



Socioeconomic Predictors of Number of Child Preference; a Study on the Ethnic Community in Bangladesh

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Authors' contributions

This work was carried out in collaboration between all authors. All authors read and approved the final manuscript.

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ABSTRACT

Bangladesh is a most densely populated nation, with a population density of 1134 population per square kilometer [1]. Bangladesh has to face different types of problem and crisis for limited resources and unlimited wants of the increased population. Despite of being concerned about the present situation, the fertility rate is now at 2.4 children born per women [2]. The objective of the study is to estimate the socio-economic factors responsible for the Number of Child Preference in the Ethnic Community in Bangladesh. The study analyzed a total of 113 (82 Manipuri & 31 Khasia) respondents from Manipuri and Khasia community purposively selected from Sylhet district. The information was recorded in a pre-structured questionnaire. Bi-variate distribution i.e. chi-square test and multinomial logistic regression model were fitted to determine the influencing factors responsible for the Number of Child Preference in the Ethnic Community. Educational Status, Head of the Family, Contraceptive Use, and Family Planning Decision were found correlated with

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the dependent variable i.e. Number of Child Preference. All of the illiterate respondents were interested in having more than 1 child while only 7.84% literate respondents were interested in having 1 child. The family which was run by mutual understanding between male and female was more interested in 1 child (8.33%) than the Male dominated family (5.88%). No one was interested in having 4 or more children from the family which was run by both male and female. Those who used contraceptive, 13.33% of them were interested in 1 child while only 2.94% of the respondents who didn't use contraceptive were interested in 1 child. The preference for 4 or more children was less among the respondents who used contraceptive (2.22%) than who didn't use contraceptive (4.41%). If the family planning decision was taken by female, they would prefer 4 or more children for their family while male would prefer 2 children. If the family planning decision was taken by mutual consideration of male and female, 78.70% would prefer 2 children followed by 11.11% of 3 children, 7.41% of 1 child, and 2.78% of 4 or more children. Contraceptive Use was found only the predictors of the Number of Child Preference in the Ethnic community. Finally, this study suggested that government can take a strong initiative for the provision of contraceptive use and educational facilities to control the family size of the Ethnic community.

Keywords: Socio-economic status; ethnic community; child preference; Bangladesh.

1. INTRODUCTION

The majority of Bangladesh's 142.3 million people are Bengalis but approximately 3 million are indigenous peoples belonging to at least 54 different ethnic groups speaking at least 35 different languages. These peoples are concentrated in the north and Chittagong Hill Tracts (CHT) in the south-east of the country [3]. The indigenous ethnic groups are the pride of Bangladesh. They enriched the country by their distinct culture and activities. The indigenous ethnic groups in Bangladesh are as follows. Bawm, Biharis, Bishnupriya, Banal, Bediya, Bhumij, Bagdi, Chak, Chakma, Dalu, Garo, Gurkha, Hajonj, Jaintia, Khasi, Khajons, Khumi, Khyang, Koch, Khatriya Barman, Kharia, Karmakar, Khondo, Khumi, Kole, Lushai, Meitei, Mundas, Mros (Mrus or Moorangs), Marmas, Manipuri, Munda, Marma, Mahato, Malo, Mahali, Muriyar, Musohor, Mandi, Oraon, Patro, Pangkhu, Pahan, Rohingyas, Rajbongshi, Rakhain, Rajuar, Rai, Santal, Tripuri, Tanchangya, Turi [4]. The main ethnic groups in the plain lands of Sylhet are Khasi, Manipuri, Garo, Patro, Bishnupriya and Tripura, although ECDO non-formal research has indicated that there are approximately 30 different indigenous communities living in Sylhet region. Among these groups, the Manipuri and the Khasi are the largest in population. Each group has distinct linguistic and cultural practices [5].

Government and non-governmental organization can take effective initiatives collaboratively for the sound livelihood of this ethnic community along with proper reproductive health care facilities especially the rate of contraceptive use

may be on prime concern emphasizing the active roles of their representative leaders for the development of their reproductive norms along with their socio-economic conditions. As the member of the state, the Khasia have the equal rights in every development initiatives which must be protected and ensured by the state [6].

In Manipuri community, 73.17% respondents were in good socio-economic condition while in Khasia community, only 6.45% respondents were in good socio-economic condition and for the Ethnic community (Manipuri and Khasia), 54.86% respondents were in good socio-economic condition. School, colleges, University, Night School for Elder & worker etc initiatives can be taken to ensure the education for the Ethnic community people. Income generating activities should be raised for ethnic community. They usually have limited access to the other jobs rather than their ancestral jobs [7].

Shikdar, Biswas & Mollick [8] mentioned major findings on the condition of Khasia people. Education is low among ethnic groups. This is particularly evident in the Khasi community where education of children rarely progresses past primary level. The cause of these problems can be attributed partly to the remoteness of ethnic community villages; there are no secondary schools located nearby. There is very little awareness about the threat of HIV/AIDS within ethnic communities, and the general education rate is very low which limits the understanding of HIV/AIDS and connected issues. Employment problems are prevalent throughout indigenous communities.

Though contraception is not simply about avoiding pregnancy, Access to reliable birth control also allows women to space births which has measurable outcomes for their own health and that of their babies [9]. Moreover, that, as income inequality grows families without access to reliable contraception are potentially at a greater disadvantage. Poorer children experience more health problems, live in more dangerous neighborhoods and have higher rates of delayed academic development [10].

Those reviews indicate that ethnic communities were having different types of the problem from social to economic or educational which impact the socio-economic condition. But, no one study showed the reason behind the high number of child preference among the ethnic communities. To control the increased population, it is high time to know the factors which trending them for more children. The objective of the study is to estimate the socio-economic factors responsible for the Number of Child Preference in the Ethnic Community in Bangladesh. However, the specific objectives are:

- To estimate the socio-economic factors responsible for number of child preference in the Ethnic Community in Bangladesh.
- To find out the correlation between socio-economic factors and number of child preference in the Ethnic Community in Bangladesh.

2. MATERIALS AND METHODS

Sylhet division which is the most populous place of the Manipuri and Khasia indigenous ethnic community located in the northeastern region of Bangladesh. From the Sylhet division two upazillas namely Sylhet Sadar and Gowainghat were selected purposively on accounts of availability of a large number of respondents; easy accessibility and good communication facilities. Respondents of 113 ethnic ever-married 15-49 aged females of these upazillas were selected randomly. Data were collected from the selected respondents through the direct interview with structured questionnaire during the period from January to May 2016.

2.1 Tools and Techniques

Univariate analysis, Bi-variate distribution, Multinomial logistic regressions were performed through SPSS (Version 20.00).

2.2 Variables

The dependent variable is the child preference or No of child preferred by the respondent. The independent variables are as follows:

- Residential Status
- Age
- Education
- Occupation
- Family Type
- Head of the family
- Income
- Expenditure
- Credit access
- Health facility
- Electronic device
- Maternal care
- Contraceptive use
- Family planning decision

3. RESULTS AND DISCUSSION

The association between dependent and independent variable was determined through Chi-square test and the results of the test are shown and significant variables are discussed in Table 1.

3.1 Educational Status

Educational status has association with the dependent variable i.e. Number of child preference. Out of 113 respondents, 102 respondents were literate where 11 respondents were illiterate. All of the illiterate respondents were interested in having more than 1 child while only 7.84% literate respondents were interested in having 1 child. 72.73% of illiterate respondents and 79.41% of literate respondents were interested in 2 children. The percentage of respondents who were interested in 4 or more children was lower for literate respondents which were only 1.96% than the illiterate respondents (18.18%). Either the respondents illiterate or literate, they were more interested in 2 children.

3.2 Head of the Family

The test found that there was close association between Head of the Family and Number of Child Preference. Out of 113 respondents, 2 were from female-headed family, 51 were from male-headed family and 60 of them were from both (Male and female) headed family. It was found that female-headed family were fond of

Table 1. Differentials of number of child preference for ethnic community

Associated factors	Child preference or number of children preferred				Row total	Total	Chi-square value	P-value
	1	2	3	4 or more				
Residential Status								
Rural	3(6.67%)	36(80%)	3(6.67%)	3(6.67%)	45	113	3.198	.362
Urban	5(7.35%)	53(77.94%)	9(13.24%)	1(1.47%)	68			
Age								
Less Than 18	0(0 %)	0(0 %)	0(0 %)	0(0 %)	0	113	0.831	.842
18-21	0(0 %)	3(100 %)	0(0 %)	0(0 %)	3			
Over than 21	8(7.27%)	86(78.18%)	12(10.90%)	14(12.73%)	110			
Educational status								
Illiterate	0(0 %)	8(72.73%)	1(9.09%)	2(18.18%)	11	113	8.326	.040
Literate	8(7.84%)	81(79.41%)	11(10.79%)	2(1.96%)	102			
Occupational status								
Not Employed	0(0 %)	3(75%)	0(0 %)	1(25%)	4	113	6.136	.105
Employed	8(7.34%)	86(78.90%)	12(11.01%)	3(2.75%)	109			
Family type								
Joint Family	7(9.59%)	58(79.45%)	7(9.59%)	1(1.37%)	73	113	4.796	.187
Single Family	1(2.5%)	31(77.5%)	5(12.5%)	3(7.5%)	40			
Head of the family								
Female	0(0 %)	1(50%)	0(0 %)	1(50%)	2	113	16.094	.013
Male	3(5.88%)	39(76.47%)	6(11.77%)	3(5.88%)	51			
Both	5(8.33%)	49(81.67%)	6(10%)	0(0 %)	60			
Income								
0-10000	5(10.42%)	37(77.08%)	3(6.25%)	3(6.25%)	48	113	5.246	.513
10001-20000	2(5.41%)	30(81.08%)	5(13.51%)	0(0 %)	37			
20000+	1(3.57%)	22(78.57%)	4(14.29%)	1(3.57%)	28			
Expenditure								
0-10000	6(8.70%)	52(75.36%)	8(11.60%)	3(4.35%)	69	113	2.959	.814
10001-20000	1(3.45%)	25(86.21%)	3(10.35%)	0(0 %)	29			
20000+	1(6.67%)	12(80%)	1(6.67%)	1(6.67%)	15			
Credit status/ Loan status								
No	3(5.77%)	44(84.62%)	4(7.69%)	1(1.92%)	52	113	2.141	.544
Yes	5(8.20%)	45(73.77%)	8(13.12%)	3(4.92%)	61			
Health facility								
No	2(5.72%)	27(77.14%)	3(8.57%)	3(8.57%)	35	113	3.977	.264
Yes	6(7.69%)	62(79.49%)	9(11.54%)	1(1.28%)	78			
Electronic devices								
No	1(33.33%)	1(33.33%)	1(33.33%)	0(0 %)	3	113	5.414	.144
Yes	7(6.36%)	88(80%)	11(10%)	4(3.64%)	110			
Maternal care								
No	0(0 %)	13(100%)	0(0 %)	0(0 %)	13	113	3.961	.266
Yes	8(8%)	76(76%)	12(12%)	4(4%)	100			
Contraceptive use								
Yes	6(13.33%)	35(77.78%)	3(6.67%)	1(2.22%)	45	113	5.607	.013
No	2(2.94%)	54(79.41%)	9(13.24%)	3(4.41%)	68			
Family planning decision								
Female	0(0 %)	0(0 %)	0(0 %)	1(100%)	1	113	28.547	.000
Male	0(0 %)	4(100%)	0(0 %)	0(0 %)	4			
Both	8(7.41%)	85(78.70%)	12(11.11%)	3(2.78%)	108			

*p-values are based on Chi-square test. Within brackets add to row percentages.

Source: Author's Research, 2016

having more than 1 child. The family which was run by mutual understanding between male and female was more interested in 1 child (8.33%) than the Male dominated family (5.88%). No one was interested in having 4 or more children from the family which was run by both male and female.

3.3 Contraceptive Use

Contraceptive use was associated with number of child preference. In the ethnic community, less than half i.e. 45 out of 113 respondents were using contraceptive for family control. Those who used contraceptive, 13.33% of them were

Table 2. Determinants of number of child preference for ethnic community

No of child preferred	Associated Factors (contraceptive use)	Multinomial logistic regression analysis				
		β	P-value	Odds Ratio	CI for odds ratio	
		Lower CI	Upper CI			
1 [®]						
2	1=Yes [#]	-	-	-	-	-
	0=No	1.660	.057*	1.190	1.034	2.049
3	1=Yes [#]	-	-	-	-	-
	0=No	2.479	.023**	1.084	1.010	1.709
4 or more	1=Yes [#]	-	-	-	-	-
	0=No	17.094	.089*	1.046	1.015	1.695

Note: [®] denotes reference category in dependent variable; [#] denotes reference category in independent variable; *p<.10, and **p<.05 are the levels of significance

interested in 1 child while only 2.94% of the respondents who didn't use contraceptive were interested in 1 child. The preference for 4 or more children was less among the respondents who used contraceptive (2.22%) than who didn't use contraceptive (4.41%). Either the respondents used contraceptive or not, they were more interested in 2 children.

3.4 Family Planning Decision

The association between family planning decision and number of child preference was found significant. Out of 113 respondents, 1 was from the family where family planning decision was taken by female, 4 were from the family where family planning decision was taken by male and 108 of them were from the family where family planning decision was taken by mutual consideration of male and female. It was clear that if the family planning decision was taken by female, they would prefer 4 or more children for their family while male would prefer 2 children. If the family planning decision was taken by mutual consideration of male and female, 78.70% would prefer 2 children followed by 11.11% of 3 children, 7.41% of 1 child, and 2.78% of 4 or more children.

The Chi-square test revealed that Educational Status, Head of the Family, Contraceptive Use, and Family Planning Decision were significantly associated with the dependent variable i.e. Number of Child Preference. Chi-square test examines the individual relationships of the variables with the dependent variable. To examine the relative importance of all the independent variables, multinomial logistic regression has been used. Only significant independent variables with 10 percent level of

significance were considered in the regression analysis. Among the variables considered in multinomial logistic regression analysis, only the expounding variable "Contraceptive Use" had a significant effect on the Number of Child Preference at 10 percent level of significance.

3.5 Contraceptive Use

Contraceptive use was statistically significant with Number of Child Preference for Ethnic Community. The respondents who didn't use contraceptive were 1.190 times more likely to prefer 2 children than the respondents who preferred 1 child. The respondents who didn't use contraceptive were 1.084 times more likely to prefer 3 children than the respondents who preferred 1 child. The respondents who didn't use contraceptive were 1.046 times more likely to prefer 4 or more children than the respondents who preferred 1 child.

4. CONCLUSION

The present study focused on the socio-economic factors responsible for the number of child preference of the Ethnic community in Bangladesh. In this research, educational status, head of the family, contraceptive use, and family planning decision were found correlated with the dependent variable i.e. Number of Child Preference. Educational status played a vital role in selecting number of children in family, as illiterate people preferred more than 1 child and also the percentage of respondents who preferred 4 or more children were less in literate people than illiterate people. It was good to spot the ceiling number of families (53%) run by mutual consideration of male and female which resulted in not selecting 4 or more children for

their family. Maximum respondents (60%) were not using contraceptive for different reason. Those who were using contraceptive, 13.33% of them preferred very small family i.e. 1 child where the percentage was only 2.94% for the respondents who didn't use contraceptive. The favorite option for ethnic family was choosing 2 children and it was not a matter of fact that the respondents were educated or not, contraceptive used or not. Moreover, multinomial logistic regression revealed that preferring 2 children were 1.190 times high in the respondents who didn't use contraceptive than 1 child while preferring 3 children were 1.084 times high in the respondents who didn't use contraceptive than 1 child. The ethnic community was very cooperative in taking family planning decision as the outcome of research showed that about 96% of respondent reported to take family planning decision by mutual understanding of male and female.

5. RECOMMENDATION

Based on the research findings, the following recommendations are given.

- Proper steps should be taken by the government or other organization for educating the ethnic people.
- Awareness should be increased for equal participation of male and female in family affairs.
- The government can take a strong initiative for the provision of contraceptive use to improve family structure by insisting them the bad effect of over children.
- Every stakeholder of the family should be given same priority in making decision of family planning

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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