

## Reproductive Health Care Seeking Behavior of Adolescent Mothers in Rural Area of Bangladesh

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### Abstract:

Adolescent are large and growing segment of population of the world. A cross sectional study was done to assess the reproductive health care seeking behavior of rural Adolescent mothers. The study was conducted during the period of January to December 2015. The sample size 227 Adolescent mothers was selected purposively. Data was collected face to face interview through semi structure questionnaires. The analysis of data was done with Statistical Package for Social Science (SPSS) program, 19 versions, of computer on the basis of difference variables. The study was found 68.3% of respondents were received first treatment from Govt. hospital, 71.4% were received treatment from Govt. doctor, 58.6% were received treatment delayed (3-7) days after developing physical problem, 41.4% were helped by their mother-in-law, 59.9% were not taken decision for health care by themselves, 95% were taken antenatal care during pregnancy among them 62.5% were treatment received from private hospital/clinic and 27% of respondents went hospital 4 times for ANC, all 100% respondents had done physical examination and 85.6% had done blood and urine test, 87.5% of respondents had no complications before delivery, 66.7% had abdominal pain, Among them 96.3% were taken Allopathic treatment for complications, 54.5% of respondents had no treatment during pregnancy due to having no support from family, 71.8% had their delivery in hospital, 46.9% of respondents delivery at home due to no complication, 74% home delivery had delivered by trained Dhai, 64.4% of respondents done Caesarian section among them 37.1% had done caesarian section due to abnormal condition of fetus, 70.5% had check-up after delivery (PNC), Around 61.9% had the check-up 2 times, 65.7% due to having no problem, less than half 41.7% due to vaginal tear, 75% taken treatment for the problems, 44.4% taken treatment in private clinic, 52.% of respondents used birth control methods before, 54.2% of the respondents used now, 59.3% of respondents used oral contraceptive pills, 83.7% of respondents used birth control methods due to maintain interval between two children, 69.2% not suffered from reproductive health problems. The differences between age and taking decision for reproductive health care seeking were found to be statistically significant ( $p < .05$ ). This situation requires attention of every section of society in order to prevent Adolescent reproductive health problem and improve care seeking behavior.

**Keywords:** Reproductive Health, Health Care Seeking Behavior, Adolescent Mother, Rural Area.

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### INTRODUCTION

Adolescence is one of life's most fascinating and complex stages of human life. The World Health Organization defines adolescents as young people aged 10-19 years (WHO, 2002). It is the time when young people take on new responsibilities and start experiencing life with independence (UNICEF, 2003 and WHO, 2002). In the process of experiencing this independence adolescent girls and boys start having internal and external pressures, which force them to indulge in premature sexuality at a very young age. These adolescents start feeling the urge to have sex as early as 10 to 15 years when they are still at school (Kanthiti, 2013).

The adolescents (10-19 years) constitute about 23% of the population in Bangladesh. The annual growth rate of the adolescent population is 4.3% compared to 1.37% general population growth rate. Early marriage and motherhood are common in Bangladesh. About 50% of all 15-19 years old females are married,

of whom about 33% are already mothers, and another 6% are pregnant having risks to their health. Their knowledge on unprotected sex is also limited that may expose them to STDs, unwanted pregnancies, and abortions. In consideration of the above facts, the adolescent health program has been incorporated into school health program under HPNSDP running 2011-2016. The objectives of the program include; (i) improvement of knowledge of adolescents on adolescent reproductive health issues; (ii) creation of positive changes in the behavior and attitude of the gate-keepers of the adolescent toward reproductive health; (iii) providing easy

access of all adolescents to adolescent-friendly and related health and other services. The adolescent health program provided training of trainers in 2011-2012 to 121 officers of both health and education departments to train the field-level health workers, teachers, and students, provided training to 1,118 health personnel and 1,889 secondary and higher secondary teachers of Kushtia, Rangpur and Mymensingh district to develop their skills for fostering the objectives of adolescent health program (BDHS, 2013).

They are large and growing segment of global population. Many countries in the world are undergoing demographic transition and therefore today's world is facing the largest generation of adolescents ever in history. In Bangladesh, about 23% of the total population is adolescent (Population Census, 2012). Health and well-being of adolescents are challenged by several environmental factors, including family, peer group, school, neighborhoods, socioeconomic status, political instability, and socio-cultural factors. They frequently indulge in health-related risky behavior with widespread consequences. More than 33 percent of the disease burden and almost 60 percent of premature deaths among adults stem from risky behavior and conditions adopted during period of adolescence (WHO, 2012). Many such risk processes that lead to chronic non-communicable diseases in later life, include tobacco, alcohol, and illicit substance misuse, unsafe sex, malnutrition, obesity, and lack of physical activity (Gore *et al.*, 2011). Besides health consequence, these issues often bring familial sufferings and disharmony, social unrest and thus disrupt peace in society. Adolescence-related risk factors are existent across the world although their magnitude varies from country to country. Health need of this young generation is poorly addressed by existing social attitude and current health programmers. The Millennium Development Goals (MDGs) have incorporated only sexual and reproductive health issue (Beaglehole *et al.*, 2013).

A growing concern of immense public health importance has emerged considering the potential impact of unhealthy behaviors practiced by adolescents. Therefore, diseases experienced during adolescence and risk factors with their roots in adolescence should be focused for attention. Globally, adolescents are the most vulnerable group of acquiring sexually transmitted diseases (STD) including HIV/AIDS. Of the reported cases of HIV infection half occur in people under age 25 (UNAIDS, 2013). This vulnerability is related to lack of knowledge regarding safer reproductive health, safe sexual behavior and health seeking behavior for reproductive health (RH) illnesses (Barkat *et al.*, 2012). Rapid urbanization, increased sexual behavior and prostitution involving adolescent girls has begun to fuel STD and HIV transmission in some part of the world (Senanayake & Ladjali, 2013). Unsafe/unprotected sexual behavior also put adolescent girls at risk of unintended teen-age pregnancy, iatrogenic abortion, genital tract hemorrhage and infection, contributing to high Maternal mortality ratio (MMR) and a high infant mortality rate (IMR) (Save the Children U.S.A. 2014). In Bangladesh, adolescents have been identified as an under-served priority target under existing health programmers. WHO has advocated measurable adolescent health indicators in the national adolescent health programs but the main focus of adolescent health programs is on sexual and reproductive health, including prevention of HIV infection. Holistic efforts encompassing areas of health, education, legislation is needed to address all-important issues such as nutrition, healthy lifestyles, mental health and mental well-being, substance abuse, prevention of violence and injuries as well as sexual and reproductive health. Adolescent Friendly Health Services (AFHS) which provide a broad range of preventive, primitive and curative services under one roof can help to ensure improved availability, accessibility and utilization of health services. Parents, members of the community, service providers, and social institutions have responsibility to both promote adolescent development and adjustment and to intervene effectively when problems arise. Adolescents are important family, social and national asset. Health outcomes for adolescents and young Bangladesh J Child Health 2014;60 adults are grounded in their social environments and are frequently mediated by their behaviors. This phase of life if nurtured will contribute to prosperity but if neglected will have serious repercussions on the individual's health and well-being as well as an adverse effect on the national economy and development. This study has been carried out to find out the status of reproductive health care seeking behavior of rural adolescent mothers.

In rural areas of Bangladesh, people are in a vulnerable situation in terms of health care facilities. This situation is worse for women when it comes to their health care seeking behaviors and the services they received during pregnancy and after childbirth. Health care seeking behavior is not an isolated event; rather, it is an integral part of a woman's status in her family and community. It is a result of an evolving mix of her personal, familial, social, religious, and economic factors. The process of seeking health care can be too complicated to be described in a straightforward term. A woman's decision to seek a particular health care service is the composite result of her personal needs, social forces, the availability and qualifications of the care providers, and the location of the services. Some factors that might affect women's health care seeking behaviors for safe motherhood in rural areas of Bangladesh are age at marriage, age at childbirth, education level, work status, economic status, location of the residence, and husband's awareness and so on. Another serious problem in this regard is that there are many non-qualified health care providers in Bangladesh who provide services in rural areas do not have formal medical education and a government-issued license for providing medical

services. Another serious problem in this regard is that many sales persons at drug stores provide services. It has been

noticed that people go to drugstores, explain their illness to a salesperson, and seeks health care services from them. It is a common practice for the salespersons to sell medicine without a prescription from a doctor. Salespersons at drugstores and non-qualified providers make the health care sector very dangerous for the general people. *Bangladesh e-Journal of Sociology*. Volume 9, Number 2. 2012.

Rahman (2000) found that in rural areas of Bangladesh 86 percent of women received health care services from non-qualified health-care providers. The importance of safe motherhood to the overall development of a country has already been acknowledged at the highest levels. Without improving women's health care seeking behavior regarding safe motherhood, the overall development of the country will be hindered (Akter, 2012).

Adolescent childbearing has now become a global concern due to the potential impact on individual health or socio-economic consequences and also because of broader development implications. Each year, about 16 million girls aged (15–19) give birth and about 2 million girls give birth before the age of 15 in low-income countries (LIC). Because of the severity of the problems of adolescent childbearing, the first substantive UN General Assembly adopted the resolution of banning of all kind of child, early and forced marriage. Adolescent pregnancy is associated with substantial health risks for both the girls and their newborns. It is associated with maternal complications, anemia and Caesarean delivery, and with complications for infants such as premature birth, low birth weight, prenatal mortality and increased infant mortality. Annually, about 70,000 adolescents die of causes related to pregnancy and childbirth in LIC. Physical immaturity, poverty and lack of education which influence access to health services, health beliefs, social structure and customs including the power in decision-making process to use services, willingness to be pregnant and unsafe abortion are major determinants of maternal and newborn mortality and morbidity. Adolescents are less likely to receive antenatal and post-partum care than older women, and facility-based deliveries are also less common than for adult women. Over the past three decades, unlike other low-income countries, Bangladesh has dramatically reduced maternal mortality ratios and increased the use of contraceptives. Despite substantial improvement of several maternal health indicators, adolescent childbearing remains a persistent problem in Bangladesh. Child marriage has traditionally been the leading cause of pregnancies among adolescent girls. About 66% of adolescent girls get married before the age of 18; 33% of them become pregnant by the age of 19. Although several studies have been conducted in Bangladesh on the use of maternal health services by adolescent women, none of these thoroughly reviewed the literature to explore all aspects of their health care-seeking behavior. Hence, this systematic review aimed to fill the gap, to help policymakers, programmer planners and researchers improve the maternal health of adolescent women in Bangladesh. Shahabuddin. (2015).

The researcher's intention was to develop health promotion guidelines to promote adolescent mother's health seeking behavior of adolescent mothers. There is a dearth of study related to identifying the reproductive health care seeking behavior in rural adolescent mothers in Rural Areas in Bangladesh. Therefore, it is necessary to conduct the study on the reproductive health care seeking behavior in rural adolescent mothers in rural areas of Bangladesh.

## **Research Objectives**

### **General objective**

To assess the reproductive health care seeking behavior in rural adolescent mothers in Rural Areas.

### **Specific objectives**

- To find out the pregnancy related care seeking behavior of adolescent mothers.
- To assess the use of contraceptive method in adolescent mothers.
- To find out the factors related to reproductive care seeking behavior of adolescent mothers.
- To identify the socio-demographic characteristics of adolescent mothers in rural area.

## **MATERIALS AND METHODS**

### **Study Design**

It was a descriptive type of cross-sectional study, conducted among adolescent mother who have at least one child.

### **Study Period**

The study was conducted for the one year during the period of January 2015 to December 2015. It started with literature review, then protocol presentation, data collection and finished with final report submission.

### **Study Place**

The study was carried out in rural area in Chandpur Matlab (Charmukundi, Dogorpur, Kaladi, Baispur).

### **Study Population**

The study was conducted among adolescent mothers who have at least one child (age 2 to 12 months) and age between 13-19 years.

### **Inclusion Criteria for Study Subjects**

- Respondents are available on the spot at the time of data collection.
- Adolescent mothers who have at least one child.
- Voluntary participate in the study.

### **Exclusion Criteria for Study Subjects**

- Severely ill.
- Adolescent mothers who have at least one child in selected area but deny taking part in this study.
- Second time participation.
- Suffering from mental problem.

### **Sample Size**

Sample size was determined by using formula is:

$n =$

$$Z^2 pq / d^2$$

re,

$n =$  the desired sample size for the study population.

$z =$  the standard normal deviation. Usually set as 1.96 at 5% level which corresponds to 95% confidence level.  $p =$  It is the assumed target proportion to have a particular characteristic. (In this study proportion of respondent with particular characteristics ( $p$ ) is unknown. So, the best choice is  $p = 50\%$  (0.50), was used.

$$q = 1 - p = (1 - 0.5) = 0.5$$

$d =$  degree of accuracy, usually set as 5% (0.05) at 95% confidence level. Ultimate sample size will be,

$$n = Z^2 pq / d^2 = (1.96)^2 \times 0.5 \times 0.5 / (0.05)^2 = 384.$$

However, for convenient of the researcher determined the sample size of this study was 227 respondents.

### **Sampling Technique**

The respondents were selected by purposive sampling. The respondent who met the inclusion criteria were approached and asked to participate in the study and those who did not meet the criteria were excluded from the study.

### **Research Instruments**

A pretested, semi-structured questionnaire was used to collect information from adolescent mothers.

The instruments were prepared keeping in view the objectives and variables of the study.

**Data collection procedure:** At the beginning of data collection, permission from commissioner was taken. A pretested semi-structured questionnaire was used for data collection and the respondents were Adolescent mother's. The purpose of the study was explained in details to the respondents. After that verbal consent as per selection criteria of the study, data from the respondents were collected through face-to-face interview. Questions were asked in Bengali. The respondents were given full assurance on some ethical point of view that under no circumstances any part of the interview will be disclosed to any unauthorized person. Collected data were checked and verified at the end of work. Any inaccuracy and inconsistency were corrected in the next working day.

### **Data processing and analysis**

At the end of the day of data collection, individual questionnaire was edited through checking and rechecking to see whether it was filled completely and consistently. Then the data were entered into the computer with the help of software SPSS program version 20 by the researcher. An analysis plan was developed keeping in view with the objective of the study. Frequency distributions of all continuous variables were checked. For analysis of the study results mean, percentage and standard deviation was used.

### **Ethical consideration**

All the information collected for the study was utilized only for the purpose of research and was not

disclosed to anyone outside the research team. Verbal consent was taken from all participating respondents. The participation was completely voluntary. Their right to refuse to participate in the study (if they wished so) was respected. Ethical clearance was taken initially from the Ethical Committee of NIPSOM. Neither any invasive nor any intervention was done. Privacy and confidentiality were maintained. The study will be beneficial for reducing adolescent's reproductive health problem.

**RESULTS AND DISCUSSION**

This cross-sectional study was carried out among 227 Adolescent mothers in Chandpur Matlab. They were interviewed by specific questionnaire to find out the Reproductive Health Care Seeking Behavior of Adolescent Mothers in Rural Area. This chapter presents findings of those data. Data were presented through tables and figures and were organized under following sections.

**Table 1: Distribution of the respondents by their age in years [n=227]**

Age in years	Frequency	Percent
15-17 years	44	19.4
18-20 years	183	80.6
<b>Total</b>	<b>227</b>	<b>100.0</b>
Mean±SD-18.2952±.88429, Min=16, Max=19		

Data analysis shows that, among 227 respondents 80.6% were in between the age group of 18-20 years and 19.4% were in 15-17 years of age group. The Mean±SD was 18.2952±.88429. (Table 1).

**Table 2: Distribution of the respondents by their husband age in years [n=227]**

Age in years	Frequency	Percent
Less than 25 years	42	18.5
25-27 years	126	55.5
28-30 years	56	24.7
More than 30 years	3	1.3
<b>Total</b>	<b>227</b>	<b>100.0</b>
Mean±SD-26.26±2.084, Min=17, Max=33		

Data analysis shows that, among 227 respondents 55.5% were in the age group of 25-27 years, 24.7% were in between 18-30 years, 18.5% were less than 25 years and 1.3% were more than 30 years. The Mean±SD was 26.26±2.084 (Table 2).

**Table 3: Distribution of the respondents by their youngest son age in months [n=227]**

Age in years	Frequency	Percent
Less than 5 months	83	36.6
5-10 months	116	51.1
More than 10 months	28	12.3
<b>Total</b>	<b>227</b>	<b>100.0</b>
Mean±SD-6.0441±3.21195, Min=1 month, Max=12 month		

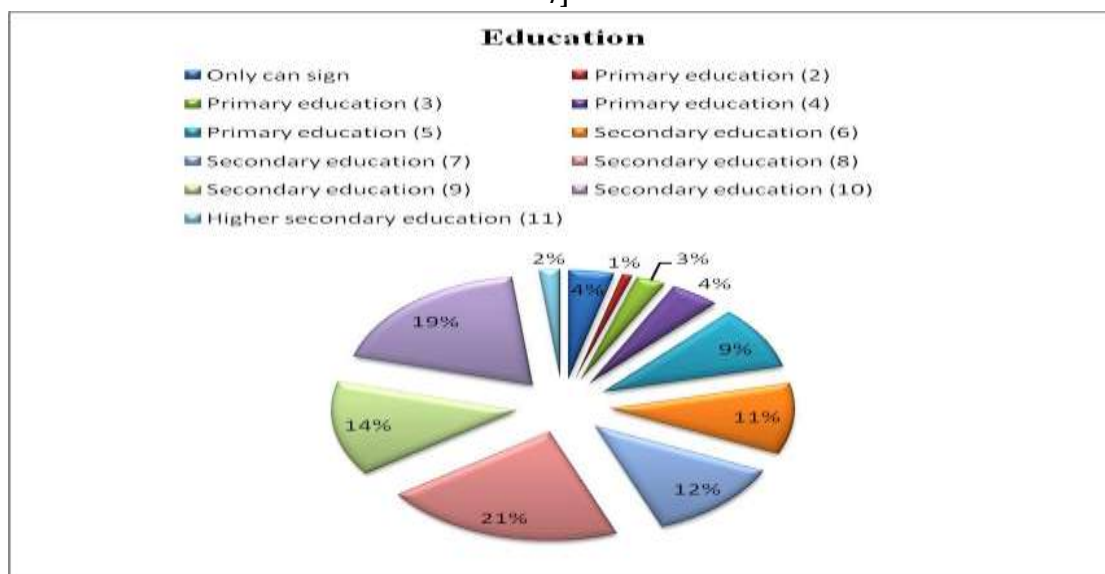
: Study shows that, among 227 respondents 51.1% were in between the age group 5-10 months, 36.6% were less than 5 months and 12.3% were more than 10 months. The Mean±SD was 6.0441±3.21195 (Table 3).

**Table 4: Distribution of the respondents by their religion [n=227]**

Religion	Frequency	Percent
Muslim	210	92.5
Hindu	16	7.0
Christian	1	0.4
<b>Total</b>	<b>227</b>	<b>100.0</b>

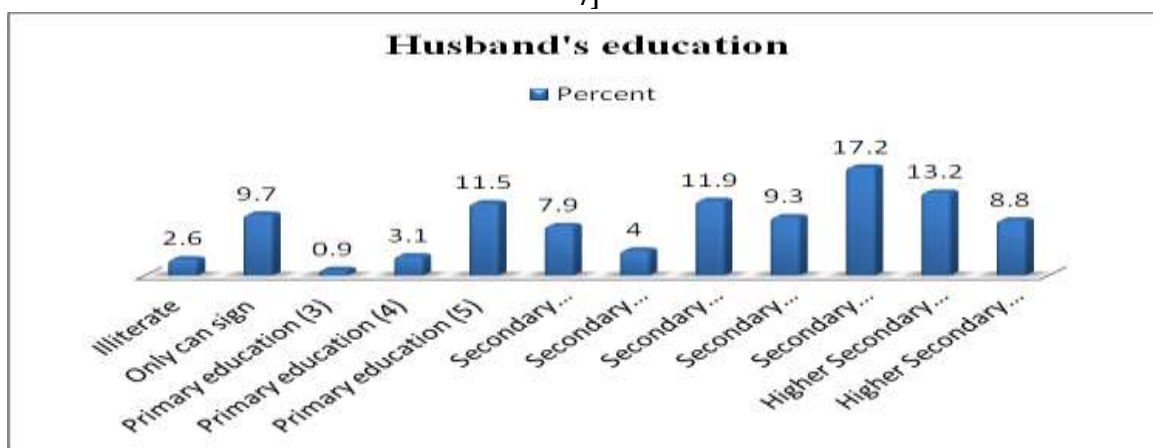
Data analysis shows that, among 227 respondents, 92.5% were Muslim, 7.0% were Hindu and 0.4% was Christian. (Table 4).

**Figure 1: Distribution of the respondents by their educational qualification [n=227]**



Data analysis shows that among 227 respondents 21% were passed secondary education (8), 19% were passed secondary education (10), 14% were passed secondary education (9), 12% were secondary education (7), 11% were passed secondary education (6), 9% were passed primary education (5), 4% were passed primary education (4), 4% were only can sign, 2% were passed higher secondary education (11), 3% were passed primary education (3) and rest 1% passed primary education (2) (Figure 1)

**Figure 2: Distribution of the respondents by their husband's educational qualification. [n=227]**



Data analysis shows that among 227 respondents 11.9% were passed secondary education (8), 17.2% were passed secondary education (10), 9.3% were passed secondary education (9), 4.0% were secondary education (7), 7.9% were passed secondary education (6), 11.5% were passed primary education (5), 3.1% were passed primary education (4), 9.7% were only can sign, 2.6% were illiterate, 13.2% were passed higher secondary education (11), 8.8% were passed higher secondary education (12) and 0.9% were passed primary education (3). (Figure 2).

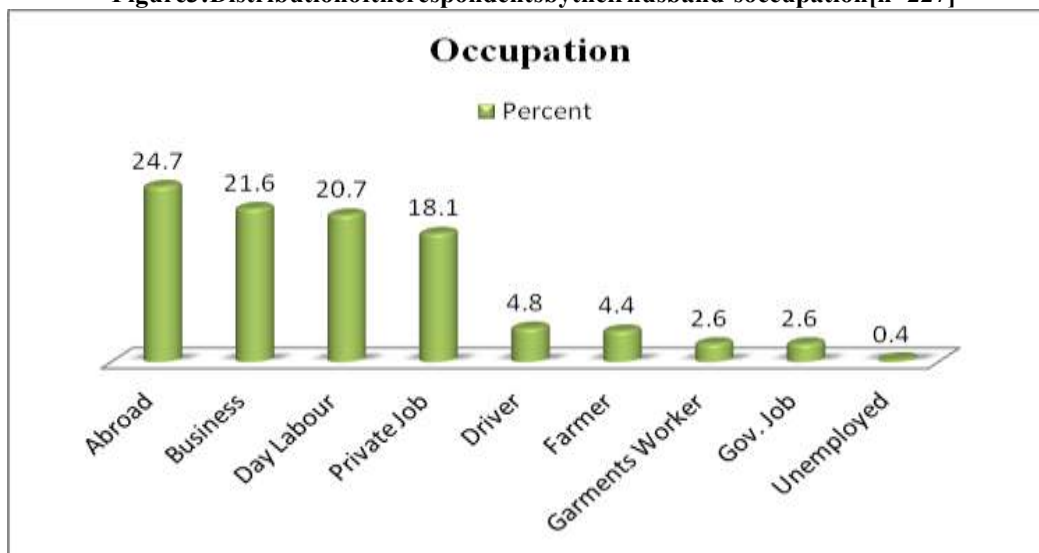
**Table 5: Distribution of the respondents by their occupation [n=227]**

Occupation	Frequency	Percent
House Wife	220	96.9

Day Labor	2	0.9
Private Job	2	0.9
Garments Worker	3	1.3
<b>Total</b>	<b>227</b>	<b>100.0</b>

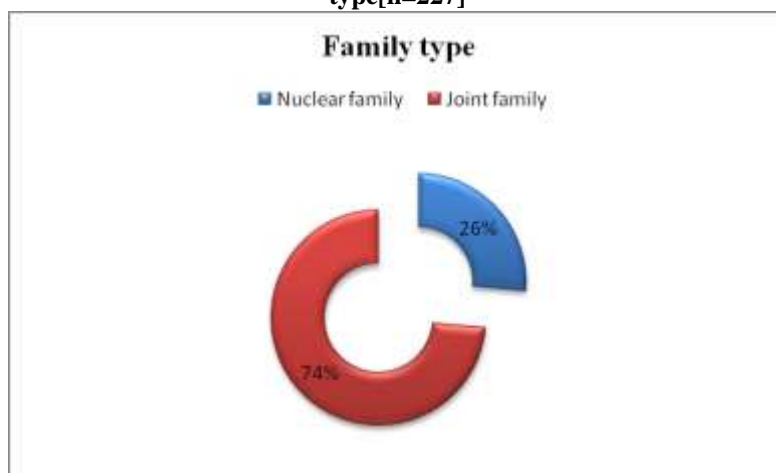
Its evident shows that, majority of the respondents 96.7% were occupied as housewife, 1.3% were garments worker, 0.9% were in private job and 0.9% were day labor. (Figure 2).

**Figure 3: Distribution of the respondents by their husband's occupation [n=227]**



Data analysis shows that Only 24.7% husbands were in abroad, 21.6% were business man, 20.7% were day labour, 18.1% were employed in private job, 4.8% were driver, 4.4% were farmer, 2.6% were garments worker, 2.6% were in Govt. job and 0.4% were unemployed

**Figure 4: Distribution of the respondents by their family type [n=227]**



Its evident shows that among 227 respondents 74% were lived in joint family and 26% were lived in single family (Figure 4).

**Table 6: Distribution of the respondents by their monthly income [n=227]**

Monthly income	Frequency	Percent
No income	220	96.9



Less than 5000 BDT	4	1.8
Equal and more than 5000 BDT	3	1.3
<b>Total</b>	<b>227</b>	<b>100.0</b>
Mean±SD=4000±1.73, Min=2000, Max=7000		

Regarding 227 respondents 96.9% had no income, 1.8% was earned less than 5000 BDT and 1.3% earned equal and more than 5000 BDT per month. The Mean±SD was 4000±1.73 (Table 6).

**Table 7: Distribution of the respondents by their monthly family income [n=227]**

Income	Frequency	Percent
≤10,000 BDT	61	26.9
10,001-20,000 BDT	86	37.9
20,001-30,000 BDT	43	18.9
30,001-40,000 BDT	13	5.7
40,001-50,000 BDT	7	3.1
≥50,000 BDT	17	7.5
<b>Total</b>	<b>227</b>	<b>100.0</b>
Mean±SD=23440.53±19555.226, Min=4000, Max=100000		

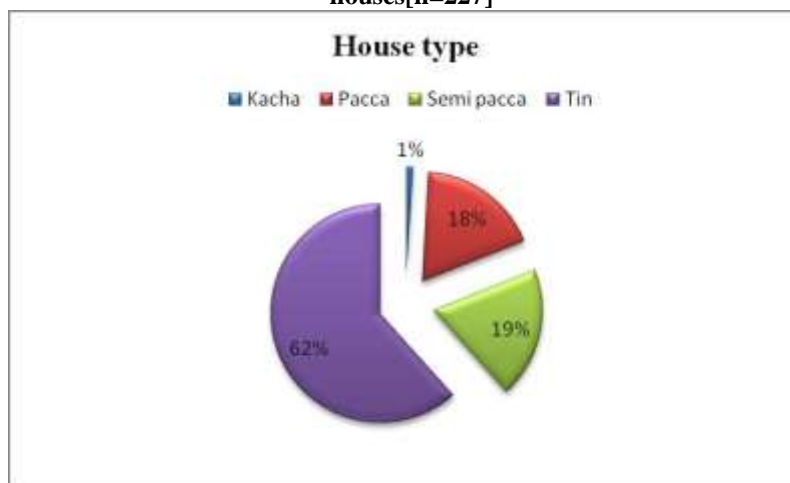
Study shows that, among 227 respondents 37.9% were earned in between 10,001-20,000 BDT, 26.9% were earned less and equal 10,000 BDT, 18.9% earned 30,001-40,000 BDT, 7.5% earned more than 50,001 BDT, 5.7% earned in between 30,001-40,000 BDT and 3.1% earned in between 40,001-50,000 BDT. The Mean±SD was 23440.53±19555.226 (Table 7).

**Table 8: Distribution of the respondents by their family members [n=227]**

Family members	Frequency	Percent
less than 4 persons	86	37.9
4-6 persons	102	44.9
7-9 persons	30	13.2
More than 9 persons	9	4.0
<b>Total</b>	<b>227</b>	<b>100.0</b>

Data shows that, among 227 respondents 44.9% had 4-6 persons in their family, 37.9% had less than 4 persons, 13.2% had 7-9 persons and 4.0% had more than 9 persons in their family as family members. (Table 8).

**Figure 5: Distribution of the respondents by their types of houses [n=227]**



Present study shows that most of the respondents 62% were lived in Tin made house, 19.4% were lived in Semipacca house, 18% lived in Pacca house and 0.9% (Figure 5)

**Table9: Distribution of the respondents by their first place of receiving health care treatment\* [n=227]**

Place	Frequency	Percent
Govt.hospital	155	68.3
Private hospital/clinic	84	37.0
Subcentre	4	1.8
Community clinic	18	7.9
Pharmacy	53	23.3
<b>Total=227</b>		

**[\*Multipleresponses present]**

In regards their first place of receiving health care treatment 68.3% were received from Govt. hospital, 37.0% received from private hospital/clinic, 23.3% received from Pharmacy, 7.9% from community clinic and 1.8% from subcenters (Table 9).

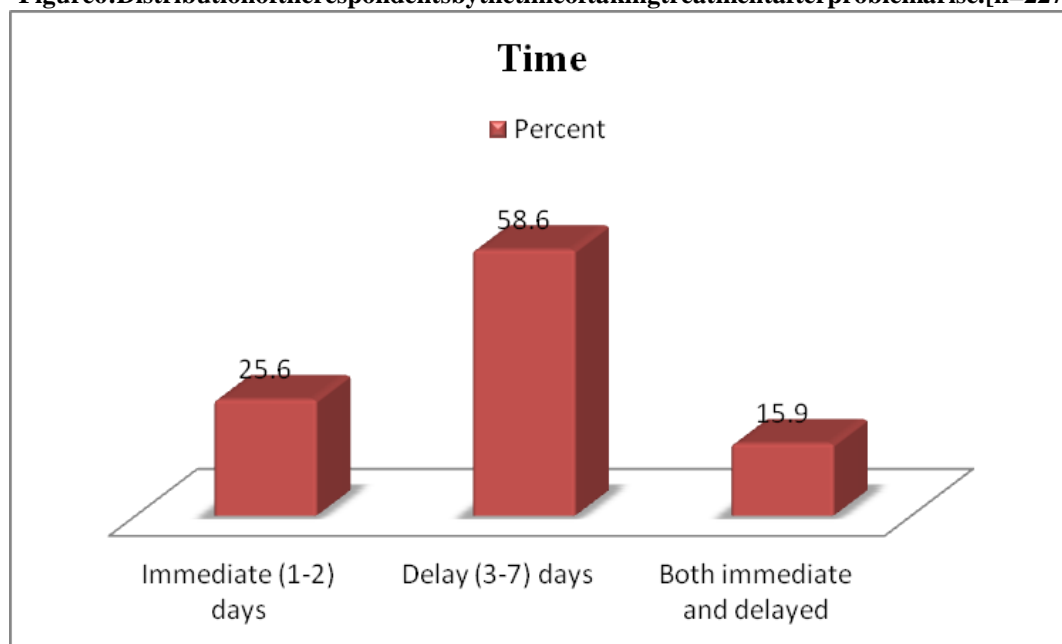
**Table10: Distribution of the respondents by their first person of receiving treatment. [n=227]**

Place	Frequency	Percent
Govt.doctor	162	71.4
Private doctor	84	37.0
Village doctor	2	.9
Home doctor	4	1.8
Pharmacy	50	22.0
CHCP	10	4.4
<b>Total=227</b>		

**[\*Multipleresponses present]**

Table 10: Its evident shows that, in regards their first person of receiving treatment 71.4% were received treatment from Govt. doctor, 37.0% from private doctor, 22.0% from pharmacy, 4.4% from CHCP, 1.8% from home doctor and 0.9% from Village doctor (Table 9).

**Figure6: Distribution of the respondents by the time of taking treatment after problem arise. [n=227]**



Data analysis shows that among 227 respondents 58.6% received treatment delayed (3-7) days after a rise in physical problems, 25.6% received treatment immediate (1-2) days and 15.9% received treatment both immediate and delayed days (Figure 6).

**Table 11: Distribution of the respondents by the person help them during treatment [n=227]**

Persons	Frequency	Percent
Husband	58	25.6
Mother-in-law	94	41.4
Herself	67	29.5
Parents	46	20.3
Sister or sister-in-law	7	3.1
<b>Total=227</b>		

[\*Multipleresponses present]

Data shows that, the person helps them during treatment 41.4% were helped by their mother-in-law, 29.5% helped by themselves, 25.6% helped by their husband, 20.3% helped by their parents and 3.1% helped by their sister or sister-in-law (Table 11).

**Table 12: Distribution of the respondents by priority to take decision for using health care services by themselves [n=227]**

Priority to take decision	Frequency	Percent
Yes	91	40.1
No	136	59.9
<b>Total</b>	<b>227</b>	<b>100.0</b>

Data analysis shows that among 227 respondents 59.9% were not take decision for using health care by themselves and 40.1% were take decisions by themselves. (Table 12).

**Table 13: Distribution of the respondents by their marriage age in year [n=227]**

Marriage age in years	Frequency	Percent
Less than 15 years	61	26.9
15-17 years	157	69.2
More than 17 years	9	4.0
<b>Total</b>	<b>227</b>	<b>100.0</b>

Mean±SD-16.0639±1.07222, Min=12, Max=18

It's evident shows that, among 227 respondents 69.2% were married in between the age group 15-17 years, 26.9% were married at less than 15 years and 4.0% were married at more than 17 years. The Mean±SD was 16.0639±1.07222 (Table 13).

**Table 14: Distribution of the respondents by their first pregnancy time after marriage [n=227]**

First pregnancy time	Frequency	Percent
Within 3 months	67	29.5
Within 3-5 months	67	29.5
Within 6-7 months	54	23.8
Within 8-10 months	7	3.1
After 10 months	32	14.1
<b>Total</b>	<b>227</b>	<b>100.0</b>

First pregnancy time	Frequency	Percent
Within 3 months	67	29.5
Within 3-5 months	67	29.5
Within 6-7 months	54	23.8
Within 8-10 months	7	3.1
After 10 months	32	14.1
Mean $\pm$ SD-5.4229 $\pm$ 4.41508, Min=1 month, Max=24 months		

Data analysis shows that among 227 respondents 29.5% became pregnant within 3-5 months after marriage, 29.5% within 3-5 months after marriage, 23.8% within 6-7 months after marriage, 14.1% became pregnant after 10 months of marriage and 3.1% within 8-10 months after marriage. The Mean  $\pm$  SD was 5.4229 $\pm$ 4.41508 (Table 14).

**Table 15: Distribution of the respondents by taking antenatal care during pregnancy [n=227]**

Taking ANC	Frequency	Percent
Yes	216	95.2
No	11	4.8
<b>Total</b>	<b>227</b>	<b>100.0</b>

Its evident shows that majority of the (227) respondents 95.2% were taken antenatal care during pregnancy and 4.8% were not taken antenatal care (Table 15).

**Table 16: Distribution of the respondents by their place of receiving antenatal treatment. [n=216]**

Place	Frequency	Percent
Govt. hospital	79	36.6
Private hospital/clinic	135	62.5
Community clinic	19	8.4
Pharmacy	2	0.9
<b>Total=216</b>		

[\*Multipleresponses present]

It's evident shows that In regards their place of receiving antenatal treatment 62.5% were received from private hospital/clinic, 36.6% received from Govt. hospital, 8.4% from community clinic and 0.9% received from Pharmacy (Table 16).

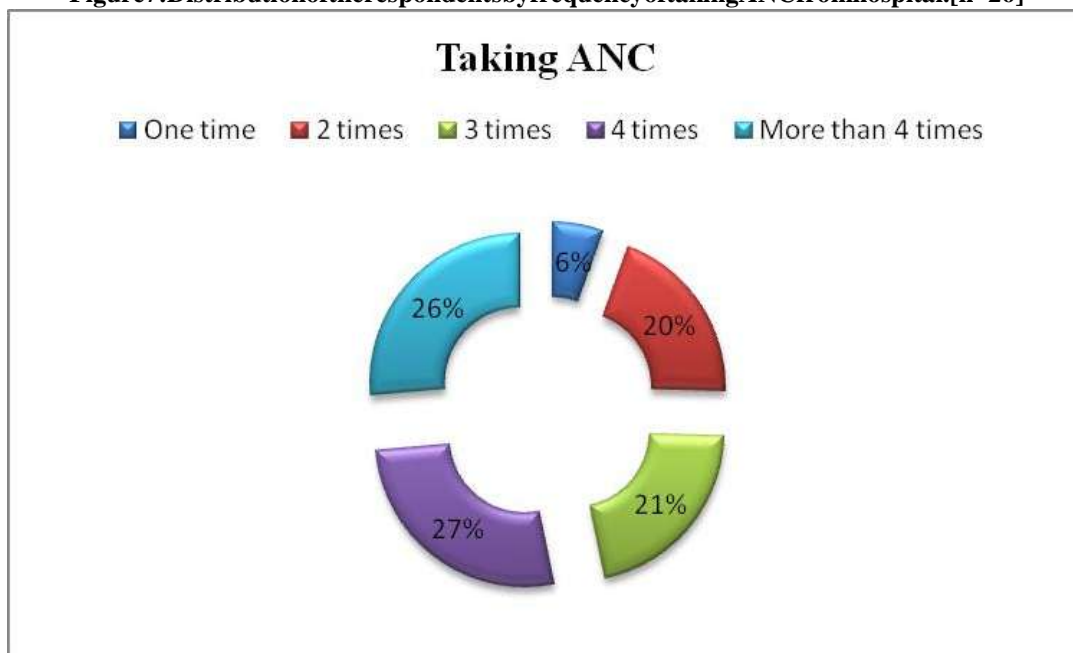
**Table 17: Distribution of the respondents by the person of receiving antenatal service\* [n=216]**

Place	Frequency	Percent
Govt. doctor	65	30.1
Private doctor	97	44.9
Health assistant	100	46.3
Nurse	4	1.9
Village doctor	1	0.5
<b>Total=216</b>		

[\*Multipleresponses present]

Data shows that, in regards the person of receiving antenatal treatment 46.3% received treatment from health assistant, 44.9% were received treatment from private doctor, 30.1% from Govt. doctor, 1.9% from nurse and 0.5% from Village doctor (Table 17).

Figure 7: Distribution of the respondents by frequency of taking ANC from hospital. [n=26]



Study shows that, among 26 respondents 27% went hospital 4 times for ANC, 26% went hospital more than 4 times for ANC, 21% went 3 times, 20% went 2 times and 6% went hospital 1 time for ANC (Figure 7).

Table 18: Distribution of the respondents by types of ANC taken [n=216]

ANC type	Frequency	Percent
Physical examination	216	100
Blood and urine test	183	84.7
Ultrasonography	185	85.6
<b>Total=216</b>		

[\*Multipleresponses present]

Data shows that, in regards the respondents taking antenatal care services 100% had done physical examination, 85.6% had blood and urine test and 84.7% had Ultrasonography (Table 18).

### Discussions

Adolescence is widely defined as the time in life when the developing individual attains the skills and attributed necessary to become a productive and reproductive adult (Barker, 2011). According to the present study, shows that, majority 80.6% were in between the age group of (18-20) years and 19.4% were in (15-17) years of age group. The Mean  $\pm$ SD was 18.2952  $\pm$  .88429. However, Shahjahan *et al* 'Factor Associated with Use of Antenatal Care Services in a Rural Area of Bangladesh' shows mean age of the respondents were 24 (SD  $\pm$  4.4). This is not consistency with the present study (Shahjahan *et al.*, 2012).

In the present study, shows that half 55.5% of samples husbands were in the age group of (25-27) years with the Mean  $\pm$ SD was 26.26  $\pm$  2.084. Regarding the present study, most 92.5% were Muslim. On the other hand, 'Factor Associated with Use of Antenatal Care Services in a Rural Area of Bangladesh' shows mean age of the respondents were 24 (SD  $\pm$  4.4). Study shows (81.9%) of samples were Muslim. This is consistency with present study (Shahjahan *et al.*, 2012).

Regarding the present study shows that few 21% of samples were passed secondary education. However, Banda *I et al* 'Factor Associated with Late Antenatal Care Attendance in Selected Rural and Urban Communities of the Copper belt Province of Zambia' shows 54.6% of samples were secondary passed. This is not consistency with the present study.

In the present study most 96.7% were occupied as house wife, However, Shahjahan *et al* 'Factor Associated with Use of Antenatal Care Services in a Rural Area of Bangladesh' shows that most 95.6% of the

respondents were housewives. This is consistency with the present study (Shahjahan *et al.*, 2012)

Regarding the present study shows that majority 74% of samples were lived in joint family. Most 96.9% of samples had no income but less than half 37.9% of samples husbands were earned in between 10,001-20,000 BDT with the Mean  $\pm$  SD was 23440.53  $\pm$  19555.226.

Regarding the present study less than half 44.9% of samples had (4-6) persons in their family and majority 62% were lived in tin-made house.

Regarding the present study in regards their first place of receiving health care treatment, majority 68.3% of samples were received treatment from Govt. hospital.

In the present study, in regards their first person of receiving treatment majority 71.4% were received treatment from Govt. doctor. However, Shahjahan *et al.* 'Factor Associated with Use of Antenatal Care Services in a Rural Area of Bangladesh' shows less than half 34.2 of the respondents were received treatment from Govt. Field health care worker. This is not consistency with the present study (Shahjahan *et al.*, 2012)

More than half 58.6% received treatment delayed (3-7) days after arisen of physical problems. In regards the person helps them during treatment less than half 41.4% were helped by their mother-in-law. In the present study more than half (59.9%) were not take decision for using health care by themselves. few 29.5% of samples became pregnant within 3-5 months after marriage and most 95.2% were taken antenatal care during pregnancy and in regards their place of receiving antenatal treatment 62.5% were received from private hospital/clinic.

In regards the person of receiving antenatal treatment less than half 46.3% received treatment from health assistant. However, Antenatal care coverage (at least one visit by skilled health professional) (%): 54.6 (BDHS 2011); 58.7 (MICS 2012-2013) Antenatal care coverage (at least four visits) (%): 25.5 (BDHS 2011); 24.7 (MICS 2012-2013) Birth rate among adolescent mothers/1,000 women: 105.0 (BDHS, 2011)

In the present study shows that few 27% of samples went hospital 4 times for ANC which was recommending by WHO, On the other hand, Shahabuddin *et al.*, (2015) Use of maternal health services among adolescent women in Bangladesh. Shows Antenatal care by adolescent women belonging was 12%. The number of antenatal visits made by women married age before they turned 18 was 14.5% lower than for women married at over 18 years of age (Shahabuddin *et al.*, 2015)

Regarding the present study, in regards the respondents taking antenatal care services 100% had done physical examination among them most 85.6% had blood and urine test and 84.7% had Ultrasonography. Majority 87.5% of samples had no complications before delivery. Regarding the present study had complications before delivery, majority 66.7% had abdominal pain, among them 96.3% were taken Allopathic treatment for complications and majority 71.8% had their delivery in hospital.

In the present study those who had their delivery at home among 64 respondents, less than half 46.9% due to no complication. Majority 74%, home delivery had delivered by trained Dhai. In the present study in regards the types of delivery in hospital 64.4% had Caesarian section, on the other hand, Births attended by skilled health personnel: 26.5% (BMMS, 2010); 31.7% (BDHS, 2011); 43.5% (MICS, 2012-2013). This is not consistency with present study.

Regarding the present study, among 105 respondents less than half 37.1% had caesarian section due to abnormal condition of the unborn child; majority 70.5% had check-up after child delivery. In the present study, among 160 respondents had no check-up after delivery majority 65.7% due to having no problem, However, Postnatal care received by mothers from a trained care provider within 2 days after delivery: 27% (BDHS, 2011) and 41.2% (MICS, 2012-2013). This is not consistency with present study.

According to the present study, most 84.1% respondent had no problems after delivery. In the present study, among 36 respondents had problems after delivery, 41.7% due to tearing vaginal pathway, among 36 respondent's majority 75.0% taken treatment for the problems. In regard taken treatment for the problems less than half 44.4% taken treatment in private clinic and half 52.0% of samples used birth control methods before.

In the present study among 227 respondents half 54.2% of samples, used birth control methods now.

Regarding the present study used birth control methods half 59.3% of samples used oral contraceptive pills

In the present study, among 123 respondents most 83.7% of samples used birth control methods due to maintain interval between two children. Regarding the present study taken decisions for using birth control methods 83.7% taken decisions by both husband and wife.

In the present study, among 104 respondents not used birth control methods 47.1% due to had infant.

Regarding the present study 69.2% not suffered from reproductive health problems.

It's evident shows that, Among 70 respondents suffered from reproductive health problems less than half 35.7% suffered from discharge of mucous, Among 70 respondents suffered from reproductive health problems less than half 41.4% of samples were not taken any treatment for that, 40.0% treated at public hospital, Regarding the present study aged between (15-17) years 20.5% were decided to taken health care services. It also appears that, among 183 aged between (18-20) years 44.8% were decided to take health care

services and 55.2% were not decided that. The differences were found to be statistically significant ( $p < .05$ )

Data analysis shows that, among 61 respondents married in less than 15 years few 27.9% of samples were decided to take health care service and 72.1% were not decided to take health care services by themselves. Among 157 respondents married in between (15-17) years, 45.2% were decided to take health care service and 54.8% were not decided to take health care services by themselves. Among 9 respondents married in more than 17 years 33.3% were decided to take health care service and 66.7% were not decided to take health care services by themselves. The differences were found to be statistically not significant ( $P > .05$ )

Regarding the present study, among 61 respondents married in less than 15 years half 55.7% of samples were aged in between (15-17) years and 44.3% were aged between (18-20) years. Among 157 respondents married in between (15-17) years 6.4% were aged in between (15-17) years and 93.6% were aged between (18-20) years. Among 9 respondents married in more than 17 years 100% were aged between (18-20) years. The difference is found to be statistically significant ( $P < .05$ ).

Among 61 respondents married in less than 15 years and majority 65.5% of samples used birth control method now and 44.3% were not used that. Among 157 respondents married in between (15-17) years 51.0% used birth control method now and 93.6% were not used that. Among 9 respondents married in more than 17 years 33.3% used birth control method now and 66.7% were not used that. The difference is found to be statistically not significant. ( $P > .05$ )

Regarding the present study monthly family income less and equal 10,000 BDT 42.6% take decisions of using health care themselves and 57.4% not take decision by themselves. Among 86 respondent's monthly family income in between 10,001-20,000 BDT 32.6% take decisions of using health care themselves and 67.4% not take decision by themselves. Among 43 respondent's monthly family income in between 20,001-30,000 BDT 58.1% take decisions of using health care themselves and 41.9% not take decision by themselves. Among 13 respondent's monthly family income in between 30,001-40,000 BDT 23.1% take decisions of using health care themselves and 76.9% not take decision by themselves. Among 7 respondents monthly family income in between 40,001-50,000 BDT 28.6% take decisions of using health care themselves and 71.4% not take decision by themselves. Among 17 respondent's monthly family income more than 50,000 BDT 41.2% take decisions of using health care themselves and 58.8% not take decision by themselves. The difference is found to be statistically not significant. ( $P > .05$ )

Study shows that, monthly family income less and equal 10,000 BDT 59.0% used birth control method before and 41.0% were not used that. Among 86 respondent's monthly family income in between 10,001-20,000 BDT 52.3% used birth control method before and 47.7% were not used that. Among 43 respondent's monthly family income in between 20,001-30,000 BDT 41.9% used birth control method before and 58.1% were not used that. Among 13 respondent's monthly family income in between 30,001-40,000 BDT 23.1% used birth control method before and 76.9% were not used that. Among 7 respondents monthly family income in between 40,001-50,000 BDT 57.1% used birth control method before and 42.9% were not used that.

Among 17 respondent's monthly family income more than 50,000 BDT 17.6% used birth control method before and 82.4% were not used that. The difference is found to be statistically significant ( $p < .05$ ).

It's evident shows that, among 61 respondent's monthly family income less and equal 10,000 BDT 72.1% used birth control method now and 27.9% were not used that. Among 86 respondent's monthly family income in between 10,001-20,000 BDT 55.8% used birth control method now and 44.2% were not used that. Among 43 respondent's monthly family income in between 20,001-30,000 BDT 34.9% used birth control method now and 65.1% were not used that. Among 13 respondent's monthly family income in between 30,001-40,000 BDT 61.5% used birth control method now and 38.5% were not used that. Among 7 respondents monthly family income in between 40,001-50,000 BDT 42.9% used birth control method now and 57.1% were not used that. Among 17 respondent's monthly family income more than 50,000 BDT 29.4% used birth control method now and 70.6% were not used that. The difference is found to be statistically significant ( $p < .05$ ).

### **Conclusion**

This study addressed four by fifth of adolescent mother were in between the age group of (18-20) years, nearly all of them were occupied as house wife, nearly all of them had few incomes. Three by fifth of adolescents mother were received from Govt. hospital and Govt. doctor, half of adolescents mother were helped by their mother-in-law during their treatment and not take decision for using health care by themselves. Few of adolescents mother became pregnant within 3-5 months after marriage, near about all adolescents mother were taken antenatal care during pregnancy. Three by fifth adolescents' mother were received

antenatal treatment from private hospital/clinic, less than half adolescents mother received treatment from health assistant, few of adolescent's mother went hospital 4 times for ANC. All of them ANC treatment done by physical examination, three by fifth of adolescent girl had abdominal pain, Half of adolescent's mother had not taking treatment during pregnancy due to having no support from family. less than half adolescents mother delivery at home due to no complication, two third of adolescents mother did delivery at home and delivered by

trained Dhaki, less than half of adolescents' mother had caesarian section due to abnormal condition of the unborn child, Two third of adolescents' mother had check-up after child delivery. Two third of adolescents' mother had no checkup due to having no problem. Four by fifth of adolescent's mother had no problems after delivery, among them two third taken treatment for the problems. less than half of adolescent's mother taken treatment in private clinic, half of adolescent's mother, used birth control methods now among them half of adolescent's mother used oral contraceptive pills, four by fifth of adolescent's mother used birth control methods due to maintain interval between two children. Fourth by fifth adolescents' mother taken decisions by both husband and wife, half of adolescents' mother not used birth control method due to had infant. Three by fifth of adolescent's mother were not suffered from reproductive health problems. less than half of adolescent's mother suffered from discharge of mucous, less than half) of samples were not taken any treatment for that, The differences between age and taking decision for health care service and monthly family income and birth control method now were found to be statistically significant. ( $p < .05$ ). The difference between aged and used birth control method now and take decisions of using health care themselves and monthly family income is found to be statistically not significant. ( $p > .05$ ). Programmes should be taken to improve Adolescent reproductive health and their health seeking behavior. Reduce early marriage and early pregnancy.

### **Recommendation**

The present cross-sectional study with a comparatively small sample size to recommend was done to portrait the Condition of Reproductive Health Care Seeking Behavior of whole Adolescent mothers. However, some recommendations can be made on the basis of finding of the study:

1. Special attention should be given to overcome Adolescent reproductive health problem and improvement of health care seeking behavior.
2. Maternal health status should be improved by reducing early marriage and adolescent pregnancy through improvement of health care service.
3. To be alert to special problems that require particular attention among adolescents, including anemia, poor nutritional status, malaria, HIV and other sexually transmitted infections and access to services for preventing the mother to child transmission of HIV;
4. To develop a plan for birth with the adolescent mothers and her family, including the place of birth, availability of transport and the costs involved;
5. To give special attention to adolescents younger than 16 years during obstetric care because they are at a specially high risk of complications and death.
6. Gatekeeper, formal and informal community leaders, and religious leader at all levels need to be motivated and trained on ARH.
7. Special training should be conducted for adolescent's girl at community clinics, satellite clinics, family welfare centers and UHCs.
8. Develop more effective preventive measures for teenage pregnancy and have solutions that might prevent unplanned teenage pregnancy.
9. Pregnancy prevention programs with guidelines should be available and utilized appropriately in all areas where teenagers are found.
10. Teenagers should be offered information on how to use contraceptives. Contraceptive use should be promoted through education and service provision to reduce teenage or adolescent pregnancy.
11. Facilitate the establishment of adult-teenage communication programs with guidelines to give adults information and skill to communicate effectively with young people about reducing risky behavior.

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