearing. As expected, the proportion of women who have begun childbearing rises rapidly with age, from 16 percent of those age 15 to 57 percent of those age 19. Place of residence is also shown a relationship, 25.5 percent of urban adolescent resident begun childbearing; on the other hand the percentage is 37.0 for the counterparts of rural residence. Education is strongly related to early childbearing. Girls with no education are far more likely to have begun childbearing than those with primary and especially those with some secondary education. 55.7 percent of adolescent who have no education have started childbearing. 45.3 percent, 43.3 percent and only 20.9 percent of adolescent who has respectively primary incomplete, primary complete and secondary + education have started childbearing.

**Age at First Marriage:** Marriage marks the beginning of the period of potential childbearing and, therefore, is considered the prime determinants of fertility in the face of the countries relatively low contraceptive use rate (Islam and Mahmud, 1996). Bangladesh has a long tradition of early marriage among the females (Maloney *et al.*, 1981; Aziz and Maloney, 1985), which is still prevailing. Table 4 gives information on age at first marriage. The

Table 2: Age Specific and Total Fertility Rates (TFR) among Women aged 15-49 in Bangladesh (1975 to 1999-2000)

Age group	Fertility Rates					Percentage ChangeAge group		
	1975 BFS	1989 BFS	1993-1994 BDHS	1996-1997 BDHS	1999-2000 BDHS	1975-1993 -1994	1993-1994 -1996-1997	1975-1999 -2000
15-19	109	182	140	147	144	+28.4	+2.8	+32.1
20-24	289	260	196	192	188	-32.2	-4.1	-34.9
25-29	291	225	158	150	165	-45.7	+4.4	-43.3
30-34	250	169	105	96	99	-58.0	-5.7	-60.4
35-39	185	114	56	44	44	-69.7	-21.4	-76.2
40-44	107	56	19	18	18	-82.2	-5.3	-83.2
45-49	35	18	14	6	3	-60.0	-78.5	-91.4
TFR	6.33	5.12	3.44	3.27	3.31	-45.7	-3.8	-47.7

Source: Bangladesh Demographic and Health Survey 1999-2000.

Table 3: Percentage of women aged 15-19 who are mothers or pregnant with their first child, by selected background characteristics in Bangladesh (1999-2000)

Background characteristic	Percentage who are		Percentage who have begun child-bearing	Number
	Mothers	Pregnant with first child		
Age				
15	11.6	4.3	15.9	704
16	22.2	3.8	26.0	703
17	30.8	5.7	36.5	584
18	39.0	6.0	45.0	638
19	52.5	4.8	57.3	520
Residence				
Urban	22.0	3.6	25.5	627
Rural	31.8	5.2	37.0	2,522
Education				
No education	50.6	5.1	55.7	635
Primary incomplete	40.2	5.1	45.3	554
Primary complete	36.0	7.3	43.3	331
Secondary +	16.7	4.2	20.9	1,652
Total	29.8	4.9	34.7	3,149

Source: Bangladesh Demographic and Health Survey 1999-2000.

table shows the percentage of all women (ever-married and never married) who first married by specified exact ages and the median age at first marriage according to current age. Overall, more than three-fourth (78.2 percent) of women married by the time they were aged 18. The proportion of married by the age 18 falls steadily from the time the oldest to youngest age group. The proportion falls from 90 per cent for women aged 45-49 to 65 per cent for women aged 20-24. By age 20, almost 87 per cent were married and only 13 per cent were married after age 20. The 1999-2000 BDHS demonstrates higher proportion of marriage at higher ages compared to the 1993-1994 BDHS. This indicates a rising age at first marriage in Bangladesh in recent years. The median age at first marriage among the women of age group 20-49 is 15 years in 1999-2000, an increase of one year since the 1996-97 BDHS. The rising trend in age at first marriage is confirmed by the higher age at first marriage among the women of age group 20-49 is 15 years in 1999-2000, and increase of one year since the 1996-97 BDHS. The rising trend in age at first marriage is confirmed by the higher age at first marriage among the young cohort than their older counterparts. The median age at marriage has increased from 13.8 years among the women currently aged 45-49 to 16.1 year for those aged 20-24 years.

However, 80 percent of women marry when they are still teenagers, which increase the likelihood of their having high-risk births in the absence of contraceptives use before the first birth.

**Age at First Birth:** The age at which childbearing begins has important demographic consequences for society as whole as well as for the health and welfare of mother and child. In many countries, postponement of first births reflecting an increase in the age at marriage\_ has contributed greatly to overall fertility decline. Early ignition into childbearing is generally a major determinant of large family size and rapid population growth, particularly in countries where family planning is not widely practiced. Moreover, bearing children at a young age involves substantial risks to the health of both the mother and child. Early childbearing also tends to restrict educational and economic opportunities for women (Mitra *et al.*, 2001).

Table 5 presents the percent distribution of women by age at first birth according to current age. The median age at first birth for women age 20 and over is presented in the last column of the table. Childbearing begins early in Bangladesh, with the large majority of women becoming mothers before they reach the age of 20. The median age

Table 4: Percentage of Women Who Were First Married by Exact Ages and Median Age at First Marriage by Current Age in Bangladesh (1999-2000)

Current Age	Percentage Who were Married by Exact Age						Percentage Never Married	Number	Mean Age at First Marriage
	12	15	18	20	22	25			
15-19	1.2	27.3	NA	NA	NA	NA	51.9	3,149	a
20-24	2.5	38.2	65.3	75.4	NA	NA	18.5	2,373	16.1
15-29	3.1	45.4	74.8	84.7	90.2	94.1	4.2	2,062	15.4
30-34	4.9	50.8	80.8	90.2	95.9	98.1	0.1	1,622	14.9
35-39	7.8	56.4	85.6	92.2	96.1	98.0	0.2	1,337	14.5
40-44	8.5	65.1	89.4	95.1	97.5	98.4	0.0	1,126	14.0
45-49	13.3	69.2	90.4	95.4	97.6	98.4	0.0	853	13.8
20-49	5.5	50.6	78.2	86.6	91.0	93.1	5.7	9,373	15.0

Source: Bangladesh Demographic and Health Survey 1999-2000.

NA = Not Applicable

a = Omitted because less than 50 percent of the women in the age group 15-19 were first married by age 15

Table 5: Percentage distribution of women by age at first birth, according to current age in Bangladesh (1999-2000)

Current age	Women with no births	Age at first birth						Total	Number	Median age at first birth
		<15	15-17	18-19	20-21	22-24	25+			
15-19	70.2	6.5	20.3	3.0	NA	NA	NA	100.0	3,149	A
20-24	27.3	10.1	33.5	17.7	8.3	3.0	NA	100.0	2,373	18.7
25-29	8.6	10.1	37.6	18.7	12.4	9.4	3.2	100.0	2,062	18.2
30-34	3.3	11.3	39.1	21.4	12.3	8.0	4.6	100.0	1,622	18.0
35-39	2.5	11.1	38.1	20.6	12.1	9.0	6.5	100.0	1,338	18.1
40-44	2.3	16.6	41.9	17.6	8.3	8.1	5.2	100.0	1,126	17.2
45-49	1.7	17.8	48.3	16.7	7.1	5.1	3.2	100.0	853	16.9

Source: Bangladesh Demographic and Health Survey 1999-2000.

NA = Not Applicable

A = Omitted because less than 50 percent of the women in the age group 15-19 have had a birth by age 15.

at first birth is between 17 for older women to about 19 for women in their median age at first birth have increased slightly from about 17 for older women to about 19 for women in their early twenties. This slight change to later age at first birth is reflected in the smaller proportion of younger women whose first birth occurred before age 15; about 18 percent of women in their forties report having had their first birth before age 15, compared with only 7 percent of women age 15-19.

**Knowledge and Practice of Family Planning Methods:** Knowledge of FP method is high among the couples. Virtually all respondents know at least one modern method. There is a little difference between adolescent (15-19) and all women into reproductive age (15-49). Table 6 shows that 99.9 percent respondent of age group of 15-49 years, knows about FP method, on the other hand 99.8 percent and 96.8 percent married adolescent know about any FP method and any modern method respectively.

Table 6 shows that about 38 percent of married adolescents were currently using any FP methods of which 30.6 percent used modern contraceptive methods and another 7 percent used traditional methods. In case of total population the rate of contraceptive use is 53.8 percent of which 43.8 percent respondents use modern method. While husband-wife communication about family planning and agreement to use contraceptive methods is not necessary for the adoption of certain contraceptive methods, its absence may be a serious impediment to use. About half of the female adolescents said that they never talked to their husbands regarding family planning. With regard to the discussion of family planning, married women at older age groups expressed nearly similar opinion too. This gives a clear indication that although knowledge of contraceptive methods was universal, the topic is not always discussed between husband and wife. Although the current use of contraceptive methods is on the rise among married adolescents, the unmet need still remains high in this group. Unmet need for contraception among adolescent group is 20.0 percent, which is higher compared to older age groups.

**Reasons for Non-use of Family Planning Method:** Table 7 describes the reasons for not practicing family Planning methods by the currently married adolescents who have tried but discontinued contraceptive methods. The most frequently cited reason for discontinuation was desire for children (39.2 percent), followed by side effects or health concerns (16.9 percent).

On the other hand, the major causes of discontinuing family planning method for all women were side effect (36.2 percent), and 20.4 percent women for having children.

Table 6: Percentage distribution of married female adolescents by their knowledge and practice of family planning methods (1999-2000)

Issues	Age Specific Percentage Distribution	
	15-19	15-49
<b>Knowledge of family planning</b>		
Any method	99.8	99.9
Modern method	96.8	99.9
Traditional method		79.1
<b>Use of family planning method</b>		
Any method	37.8	53.8
Modern method	30.6	43.8
Traditional method	7.2	10.0
Never used contraception	39.1	25.4
<b>Discuss FP with husband</b>		
Never	48.5	52.0
Once or twice	42.3	39.8
More often	9.2	8.2
Unmet need for family planning	20.0	15.3
N	1468	9730

Source: Bangladesh Demographic and Health Survey 1999-2000.

## Mahabub-ul-Anwar: Adolescent fertility in Bangladesh

Table 7: Percentage distribution of married female adolescents by the causes of discontinuing family planning methods in Bangladesh 1999-2000

Causes	Age Specific Percentage Distribution	
	15-19	15-49
Method failure	13.3	10.7
Want children	39.2	20.4
Husband disapproved	7.2	6.1
Health concern/side effect	16.9	36.2
Other	23.3	26.6
N	360	6930

Source: Bangladesh Demographic and Health Survey 1999-2000.

### Conclusion

About one fourth of the total population of Bangladesh is adolescent, which will continue to grow in a near future at a higher rate than the overall population growth due to population momentum effect. Bangladesh has the highest rate of adolescent fertility among Asian countries (Singh, 1998). Data show that adolescent fertility is rising though the overall total fertility rate is falling gradually. From 1975 to 2000, overall TFR falls 47.7 percent from 6.33 to 3.31 and in case of adolescent it rises 32.1 percent from 109 births to 144 births per thousand women. 35 percent of adolescent began childbearing, but it shows a declining trend and there is a positive relationship between education and childbearing. 55.7 percent of adolescent with no educations started childbearing on the other hand only 20.9 percent of adolescent with secondary education started childbearing

With traditional values and culture, marriage is universal in Bangladesh. Traditionally, young ages at marriage and early childbearing have been encouraged here. According to Aziz and Maloney (1985), Bangladesh children, especially in rural areas, are socialized to assume their respective male and female roles well before puberty. Though the government fixed minimum legal age at marriage at 18 and 21 years for females and males respectively, through an ordinance in 1978, the law is hardly maintained in Bangladesh. Data show that more than three fourth (78 percent) women marry before their age 18 and the mean age at first marriage is 15.0 years among 20-49 years of age group, but a trend of rising age at marriage is shown.

The family planning program in Bangladesh has been considered as an example of success story in a country without a high level of socio-economic development, often considered as a necessary precursor to successful family planning (Koenig *et al.*, 1987 and Duza and Nag, 1993) With the help of concerted efforts of the government in conjunction with NGOs in the field, the national family planning program has achieved a remarkable success in a short period of time, attaining a current contraceptive prevalence rate (CPR) of 53.8 percent in 1999-2000. (Mitra *et al.*, 2001). Knowledge about contraceptives is universal; almost all married women know at least one method. Contraceptive prevalence rate is 54 percent, but 15 percent of married women in Bangladesh have an unmet need for family planning services. The total unmet need and the proportion of women who are using a contraceptive method together constitute 71 percent of the demand for family planning services.

For the consistent high rate of adolescent fertility in Bangladesh, appropriate policy and measures should be undertaken to curb the situation. Low age at marriage may be the main cause of early fertility here, which cannot be protected only by enforcing law. There needs a massive social motivation only through which age at marriage might be increased. Adolescent, their parents and community should be made more aware of the negative health, social and economic consequences of early marriage and early fertility. Such awareness could be created through social mobilization, education and communication campaigns, in where media and religious personnel could play a vital role. There are other avenues, which also could help to increase the age at marriage such as education of women, empowerment of decision-making, employment outside the home for young women. Appropriate policy and programs should be taken on these issues.

Proper policy and program on family planning program should also be taken to handle the situation carefully. There is a huge unmet need in contraceptive use in Bangladesh, 15 percent for all ages and if, all women who have an unmet need for family planning were use methods, the contraceptive prevalence rate would be increase from 54 percent to 69 percent, which is vary close to 71 percent, the level required for replacement level fertility in most societies, in case of adolescent the rate would be 57.8 percent instead of 37.8 percent. So policy planners should also take this issue into consideration focusing the adolescent needs.

### References

Aziz, K. M. A. and C. Maloney, 1985. Life Stage, Gender and Fertility in Bangladesh (Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, ICDDR,B).

## **Mahabub-ul-Anwar: Adolescent fertility in Bangladesh**

- Bongaarts, J., 1996. Population Growth Scenarios and Policy Options Paper 2, UNU/IAS Working Paper (Tokyo, The United Nations University).
- Duza, M. B. and M. Nag, 1993. High Contraceptive Prevalence in Matlab, Bangladesh: Underlying Process and Implications, in Richard Leete and Iqbal Alam (eds), *The Revolution in Asian Fertility: Dimensions, Causes and Implications* (Oxford, Calendon Press).
- Haider, Syeed J., Shamsun N. Saleh, Nashid Kamal and Alan Gray, 1997. *Study of Adolescents: Dynamics of perception, Attitude, Knowledge and Use of Reproductive Health Care* (Dhaka, Population Council).
- ICDDR, 1999. *Reproductive Health Needs of Adolescents in Bangladesh: A Study Report Paper 8*, ICDDR Working Paper, (Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, ICDDR,B).
- Islam, M. M., 1999. Adolescent Childbearing in Bangladesh *Asia-Pacific Population J.*, 14:73-87.
- Koenig, M. A., J. F. Phillips, R. Simmons and M. A. Khan, 1987. Trends in Family Size Preferences and Contraceptive Use in Matlab, Bangladesh *Studies in Family Planning*, 18:117-127.
- Maloney, C., A. K. M. Aziz and P. C. Sarker, 1981. Beliefs and Fertility in Bangladesh (Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, ICDDR,B).
- Manzur, Laurie Ann, 1997. *High Stakes: The United States, Global Population and Our Common Future* (New York, The Rockefeller Foundation).
- Mitra, S. N., Ahmed Al-Sabir, Tulsi Shaha and Susil Kumar, 1997. *Bangladesh Demographic and Health Survey 1995-1996* (Dhaka, Mitra and Associates).
- Mitra, S. N., Ahmed Al-Sabir, Tulsi Shaha and Susil Kumar, 2001. *Bangladesh Demographic and Health Survey 1999-2000* (Dhaka, Mitra and Associates).
- MOHFW, 1999. *Population and Development: Post-ICPD Achievements and Challenges in Bangladesh*, Prepared for Special Session on the UN General Assembly, UN, NY, June 30-July 02, 1999.
- Senderowitz, Judith and John M. Pazman, 1985. Adolescent fertility: Worldwide concerns" *Population Bulletin* 40:3-51.
- Sharma, Suresh, 2003. *Adolescent Fertility in Selected States of India* (Delhi, Population Research Center).
- Singh, Susheela, 1998. Adolescent Childbearing in Developing Countries: A Global Review *Studies in Family Planning* 29:117-136.
- UNFPA, 2003. *The State of World 2003. Making 1 Billion Count: Investing the Adolescents' Health and Right* (New York, UNFPA).
- United Nations, 1995. *The World's Women, 1995: Trends and Statistics* (New York, United Nations).
- World Health Organization, 1995. *Adolescent Health and Development: The Key to the Future* (Geneva, WHO).