OPEN ACCESS Freely available online
www.banglajol.info/index.php/JSF
Journal of Science Foundation
January 2018, Vol. 16, No. 1, pp. 3-7
ISSN (Print) 1728-7855
DOI: http://dx.doi.org/10.3329/jsf.v16i1.38172

Original Article

Socio-Demographic Characteristics of Teenage Pregnancy: Experience of 50 Cases of Bangladesh

Rumi Farhad Ara[1], Jahangir Alam[2]

Abstract

Background: Teenage pregnancy is a huge problem in developed as well as developing countries. **Objective:** The purpose of the present study was to see the socio-demographic characteristics of teenage pregnant mother. **Methodology:** This cross-sectional study was conducted in the Department of Obstetrics and Gynecology, Dhaka Medical College & Hospital, Dhaka, Bangladesh and Sir Salimullah Medical College & Mitford Hospital, Dhaka, Bangladesh from April to July 1999 for a period of four (4) months. The teenager mothers with the age group of 11 to 19 years who were admitted in the study period was selected as study population. At the time of entry, all relevant parameters like religion, residence, occupation, education and monthly income were recorded in a predesigned data sheet. **Result:** A total number of 50 teenager mothers were recruited for this study. Majority of the study population were Muslim which was 45(90.0%) cases followed by Hindu which was 3(6.0%) cases. Maximum were non-city dweller which was 26(52.0%) cases followed by city and slum dwellers which were 16(32.0%) cases and 8(16.0%) cases respectively. Majority of the study were housewife which was 49(98.0%) cases. Monthly income was less than 3000 taka in 29(58.0%) cases. Majority of the study population were completed the primary education level which was 26(52.0%) cases. Married was found in 49(98.0%) cases. **Conclusion:** In conclusion Muslim non-city dwellers housewife were the most common group of teenager mother. *[Journal of Science Foundation 2018;16(1):3-7]*

Keywords: Teenage pregnancy; socio-demographic; teenager mother

*[**Reviewed:** 3 October2017; **Accepted on:** 1 November 2017; **Published on:** 1 January 2018]*

Introduction

Teenage pregnancy causes a great problem in developing countries like Bangladesh (Nessa et al., 2014). This type of pregnancy can result in lot of hardship for the women including various health conditions, poor

[1]Associate Professor, Department of Gynaecology & Obstetrics, Kushtia Medical College, Kushtia, Bangladesh
[2]Associate Professor, Department of Surgery, Shaheed Suhrawardy Medical College, Dhaka, Bangladesh

Correspondence: Dr. Rumi Farhad Ara, Associate Professor, Department of Gynaecology & Obstetrics, Kushtia Medical College, Kushtia, Bangladesh; Email rumidr12@gmail.com; Cell no.: +8801711480437

living habit and huge burden of child upbringing (Dutta 2014). These factors lead to cause lot of damage to the teenage mother's psychology.

In 2015, a total of 229,715 babies were born to women aged 15 to 19 years, for a birth rate of 22.3 per 1,000 women in this age group (CDC 2017). This is another record low for U.S. teens and a drop of 8% from 2014. Birth rates fell 9% for women aged 15 to 17 years and 7% for women aged 18 to 19 years (Martin 2017). Although reasons for the declines are not totally clear, evidence suggests these declines are due to more teens abstaining from sexual activity, and more teens who are sexually active using birth control than in previous years (Santelli et al., 2007; Lindberg et al., 2016). Still, the U.S. teen pregnancy rate is substantially higher than in other western industrialized nations (Martin 2017) and racial/ethnic and geographic disparities in teen birth rates persist (Santelli et al., 2007).

Pregnancy can occur around 12 or 13 years of age and being the stage at which a female becomes potentially fertile (CDC 2017). It has been reported that 16% of women, aged 15 to 19 years, have already started childbearing (Martin 2017). In rural regions, the rate is much higher that is 21.21% than it is in urbanized areas (Nessa et al., 2014). There are some social factors which are directly related with the teenage pregnancy.

In India, studies have showed a rate of teenage pregnancy from 5.1% to 33.17% (Dutta 2014). In developed regions, teenage mothers tend to be unmarried, and adolescent pregnancy is seen as a social issue, whereas, in developing countries, such pregnancies mostly occur in married teenagers, and their pregnancy is most often welcomed by family and society (Lindberg et al., 2016). This present study was undertaken to see the socio-economic condition of teenage pregnancy at a tertiary care hospital in Bangladesh.

Methodology

This was a descriptive type of cross-sectional study. This study was conducted in the Department of Obstetrics and Gynecology, Dhaka Medical College & Hospital, Dhaka, Bangladesh and Sir Salimullah Medical College & Mitford Hospital, Dhaka, Bangladesh from April to July 1999 for a period of four (4) months. The teenager mothers with the age group of 11 to 19 years who were admitted in the study period were selected as study population. Pregnant women with the age group of more than 19 years were excluded from this study. Pregnancy status was confirmed by ultrasonography and other relevant test. At the time of entry, all relevant parameters like religion, residence, occupation, education and monthly income were recorded in a predesigned data sheet. Monthly income was assessed. Patients were grouped into three groups according to their average income. Details about antenatal check-up were asked. Statistical analysis was performed by the Statistical package for the Social Science (SPSS, Texas, USA) version 22.0. The qualitative variables were expressed as frequency and percentage.

Results

A total number of 50 teenager mothers were recruited for this study. Majority of the study population were Muslim which was 45(90.0%) cases followed by Hindu which was 3(6.0%) cases. However the others religion was found in only 2(4.0%) cases (Table 1).

Table 1: Distribution of Religion among the Study Population (n=50)

Religion	Frequency	Percentage
Muslim	45	90.0
Hindu	3	6.0
Others	2	4.0
Total	**50**	**100.0**

Regarding residency, maximum were non-city dweller which was 26(52.0%) cases followed by city and slum dwellers which were 16(32.0%) cases and 8(16.0%) cases respectively. From this result it was clear that the most of the patients were from the non-city residents. Furthermore city residents were the next highest number of the patients. However, slum dweller was also present in this study (Table 2).

Table 2: Distribution of Living Area among the study Population (n=50)

Resident	Frequency	Percentage
City dweller	16	32.0
Non-city dweller	26	52.0
Slum dweller	8	16.0
Total	**50**	**100.0**

Majority of the study were housewife which was 49(98.0%) cases. Day worker was found in 1(2.0%) case (Table 3).

Table 3: Distribution of Study Population according to Occupation

Occupation	Frequency	Percentage
Housewife	49	98.0
Day worker	1	2.0
Service	0	0.0
Total	**50**	**100.0**

Monthly income was less than 3000 taka in 29(58.0%) cases. However, monthly income in the range of 3000 to 5000 taka was in 13(26.0%) cases. Only 8(16.0%) cases were in the group of more than 5000 taka (Table 4).

Table 4: Distribution of Study Population according to Monthly Income (n=50)

Monthly Income	Frequency	Percentage
Less Than 3000 TK	29	58.0
3000 to 5000 TK	13	26.0
More Than 5000 TK	8	16.0
Total	**50**	**100.0**

Majority of the study population were completed the primary education level which was 26(52.0%) cases. Illiterate was in 11(22.0%) cases. Can give the signature was in 7(14.0%) cases (Table 5).

Table 5: Educational Status of the Patients

Educational Status	Frequency	Percentage
Illiterate	11	22.0
Can sign only	7	14.0
Primary education	26	52.0
Secondary education	6	l2.0
Higher Secondary	0	0.0
Total	**50**	**100.0**

Married was found in 49(98.0%) cases and only 1(2.0%) case was reported as unmarried (Table 6).

Table 6: Marital Status of the Study Population

Marital Status	Frequency	Percentage
Married	49	98.0
Unmarried	1	2.0
Total	**50**	**100.0**

Discussion

Bangladesh is a developing country with about 16 crore populations (Nessa et al., 2014). About half of this population are women and 3.4 million (15.4%) belong to less than 20 years of age (CDC 2017). Perinatal period of life is most neglected in the developing countries (Lindberg et al., 2016). The poor perinatal situation in Bangladesh is reflected by percentage of LBW and low mean pregnancy weight gain (Nessa et al., 2014). Current status of adolescent reproductive health in Bangladesh shows that mean age of first marriage is 15 years, and 27 percent of teenage girls are mothers (Sarkar et al., 1991). The present study was done on 50 teenage pregnant mothers admitted in Dhaka Medical College Hospital and Sir Salimullah Medical College & Mitford Hospital, Dhaka, Bangladesh. These are the important referral hospitals of the country.

Majority of the study population were Muslim which was 45(90.0%) cases followed by Hindu which was 3(6.0%) cases. Bangladesh is a Muslim majority country, therefore this data reflect that issue. The second largest minority of religion is the Hindu. However there is no such type of studies which have been found that gives in support of this. It has been said that teenage pregnancy is the common trend.

In this study regarding residency, maximum were non-city dweller which was 26(52.0%) cases followed by city and slum dwellers which were 16(32.0%) cases and 8(16.0%) cases respectively. Similar to the present study result, it has been reported that 52.0% percent of teenage patients are non-city dwellers. Study of Sarker et al (1991) shows 51.3 percent from rural area which is comparable to present study.

In this series, majority of teens are housewives (90%) and belongs to low income group (84%). Majority of patients are from low and middle class socioeconomic status. Yoder et al[8] have found in their study that teenage groups are of predominantly lower income group which is consistent with the present study result. In another study it has been reported by Tufail et al (2008) that most teenage pregnancies occur in the lower socioeconomic group; however, especially the unmarried with increasing sexual freedom, teenage pregnancies are also increasing in the higher socioeconomic group, but the rate of abortion in this group is high.

Majority of the study population were completed the primary education level which was 26(52.0%) cases. Illiterate was in 11(22.0%) cases. Can give the signature was in 7(14.0%) cases. Lack of knowledge and education are the main factors that play role in the teenage pregnancy. The teenage group is very vulnerable regarding the reproductive health. Married was found in 49(98.0%) cases and only 1(2.0%) case was reported as unmarried. They don't know about the use of contraceptives; therefore they become pregnant (Barkat and Majid 2003; Bari et al., 2002; Banerjee et al., 2009).

Married was found in 49(98.0%) cases and only 1(2.0%) case was reported as unmarried. The teenage marriage is also an important factor that plays a key role for the causation of teenage pregnancy. Barkat and Majid (2003) have reported a similar study result and have added that due to social stigma there is an increase trend of teenage pregnancy.

There are some limitation so this study. Great majority of childbirths take place at home with help of traditional birth attendants or family members and there is no civil registration. Most of the peoples are not aware of the health facilities available. They only attend hospital when complication arises. So, from this small percent of population who attend the hospital, exact situation of the whole country cannot be calculated. Hospital stay is only for a short period. Therefore, the exact number of teenage pregnancy is underestimated.

Conclusion

In conclusion Muslim is the most common religion representing the teenage pregnancy. The non-city dwellers are the common resident. Majority of the study population have completed that primary education

or illiterate. Most of the study populations are married coming from low socio-economic group. Further large scale study should be carried out to observe the actual picture.

References

Banerjee B, Pandey GK, Dutt D, Sengupta B and Mondal M. Teenage Pregnancy: A socially inflicted health hazard. Indian J Community Med 2009; 34: 227-231

Bari W, Chowdhury RT, Islam MA, Chacraborti N, Akhter HAH. The determinants of perinatal mortality in rural Bangladesh. European J Contra Repro HC 2002;7(48):216-222

Barkat A, Majid M. Adolescent and youth reproductive health in Bangladesh: status issues policies and programs. 2003;1-10

Center for Disease Control. Teen Pregnancy in the United States. Last reviewed: May 4, 2017; updated on: May 9, 2017; Viewed on: 18 December 2017; [https://www.cdc.gov/teenpregnancy/about/index.htm]

Dutta I. Teenage pregnancy–A Socio-demographic study at a Rural Medical College Hospital in Southern India. Asian J Med Sci 2014;5(4):29-33

Lindberg LD, Santelli JS, Desai, S. Understanding the Decline in Adolescent Fertility in the United States, 2007–2012. J Adolesc Health 2016: 1-7

Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National vital statistics report; vol 66, no 1. Hyattsville, MD: National Center for Health Statistics. 2017

Nessa K, Zebunnesa M, Bari N, Saleh AB. Study of Some Sociodemographic Factors in Teenage Pregnancy. Chattagram Maa-O-Shishu Hosp Med Coll J 2014;13(3):21-5.

Santelli J, Lindberg L, Finer L, Singh S. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. Am J Public Health 2007;97(1):150-6

Sarkar CS, Giri AK, Sarkar B. Outcome of teenage pregnancy and labour: a retrospective study. J Indian Med Assoc 1991;89(7):197-9

Tufail A, Halima A, Hasmi. Maternal and Perinatal outcome in teenage pregnancy in a community based hospital. Pakistan J Surg 2008;24(2):130-134

Yoder BA, Young MK. Neonatal outcomes of teenage pregnancy in a military population. Obstet Gynecol 1997;90(4):500-6