

Determinants of Adolescent Fertility Behaviour in Bangladesh, 2007

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Abstract: Adolescent fertility is a complex phenomenon in Bangladesh due to various factors. It is found that complex set of relationship exists among the various socio-economic, cultural and demographic events, which affect the fertility in Bangladesh and can provide us a preliminary idea of how important each variable is by itself. Result shows that more of teenage mothers come from rural areas of Bangladesh, where early and forced marriage is the ideal and marital fertility is high at 96.40% married at such adolescent age. Meanwhile, mean number of living children is gradually decreases as education level increase and pill is the most prepared contraception methods of young women for birth control. Findings need to be scientifically used in suitable programs addressing the case of fertility control in the developing countries as well as in Bangladesh.

Key words: Adolescent fertility, determinants, teenage mother, birth control, Bangladesh

INTRODUCTION

Bangladesh is the seventh most populous country in the world with a population of about 161.3 million and it is lie in the Northeastern part of South Asia between 20°34 and 26°38-North latitude and between 88°01 and 92°41-East longitude. The area of the country is 56,977 miles² or 1, 47,570 km². Adolescent fertility is a major social and health concern in Bangladesh. Teenager women are more fertile and more produce children than old age. The total fertility rate is 4.2 in 1990 (Mitra *et al.*, 1993), but at present total fertility rate is 2.7. There has been a substantial decline in the crude birth rate in Bangladesh, it was 34.4 per thousand populations in 1986, declined to 30.8 in 1992, but at present 24 in 2008.

Mothers in the third world countries with their limited resources and cultural background, rarely give priority to their own health problems except when, there is a life threatening danger (Brady and Winikoff, 1992; Bhatia and Cleland, 1995). Pregnancy related complication is one of the most prime women's health problems especially is early pregnancy of the world's public health and its consequences are still the leading causes of death, disease and disability among young women of reproductive age in developing countries. It is more serious in case of developing countries like Bangladesh. About 320 mothers die per 100,000 due to pregnancy related complications every year. Maternal Mortality Ratio (MMR) did fall from 620 per 1000 live births in 1982 to 440 in 2000. The obstacles, which lead to maternal deaths in Bangladesh do not relate only to deficiencies in health care, they are largely social, cultural and economic. Bangladeshi many people live in slums and under the

poverty line. They can not think to save money for safety where it is too hard to get proper food. So, they can not be able to take proper care for maternity health.

In developed countries, people don't suffer lack of proper maternity treatment and <1% of mothers die from the complication of pregnancy and child born. But in developing countries, the picture is totally different from developed countries. In world, today about 529,000 women die every year due pregnancy related complication and childbirth and that most of the death occur in developing countries. Many of these factors are intertwined with gender inequality, reflected in women's lower status in the society. Most of them are resulted from poor socio-economic conditions, high fertility and the disadvantaged status of women, the latter responsible for limited access of women to key resources such as food and health care (Fauveau and Blanchet, 1989). Women who live in urban areas are often three times as likely to have delivery care as their rural counterparts (Stewart *et al.*, 1997). The majority of maternal deaths are due to unexpected complications. One of the reasons for this focus on skilled attendance at delivery is that epidemiological data relating to maternal deaths in developing countries shows that about two-thirds of deaths occur at around the time of delivery (Abou Zahr, 1998). During pregnancy, any woman can develop serious life threatening complications that require medical care. Because, there is no reliable way to predict, which women will develop these complications, it is essential that all women be treated with watchful expectancy during delivery and that emergency obstetric care remains within reach of all pregnant women (Maine and Rosenfield, 1999). These situations require

access to skilled care during delivery, with the implication that there will be benefits for care throughout the pregnancy for the mother as well as the neonate.

The World Health Organization (WHO) considers pregnancy during an early age (<18 ages) and >34 ages be to a time of high risk for poor maternity care and infant outcomes and teenagers suffer more complications of pregnancy (Hobcroft *et al.*, 1985; Hoffman, 1998; Senderowitz, 1995). Young age is a risk factor for poor maternal and infant outcomes, thus, a direct relationship between adolescents and poor maternal outcomes is often presumed (Reynolds *et al.*, 1998). It has been suggested that younger women tend to use health care service more than frequently than older women, because the availability of modern health care services has increased in recent years. A cohort effect may also be operating, since, generally older women tend to have lower educational levels due to lower availability of educational services in the past. On the other hand, experience and skills acquired by older women should have a positive influence on the use of health care service (Islam, 2003). In this context, the adolescent fertility is one of the major parts of fertility in Bangladesh. These facts have been the major motive of conducting the current research on determinants of adolescent fertility behaviour in Bangladesh.

Objective of the study: In present study based on following objectives:

- To identify the factors affecting of adolescent fertility
- To examine of the contribution of each of the determinants of adolescent fertility
- To investigate the factors affecting adolescent fertility to practice of contraception

MATERIALS AND METHODS

The data for the present study have been derived from the Bangladesh Demographic and Health Survey (BDHS), 2007.

In this study, we use simple percentage tables to analyze determinants of adolescent fertility reproductive behaviour using data from the BDHS 2007. The focus is on adolescent women aged 15-19 at the time of survey and it also adolescents women aged 20-24 to examine those, who are about to complete their adolescence.

RESULTS AND DISCUSSION

Teenage pregnancy and motherhood: Teenage mothers are more likely to suffer from severe complications during

Table 1: Percentage of adolescent's age 15-19 years who have living children or age with their first child, by selected background characteristics, Bangladesh, 2007

Background characteristics	Percentage of women who have living children	Percentage of women who are age at first birth	Percentage who have begun child bearing	No. of adolescents
Age				
15	26.10	10.90	37.00	138
16	37.30	25.40	62.70	185
17	49.20	44.60	93.80	260
18	59.90	53.50	113.40	387
19	58.80	62.20	131.00	378
Residence				
Urban	52.00	44.90	96.90	410
Rural	54.60	46.50	101.10	938
Education				
No education	65.30	52.10	117.40	144
Primary	58.20	48.80	107.00	383
Secondary	50.30	43.90	94.20	779
College and higher	38.10	38.10	76.20	42
Region				
Barisal	49.10	42.30	91.40	175
Chittagong	54.30	47.40	101.70	247
Dhaka	50.70	44.00	94.70	284
Khulna	49.80	40.70	90.50	209
Rajshahi	59.90	47.70	107.60	279
Sylhet	58.40	55.80	114.20	154

Computed from 2007 BDHS

delivery, which result in higher morbidity and mortality for both themselves and their children. Young mother also may not be sufficiently emotionally mature to bear the burden of childbearing and rearing. Table 1 shows, the percentage of women aged 15-19, who have living children or age at first child. As shown, 37.00% had begun child bearing by age 15, 62.70% by age 16 and 93.80% by 17. More of teenage mothers come from rural areas of Bangladesh, where early and forced marriage is the ideal. For example, 96.90% of urban mothers had begun child bearing, when compared to 101.00% of their rural counterparts. Delayed childbearing is strong related to education among young women age 15-19. Only 42% of the teenagers who completed college and higher education had begun childbearing, compared with 117.40% of those with no education. In addition, Sylhet division's teenager and Barisal division's teenager, respectively is likely to have more and less births than the other division's teenager.

Nearly three-fourth women age 15 have never given birth. The data indicate that whereas most adolescents have begun childbearing, have or given birth once, a small proportion have given birth twice and this proportion gradually declines as adolescent age increase on the other hand, the percentage of children who have 1 or 2+ children are also gradually increase as adolescent age increase. Table 2 shows, the distribution of women age 15-19 by number of children ever born; excluding those, who are currently pregnant and the mean number of

Table 2: Percentage distribution of adolescents 15-19 by number of Children Ever Born (CEB) Bangladesh, 2007

Age	Number of children ever born			Total	Mean number of children ever born	No. of adolescents
	0	1	2+			
15	73.90	26.10	0.00	100	0.26	138
16	62.70	34.60	2.70	100	0.40	185
17	50.80	45.80	3.50	100	0.53	260
18	40.10	49.90	10.10	100	0.70	387
19	31.20	54.80	14.00	100	0.83	378
Total	11.40	21.60	66.90	100	1.55	1348

Computed from 2007 BDHS

children ever born is 1.55. Again, about 10% of women age 18 have given birth to two children. By giving birth early and presumably with short birth intervals, these women and their children are at a higher risk of dying given the poor state of health facilities and nutrition available to them.

Proximate determinants of adolescent fertility: The major factor of proximate determining adolescent fertility is the early age at marriage and child bearing in Bangladesh. The populations, in which age at marriage is low tend to experience early child bearing and high fertility; hence, trends in age at marriage, type of union and age at first sexual intercourse and recent sexual activity must be considered. Table 3 shows that marital fertility is high at 96.40% married at such tender age. Marriage in Bangladesh marks the point in a women's life when childbearing becomes socially acceptable. This confirms the observation made earlier that there is a sexual revolution among adolescents in their husband of intimacy, pleasure and under a crumbling moral and economic order.

Fertility preferences: The desire for future childbearing is limit of young mothers. Vast majority of births are wanted to cease. In Bangladeshi culture women does not want any number of children <1 or 2. The BDHS data having only one living children is a reason to want to have at least two additional children. Table 4 presents data on the mean number of living children for aged 15-19 and 20-24 by background characteristics. The mean number of living children for women is slightly higher in rural areas than urban areas and it is inversely related to region and education. The mean number of living children in age group 15-19 years is highest in Sylhet (0.67%) and lowest in Barisal (0.55%) on the other hand, this figure difference in age group 20-24 years highest is Barisal and lowest in Khulna. Education is the main variables that is most strongly and consistently associated with delayed child bearing among adolescents in Bangladesh. The percentage of mean number of living children is gradually decreased as education increase in both age groups 15-19 and 20-24 years.

Table 3: Percentage distribution of adolescent's fertility by Proximate Fertility Determinates and selected characteristics

Variables	Percentage	Age(15-19)
Marital status		
Married	96.40	1300
Separated	1.80	24
Deserted	0.40	5
Divorced	1.10	15
Widowed	0.30	4
Total	100.00	1348

Table 4: Percentage distribution of adolescents aged 15-19 and 20-24 by mean number of living children by selected backgrounds

Background characteristics	Age women (years)		Total
	15-19	20-24	
Residence			
Urban	0.58	1.20	1.53
Rural	0.63	1.31	1.57
Region			
Barisal	0.55	1.31	1.57
Chittagong	0.65	1.27	1.57
Dhaka	0.60	1.28	1.57
Khulna	0.56	1.21	1.51
Rajshahi	0.66	1.27	1.54
Sylhet	0.67	1.26	1.56
Education			
No education	0.81	1.48	1.75
Primary	0.69	1.43	1.63
Secondary	0.55	1.20	1.34
College and higher	0.38	0.63	1.25

Computed from 2007 BDHS

Adolescents and fertility: Determining the level of knowledge of contraceptive methods and of services was a major objective of the Bangladesh Demographic and Health Survey (BDHS). Since knowledge of specific methods and the places where, they can be obtained is a pre-condition for use the BDHS data reveal that 12.20% of adolescents (age 15-19 years) knows modern methods and 0.01% knows no any methods. In terms of residence 30.40% urban respondents know modern method and knowledge is higher in rural areas where, 69.40% knows modern method. Regional differences show high knowledge in Dhaka division 21.10% followed by Sylhet 11.40% knowledge is lowest (Table 5).

Use of contraceptives method is widespread in Bangladesh. Table 6 reveals that about 15% teenagers no currently use any contraceptives method. Almost, all

Table 5: Percentage distribution of adolescents aged 15-19 by knowledge of contraception methods

Distribution of adolescents	Knows no methods	Knows modern methods
Total adolescent	0.01	12.20
Residence		
Urban	0.00	30.40
Rural	0.20	69.40
Region		
Barisal	0.00	13.00
Chittagong	0.10	18.20
Dhaka	0.00	21.10
Khulna	0.00	15.50
Rajshahi	0.00	20.70
Sylhet	0.10	11.40

Computed from 2007 BDHS

Table 6: Percentage distribution of adolescents aged 15-19 by method of contraception currently used

Methods currently used	%
Not using	15.30
Pill	13.20
IUD	8.60
Injection	6.90
Condom	9.50
Female sterilization	0.40
Male sterilization	1.40
Periodic abstinence	4.30
Withdrawal	10.30
Norplant	2.40
Number of areas	1348

Computed from 2007 BDHS

young women (in age group 15-19 years) more have used pills (13.20%), Withdrawal (10.30%) and (8.60%) than others methods.

CONCLUSION

Teenagers (adolescent age) is one of the vital indicators of influences fertility. This study provides empirical evidence that the institution of adolescent marriage in developing countries is costly for women in several dimensions. As a result of high rates of marriage at very young ages, girls in rural Bangladesh attain significantly less schooling, experience more frequent reproductive health complications have higher fertility and experience lower levels of gender equality in marriage. Determinants adolescent fertility behaviour in Bangladesh has long been a topic of interest to population research, because of fertility apparent direct relationship with lack of health facilities and indirectly with the poverty. Though it is difficult in poor setting Bangladesh, the regarding authority should take proper steps in improving the situation of mother education in rural areas as well as throughout the country. The fact that teenage marriage appears to be causally related to female outcomes in adulthood indicates that the current policy

focus on enforcing or instituting age of consent laws is justified in many contexts and legal bans on marriage below this threshold may be comparable in effectiveness and more feasible policy measures in settings, in which adolescent marriage is costly to prevent. Again, the impact of fertility also marriages related deepen on govt. policy.

As the country govt. policy will be cruel and actual then the country will be lie on fertility level and fertility rate with respect to fulfill consistency of natural resources. However, there is a real need for more in depth studies on this regard. Thus, necessary action in called for to reduce future level of mortality in the country in order to achieve better living conditions in future.

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