Adolescents' reproductive health status related to contemporary factors, with special emphasis on gender differences in Bangladesh

Lutfa Begum
Jeroen Van Ginneken

Lutfa Begum is Researcher, Population Research Centre, Faculty of Spatial Sciences, University of Groningen, The Netherlands and a fellow at the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B). Email: l_begum@bdonline.com. Jeroen Van Ginneken is Head, Population and development, The Netherlands Interdisciplinary Demographic Institute (NIDI). Email: ginneken@nidi.nl

Abstract: Adolescent ranging from 10 to 19 constitutes the largest population of the world; they number over one billion and the number is increasing. Since the International Conference on Population and Development (ICPD) in Cairo, a radical development marks the field of adolescents' reproductive health. Today the population study centres more on individual's rights, needs, and ambitions than on demographic targets. The present paper is an attempt to study the socio-cultural and gender aspects of adolescent's reproductive health in Bangladesh from a *process-context approach*. That is adolescents' reproductive health behaviour is seen as the outcome of a *process* involving a series of individual decisions and actions occurring within social, economic, ecological, cultural and political *contexts*. Therefore, the needs and aspirations of adolescents are not only determined by biological and behavioural factors, but through socio-cultural and gender standpoints. Cultural specific researches, policies, and programs can help adolescents to meet their fresh demands, flourish their innovative ideas, thoughts and equip them with the kind of education, skills, and outlook they need in a changing environment.

Introduction

Today adolescents ranging from 10 to 19 constitute the largest population of the world; they number over one billion and the number is increasing. With the advancement of men's knowledge through numerous experiments and researches, revolutionary changes in communication and information technology have turned the world into a variable stage and the ever changing world paves the way for germination of fresh and unprecedented ideas, demands, and thoughts in young hearts. These are constantly creating troubles for the old fashioned parents, totally unanticipated by them before (Alan Guttmacher 1998). Mensch states "adolescence is a powerfully formative time of transition to adulthood, roughly concurrent with the second decade of life… (this) shapes how girls and boys live out their lives as women and men-not only in the reproductive arena, but in the social and economic realm as well. Yet, despite its impact on human development, adolescence has been sidelined as a research and policy subject in developing countries. As a result we know little about young people's lives in these societies (Mensch et al 1998:1). Adolescents who constitute 30 per cent of total population in Bangladesh (BDHS, 1997) are attracting attention of

researchers, policymakers. With a view to developing new strategies for addressing adolescents' needs, UNFPA began the groundwork by commissioning reports focussing on the adolescent girl and identifying the reproductive health issues she faces in the current social, legal, and economic environment (Rafiq 1996; UNFPA 1998a).

In this paper we are particularly interested in gender role socialization, by which social norms for appropriate behavior are strongly sanctioned for girls and boys are expected to display femininity or masculinity through their attitudes and behaviors in contemporary Bangladesh. Therefore, the focal point of this review is the social, cultural, gender and economic constraints the adolescents face as they grow up. Moreover, literature clearly shows that adolescents hardly enjoy the information, rights, and access elements essential for reproductive health. Consequently, understanding gender role acquisition is important particularly for implication further research and program are discussed.

Toward understanding of adolescents

'Meaning of adolescence'

For both boys and girls this is a happy thorny period full of peculiar unprecedented feelings, and psycho-social dilemma. The term "adolescence" has been associated with the transition from childhood to adulthood, encompassing the interval between puberty and marriage, and it has been evolved into a distinct period of biological clock (Mensch et al. 1998). In the eye of UNFPA, people ranging from 15-24 are "youth" and people belonging under this mark are classified as "children" and to WHO people aging 10-19 is an adolescent (WHO 1975). As regards, the government of Bangladesh also defines "children" between ages 1-14. UNICEF opines that those who age between 5-19 are "children".

The WHO however, emphasised that adolescence is neither merely a social classification nor merely a specific age limitation, rather the combination of the two (WHO, 1975, p.10). Pachuri states that "puberty marks the biological beginning of adolescence, but of its completion are varied and ill-defined. Thus, age and puberty are important defining criteria for adolescence…The only universal definition of adolescence appears to be that, although no longer considered a child, the young person is not yet considered an adult." She further states that the meaning or perception of adolescence, as a social construct varies across

cultures. According to her, adolescence cannot be defined only by age, puberty, sexual intercourse or marriage. To some extent, to have a clear meaning of adolescence in different cultures the aforementioned events must be viewed within the context of gender relations, age hierarchies and social class, (e.g. Pachuri, 1998,pp.118-119, Bansal et al, 1998, p1, Sikes, 1996). The literature also provides examples of how social norms fabricate the behaviour and attitudes of young people. As Jejeebhoy states,"variation in social and cultural settings between countries and biological differences concerning age of physical maturation render different connotations to the meaning of adolescence in different settings. In India, traditionally, the transition from childhood to adulthood among females has tended to be sudden" (Jejeebhoy, 1998, p. 1275). She adds that the menarche occurs lately as a result of poor nutritional status and it delays the biological onset of adolescents'. On the other hand, adolescents reaching menstruation early enter into marriage, sexual activity, pregnancy, and child bearing before they attain physical maturity. Sexual activity before marriage is looked down upon as a great sin and "virginity" or "chastity" before marriage is a great social and religious concern. To stark contrast to it, male adolescents do not meet similar treatment and terms such as "virginity" or "chastity" is not applied to them. (e.g. Jejeebhoy, 1998,p. 1276). The social thinking processes help to construct adolescents' perceptions that as a wife and mother she has social value and financial protection (Pachuri 1998, p. 122). The socio-biological events, marking the passageway from childhood to adulthood, such as bodily change, menarche, menstruation, early marriage, sexual initiation, childbearing perceptions and characterization exist in a multiple ways even in a specific cultural context.

In most culture generally the onset of puberty is deemed as the beginning of adolescence but the mark of ending of this stage differs even within a specific culture setting. In accordance with this view, it is difficult to define adolescence as a specific universal period. In the context of the contemporary Bangladeshi society, particularly in rural areas when girls reach their menstruation they are traditionally looked upon as adults. Consequently, the family members think that they have become mature enough for marriage and in most cases they are not allowed to go to school. As a result, the period between childhood and adulthood is very short and there hardly exists anything-called "adolescence" (Bansal & Mehra, 1998,

p.1). Caldwell sates "young males always faced a longer period between puberty and marriage" (Caldwell et al. 1998:147). In many developing countries the concept regarding this transition in life stage appeared to be completely new even 20 years ago and the idea is still new in some regions (Pachuri 1998, p.117). In Bangladesh one out of five people lives in urban area, and the statistic clearly shows that rural atmosphere greatly outnumbers the urban one. Adolescents' reproductive health can be viewed not only from a context perspective, but also from a lifetime perspective. As vagueness is yet to be cleared regarding the boundaries of adolescence reproductive health, research concerning what influences contemporary factors and its attendant are exercising on adolescents in Bangladesh, is still at a preliminary stage. On the one hand, the age parameter 10-19 has its drawbacks: married adolescents are often treated as children at the household level until they are well into adulthood. However, in spite of these limitations, the age parameter 10-19 still covers a general period of transition that is neither clearly childhood nor adulthood, and is therefore uniquely its own (Aeysha 2000).

Socialization processes of adolescents within the life course

A life course approach to reproductive health is an ingenious way for investigating adolescents' reproductive health as a lifelong process. In Bangladesh, culture divides the life course into life stages of infant, child, adults, and old person; in developed countries there are many more categories, including adolescence stage. "Each life stage or health stage seems distinct, in real life; sifts in age and health status are often gradual, taking place over several or even many years. Whether gradual or sudden, health changes may result not only from single causes (trauma, infection) but from the interaction of physiological and socio-cultural events, along with individual differences" (Cattel G. Maria 1996:95)

Girl child is completely discriminated from the very beginning of their life. For instance, "when a boy is born the *azzan* (Islamic way to announce good news or to call for prayer) is said louder, when a girl is born it is said in a lower voice. Moreover, after the birth, *'aquiqa'* (immolation of an animal in the child's name in order to distribute the meat among poor people), a ceremony must be followed by rich Muslim family and for girl child one goat and for boy child two goats (Afsaruddin, 1990,pp.111-112).

During adolescence period boys and girls in particular learn and internalise behavioural patterns for the reproductive period. These patterns are closely connected with cultural norms, which are, to some extent, gender-specific. In Bangladesh, many of these patterns must be understood within the culture of "*purdah*," which is exacted by religion. According to Ross (1996b, p. 33) *purdah* "enforces a high standard of female modesty, dictated propriety in deed and thought, restricts mobility, limits autonomy, and makes women dependent". In the rural parts of Bangladesh in particular, "(...) *purdah* defines the roles of women and their ability to control their lives" (Ross 1996b, p. 33). Observance of *purdah* entails adopting certain behaviours, which may indirectly or directly affect someone's health status. The fact that while the overwhelming majority of the doctors are men, it is culturally prohibited for a woman to be seen, let alone physically examined by any male other than her husband, except under dire circumstances (...)" limits women considerably in seeking professional health care (Ross 1996b, p. 33).

Late adolescence (*nabajauban*) is a dangerous stage: parents should be careful and watch an unmarried girl, and "gender role expectations become exaggerated in this period". Girls should cover their head and body well, so that people cannot see their body and hair which "might provoke sensual desire". If men do see either body or hair, it is the girls who bear the shame. Moreover, the authors illustrate the concept of shame in social relationships, by describing how adolescent boys can share their fantasies about sexuality with friends, while girls, if they share with their friends, will be criticized as being shameless (Aziz and Maloney, 1985, pp. 52-53). There are more rules for girls, which are applied more strictly, than for boys. For instance, a girl in the pre-adolescence period is asked to learn to observe *purdah* and to keep her head under a cover in the presence of older men. An early-adolescent girl should attend to domestic cares, cannot go outside alone at night unless she is accompanied by an elder woman, and is not supposed to speak loudly, should talk soft, and move politely. The only rule mentioned for boys in this same period is that they are expected to learn farming tasks or other work (Aziz and Maloney 1985, p.48-49).

In Bangladesh, adolescence seems to be shorter for girls than for boys, and to start earlier. Bangladeshi girls are expected to learn the female role even before the end of childhood (up to 10 years old). Ross (1996, p.5) concludes that " ... it is during childhood and adolescence that gender roles are internalized

and perpetuated. By the time she reaches puberty a Bangladeshi woman has already experienced a life-time of discrimination compared to males" for instance, a girl from the poorer family gives-up her education while the boy child continues.

The different periods of adolescence are also characterised by the clothes they put on. A girl in the pre-adolescence period still wears pants and blouse (unless she attends Quranic school); while a girl in early adolescence should wear a *saree* to protect her breasts and cover her head. Boys may swim naked in the ponds and channels up to the pre-adolescent period, but in the early adolescent period they feel ashamed to do so. A 16-year-old mother is not considered as an adult who is adequately equipped with the resources and decision making power to fulfill her responsibilities. Throughout childhood, boys, and girls learn specific social norms and rules of behaviours that they are expected to practise in practical life. Mostly girls are doubly disfavoured when they enter their adolescence period. The reason for this particular behaviour to girl children is not only economic conditions but also social norms and values that influence to prevent girls from a healthy development (Network1997, p.26). A study by the Population Crisis Committee (1988) ranked the status of women in Bangladesh as the lowest in the world. Of the 2 and 1.5 per cent of GNP spent annually by the Government of Bangladesh (GOB) on respectively education and health (UNDP 1995, in: Ross 1996b, pp. 7-8), much less is spent on girls than on boys.

In Bangladesh, socio-cultural and gender norms can be seen to play an important role in their reproductive health status. A woman is compelled to suffer low self-esteem because of her subordinate position in traditional way, and she feels the birth of a daughter as a misfortune to the society. Based on constitutional law, religious and cultural traditions reinforce the devaluation of daughters. From childhood to adolescence a Bangladeshi girl experiences these discriminations because she is a girl and this effects their feelings, values, behaviours, and activities in later life. As the WHO Director General states, " the reproductive health reflects health in childhood and adolescents. It sets the stage for health beyond the reproductive years for both men and women" (PROGRESS, 1999, p.5).

In addition, now a days in the rural areas, more young girls are going to school, which gives girls more space extended childhood, compared to that of boys (Blanchet 1996, p. 57). This might imply that the

definition of what adolescence is and what is proper in this period of life for girls and boys is changing. An adolescence girl constantly gets training about her womanly behaviours (*mey manusher dhormo*) from her mother and other family members within the family framework. “She learns how she is different from the boys in respect of their female dresses, games, hair cutting, ornaments, and also gets lessons about a set of inherited womanhood sacrifice attitudes for her future husband and in-laws as well. Mothers expressly concentrate on training their daughters in these skills, which will in future render them ‘good’ daughters-in-law. To be protective, conservative, and to save store and preserve things are the basic requirements” (Kotalova 1993,p.73). In contrast to boys, whose spatial horizon continues expanding and the improvement of whose skills centres on boating, fishing, husbandry, and marketing calculations, the girls gradually withdraw from the areas beyond their *para*, and the fireplace (*chula*) becomes the central point of interest. Their outings are restricted to fetching water, shopping in the village shop and visits in the immediate neighbourhood (e.g. Kotalova 1993, pp.72-73). Within the boundaries of typical gender difference of social structure in Bangladesh adolescent girls are remarkably vulnerable. Girls enjoy less liberty in terms of food intake, free mobility, right of entry or complete the education, access to health care, and decision making regarding their marriage, contraception, child- bearing than their brothers. On the other hand, as most rural adolescent girls are not involved with any visible income, they are give long hours to the household works and those are not counted as economic activities. As Jejeebhoy states "Given the seclusion norms that widespread from puberty onwards, adolescent girl unlikely to have much exposure or physical access to the outside world. Without any education, without a skill or opportunity for employment, and with relatively poor health and nutrition, they are caught in a web of ignorance, poor reproductive health, life long economic dependency, physical seclusion, early marriage and frequent childbearing" (Jejeebhoy, 1998, p. 1276). In addition, in rural areas girls are migrating and moving away from their family and community during their menarche and marriage. Family structure and relationships are changing. The socio-cultural and economic environment affect boys and girls in differently. Individual beliefs and practices may conflict with the existing social norms and expectations for particular behaviours (Anonymous, 1997). Adolescents, especially in developing countries, are at risk of serious

illness, nutritional deficiencies, inadequate education and training, violence, and the multilevel effects of poverty. These effects can be alleviated if communication is properly established between adolescents and their families, communities, and homogeneous groups (ICRW, 1996). In Bangladesh, cultural and social beliefs determine a differentiated position for girls and women and their lower position in society or family deprives them of reproductive rights, freedoms, and choices (Sai & Nasim, 1989, p.105). In this regard we need to know that how a specific culture may place emphasis on different aspects of adolescents' behaviours. If adolescence health can be promoted through modification of cultural values and beliefs that would be a fantastic achievement (Friedman, 1999, p.5). The values of people can be markedly diverse in different cultures where they live in. He states " this is often reflected in what is valued most among the richly diverse aspects of human potential including the physical, psychological, social, sexual, spiritual, artistic, and economic development of the individual along with the flowering of a sense of humour. Many of these qualities are given a window of opportunity during the highly dynamic period of adolescence. Providing the young people with necessary support and chances for development and to fulfil their potential is the surest way to enrich society (e.g. Friedman, 1999, p. 5)". “Gender issues in adolescent health are determined by the differential characterization of adult men and adult women, the differential approach to male and female sexuality, the lack of a gender-appropriate definition of reproductive health, and the need to discuss a broader concept for health in adolescence” (Henriques et al 1993).

Table 1 Gender differences in socialization of Bangladesh

	Nature of difference
Time uses	Girls have heavier domestic burden, less mobility. Boys are allowed to go out side, free mobility.
Attitudes toward menstruation	Shameful, disgusting, womanhood, fertility.
Attitude toward marriage	
Suitable age at marriage for women	Parents favor early age,
Suitable age at marriage for men	Parents favor older age.
Characteristics of spouse	Parents prefer favor larger age difference between spouses, has wealth, and a good job. Boys prefer a wife who is chaste, religious, polite, and from good family. Girls hardly think about her husband.
Attitudes toward fertility	Girls are responsible for give birth,
Suitable age for pregnancy	Men are decision-maker to have a child.
Attitudes toward gender roles	
Wife deferential to husband	Boys more likely to think wife should be deferential.
Spouses share decision making	Boys supports do not shared decision-making.
Spouses share tasks	Girls more likely to support sharing of household tasks.

Cultural meaning and gender aspects of reproduction

Perceptions concerning puberty and menstruation

Onset of puberty refers particularly to biological changes that mark the commencement of reproductive system (Riley, 1987, p.8). '*puberty*' locally called as *Maiya boro howya* (girl growing up), *joubon shuru howya or boyosh kal*. In this stage a girl's breasts start to develop and experience pain in the breasts (*buk otha and buk betha*) and this is followed by menstruation (*Mashik suru*) (Nasreen et al. 1998:3). All the term bears symbolic implication and the society perceives the event as the awakening of maturation and emergence into the world of womanhood, sexuality, and fertility. A Muslim girl who has not reached menarche is called *nabalika* (immature), and a girl who has reached it is *sabalika* (mature). A Hindu girl in the latter stage is called *upajukta* (mature), which literally means a girl who is fit for coitus. Menarche is a private matter in Muslim religion. As soon as a Muslim girl reaches menstruation she is instructed to pray five times a day, to keep fast, to wear special clothes such as long shirt and trouser (*kamiz & salwar*), most importantly an extra piece of clothe to follow "*purdha*"(veil), i. e., to cover head and breast. Besides

these restrictions they are not allowed to move alone anywhere, even to the school. In general, mothers often do not talk to their daughters about menstruation. However, a married woman except her mother cautions a girl during her first menstruation girls not to pollute anyone by preparing or serving food, not to go anywhere bare footed. George states that "the meanings which are ascribed to menstruation and the cultural practices associated with it have a bearing on a woman's sexuality, on her reproductive health status and consequently on her overall health status" (George 1994, p.168).

The adolescence period begins with 'puberty' or 'menarche', which is looked down upon as a dirty (kharap) word and the stage, is considered very sensitive in Bangladesh. All the local terms used to signify this event relate a state of illness, e. g., '*oshuk*' (sickness), *shorir kharap* (having one's body in bad condition) or '*rokto bhange'* (blood breaks off). The period is also commonly associated with vulnerability and pollution, and is treated with disgust and shame. During the time of menstrual cycle “women are expected to avoid sex, prayers, and are forbidden to enter the cow shed, kitchen and fields” (Ross et al. 1996, p. 32). To perform religious rituals purification is prerequisite for both Muslim and Hindu women. The Holy Quran and the Manu describe how purification of the body should be attained from the polluted state before approaching to the God (Blanchet 1984,p.28).

In Bangladesh girls are not informed about their menstruation, sexuality, and contraception and this traditional attitudes often cause reproductive health problems in adolescents later life. Most women belief that irregular menstruation (*mashik animito*) is due to sexual intercourse during menstruation (Begum et al, 1997). In case there is any conception it may result in miscarriage or some ill consequences (*parinam kharap hate pare*) (Maloney & Aziz 1981, p.149).

In a Bangladeshi society a teenage daughter reaching menstruation becomes a problem or a burden for many parents, because, preservation of her virginity is the greatest concern for a bride. So, to get rid of awkwardness or to avoid risk mostly parents like to get their daughters married as early as possible. "She becomes shy and modest in her movements, and talk of her possible marriage or even the sight of an unknown man makes her feel shy" (Aziz & Maloney 1984,p.53).

The tendency of not informing or poorly informing adolescents' about their puberty onset, and their health is a prevailing typical attitude in a Bangladeshi society. They are mostly informed about prevailing social norms and what should be their attitudes. However, food intake during menstruation is also restricted in this society, particularly in rural areas. All kinds of fish should be avoided to stop spreading fishy smell of menstrual blood. Also because, *Bhut* (Evil eyes) are very fond of fish and bloody life matter (Blanchet 1984,p.39).

The onset of menstruation is an important indication of having womanly behaviour to perform religious functions and to enter into conjugal life as well. A girl is warned to be extremely cautious about the pollution of her first menstruation. These beliefs originate from the traditional social norms as it is the popular belief that one's behaviour not only shapes one's life, but influences others e.g., children and his or her family members (Maloney & Aziz 1981,p.163). Blanchet refers that "it is clear that belief in the polluting powers of women contributes to keeping them inside, separate and dependent…pollution, *purdha,* and the economic dependency of women are closely related" (e.g. Blanchet 1984, p.48).

All of these cultural perceptions are responsible for women's limitation in religious, social and household activities while they are menstruating. It is because of religious and social traditions or taboos that menstruation is looked upon as more than just a biological process; it turns into an event that has social, cultural and psychological implications. An adolescence girl has twofold perceptions of menstruation for instance, first from her own actual feeling and second, from her position as a member of her family and society, which has ascribed certain meanings to menstruation. The intercommunication of these two components shape her attitude to menstrual bleeding and reproductive health.

The onset of puberty of boys

It is traditionally believed that, boys' onset of puberty is comes later than that of the girl in Bangladesh. Growth of spurt and production of semen mark boys' early adolescence stage (kaisor kal), and it may occur 2 or more years later in Bangladesh than in well-nourished Western populations. The transition period of boys from childhood into adulthood covers the age 16 to 20 years (Aziz & Maloney 1984,p.51). Study findings revel that boys feel an excitement internally during their puberty. Some of them felt a

desire for sex and they masturbated (Nasreen et al, 1998:4). MacGilvray, having conducted a study about sexual power and fertility in Sri Lanka, found that, in Muslim community circumcision (*sunnot-e-khotna* Arabic word, custom sanctioned by the Prophet) is performed well before what is believed to be the age of sexual maturity (ed. MacCormack 1982,p.50). Similarly, in Bangladesh it is performed around the age of 9 or 10, the early adolescence' period. The author states that, "Muslim circumcision conforms in many ways to the symbolic model of the wedding...traditionally the boy was elaborately decorated and taken in procession through the village before the operation was performed. An informal arrangement for the boy is 'circumcision bridegroom' and, as with all weddings, wealthier families today distribute printed invitations" (ed.MacCormack 1982,p.52). The ritual of circumcision comes to an end with a special bath and with a big party like "wedding ceremony" in Bangladesh too. Special bath here symbolically means giving purification.

The production of semen for the boys is an important indicator of biological development at this stage: they are called either '*nabalak'* (immature, who has no semen) or '*sabalak'* (mature who has semen) (Aziz & Maloney 1985). During this period they are instructed to wear *lungi* (traditional men skirt), to pray five times a day (*namaz*) as religious duties, not to talk with adolescent girls alone, and not to look at them with a bad intention even.

Attitudes to and Perceptions of marriage, fertility and contraception

There is a popular cultural proverb existing in Bangladesh "girl at twenty is old" (*nari kurite buri*) but a man is still young at 70 (*purusher jauban ciroden*). Most parents and guardian are motivated by this popular proverb and they arrange marriage for girls, soon after their menarche and some times before menstruation in rural areas even nowadays. As a result, a social, and emic biological clock rather than an institutional clock decide the timing of marriage in Bangladesh. Most of the rural people who are influenced by the social norms and rules bequeathed to them by their ancestors, and guardians arrange marriage for their girls following their own will and irrespective of the minimum age of marriage. A girl's virginity (*ejjot rokkha kora*) is a top priority in marriage .A girl after menstruation has to be kept out of public sight, must be taught modesty and most importantly she must keep bodily purity for her marriage

market (Kotalova, 1993,p. 159). With the parental consent comes the acceptable by the society members and institution as well. Most of these unregistered marriages give the husbands ample chance to abandon them or to get way with verbal divorces when it suits for men.

If marriage is late, a girl's value suspends and she draws unfriendly attention from the whole family; family reputation and guardian's position in society falls into jeopardy. Besides, a girl should be married "in time", i.e., soon after menarche, otherwise her age since puberty affects her evaluation at the time of marriage negotiations (Kotalova, 1993, p.190). Moreover, they need large amounts of dowry and expenses for weddings and after marriage they do not provide any support for the family (Okojie 1994, cited by Dey, 1998,p.6). Adolescent girls often leave schools after their puberty begins for getting married. Adolescents have little power to say anything against their parents. As thus, parental and partner dominance is socially recognised in many contexts in Bangladesh. Parents and partner, in a sense, control adolescents' lives.

Fertility

In this society, the meaning of the comparison of an edible plant with a women's body, and sexual intercourse with food consumption, and its after affect is the children, are clear from the grouping of pre-adolescent girls (Kotalova, 1993, p.75). The comparisons are made between the agricultural cycle and stages of development of women. Adolescent girls are referred to as *auisya* or *amuinya* -according to their physical development- concepts used for paddy plantation; the first type is ready to be harvested after 3 months, the latter after 5 months…In this society women are compared to cultivating land and male semen seen as seed. According to the Holy Quran: **"Your women are lands for you; so plough them as you wish"** (Quran II: 223 quoted Maloney & Aziz, 1981, p.12).

Many adolescents become mothers before even knowing what it entails for them. Many studies showed that early marriage can cause severe health risks for themselves and also for their child. Several study in Matlab, Bangladesh showed that relationship between teenage fertility, and high infant mortality are intimately related with physical immaturity of teenage mothers (Alam, 2000:229). Further author states that "first born exhibited higher risks of neonatal and post-neonatal than second borns to women between

the ages of 20 and 24 years. According to Bangladesh Demographic Health and Survey data, 31 per cent of teenagers ranging from 15 to 19 are mothers and another 5 per cent is pregnant with their first child (BDHS, 1997, p. 40). Since the society is patriarchal, traditionally women are responsible for reproduction but the decision regarding fertility is in the hands of men. The status of girls and women in family or society, and what treatment they from others are crucial determinants of their reproductive health… It is strengthened by various institutions-for instance, religious, economic, political, social and legal institutions (Dey, 1998,p.3). According to existing Muslim family law an infertile woman inherit family property less than a fertile woman do. "Under the Muslim Personal Law the wife gets one-eighth of the husband's property if there is a child and one sixteenth if there is no child after husband's death (Khan, 1988, p.18). In spite of this fact, sons are considered as asset for the family as it is considered that sons only can maintain and extend the lineage (*bongsho rokha kora*). For this, sons inherit father's property; they are more valued because they can earn money, they are support for parents in old age, and they can cultivate family land (Okojie, 1994 cited by Dey, 1998, p.6).

In Bangladesh, society draws a distinguishing line between male and female on the basis of sex and then determines their reproductive health status and reproductive health needs on the basis gender distinction. It is well-known about Bangladesh that there is an effect of gender preference on child mortality, for instance, several studies in Matlab showed that at specific age mortality was higher for females than males (Bairagi et al, ed. Fauveau, 1994, p. 313). Compared to other developing countries female infant mortality is very high in Bangladesh. Further the author states that "in looking for the excess mortality of female in Matlab, it was observed that the allocation of food and health care, two important proximate determinants of mortality, were biased in favour of male children" (Bairagi et al, ed. Fauveau, 1994, p. 313). It is widely practised in Bangladesh, if daughter is born, family members treat mother as an unlucky person. As a result, mother neglects a girl child in respect of food intake and necessary health care during illness. In this society parents prefer to have male child. "If the expectation is fulfilled the parents rejoice and give the midwife a double present, but if not the baby may receive a cool reception, particularly from the father or his relatives" (Aziz &Maloney, 1981. p.166).

Adolescents' fertility encourages population growth and it influences socioeconomic development and the level of mortality risks among reproductive age women and their children (Kane, 1990). A study in Matlab, showed that girls ageing in between 10-14 had maternal mortality rate five times higher than women ageing in between 20-30. And for teenagers (15-19) the rate was double than that of the women in between 20-24 (WHO 1991, p.6).

Contraception

In this society, adolescent girls often face unwanted pregnancy either through failure of contraceptive methods or by non-use. Moreover, because of early marriage, childbearing is the common norm, unintended pregnancies are not deemed very unusual (Pachauri, 1998, p.125). The decision for the pregnancy termination depends on husband or on other family members. As the socio-cultural beliefs regarding abortion are very restrictive in terms of the existing general abortion law of the country, induced abortion is viewed as a shameful act because it is frequently done to end illicit (*apagarbha or kalangka janak kaz*) pregnancy (Maloney & Aziz, 1981, p. 217).

Institutionally, to go back to history, induced abortion was termed illegal an earlier person the Bengal Penal Code (1860), by the British in 1860. But it was permitted in some cases, e. g., if pregnancy is early and threatens the life of the mother then abortion should be legal. According to Maloney, at that time, the British expected positive reaction from the natives regarding the newly promulgated law. But Hinduism preaches about destiny and rebirth, i. e., a child predestined to be born is emerging into the world with an earlier person's soul in the form of rebirth (Maloney & Aziz, 1981,p. 215). In 1967, Pakistan Family Planning Association stated " abortion is not a method that can be used in Pakistan. Abortion is expressly forbidden in the Holy Quran and can not be considered in foreseeable future. Religion is paramount in Pakistan and its importance must never be underestimated." In Bangladesh, the demographic importance of abortion is fully understood by the Government, but it is yet to be made legal or political parties also tactfully avoid the (Maloney & Aziz, 1981, p.217). Since 1970s menstrual regulation has been available in Bangladesh but this is not very convenient for younger women as they must seek consent from husband or family members earlier. (IPPF, 1994, cited by Pachauri, 1998, p.125). Most people believe that humans

can not create a life, so they do not have any right to destroy (*nasto*) a conception (*garbha*) ' with their own hand' (*nijer hate*). According to Islam, it is equivalent to murder, and in the day of judgement severe punishment will be inflicted for it. Induced abortion is usually thought to be the result of illicit sex (Maloney & Aziz 1981, p.212). During pregnancy antenatal care is not quite available. As a result, pregnancy related complication and childbirth, unsafe abortion are the main causes of adolescents' death (Senanayake 1994, p.138).

In the society, there are no special contraceptive services for adolescent groups (Pachauri, 1998, p.124). The countries' social norm, tradition, and legislation have tended to disapprove and restrict contraceptive uses by adolescents (WHO, 1975, p.13). In Bangladesh, "where 66 per cent of adolescents are married, only 9 per cent of them use contraceptives, compared 19.1 percent married adults" (Senanayake et al, 1994, p.140). According to Bangladesh Demographic Health Survey 1996-1997, 1 in 3 married women who age in between 15 to 19 using a method (BDHS, p. 49). "In Bangladesh, one girl out of five does not live to celebrate her fifth birthday. One 15 years old girl out of six will not survive her childbearing" (Dey, 1998, p.6, Rajagopal & Phillip, 1995). The lower position in the society of women limits their autonomy in decision making, access free mobility, and for this they are deprived of health care facilities. A study shows that women have little authority in decision making on household expenditures or other family matters, including their own health and their children…physical age is important mark for women's mobility, their mobility increases as they grow older (Balk, 1997, p.1-3). The ICRW has recommended four strategies for postponing first births among female adolescents: encouraging late marriage, providing family planning and reproductive services specially for adolescents, providing family life education about options for the future, and increasing educational opportunities for girls (ICRW, 1995). The motive of unrestricted fertility and poor health care lie mainly deep in social attitudes which account that women are only for having children. For instance, it is widely believed that modern contraceptive method specially, oral pill may lead to infertility. As a result, without any practice of contraception they want to have their first baby soon after marriage. As Jejeebhoy states "contraceptive use depends, to a large extent, on a woman's age, fertility, and duration of marriage, the education

contraception relationship should ideally be viewed with these factors controlled" (Jejeebhoy, 1995, p.141). A Matlab study findings indicate that "contraception discontinuation was 73 percent higher among parents with no surviving sons and 72 percent higher among parents with no surviving daughters, compared with parents who have children of both sexes (Rahman et al, 1992, p.236). Adolescents tend to begin contraceptive use 1.5 years after marriage, or at an average of 17 years (Islam-MM et al. 1998)

Table 2 A. ***Trends in total fertility rate, 1991-1999***

Year	TFR
1971-75	6.3
1984-88	5.1
1986-88	4.8
1989-91	4.3
1991-93	3.4
1994-96	3.3
1997-99	3.3

B. ***Trends in current use of family planning methods***

Year	CPR
1975	77
1983	19.1
1985	25.3
1989	30.8
1991	39.9
1993-94	44.6
1996-97	49.2
1999-00	53.8

Sources: main findings from the 1999-2000 BDHS

Research questions

The literature findings suggests that the opportunity of getting reproductive health information for more appropriate Behaviour Change Communication and service for adolescents depend on their age and the nature of the contemporary social-cultural and gender specific contexts. Consequently, the perceptions, needs and aspirations of adolescents are not only determined by biological and behavioural factors, but also through socio-cultural and gender standpoints. That is individual reproductive health behaviour is

seen as the outcome of a *process* involving a series of individual decisions and actions taking place within social, economic, ecological, cultural and political *contexts.*

Therefore feature research questions as follows:

1. *What is the current adolescents' reproductive health status in Bangladesh?*
2. *How much do the contemporary factors influence adolescents' reproductive health status?*
3. *What meaning does "adolescence" bear in the contemporary Bangladesh? Do any particular biases exist which can put the adolescent reproductive health, of both boys and girls, at greater risk than that of adults?*

Hypothesis:

In the light of the literature findings discussed above, it is clear that the adolescents' reproductive health status is very much influenced by the contemporary factors. Therefore our central assumptions are:

-adolescence reproductive health status is not only influenced by the economic context but also very much by social, cultural, political and individual characteristics;

-adolescents' perceptions, aspirations and expectations effect their reproductive career, sexuality, and related careers such as education or work;

- in Bangladeshi society adolescence stage is defined with highly gender role differences which imply significant determinants on their health and well-being.

Summary and Conclusion

In Bangladesh, adolescent particularly girls under age 20 do extremely suffer from a series of reproductive health pressures. We do not yet know the full range of implications that what influence modernization and its attendant forces are having on adolescents in Bangladesh because research is still at a preliminary stage. As adolescent period is not looked upon as a distinct stage in life span rather as early youth, lack of decision making power and incomplete personal development make adolescents ill equipped to handle the reproductive health pressures they face. In the light of the research findings discussed above, it is clear that the policies and programs after ICPD Programme of Action, as well as

other NGOs provisions and services of Bangladesh, do not meet the reproductive health needs of adolescents.

Therefore, comprehensive research into adolescents' needs and realities in Bangladesh is becoming a priority for the first time, and the results should lead to programs and policies that will help to facilitate a successful and empowering transition to adulthood. This refers to that the research itself will be motivated by a set of cultural and social values and beliefs about adolescent. For instance, the definition of "adolescents" and quality of their lives should be measured precisely within a specific socio-cultural context and then effective ways should be chalked out to provide adolescents with appropriate reproductive health information and services (Mensch et al, 1998). To some extent, the research will be conducted by a set of social and cultural values and beliefs about adolescents, i.e. how "adolescents" are defined and characterized, and by the standard of their living. The most conspicuous aspect of culture and social setting of a country is that it is variable and it significantly differs from those of other countries. Culture, to a greater extent, determines the definition of adolescence. So, precise understanding of the concept of adolescence in a particular culture is indispensable to direct a comprehensive research, policy making and intervention programs. As the concept of adolescence is flexible, no method ultimately proves to be universal. If any general policy is planned, it may have drawbacks (Aysha, 2000). Adolescence should not be defined only by age, but culturally, socio-economically.

Several researchers and policy makers are greatly concerned about the stronger research methodology, which is competent enough to identify specific socio-cultural basis norms, beliefs, and values influencing adolescent stage and reproductive health issues. Focusing on the gender related study is important for many purposes. This will help to develop a really good understanding of appropriate cultural context for adolescents' reproductive health information and service. Many study recommended to improve women's status by giving them education that crucial for improving sex behaviour and equalising gender roles (Passages, 1995).

Mensch et al. is of the opinion that during adolescent period when transition to adulthood is in progress, young people must be equipped with proper education, skills, decision making power, and information to

function as responsible adults in society (Mensch et al.1998). This includes complete schooling and access to services, information, and opportunities, as well as protection including contraception. It suggests, in a remote way, that experts and policymakers around the world will necessarily become engaged in some revision and re-setting of standards for adolescents to define more clearly what is meant, in a modern context, by a healthy transition to adulthood.

Ensurement of adequate adolescents' reproductive health development, thus think the contemporary intellectuals and even many great statesmen also, is an indispensable precondition for the robust development of a nation. Keeping this assumption in mind, the policy makers and programmers should think of a convenient way to improve the present unwholesome condition of the adolescents. Adolescents, for the sake of their proper physical, psychosocial development, should not undergo pressures caused by menstrual trauma, early marriage, and copulation with an older man, childbearing without knowing the purpose of child, exposure to risks of disease. Where such burdens do exist, adequate support services and opportunities for education and work must be offered to them. If they cannot be provided with such opportunities, persons in charge of them must think seriously for bettering the situation. With a view to achieving our target we should not think of bringing about a radical change in a relatively conservative society, which may arose vehement protest from the more traditional section, rather we should contrive a flexible way to manoeuvre the present socio-cultural contexts to our purpose i.e. healthy transition to adulthood.

Note

This paper is a part of the Ph.D. project entitled Adolescents' Reproductive Health in a rural Bangladesh: socio-cultural and gender aspects. The authors gratefully acknowledge The Netherlands Foundation for the Advancement of Tropical Research (WOTRO), The Hague, Healthy Reproduction Action (HERA), Population Research Centre, University of Groningen, The Netherlands, for their financial support for this research. We would also grateful to Dr. Inge Hutter and Prof. Dr. F. J. Willekens, who arranged funds and provided helpful comments on an early version of the paper.

References

Alam N. 2000. Teenage Motherhood and Infant Mortality in Bangladesh: Maternal age- dependant effect of parity one. *Journal of Biosocial Science* 32. 229-236

Aziz & Malnoey 1985. *Life stages, gender and fertility in Bangladesh*. Chapter 1 p. 7,8, 19-21 & chapter 111.

Balnchet T. 1996. *Lost innocence, Stolen Childhoods*. P.

Balk Deborah 1997. Defying gender norms in rural Bangladesh: A social demographic analysis. Population Studies, 51, 153-172.

Bansal R.D. and Mehara, 1998. Editorial, Adolescent girls: an emerging priority. INDIAN JOURNAL OF PUBLIC HEALTH. Vol. XXXXII, No.1, pp.1-2.

Bhende-AA.1994. A study of sexuality of adolescent girls and boys in under privileged groups in Bombay. INDIAN JOURNAL OF SOCIAL WORK. Oct; 55 (4): 557-71

Banladesh Demographic Health Survey report 1997, and 1999 - 2000.

Chen V 1998. Meeting the need of adolescents. AVSC NEWS. Fall; 36(3):2,8.

Cole MB1996. Adolescent Sexual Health Matters. Advocates for Youth, Apr.8 p.

Caldwell, C. John, 1982. Theory of Fertility Decline. New York: Academic Press.

Caldwell C. John, et al, 1998. The Changing Social Context. *The Construction of Adolescence in a Changing World: Implications for Sexuality, Reproduction, and Marriage*. Studies in Family Planning, Vol: 29, # 2, June.

Chaudhury RH; Ratne M; Rai V; de Rebello DM; Pradhan B. 1998. "Socioeconomic, demographic and reproductive health profiles of adolescents in SAARC countries." Kathmandu, Nepal, United Nations Population Fund [UNFPA], Jul.[2], ix,49 p.

CEDPA. 1999. Youth and Population Momentum. 1994-19999 Cairo plus five.

Ciment-J.1999. UN study reports Asian economic crisis has hit women's health. BMJ: British Medical Association. Feb 13; 318 (7181): 420

Cattel G. Maria, 1996. Gender and Health: an International Perspective. *Gender, Aging, and Health: A Comparative Approach*, Ed. by F. Sergent and Caroline B. Brettell. Prentice Hall, Upper Saddle River, New Jersey 07458

Dey Kumar Debashish, 1998. Factors Influencing Maternal mortality in Bangladesh from a Gender perspective. The Dept. of Family Medicine, Umea University, Sweden. E-mail: debashish.dey@geriatrik.gu.se

Dobbert L. Marion and Cooke Betty 1987. *Primate Biology and Behaviour: A Stimulus to Educational Though and policy*. Education and Cultural process. Anthropological approach 2nd edition. Edited by Spindler D. George. Waveland Press, Inc.

Dressler W. William 1990. CULTURE, STRESS, AND DISEASES. Medical Anthropology: Contemporary Theory and Method. Edt. By Thomas M. Johnson and Carolyn f. Sargent. Praeger, NY Westport, Connecticut, London.

Friedman HL. 1994. Reproductive health in adolescence. WHO Health Statistics Quarterly; 47(1):31-5.

Friedman HL. 1992. Changing patterns of adolescent sexual behavior: consequences for health and development. JOURNAL OF ADOLESCENT HEALTH. Jul;13 (5):345-50.

Friedman HL.1999. Culture and Adolescent Development. JOURNAL OF ADOLESCENT HEALTH. 25:1-6

Finger-WR.1997. Key factors help programs succeed. NETWORK. Spring;17 (3): 21-4

George A. 1994. It happens to us: *Menstruation as Perceived by Poor Women in Bombay*. Listing to Women Talk about their Health: Issues and evidence from India. Editors, Gittelsohn J. and et al. The Ford Foundation.

Gray A. et al. 1999. Gender sexuality and reproductive health in Thiland. Development of Research Agenda towards a Gender Sensitive Reproductive Health Program (phase I: compilation study). Final report.

Gupta RB; Khan-ME. 1995. Teenage fertility in U.P.: some results from baseline survey in Uttar Pradesh. UP Academy of Administration, 1995. 30-2

Gupta D. Monica, 1995. Life Course Perspective on Women's Autonomy and Health Outcomes. Center For Population and Development Studies and Training Center, Brown University. *American Anthropologist* 97 (3): 481-49

Henriques-Mueller MH; Yunes J. 1993. Adolescence: misunderstandings and hopes. In: Gender, women, and health in the Americas, edited by Elsa Gomez. Washington, D.C., Pan American Health Organization [PAHO],: 43-61. (Scientific Publication No.541).

Haque-ME.1998. Country watch: Bangladesh. Sexual Health Exchange. (3):6-7

ICRW INFORMATION BULLETIN.1996. Investing in the future: ICRW's program on adolescence. International Center for Research on Women (ICRW), Feb;:1-3.

Islam-MM; Islam-MN. 1998. Contraceptive use among married adolescent girls in rural Bangladesh. Journal of Family Welfare. Mar;44 (1): 32-41

Jejeebhoy-SJ.1996. Adolescent sexual and reproductive behavior. A review of the evidence from India. Washington, D.C., International Center for Research on Women [ICRW], Dec.[5], 35 p. (ICRW Working Paper No. 3)

Jejeebhoy-SJ,1995. Women's Education, Autonomy, and Reproductive Behaviour. Experience from Developing Countires. Clarendon Press Oxford.

Joseph-GA; Bhattacharji-S; Joseph-A; Rao-PS, 1997. General and reproductive health of adolescents girls in rural south India. INDIAN PADIATRICS. March;34 (3): 242-5

Kabir, S. (1997). Short term constancy to give suggestions on the reproductive health program of ICDDR,B.

Kane TT.1990. Adolescent fertility in the Gambia. Education and declining age at marriage, two limiting factors. POP SAHEL. Aug;(13):24-7.

Kotalova, J. 1993. *Belonging to Others*. Cultural Construction of Womanhood among Muslims in a Village in Bangladesh. UPSALA

Mensch BS & et al 1998. *The uncharted passage*: girls' adolescence in the developing world. NY, Population Council.

Mary Nell Wegner et al 1998. *Men's Reproductive Health*: Defining, Designing and Delivering Services. Family Planning Perspective, SPECIAL REPORT From Issues to Action Volume 24, No. 1, March http://www.agiusa.org/pubs/journals/2403898.html

Network 1997. Adolescent Reproductive Health. Family Health International, Vol. 17 No.3, Spring.

Nurun Nabi A.K.M and Krishnan P.1998. Political Demography of Bangladesh: a Preliminary analysis. Demography India. Vol. 27, No 1, pp. 129-146

Nasreen et all, 1998. Three Studies on HIV/ AIDS. *Communication network in reproductive health information dissemination to the adolescents.* Working Paper Number: 21, BRAC-ICDDR,B, Dhaka. Bangladesh.

Pachuri S 1998. Adolescents in Asia: issues and challenges. DEMOGRAPHY INDIA. Jan-Jun; 27 (1): 117-128.

Pathak B. K and Ram F., 1993. Adolescents motherhood: Problems and Consequences. *The Journal of Family Welfare*. Vol.39 (1) pp.17-23

PROGRESS,1999. Women ,reproductive health and international human rights. UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). Progress No 50, pp.1-8

PASSAGES. 1995. Gender: a new perspective for youth programs. Oct-Nov; 14 (1): pp.9-13

Ross, D.A. (1996a). *The future of the Matlab health and Research Centre: Report of a consultancy for the Community Health Division, ICCDR,B.*

Ross, J.L. (1996b*). The program response of the social and behavioural sciences to the ICDP-POA: A proposed protocol, 1996-2001*. Centre for Health and Population Research. International Centre for Diarrhoeal Disease Research, Bangladesh.

Riley A. Patricia 1987. Age at Menarche and growth among adolescents' females in rural Bangladesh: *Implications for childbearing*. A Doctoral Dissertation. Johns Hpokins University, Baltimore, Maryland.

Rich M. and Ginsburg K.R. 1999. The Reasons and Rhyme of Qualitative Research: Why, When, and How to Use Qualitative Methods in the study of Adolescent Health. JOURNAL OF ADOLESCENT HEALTH: 25: pp. 371-378

Rahman, M., Akbar J, Phillips F. James, and Becker S. 1992. Contraceptive Use in Matlab, Bangladesh: The Role Gender Preference. *Studies in Family Planning*, Vol.23, No.4, Jul/Aug, pp.229-242

Sikes OJ 1996. Approaches to adolescent reproductive health: audience-specific strategies. PROMOTION ET EDUCATION. Sep;3(3):15-7.

Senanayake,P and Ladjali, M, 1994. Adolescent health: Changing needs. International Planned Parenthood Federation. INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTERICS. 46, pp.137-143.

Sai Fred T. and Nasim J. 1989. The need for a reproductive health approach. INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTERICS. 3: 103-113

Smilansky Moshe 1991. Between Adolescents & Parents. Psychological & Educational Publications. Gaithersburg, Maryland 20886, ISBN

United Nations, New York 1998. Report and recommendations of the Expert Group Meeting on Adolescents: Implications of Population Trends, Environment, and Development, 30 September-2 October 1997, Bangkok. Vi,81 p. (Asian Population Studies series No.149)

United Nations. 1989. Adolescent reproductive behaviour, evidence from developing countries, vol.II. New York, New York United Nations, Department of International Economic and Social Affairs, xi,128 p. (Population Studies No.109/Add.1)

UNFPA, 1999. Youth At Risk and in need of Information and Services.

United Nations 1997.Family-bulding and Family Planing Evaluation. Department of Economic and Social Affairs, Population Division. New York, ST/ESA/SER.R/148

World Health Organization,1975. Report of a WHO Expert Committee. Technical Report Series No. 308, pp.7-27.

WHO 1991. *Maternal Mortality*: A Global Factbook. Complied by Carla AbouZahr and Erica Royston. Division of Family Health, WHO, Geneva.

WHO 2000. Special Theme-Reproductive Health. Measuring reproductive health: review of community-based approach to assessing morbidity. *The Bulletin of the World Health Organization, 78*. Ref. No.99-0414.