

CHARACTERISTICS OF ADOLESCENT RESPONDENTS ACCORDING TO USE OF CONTRACEPTION IN BANGLADESH

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ABSTRACT

The term 'contraceptive use' refers to the use of contraceptive method at any time before the date of interview without making any distinction between past use and current use. Any respondent reporting that she or her spouse had ever used some form of contraception was counted as an ever user regardless of the time of use. Also, an ever user might have used more than one method. The identification of the factors underlying the differentials of the contraceptive use will help in formulating strategies and programs for reducing fertility and thus improving contraceptive prevalence rate. It has been found that the regional variation in the rate of growth of population in Bangladesh is mainly due to the variations in the rate of contraceptive taking. The objective of the present section is to explore the relationship between socio-economic, demographic and programmatic factors and contraceptive taking. In order to detect covariates for multivariate analysis of ever and current use of contraceptives cross tables with associated statistics are performed and accordingly discussed here.

Key Words: Contraceptive, Adolescent, Respondent, Characteristic, Bangladesh.

Introduction

“Adolescence” or “young adulthood” is a relatively recent concept in relation to the focus of development programs, especially in developing countries where the transition from childhood to adulthood is rapid, marked by reproductive maturity and accompanying socio-economic privileges and responsibilities. The social construction of adolescence occurs in

response to expanded formal and nonformal educational opportunities for young men and women. Reproductive health (RH) is a major concern of the adolescent period, in part because earlier sexual maturation and later marriage have increased the period of risk for early or non marital pregnancy and exposure to sexually transmitted infections (STIs). Changes in familial and societal patterns and values have also resulted in a relaxation of social constraints associate with extra marital sexual activity. HIV infection is the most recent, and most serious, addition to the array of STIs common in this age group. Adolescence is also a period during which RH behavior is formed and thus can influence fertility regulation during the entire reproductive life cycle. Programs aimed, therefore, at behavioral changes in youth are likely to effect changes beyond the time in which the programs are implemented, as today's youth become tomorrow's adults.

Adolescent fertility has consequences well beyond the repercussions for the young women and their families. Adolescent childbearing, illness, and disability sometimes impose a heavy cost on society. The social and economic consequences of adolescent fertility can be related to factors of early marriage and early pregnancies that occur frequently in Ghana. Health consequences include complications of abortions and the RH risks of contracting STIs and HIV/AIDS. Teenage pregnancies may also contribute to young women dropping out of school. Adolescent females who give birth early in life not only face many possible health hazards but are also less likely to enjoy the benefits of education.

There are over one billion young people between the ages of the 10 and 19 in the world today. Adolescents comprise approximately one-fifth of the Worlds population and most of teenagers (84 percent) live in developing countries more than at any other time in history, the health, attitudes, values and actions of adolescents will define the further of their societies. Many of these societies are engaged in their own rapid transitions and face formidable challenges in providing the younger generation with the services, information and options necessary to make adolescence a time of opportunity rather than a time of risk. ("The World's Youth 2000 Data Sheet" prepared by Population Reference Bureau MEASURE Communication Wall Chart).

Adolescence, an interesting phase in human development, occurs over a period of eight to ten years. The starting point for changes in the body and motor skills for a boy may be as late as the last part of his 14th year. For a girl it may be as early as the first part of her ninth year. So, while we speak about average this and average that, keep in mind that the range of ages in which these processes occur- including development of language skills and the evolving sense of self – is far more important than the “average” ages.

The term “adolescence” is variously defined in studies like this one as “the state of process of growing up,” “the period of life from puberty to maturity” and “the period of transition from childhood to adulthood, (encompassing) both the development to sexual maturity, and to psychological and relative economic independence” (United Nations 1988a, IPPF 1994:5). The age range implied by such description is obviously imprecise. Operational definitions vary. The United Nations (1987,1988a,1989) chose to look at the reproductive behavior of teenagers; i.e., those in the age range 13 – 19, in its work on this subject. Bledsoe and Cohen(1993), the population Reference Bureau in its use of Demographic and Health Surveys data (1902; Yinger et al. 1992), and World Health Organization’s (1989a,1989b) work, The Health of Youth, focus on the age range 15 to 19. Studies of “youth” tend to address a broader and somewhat older age group-young people ages 15 to 24. Throughout this report, the term “adolescent” refers to women ages 15 to 19. Statements about “teenagers” and “teenage” behavior refer to the broader age range 13-19 (as an approximation of the post-puberty population under age 20),but as a practical matter most teenage reproductive behavior tends to occur in the age range 15 to 19 in most populations. At 1.2 billion this is the biggest-ever generation of young people and their number is increasing rapidly in many countries (UNFPA, 2003).The population of adolescents will continue to grow because of the growth momentum of age structure and the high fertility rate in the fast. Globally, the largest share of adolescents is and will continue to be in Asia, which has 60 percent of the world population (UNFPA, 1998).

Type of place of residence and use of contraception

There are social classes in which big family is not welcome. In lowering fertility urban women practice the effective methods of birth control. In developing countries like

Bangladesh there exists an inconsistent adoption of contraceptive in urban and rural areas. Level of socio-economic development of the regions provides different environments for contraceptive adoption (Stephen, Rindfuss and Bean, 1988).

Table 1 reveals the percentage distribution of respondents who have ever used and are currently using at least one contraceptive method in urban and rural areas. It can be seen from the table that ever use rate are higher in urban areas than rural areas but current use rate is higher in rural areas than urban areas.

The observed differential may be attributed to higher age at marriage, higher level of real income per person, better health services, educational facilities, employment of women in the modern sector and other social amenities in urban areas, which have effect of reducing fertility through the practice of contraception. Rural Bangladesh is lagging behind from modern facilities. The relatively higher economic cost of bearing children and lower economic value of children in urban areas, opportunity cost for mothers time might have played an important role in lowering the fertility of urban women through the practice of effective methods of birth control.

Again it can be seen from the table that the current use rate are higher in rural areas than urban areas because age at first marriage population are higher in rural areas than the urban areas, they are not wanted early child, So, they use contraceptive method. Chi-square test at 0.1 percent level of significance for ever use of contraception shows that there is an association between practice of contraception and place of residence.

Religion and use of contraception

Religion plays an important role in the early socialization process in the family. The people of Bangladesh practice a variety of religions like Islam, Hinduism, Christianity and Buddhism. Religiosity may be an important determinant of contraception.

In table 1, contraception use has been examined according to religion (Muslim and Non-Muslim). Table shows that about 50.75 and 40.21 percent of the Muslim and Non-Muslim respondents respectively have ever used at least one contraceptive. Furthermore,

Tables shows about 27.42 and 44.33 percent Muslim and Non-Muslim respondents are currently using contraceptive. So, it is clear that ever use rate is higher among Muslim than Non-Muslim respondents. But in case of current user we get vice-versa result.

Education of respondents and use of contraception

Female education has emerged as the single most important variable affecting both contraceptive use and fertility regulation. The powerful effect of education on reproductive behaviour is indeed undisputed. Female literacy has generally been found to be an association with lower fertility and higher contraceptive use (Caldwell, 1981, Cochran, 1979). Women education can also affect fertility through its effect on contraception use. Jejeebhoy and Cleland (1995) noted that within the family, educated women, by virtue of their better knowledge and greater decision-making authority and closeness with their better husbands, are better equipped to overcome costs of fertility regulation than are uneducated women. Educated women have a wider and more in-depth knowledge of contraception of at least one method of contraceptive.

Education has two effects: it raises age at marriage and within the marriage, it ultimately increases the use of contraceptives, even among newly-married women (Barkat-e-khud et.al 1997). Table 1 provides contraceptive prevalence rates by level of education. Both ever and current contraceptive uses are increase with the increase of education.

The Chi-square test at 0.1 percent level of significance shows that there is a significant association between ever used method and respondents' level of education.

Access to mass media and use of contraception

There are means of motivating men or women for family planning mainly on mass media. Exposure to modern mass media, such as listening to radio, read news paper and watching television, may have an effect on the contraception in country like Bangladesh because radio and television provide information relating health care, need for contraception and other related issues and thus expose women to modern ideas and views.

In table 1, practice of contraception by access to media has been examined. To test the association by Chi-square test at 0.1 percent level of significance, it is found that there is a significant association between only ever used method and access to mass media for read news paper and watching television.

Husband's occupation and use of contraception

Occupation of husband has been widely as an index of socio-economic status in the study of contraceptive use. The use of contraceptives tends to be high and fertility low among higher income occupations. In Lucknow; India, Saxena (1973:75) has observed that females with their husbands in higher occupations like professional, technical and related works and those engaged in administrative, executive, managerial and clerical works have lower fertility. From the table we can expatiate on the occupation of husbands determining the use of contraception. Ever use of contraception of adolescent women, whose husbands occupation is Business, is more time than whose husbands occupation are agriculture, service and others. But in case of current use of contraception of respondents whose husbands occupation is Agriculture, is more times than whose husbands occupation is other category.

The Chi-square value implies that at 0.1 percent level of significance there is a strong association between husbands occupation and only ever used of contraception but not current use of contraception.

Husband's education and use of contraception

Education is the most widely reported variable in studying the practice of contraceptive. The demographic transition literature and contemporary research in the Least Development Countries (LCD'S) have cited education as the single most important variable leading to large-scale fertility decline through the use of contraceptive. The WFS and CPS data do show a positive association between education and contraceptive use (Brackett, 1981). It is generally felt that if the parents are highly educated and employed in a better position then they will be quite conscious of having a limited family size and at the same time they will show favourable attitude towards the use of contraceptives.

From the table, we inspect that with the increase of education of husbands the practice of contraceptive increase. At every education level, the ever and current use rate of contraceptive increases by increase their education level. As for example, at “no education” level, the ever and current use rates by husbands are 39.69 and 28.44 percent respectively where as it is 81.68 and 31.30 percent respectively in higher education level.

The Chi-square test at 0.1 percent level of significance shows that there is a positive association between husband’s education and ever used contraceptive method.

Respondent currently working and use of contraceptive

The life pattern of most women in Bangladesh is conditioned by age-old tradition. Women are discouraged to work outside the household. But during the last decades several women in society. A working women can have a greater opportunity to participate in family decision making and have better husband wife communication. In her case, use of contraception is higher tending to lower fertility (Chowdhury:1976).

It is noticed from the table that the ever and current use of contraception among the respondents who are currently working are 53.15 and 27.48 percent respectively, whereas the respondents who are not working, are 49.38 and 26.91 percent respectively. i.e. currently working adolescent women practice contraception more than those who are not working.

Region and use of contraception

In this study we have six regions or division. From the table we observed that, both ever and current use of contraceptive rate is higher in Khulna division are 66.99 and 30.62 percent respectively than the other division.

Marital duration and use of contraception

Contraceptive use is positively related to the duration of married life. In case of ever use of contraceptives, it is found that the contraceptive use rate is 51.43 percent when the marital duration 0-4 and 39.24 percent when the duration is 5-9. It is also observed that 28.24

percent currently use contraceptive when marital duration is 0-4 years and 17.72 percent currently use contraceptive when marital duration is 5-9 years.

The Chi-square value at 5 percent level of significance shows that there is a positive correlation between marital duration and only current use of contraception.

Age at first marriage and use of contraception

Age at first marriage has emerged as one of the important determinants of current use of contraception. From the table it is seen that, the adolescent women whose age above 16 years practice contraceptive method more times than the adolescent women whose age less than or equal to 16 years

Desire for more child and use of contraception

In a traditional society like Bangladesh desire for additional children is the most important reason for non-use of contraception among all currently women of reproductive age. Respondents may have an access to contraceptive for birth spacing or birth limiting. When the respondents arrived at the desired family size and make up their mind to limit births, then they will have more access to contraceptives. It is observed from the table that both the ever and current use of contraceptive method are higher the respondents who have desire for more children than that of respondents who have desire no child.

Number of visits by FP field worker and use of contraception

Health workers remain a primary source of information about contraceptives in many countries. It is likely that visits of family planning workers provided opportunities to motivate women by providing them with counseling on family planning methods and family planning services and distributing supplies on a wide spread scale increases their availability (Muhury and Islam, 1985; Kabirs and others, 1988).

Bangladesh is predominantly a Muslim country and women are normally barred from activities outside their homes owing to the practice of purdah. Thus doorstep services offered by the Family planning Workers enabled the translation in to practical implementation of the

latent desires of women to limit their childbearing. Practice of contraception by the number of visits of family planning worker has been examined from the Table 1. It is clearly noticed that the more the number of visits of Family planning worker happen to respondents, the more they responds favourably to their use of contraception. Within the category “once” it is explored that the ever and current use rates of contraceptive taking are respectively 50.00 percent and 27.02 percent. The category “twice” it is explored that the ever and current use rates of contraceptive taking are respectively 51.61 percent and 25.81 percent and 3 or more visits to the respondents, it is explored that the ever and current use rates of contraceptive taking are 33.33 percent.

Number of living children and use of contraception

As contraception become widely available and commonly used, and the concept of fertility regulation became commonplace, contraception came to be extensively used for both birth spacing and limiting. Respondents who indicated that they had fewer living children when began using contraceptive than their preferred number presumably began contraception as a means to space births (i.e. delay the next pregnancy) while those the number of living children equaled or exceeded their current preferred number presumably practiced contraception to limit family size (i.e. prevent further births entirely). From table it reveals that about 50.24 percent of the adolescent respondents who have no children are ever use of contraceptives and the current rate of them are 28.73 percent. On the other hand 49.79 percent who have children are ever use contraceptive method and 25.52 percent are currently use contraceptive method.

Age of respondents and use of contraception

Ever use of contraceptive taking rises with the increasing level of age of women. From the table 1, it is seen that 45.82 percent of adolescents whose age below or equal to 16 years, 53.48 percent of adolescents whose age range is 16-18 years and 47.62 percent of adolescents whose age above 18 years are ever used of contraceptive method. On the other hand, 28.79 percent of adolescents whose age below or equal to 16 years, 30.45 percent of adolescents whose age range is 16-18 years and 19.58 percent of adolescents whose age is above 18 years are currently use contraceptive method.

The chi-square value at 1 percent level of significance shows that there is positive correlation between age of respondents and currently use of contraceptive method.

Table 1: Percentage distribution of adolescent respondent who have ever used and are currently using at least one contraceptive method by different characteristics

Background characteristics	Ever use	Current use
Respondent's Education		
No education	26.39 (38)	22.92 (33)
Primary	42.82 (164)	29.24 (112)
Secondary	55.97 (436)	26.19(204)
Higher	85.71 (36)	35.71(15)
Religion		
Muslim	50.75 (635)	27.42 (343)
Non-Muslim	40.21 (39)	44.33 (21)
Type of place of residence		
Urban	60.97 (250)	25.61 (105)
Rural	45.20 (424)	27.61 (259)

Division		
Barisal	41.14 (72)	23.43 (41)
Chittagong	44.13 (109)	29.15 (72)
Dhaka	56.34 (160)	27.11 (77)
Khulna	66.99 (140)	30.62 (64)
Rajshahi	50.18 (140)	24.37 (68)
Sylhet	34.42 (53)	27.2 (42)
Husband's occupation		
Agriculture	43.37 (144)	28.31 (94)
Service	50.87 (351)	26.95 (186)
Business	58.74 (168)	26.57 (76)
others	25.71 (9)	20.00 (7)
Husband's education		
No education	39.69 (127)	28.44 (91)
Primary	46.88 (218)	29.25 (136)
Secondary	51.75 (222)	22.38 (96)
Higher	81.68 (107)	31.30 (41)

Respondent currently working		Continued...
No	49.38 (556)	26.91 (303)
Yes	53.15 (118)	27.48 (61)
Marital duration		
0-4	51.43 (612)	28.24 (336)
5-9	39.24 (62)	17.72 (28)
Age of respondents		
below 16	45.82 (148)	28.79 (93)
16-18	53.48 (346)	30.45 (197)
above 18	47.62 (180)	19.58 (74)

Number of visits		
Once	50.00 (657)	27.02 (355)
Twice	51.61 (16)	25.81 (8)
Three or more	33.33 (1)	33.33 (1)
Desire for more children		
No more or none	48.65 (72)	24.32 (36)
Have another child	50.52 (582)	27.17 (313)
Age at first marriage		
below 16	49.03 (530)	26.83 (290)
above 16	53.93 (144)	27.72 (74)
Access to mass media		
**Listen to the radio		
No	50.77 (461)	28.30 (257)
Yes	48.41 (213)	24.32 (107)
**Read newspaper or magazine		
No	51.81 (430)	26.75 (222)
Yes	64.98 (154)	28.69 (68)
Watch television		
No	39.32 (221)	28.65 (161)
Yes	57.63 (453)	25.83 (203)
Number of living children		
No child	50.24 (313)	28.73 (179)
Have child	49.79 (361)	25.52 (185)
Total	50.00 (674)	27.00 (364)

Table 2: Cross tabulation and associated summary statistics for ever and current use of contraceptive

Variables	Ever use			Current use		
	Chi-square Value	D.F	Significant level	Chi-square Value	D.F	Significant Level
Respondent's Education	64.391	3	0.000	3.038	3	0.386
Religion	0.958	1	0.328	0.000	1	0.983
Type of place of residence	39.069	1	0.000	0.363	1	0.547
Division	45.377	5	0.000	2.125	5	0.832
Husband's occupation	30.484	3	0.000	1.972	3	0.578
Husband's education	73.038	3	0.000	3.694	3	0.296
Respondent currently working	0.656	1	0.418	0.633	1	0.426
Marital duration	0.690	1	0.406	3.664	1	0.056
Age of respondents	6.908	2	0.032	8.696	2	0.013
Number of visits	1.242	2	0.537	0.153	2	0.926
Desire for more children	0.001	1	0.971	0.440	1	0.507
Age at first marriage	1.514	1	0.219	0.191	1	0.662
Husband lives in house	3.641	1	0.056	2.622	1	0.105

Conclusion

From the study of contraception, it is found that 50 percent of adolescent respondents are ever user of contraception, whereas 27 percent are currently using contraceptive methods. Both the figures are not encouraging in the context of fertility rate in Bangladesh. This low use rate prevailing in our country due to illiteracy, religiosity, lack of better communication with Family Planning field workers, lack of husband-wife communication regarding family planning and poor access in media. It is found that 33.8 percent of respondents never used any method of contraception, the percentage of ever use of modern method is 63. Use of contraception by different methods show that pill is widely used by the respondents, which is followed by injection and condom respectively. In future, about 43.3 percent respondents are intended to use pill whereas, about 36.6 percent did not decided yet about future use of any methods. This means that awareness about contraception is still not clear among the respondents.

The study shows that several socio-economic and demographic characteristics influence on contraceptive use. Among these characteristics, region is one of the most important variables, which have influenced on contraceptive use. In the study, differences in contraceptive use are found to be markedly high amongst administrative division. This aspect of area variation in contraceptive use has been extensively discussed has been extensively in various studies (Kamal and Cleland, 1996; Mohsena and Kamal, 2006). The percentage of contraceptive method (pill, condom, injection, etc) use is highest in Barisal division and Sylhet division has shown the worst performance. UNFPA has already taken this matter into consideration and has opened a branch of UNFPA in Sylhet division so that concerted efforts can be made to serve the population with adequate FP and safe motherhood service (Mohsena and Kamal, 2006). On the other hand both ever and current use of contraceptive method is highest in Khulna division. The issue of contraception is considered to be extremely private and confidential, and women in rural Bangladesh feel shy to express a desire to limit family size

(Kamal, 1994). Our study shows that urban women are more likely to ever use of contraception than their counterparts in rural area. But the rural women are more likely to current use of contraception than their counterparts in urban area.

References:

- Balnc, A.K. and Way, A.A. 1996 Studies in Family Planning, 29(2), 106, Bangladesh
- Bureau of Statistics (BBS) 1994 Bangladesh population census Report 1994, National Volume, Dhaka, Bangladesh.
- Bangladesh Bureau of Statistics (BBS) 2001 Bangladesh population census 2001, National Volume, Statistics Division, Ministry of Planning, Dhaka, Bangladesh.
- Aziz, K.M.A and C. Maloney 1985 “Life Stage, Gender and Fertility in Bangladesh”, Dhaka: International center for Diarrhoea Disease Research, Bangladesh, ICDDRDB.
- Bongaarts, J 1990 The measurement of Unwanted Fertility, *Working Paper No. 10*. The Population Council, New York.
- Brackett, James W. 1978 “Family Planning in four Latin American Countries: Knowledge, Use and unmet need”, International family planning perspectives and Digest 4(4): 116-123
- Akanda, L., and I. Shamim. 1985. Women and violence: A comparative study of rural and urban violence in Bangladesh. *Women’s Issue 1*: 1-32.
- Bangladesh Bureau of Statistics (BBS). 2001. Statistical year book of Bangladesh 1999. Dhaka, Bangladesh: BBS.
- Bangladesh Bureau of Statistics (BBS), Planning Division, Ministry of Planning. 2007. Population Census – 2001, National Series, Vol. 1 Analytical Report. Dhaka, Bangladesh: BBS.
- Bangladesh Bureau of Statistics (BBS). 2008b. Statistical year book of Bangladesh 2006. Dhaka, Bangladesh: BBS.
- Bangladesh Bureau of Statistics (BBS). 2008c. Report on sample vital registration system, 2007. Dhaka, Bangladesh: BBS.
- Bangladesh Bureau of Statistics (BBS) and UNICEF. 2007. Multiple Indicators Cluster Survey Bangladesh 2006, Key findings. Dhaka, Bangladesh: BBS and UNICEF.

- Bennett, L.R., and L. Manderson. 2003. Introduction: Gender inequality and technologies of violence. In *Violence against women in Asian societies*, ed. L. Manderson and L.R. Bennett. New York: Routledge Curzon.
- Boerma, T.J. 1988. Monitoring and evaluation of health interventions: Age- and cause-specific mortality and morbidity in childhood. In *Research and interventions issues concerning infant and child mortality and health. Proceedings of the East Africa Workshop, Manuscript Report 200e*. Ottawa, Canada: International Development Research Center. 195-218.