

DHS Further Analysis Reports No. 99



Why So Young? The Social Context of Early Childbearing and Contraception among Young Women in Khulna, Bangladesh

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The Social Context of Early Childbearing and
Contraception among Young Women in Khulna,
Bangladesh**

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March 2016

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Acknowledgment: The authors gratefully acknowledge the study's field research team: Syeda Nurunnahar, Sharmin Islam, Fatama Khatun, Meghla Islam, and Salim Prodhania. These individuals worked diligently under the supervision of Marzia Sultana and Rasheda Khan to collect data of high quality, under sometimes difficult conditions. The authors would also like to thank Lyndy Worsham for contributing maps, Erica Nybro for developing graphical displays of the data, and Thea Lange for her assistance with literature. Our gratitude is extended to Kanta Jamil, USAID, who spearheaded the study idea. She and Peter Kim Streatfield provided thoughtful input on emerging results throughout the study. We extend our appreciation to Laurie Liskin who provided a thoughtful review and Erica Stephan for editorial efforts. The authors are grateful to the governments of Bangladesh, Canada, Sweden, and the United Kingdom for providing core/unrestricted support to icddr,b for its research efforts. Finally, we are deeply indebted to the 30 young women who so generously shared their time and personal stories with us.

Editor: Erica Stephan

Document Production: Natalie La Roche

This study was carried out with support provided by the United States Agency for International Development (USAID) through The DHS Program (#AID-OAA-C-13-00095). The views expressed are those of the authors and do not necessarily reflect the views of USAID or the United States Government.

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Recommended citation:

MacQuarrie, Kerry L. D., Quamrun Nahar, Rasheda Khan, and Marzia Sultana. 2016. *Why So Young? The Social Context of Early Childbearing and Contraception among Young Women in Khulna, Bangladesh*. DHS Further Analysis Reports No. 99. Dhaka, Bangladesh and Rockville, Maryland, USA: National Institute of Population Research and Training (NIPORT), International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b), and ICF International.

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Abstract

This study on the social context of early childbearing is one of three qualitative studies emanating from the 2014 Bangladesh Demographic and Health Survey (BDHS). The qualitative study adopted a nested design and drew its sample from among eligible respondents to the BDHS. This study conducted in-depth interviews with 30 women age 15-22 who had married before age 18 in Khulna division, Bangladesh. The study was motivated to investigate why young, married women bear a first child at a young age. We find that women enter into marriage suddenly and without knowledge of contraception. Young women want to delay a first pregnancy, but still want a birth within adolescence. Spousal communication and women's decision-making are low and young women defer decisions on childbearing and contraception to others. Women's fertility desires are frequently discordant with those of their husbands, their in-law family, or both. Women, their husbands, and their family members are all concerned with the health consequences of early childbearing. However, concerns about the health effects of contraception promote early pregnancies. Thus, women's abilities to meet their fertility aspirations are challenged by discordant childbearing aims, limited options for contraceptive methods, and discontinuation of contraception due to side effects and concerns about infertility.

1. Introduction

Early age at marriage is socially acceptable in South Asian culture (Riley 1994), and Bangladesh has long been characterized by early marriage and high adolescent fertility. According to the 2014 Bangladesh Demographic Health Survey (BDHS), 89% of women age 20-49 were first married by age 20. In spite of increases over the last decade and a half, de facto age at marriage for women remains low, well below the legal minimum marriage age. Between 1997 and 2014, the median age increased by 2 years, from 14.2 to 16.1 (Mitra et al. 1997; NIPORT, Mitra and Associates, and ICF International 2016). Many of these marriages are arranged by the parents, with little participation by the girl (Shrestha 2002).

Marriage is the leading social and demographic indicator of exposure of women to the risk of pregnancy and a key proximate determinant of fertility (Bongaarts 1982). This is especially so in South Asia, where marriage is near universal and childbearing occurs almost entirely within marriage. In Bangladesh, the total fertility has fallen rapidly (from 3.3 in 1997 to 2.3 in 2014) and the modern contraceptive prevalence rate has risen from 42% to 52% in the same time period. Nonetheless, the probability of a first birth before age 20 has remained static since the 1990s (Nahar and Min 2008). Nearly 31 percent of adolescents have begun childbearing. Women's median age at first birth in Bangladesh is 18.4 years (NIPORT, Mitra and Associates, and ICF International 2016).

Adolescent pregnancy poses risks for a range of negative maternal and peri-natal health outcomes, with the risk increasing for the youngest girls (Cooper, Leland, and Alexander 1995; Haldre et al. 2007; de Vienne, Creveuil, and Dreyfus 2009; Goonewardene and Waduge 2009). The World Health Organization estimates that births to women younger than age 20 account for 11% of all births worldwide, but account for 23% of the burden of disease from pregnancy and childbirth among all women (Chandra-Mouli, Camacho, and Michaud 2013). In particular, girls younger than 20 have an increased risk of miscarriages, stillbirths, and neonatal deaths, as well as preterm birth and low birth weight infants. Early marriage is associated with poor fertility control and negative reproductive outcomes (Godha, Hotchkiss, and Gage 2013; Kamal and Hassan 2015). Women who marry young are not only likely to have their first birth at a young age, but tend to have shorter birth intervals (also a health risk) and higher total fertility. Beyond health risks, adolescent mothers also have social disadvantages. They may be socially isolated, without partner or family support, and often unable to complete their education. They may transmit some degree of socioeconomic disadvantage in health outcomes and behavioral risks to their own children.

Young, recently married women enter an institution in which social norms emphasize childbearing, where they may face direct pressures to have a child, where proving one's fertility is a means to improving one's social status, and where personal decision-making is deferred to the husband or more senior women in the household (Rashid 2006; Gipson and Hindin 2007; Henry et al. 2015). Spousal communication about matters of sexuality and reproduction is likely to be inadequate, particularly in arranged marriages, and it may be difficult for young women to articulate their fertility desires, particularly if they contravene strong social expectations. Several studies have shown that young, recently married women are less empowered than either unmarried adolescents in their natal home or older married women who have already borne children (Gage 2000; MacQuarrie 2009).

In such a context, the young woman's husband or mother-in-law may figure prominently in decisions about using contraception and the timing of childbearing (Barua and Kurz 2001; MacQuarrie and Edmeades 2015) or the woman may begin childbearing as a way to improve her standing in the household (MacQuarrie 2009). A study in Nepal showed that a higher proportion of adolescent pregnant women (67%) live in an extended family. Of these women, just over half (51%) said their husbands had authority over conception choices in spite of the adolescents' desire to make their own decision (Sharma et al. 2002).

Young women, by fact of their age and inexperience, may also lack information and access to services they need to delay the first birth. For example, only 30% of 15-19 year old women have been exposed to any information on contraception in the preceding month (NIPORT, Mitra and Associates, and ICF International 2016). Possibly as a result of these social barriers, contraceptive use among married women age 15-19 is 47%, lower than among any age group between the ages of 20 and 44, and the unmet need for family planning is higher (17%) than among women age 24-49 (12.3%) (NIPORT, Mitra and Associates, and ICF International 2013; MacQuarrie 2014, 2015). Contraception is seldom used prior to the first birth (24% of nulliparous women) (NIPORT, Mitra and Associates, and ICF International 2013).

While DHS survey data can describe the prevalence of contraceptive use and adolescent childbearing and patterns across subpopulations or time, these data do not illuminate the motivations leading to these outcomes. Therefore, the present study supplements the quantitative data with a qualitative investigation into the social context that shapes young women's fertility intentions, decisions, and contraceptive and fertility behavior in Khulna division of Bangladesh.

2. Methods

2.1. Study Setting

Of Bangladesh's seven divisions, Khulna has one of the lowest ages at first marriage and, subsequently, ages at first birth. In 2014, the median age at first marriage among women age 20-49 was 15.5 and the median age at first birth was 18.0, well below national figures (NIPORT, Mitra and Associates, and ICF International 2016). On average, Khulna women have an interval of 30 months between marriage and first birth. This stands in sharp contrast to a median of 63.8 months between subsequent births (national median is 51.7 months) (NIPORT, Mitra and Associates, and ICF International 2016). This low age at marriage and short interval from marriage to the first birth make Khulna an ideal setting to explore the normative context that underlies these demographic behaviors. This study on early childbearing draws its sample from rural clusters in Khulna division.

2.2. Study Design and Instruments

This qualitative study on the social context of early childbearing is one of three qualitative studies emanating from the 2014 Bangladesh Demographic and Health Survey (BDHS). Two other studies examine the pregnancy risk and family planning needs of women with migrant husbands and women's perspectives on and experiences with antenatal care. These studies are presented in DHS Further Analysis Reports Nos. 98 and 100, respectively. All three qualitative studies and the quantitative Bangladesh DHS survey are supported by USAID/Bangladesh through The DHS Program (contract # AID-OAA-C-13-00095). The International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) is the implementing organization of the study, led by principal investigators from icddr,b and The DHS Program.

The three qualitative studies are all nested studies (Tashakkori and Teddlie 2010; Harrits 2011) embedded within the broader, quantitative BDHS. This research design allows large n quantitative and small n qualitative analysis on the same topic and using the same sample population, so that the methodologies complement each other. Specifically, this study adopts a data-linked nested research design (Schatz 2012). This design facilitates strategic sampling: namely, the qualitative study uses a sub-sample of the larger BDHS sample.

The primary data collection method was in-depth, in-person interviews. The targeted number of interviews (30) was guided by the principle of saturation (Morse 1994; Patton 2005; Guest, Bunce, and Johnson 2006). Saturation was confirmed upon the analysis stage of the study. In-depth interviews were semi-structured and guided by an interview guide of open-ended questions and possible conversational prompts and probes. Interviews began with general topics and progressed to more sensitive topics. The interview guide encouraged informants to discuss their experiences and attitudes about marrying, their fertility aspirations upon marriage, communication between the couple, knowledge of and behavior around family planning and childbearing, young women's agency and decision-making around fertility, and the influences of their spouses, parents, in-laws, and others in the community on their reproductive behavior.

2.3. Study Cluster Selection

The qualitative study draws its sample from among respondents to the 2014 BDHS. The 2014 Bangladesh DHS is the seventh DHS in Bangladesh. It is a nationally representative sample of 17,886 ever-married women of reproductive age (15-49 years). The BDHS achieved a response rate among eligible women of 97.9% nationally and 98.9% in Khulna.

The BDHS applied a two-stage, stratified and clustered sampling design. Each division was stratified into rural and two types of urban areas (city corporations and other than city corporations). In the first stage of sample selection, 600 enumeration units were selected with probability proportional to size. Enumeration units were delineated from the 2011 population census of the People’s Republic of Bangladesh. In the second stage, 30 households per cluster were selected with equal probability. All ever-married women age 15-49 who are de facto members of the selected household were eligible for interview. Details of the Bangladesh DHS methodology can be found in the survey final report (NIPORT, Mitra and Associates, and ICF International 2016).

Figure 1. Map of study division and clusters



The BDHS data were collected between July and October 2014. The 2014 BDHS sampled 85 clusters in Khulna division—56 rural and 29 urban. The BDHS implementing organization, Mitra and Associates, provided our study team with a list of clusters containing women who had consented during the DHS interview to a follow-up interview and met the eligibility criteria of this study. From the cluster listing, we selected rural clusters with four or more eligible respondents. Our original sampling design called for these clusters to be drawn randomly. However, the eruption of political unrest and widespread *hartals* (strikes/blockades), which had the potential to become violent, caused us to adjust our sampling procedures. We prioritized geographic proximity, replacing several selected clusters that were distant from the others with new, eligible clusters that were closer. Additionally, we increased the target

number of interviews per cluster and reduced the overall number of selected clusters. These changes allowed us to minimize the time our field teams spent on major highways into and out of Dhaka and better ensure their safety, while still achieving our desired sample size. Our final sample of informants is drawn from nine of the rural clusters sampled in the BDHS, spread over five districts in Khulna division (see Figure 1).

2.4. Informant Eligibility and Sampling

In this qualitative study on early childbearing, we sought to interview women age 15-22 who had married before age 18. Among those meeting these criteria, we expected parity to be highly skewed away from nulliparous women and toward parous and multiparous women. Therefore, we did not stratify our sample by parity or make this an eligibility criterion. Based on data from the 2011 BDHS (NIPORT, Mitra and Associates, and ICF International 2013), we estimated that, on average, we would find approximately 3.6 eligible women per rural cluster. We anticipated selecting two women each in 15 clusters to reach our desired sample size of 30 women. We later relaxed the limit of two women per cluster to maximize the number of interviews that could be conducted in each cluster.

The cluster listing identified 74 eligible women in the nine clusters selected for this study. However, to protect informant confidentiality, we did not select women from the same household or *bari* (group of households) or from adjacent households or *baris*. Furthermore, another qualitative DHS study on antenatal care was being conducted in Khulna division in some of the same clusters. Women who met the eligibility criteria for both studies were included in the selection pool for the study on antenatal care and became ineligible for selection in this study. In all, fourteen women were not considered for selection because they were either dual-eligible or living in the same *bari*. The field team attempted contact with 47 of the remaining 59 women. Fourteen of these women were unavailable for interview, including three women who had temporarily or permanently moved away and three who could not be located and were, thus, lost to follow up. Two women declined to be interviewed and a final woman consented to be interviewed but was found to be ineligible for the study because she was older than 22. Thirty women who met the eligibility criteria and had provided consent were successfully interviewed and make up our informant sample. Having reached our target sample size, interviews were not attempted with the remaining 12 eligible women in the selected clusters.

2.5. Research Team and Training

The study team included nine members: three principal investigators, a co-investigator, four research officers, and a field assistant. The male field assistant helped the field team locate and contact eligible informants in the field. The field team included the two co-investigators and the four research officers, all women, who hold a master's degree or higher in anthropology or sociology and have expertise in qualitative methods. This team conducted the in-depth, person-to-person interviews with study informants, transcription, translation, and coding of the data. The principal and co-investigators led the data analysis and prepared the study report.

In addition to their general expertise in qualitative research, the full study team participated in targeted 10-day training to prepare for field work. The training guided team members through the purpose of the study, built familiarity with study interview guides, and reviewed qualitative interviewing techniques that would be used in the study. It addressed the study's data collection process, sampling procedures and informant eligibility for the study, ethical procedures (including obtaining consent and maintaining privacy and confidentiality), field management, and information on health services related to maternal and reproductive health. The training emphasized skills such as building rapport and probing during interviews, note taking, transcribing, translating, preparing field notes, and recording complete and accurate demographic data on the cover sheet accompanying interview transcripts. The training included classroom discussion, role-play, practice interviews, and field-testing with the interview guide.

Practice interviews were observed by senior members of the research team, who provided feedback on interview techniques.

Based on experiences piloting the interview guide during the interviewer training, the guide was modified for use in main data collection. The modified interview guide was field-tested a second time before being finalized.

In addition to the training for field work, a second training was conducted with the research team on data coding and analysis.

2.6. Data Collection

Icddr,b was responsible for data collection, which occurred December-March 2015. Prior to the arrival of the full field research team in the field, the male field assistant visited the selected cluster and, using the address information generated by the BDHS implementing agency, made initial contact with selected informants and briefed them, and key members of their family, as necessary, about the upcoming presence of the field research team. He then arranged a date and time for a member of the field research team to conduct the interview.

Interviews were conducted in a convenient space where the interviewer could do her best to maintain privacy, usually in the informant's house or yard. After consent was obtained, interviews began with general aspects of women's lives (topics the interviewer could return to should interruptions occur) and then progressed to the more detailed and possibly sensitive topics of informants' reproductive and sexual health and family dynamics. Interviews were conducted in Bangla. They generally lasted 60-90 minutes, following informal discussions of approximately 15-30 minutes. All informants agreed to have their interviews recorded after having been given the option to refuse. In addition to the informant interviews, the field research team recorded information about the cluster itself, including the overall socio-economic condition, development of infrastructure, transportation network, and health services (including community health workers) available in the area.

2.7. Data Management and Analysis

Research officers transcribed verbatim the recorded interviews once they were completed. Co-investigators and one principal investigator continually reviewed transcripts for interview quality and provided feedback to the field research team. Once transcribed, one-half of the Bangla transcripts were translated into English. All interviews were entered into AtlasTi and coded.

As qualitative inquiry employs an iterative approach, transcripts were coded per a predetermined list of major themes, based on a priori research questions, and supplemented by codes for new themes and sub-themes that emerged from the respondents' own narratives. Code reports and fully coded transcripts were reviewed for quality of coding, feedback was provided to the data coders, and the coding framework was updated as needed. Finally, the principal investigators and co-investigators, comprising the analysis team, prepared thematic summaries of each transcript.

These three types of information—coded output according to major themes; thematic summaries; and full transcripts—were used along with a content analysis framework to identify key concepts in the coded data.

Two separate analysis workshops were convened. During each, the research team analyzed one-half of the interviews applying the content analysis framework. The analysis applied a modified split-half design, borrowing from an approach common to reliability testing in statistical analysis (Furr 2010).

That is, each half of the interviews were analyzed independently of one another and only once each half was analyzed in their entirety were the results of the two halves compared for their agreement in the presence of themes and interpretation of key findings. Since the findings of each separately analyzed half converged, the combined results are presented in this report. Secondly, each member of the analysis team analyzed coded output for multiple themes across all transcripts and multiple complete narratives across all themes and sub-themes. This triangulation and frequent conferring about the results allowed a solid consensus on the interpretation of findings.

2.8. Ethical Considerations

This study received ethical clearance from the institutional review board (IRB) of ICF International and the ethical review committee (ERC) of icddr,b. Informed consent of study informants was obtained twice. First, all respondents to the quantitative BDHS, regardless of eligibility or division of residence, were asked if they would agree to a follow-up interview. At the conclusion of the DHS interview, the following consent statement was read to the respondent and verbal consent obtained:

Thank you for taking the time to answer these questions. I would like to inform you that additional information on family planning and antenatal care for women who gave birth in the past 5 years will be collected in the near future to find better ways to provide health services for women and families. Another member of our team may return in a few weeks to ask you a few additional questions about these topics. Do you agree to allow another member of our team to contact you about participating in a short interview? Your responses will remain confidential.

Only women who agreed to the follow-up interview and were otherwise eligible for the qualitative study were included on the listing from which study clusters were selected. Secondly, women who were approached for in-depth, qualitative interviews were told about the study purpose by investigators and gave their written informed consent. Two women who had initially provided consent during the BDHS interview declined to consent at the time of qualitative field work. Investigators explained to potential informants that they could decline to answer any questions with which they were uncomfortable or halt the interview at any point. Interviewers made every effort to conduct the interview in a private location and were trained in ensuring privacy and data management procedures to maintain confidentiality of the data once data were collected.

2.9. Challenges and Limitations

No data collection effort is without its challenges and this study is no exception. This study encountered two major challenges.

First, severe political unrest in January and February 2015 disrupted fieldwork. *Hartals* (strikes/blockades) brought the risk of violence and threatened the security of the research team. All data collection efforts ceased for 2 months. As the intensity of the unrest eased slightly, we modified field operation and sampling procedures so that data collection could resume while protecting the interviewers. First, we re-selected several study clusters, taking into consideration their proximity to one another. Secondly, we conducted a greater number of interviews in a smaller number of clusters. This allowed the field research team to reduce their number of trips from Dhaka and instead travel directly between study clusters, although it required that they stay in the field for longer stretches at a time. Third, the field research team travelled by train and hired a car at their destination point, rather than traveling by car from Dhaka. These changes minimized the time the field research team spent on highways in and out of Dhaka, where the threat to the team's security was the greatest.

The second challenge was in reaching and securing interviews with eligible women. Though only 2 of 47 women refused to be interviewed outright, six women could not be located or were known to have moved away from the study area. Another eight women were absent or busy during the limited time the field research team could spend in each cluster. This challenge may have been compounded by the 2-month hiatus, lengthening the time between the BDHS interview and the qualitative study interview.

The perspectives of husbands, parents, or the in-laws of young, married women would have enhanced our understanding of the social context influencing early childbearing in this division of Bangladesh. However, we were unable to involve these groups as informants in the study. The reasons are two-fold. First, interviewing the husbands or in-laws would violate the commitment of confidentiality made to the index informants during the informed consent process of the BDHS quantitative survey by de facto disclosing the index informant's participation in the BDHS. Similarly, interviewing both the index informant and a spouse or in-laws linked to her could entail personal risks to the index informant if the linked informants were to become displeased with her participating in a study on such personal and potentially sensitive topics. Secondly, we had no feasible mechanism to identify and draw an unlinked sample of "men who married adolescent women", "parents of women married as adolescents", or "in-laws of daughters-in-law". For instance, the 2014 BDHS does not interview men. Furthermore, the household listing would only identify persons in one of these groups if that information were revealed by their mutual relationship to the head of household and they were co-resident at the time of the survey.

In spite of these challenges, we were, nonetheless, able to achieve our targeted sample size well within the selected clusters and the informants provided us with rich narratives of their lives. Quality informant interviews allowed us to pursue multiple analytical themes.

Thematic areas of investigation presented in the following sections include: how young, married women think about the timing of childbearing at the time of marriage and shortly afterward; the normative environment that shapes their fertility aspirations, including the extent to which young women internalize external expectations about childbearing or to which their individual fertility aspirations are at odds with social norms; with whom in the household and their social network they share and do not share fertility intentions (e.g., whether young women's and their husbands' intentions align but conflict with those of the women's in-laws, or whether young women and their husbands have differing aspirations); and how young women engage "allies" to pursue their fertility aspirations. We also explore spousal communication with regard to childbearing and family planning, attitudes toward family planning and specific contraceptive methods, and perceptions about appropriate role of contraception in spacing either the first birth or second birth. Finally, but perhaps most importantly, we examine women's power status within their households, how they navigate household decision-making processes to try to achieve their reproductive goals, and their knowledge, access, and agency-related barriers to using contraception.

3. Results

3.1. Profile of Study Informants

3.1.1. *Marital and reproductive profile*

Table 1 presents a summary of the socio-economic and demographic profile of the women in this study; Details for each informant can be found in Appendix 1. To be eligible for this study, informants were required to be age 22 or younger at the time of interview and to have married before the age of 18. At the time of the in-depth interview, our 30 informants ranged in age from 15 to 22 years, with a mean of 19.1 years, as seen in Table 1. Their age at marriage was, on average, 15.1 (range 11-18 years). Ten women were married before age 14, 14 at age 15-16, and 6 at age 17-18.

Husbands' current ages ranged from 18 to 40 (mean 27.4), meaning that women were, on average, married to a man 8.3 years their elder. Fourteen women were married to a man who was between 5 to 9 years older than they were. Among the remaining women, about half were married to a man closer to their own age and half were married to a man 10 years or older. The average duration of women's marriages was, at the time of our interview, 4.0 years, with a range of less than one year to 10 years. An equal number of women had been married for less than 3 years, between 3 and 4.9 years, and between 5 and 10 years.

Twenty-two of the 30 informants were living in extended households at the time we interviewed them, though an even greater number began their married lives in this arrangement.

Nearly two-thirds (18) of our sample had experienced one pregnancy; this figure includes three women who were currently pregnant for the first time. Nine women had had two or three pregnancies. Only three women had not yet become pregnant. Two of these three had been married only for a short time—a matter of months—at the time of interview. The distribution of the number of living children is similar to that of pregnancies. Six women were nulliparous, three who had never been pregnant and three who were currently pregnant. Seventeen women had one child, including two women who had had a second pregnancy but experienced a miscarriage, menstrual regulation or termination, or child death. Seven women had two children, including three women who had had a third pregnancy but experienced a miscarriage, menstrual regulation or termination, or child death.

3.1.2. *Socio-economic profile*

The informants generally had class 8 or less education. Two women had no education, while 10 had completed secondary school. None had higher than a secondary education. The educational profile of their husbands was similar, although seven had no education and two had higher than secondary education. In eight couples, the wife had more education than her husband and in another eight couples, the husband had more education. The educational level was the same among four couples.

There is a relatively even distribution of household wealth across the poorest three wealth quintiles. However, there are comparably few informants in the richest wealth quintile (2) and a high concentration in the second to richest quintile (10). The most common occupations among women's husbands were farming (10), working in small businesses (7), or as a van/CNG/rickshaw driver (4). The vast majority of informants reported themselves to be housewives and did not work outside of the home.

Table 1. Profile of study informants: Frequency distribution across background characteristics and means (n=30)

Women's current age (mean)	19 years	Husband's current age (mean)⁶	27.4 years
Education		Husband's education	
no schooling	2	no schooling	7
primary—incomplete	12	primary—incomplete	11
primary—complete	6	primary—complete	2
secondary or higher	10	secondary or higher	10
Wealth quintile¹		Husband's occupation⁷	
lowest	7	electrician	1
second	5	teacher	2
middle	6	farmer	10
fourth	10	day labor	2
highest	2	carpenter	1
Age at marriage (mean)²	14.9 years	business	7
≤14	9	driver	4
15-16	16	jewelry maker	2
17-18	4	butcher	1
Spousal age difference (mean)	8.3 years	imam	1
<5	7	cooperative	1
5-9	14		
≥10	9		
Marital duration (mean)³	4.0 years		
<3 years	10		
3-4.9	10		
5-10	10		
Household type			
extended	22		
nuclear	8		
Number of pregnancies⁴			
0	3		
1	18		
2	6		
3	3		
Number of living children⁵			
0	6		
1	17		
2	7		

¹ Household wealth quintiles are calculated by the 2014 BDHS.

² Includes only age at first marriage for one woman (Informant #16) who had two marriages.

³ Includes only duration of current marriage for one woman (Informant #16) who married twice.

⁴ Includes three women currently pregnant with their first pregnancy.

⁵ Includes two women who had a 2nd pregnancy and three women who experienced a 3rd pregnancy but experienced a child death/termination.

⁶ Husband characteristics refer to current husband for one woman who married twice (Informant #16).

⁷ Includes one person who is a farmer and an imam and one who is a day laborer and a driver.

3.2. Knowledge of Sex, Pregnancy, and Contraception Prior to Marriage

Eleven of the 30 women¹ had no knowledge about contraception or ways to avoid pregnancy before marriage. Moreover, some women had little basic knowledge of sex and the reproductive system. One woman, who lacked such basic body literacy when she married, remarked,

“I didn’t know that baby is born this way! I didn’t know that due the physical relations I would be pregnant.” (Informant #30, age 20, age at marriage 16)

Modesty, shyness, and a norm about what matters are unsuitable for discussion among unmarried girls perpetuate this lack of knowledge. As one informant explained:

“Parents didn’t allow us to talk to married person as we were immature to hear that information on married life. If they [married friends] would tell us about their sexual relationship we, who were unmarried, would be bad.” (Informant #8, age 17, age at marriage 15)

“My sisters-in-law discussed about these issues with neighbors but, as we were not matured enough, they didn’t allow us to hear their discussion. So we could know little.” (Informant #25, age 18, age at marriage 16)

One woman, who was married at age 11, before menses, reported ignorance about the basics of puberty and pregnancy in addition to methods of contraception, an ignorance that extended into the early days of marriage. She explains how family members avoided conversation with her about sensitive topics because of her young age.

“Nobody told me anything about this [sex, conception]. I mean that day [wedding day] or within next couple of days they didn’t say anything as I was not adult then. In fact I was not on that age that they could feel comfortable to discuss about the issue as I was too young.” (Informant #1, age 21, age at marriage 11)

The majority of women (16 of 30), however, did have *some* knowledge of contraception prior to marriage. Frequently, they were familiar with the pill, the most commonly used contraceptive method in Bangladesh. Some women also knew about condoms and, less frequently, a few knew about injections, implants, or copper-T IUD. Unmarried women often gained knowledge of contraceptive methods by observing their mothers or elder sisters-in-law take the pill.

“I knew my mother used pill [Femicon]. I knew about pill... I saw my mother take it... She took that to prevent childbirth.” (Informant #14, age 18, age at marriage 17)

Others learned from seeing television advertisements, discussions with friends and neighbors, or overhearing talk among neighbors or health workers. One well-educated woman, whose family members and a neighbor included several family planning workers, was given a book about family planning methods, but this was an anomaly.

Taboos on talking about contraception limited the informants’ knowledge, even among women who knew something about contraception prior to marriage. These women largely report that their knowledge was insubstantial at the time they married. While they were familiar with the pill and knew

¹ An additional three women did not discuss knowledge of contraception prior to marriage with the interviewer.

it would prevent pregnancy, they often did not know how to use it, where they could get it, or other details that would enable them to effectively use the pill if they so desired.

“I hadn’t any clear idea though I read about it. What was the purpose, how to use, I didn’t understand that. And I didn’t take part in the discussion when women were gossiping about those. I left the place when they talked about bad things... that time I considered those as bad topic of discussion.” (Informant #3, age 21, age at marriage 13)

“I heard about those [injections, implants], but I do not understand whether I should do this or not. I did not find the appropriate person to ask about this...Moreover a neighboring woman inserted something on her body for 5 years [implant]. I do not know what that was. She is elder than me, so I couldn’t ask her.” (Informant #24, age 19, age at marriage 17)

As a result of the imposed silence on matters of sex, fertility, and contraception for unmarried girls, women enter into marriage with inadequate information to plan or to delay a pregnancy, if that is their intention.

3.3. Getting Married

3.3.1. Decision-making and marriage

All but two women entered into arranged marriages. These marriages are either initiated by their husband’s family and accepted by the woman’s family or arranged by both families jointly. Women report having no input into whether they would marry, to whom, or when. The majority of women was unfamiliar with their future husband and did not meet him until after the marriage was planned. As one woman related:

“They [husband’s family] came to our neighbor’s house to see a girl as a bride...[but instead] saw me and chose me. At that time, my uncle who stays abroad was at home. He said that before he went abroad again, he will give me marriage. Then they came to our house and my uncle went to their house and finalized the marriage. It was very chaotic situation.” (Informant #18, age 18, age at marriage 14)

“At the wedding day, I saw him for the first time.” (Informant #14, age 18, age at marriage 17)

“The match-maker was from the same village...My sister’s husband and many other people were also.” (Informant #28, age 16, age at marriage 12)

3.3.2. Attitudes toward marriage

Most young women neither anticipated nor desired getting married at that time, but were resigned to the marriage because they knew they had to defer to their parents’ wishes or that the marriage helped their parents’ situation.

“It was parents’ wish! What could I do if parents wanted?” (Informant #28, age 16, age at marriage 12)

“What could I do? My parents are poor, so they got relief after they gave me marriage.” (Informant #18, age 18, age at marriage 14)

Several women specifically articulate either a social and personal preference for arranged marriage. One woman’s comments on the topic of love marriage reflect strong social mores about both disobeying parents and women’s sexuality.

“No, I wasn’t that kind of girl. I was determined that I would marry according to my parents’ will.” (Informant #19, age 18, age at marriage 14)

She elaborates on the potential negative consequences of love marriage:

“If I married by my own preference, then they [in-laws] will not take my responsibility after marriage. They will not stand beside me.” (Informant #19, age 18, age at marriage 14)

Meanwhile, a second informant says,

“Nowadays, people can do love marriage. At past, no one could think about it. They had to marry according to the preference of their elders. I didn’t see my husband before marriage.” (Informant #15, age 22, age at marriage 12)

Another woman comments on the prevalence of early marriage:

“It is a common practice in our society. Community people believe that early marriage is good. My parents made the mistake that they gave me early marriage... we have a lesson from our elder sister’s life history. She had early marriage and got pregnant after 3 months of her marriage...From my sister’s life I understood the fact that early marriage is bad.” (Informant #8, age 17, age at marriage 15)

3.3.3. Transition into marriage

Marriages frequently occur within just a few days of the match being arranged. Many of the informants’ narratives recount the sense of being plucked from their lives as unmarried girls and being whisked into marriage with little warning.

“My husband came on Eid vacation and went to our house to see me. My marriage happened on that night and he took me to my in-laws’ house on next morning.” (Informant #15, age 22, age at marriage 12)

“Then one of my maternal uncles said to my mother that my marriage will happen that night. My mother bought some chicken from the shop and cooked for them. Then my marriage happened at 12 o’clock that night.” (Informant #28, age 16, age at marriage 12)

“My uncle-in-law fixed our date of marriage and our marriage occurred on the next day after fixing.” (Informant #19, age 18, age at marriage 14)

Nearly all the women in our study lived in an extended household upon marrying. Two exceptions are one woman (Informant #28) without siblings whose mother took her husband as ghor jamai (the couple lived with her mother) and another woman (Informant #1) who married before she experienced menarche; she continued to live at her natal home for another year.

Women move from their natal home into their in-laws' home quickly upon marriage. For most women, this move occurred within 1-3 days after the marriage day. Thus, the majority of women had transitioned from the role of unmarried girl in their natal home to married woman in an extended household in the span of one week. The young women were neither familiar with their husband and his family nor given time to become acclimated to the news of their impending marriage. As a result, most informants describe having been shy and uncomfortable in the unfamiliar surroundings of their new home.

The transition into marriage is not only sudden, but it disrupts the activities unmarried girls engaged in. None of the informants in our study reported working for pay before marriage. All but five, however, were attending school. In all but a few cases, marriage interrupted women's educational aspirations. As one informant describes:

“My brother-in-law said, ‘A good proposal came for you. I want to give you marriage here. What is your opinion?’ I said him to do what they understand well for me...I wanted to continue education, but parents were poor and they couldn't bear my cost and gave marriage...I think it would be good if I could study more. It was too early to start family life. Now I have children.” (Informant #26, age 22, age at marriage 13)

One informant, whose marriage interrupted her education at class 6, describes her emotions when her arranged marriage nearly fell through:

“I wished to dismiss the marriage. In fact, I was happy when the marriage was dismissed...I thought, I can go to school again! It was very joyful to stay with the friends in the school. At the in-laws' house, there is only chores and chores.” (Informant #18, age 18, age at marriage 14)

Only a few women (3) were able to continue their education for a short time following marriage. One well educated informant who earned her secondary school certificate (SSC) recounts:

“My brain is not bad; actually, it is good. I was very much interested for study. My parents even didn't say that they [in-laws] are coming on that day to see me. When they told me that [I was to be married], I felt very bad and started crying. I couldn't accept it, I was crying and crying...Then I told them [father] that I will not marry now...I said that I will read. He said that they will support you to read. Then what could I say? I had nothing to say.” (Informant #14, age 18, age at marriage 17)

In all three cases, the woman's parents, husband, and in-laws all agreed that it would be desirable for her to continue her schooling and supported her efforts. Two of these women continued to spend considerable stretches of time living in their natal homes, interspersed with visits there by their husbands and visits to their in-laws' household, depending on their school schedule. Although marriage per se did not cause them to discontinue their education, a pregnancy occurring too early in their marriage subsequently forced two of the three women to abandon their education prematurely.

3.3.4. Discussion of fertility intentions before marriage

The swiftness of girls' arranged marriages afford little opportunity for the future spouses to become acquainted or to discuss when they would like to start having children or whether to use contraception. The only couples that had such conversations are among the very few who married a week or longer after their marriages were fixed. One of these outliers, who was married 6 days after her in-laws arranged for her to marry their son, recounts how she and her husband, whom she had not yet met, managed discussion:

"We had our marriage after 6 days. We had phone conversation on those 6 days. He said, 'You need to take medicine [pills]. You have to collect that. Don't forget to bring that.' ...as we don't want to take child...I want to continue to study and I don't want to take child immediately. He also didn't want to take child. We will take 2-3 years later." (Informant #14, age 18, age at marriage 17)

A second informant who married 2 months after the marriage was arranged similarly reports:

"From the beginning he said that we will take child later. Even before marriage when we had phone conversation marriage he told that we will take child later." (Informant #12, age 22, age at marriage 16)

However, these informants' experiences are highly unusual among our sample. There were unusual in that they managed to discuss their childbearing desires before the marriage and in that both husbands agreed with the woman that it would be desirable to delay having a child for some time.

The dominant refrain among all women, whether or not they continued schooling or whether or not they discussed childbearing before marriage, is of marriage being an abrupt transition from a familiar life to an unfamiliar one. Women recount experiencing a certain degree of distress when making this transition. Furthermore, as is shown in the subsequent sections, the lack of control women have over the marriage process carries over into the marriage itself where the majority of women exercise little control over fertility decisions.

3.4. First Sex within Marriage

3.4.1. Timing of first sex

Although girls are thrust quickly into marriage and marriage comes with the expectation of sexual relations, girls do not experience sexual intercourse immediately upon marriage. Rather, there is a short delay, frequently ranging from several days to a week, before the couple first engages in sexual intercourse. The majority Muslim and minority of Hindu informants, alike, commonly reports that it was not permitted to engage in sex on the first day/night of the marriage ceremony, a sacred time (*kaal raat* or *ful sojja raat*²).

There is a range across the sample as to when couples engaged in sexual relations after marriage. The timing was subject to beliefs about inauspicious days and young women's menstrual cycles. A common refrain is that sex should be avoided on certain days of the week following the ceremony to follow religious proscriptions, though which days were to be avoided varied. One informant's description is typical:

² Hindu

“At first night we couldn’t have intercourse. It is called “kaal raat”. Not only Kaal raat, but physical relation is forbidden on Saturday or Tuesday of just after marriage.” (Informant #12, age 22, age at marriage 16)

Secondly, an unexpectedly high number of women report experiencing menses at the time of or soon after marriage. This delayed sexual relations as intercourse during menses is described as unclean and undesirable. One woman, who was married at age 11 before she reached menarche, did not begin having sexual intercourse with her husband until a year into their marriage.

3.4.2. Coercive first sex

Reflecting perhaps both the lack of preparation to enter into marriage and their lack of agency, informants describe themselves as considerably tentative and reluctant during their first sexual encounters. Some young women’s accounts further reveal varying levels of coercion and force. Occasionally, a few husbands engaged family members to aid in convincing a reluctant spouse. The following informants illustrate a range of experiences.

“I was afraid to have sex...Actually my sister-in-law [brother’s wife] told me before my marriage that my husband would have physical relation with me but they didn’t inform about the details of that. So I got afraid.” (Informant #11, age 22, age at marriage 16)

“At the first night, I was crying a lot. We did not do anything. After 3 days,...my sister-in-law [husband’s brother’s wife] told me it’s natural to have sex with husband, they convinced me...My husband told his elder Bhabi, ‘Bhabi, she yet not listen to me’. Then they told me after marriage it’s natural to stay with husband...Then we did it.” (Informant #30, age 20, age at marriage 16)

“First, he tried to come near me. Then I said can’t we do this after some days after my exam? He said no, it is not possible. You are my new wife.” (Informant #22, age 18, age at marriage 16)

3.4.3. Contraceptive use during first sex

Married sisters, sisters-in-law, or other older women frequently supplied young women directly or indirectly via their husbands with oral contraceptive pills on their wedding day. It appears from informants’ accounts that they did so in anticipation of their initiation as sexually active, married women. Husbands could—and occasionally did—prevent their use at first sex. Sisters/sisters-in-law often provided perfunctory, superficial instructions about the pills’ purpose and use, but did so with preparation for sex in mind and without any consideration of the women’s desires for initiating or delaying childbearing. Frequently, pills or information about contraception were provided in the context of teasing brides about becoming sexually active and entering married life.

Frequently, pills or information about contraception were provided in the context of teasing brides about becoming sexually active and entering married life. There is little emphasis evident on educating young women about their bodies and sex or about assisting them to articulate or achieve their fertility intentions.

“I heard it from my sisters-in-law as they always tried to make fun with me after fixing the wedding date. But it was not clear to me. They always pinched me that my husband will touch me and will do something with me then I would have to take pill. I felt shy to

hear those so I didn't ask them anything. They told about pill but I didn't know how it looks like or how to take it. I just heard from them.”(Informant #11, age 22, age at marriage 16)

“My sister-in-law came to me on my wedding day and brought Femicon pill for me. She told me that when my husband would come to have sex with me I would take the pill that night.” (Informant #8, age 17, age at marriage 15)

“I have a neighbor bhavi (sister-in-law) and she put a pill in my bag [at the wedding day]. She said to eat the medicine.” (Informant #14, age 18, age at marriage 17)

Like the informant above who was given a single contraceptive pill, the manner in which this woman, who received pills from her sister-in-law, used contraceptive pills in the first days of her marriage reflects the lack of instruction that accompanied the provision of contraception:

“I didn't know about [pills]...I took first pill on the first day of our sex and after one day we again had sex and I took pill again. That means I took pill on 4th and 6th day of my marriage.” (Informant #8, age 17, age at marriage 15)

In several instances, the contraceptive properties of the pill and understanding how to avoid pregnancy were clearly secondary to the purpose of facilitating sexual intercourse, as is demonstrated by this informant:

*“After 6 days your husband told you to take pill?”
“He wanted that so that my period would stop...That time I even didn't know whether pill prevent pregnancy or not. Even I didn't know why I need to take pill. I never saw my mother to take pill. And he didn't explain me anything. He just told to eat the pill.”*
(Informant #28, age 16, age at marriage 12)

Although the norm was to provide pills with little, if any, information at the time of marriage, sisters-in-law, aunts, and others provide more information about how to use contraception, often after the informants had been married for several months. Over time, women's contraceptive knowledge increases. The following informant illustrates the positive influence her sister-in-law had on her knowledge of the pill.

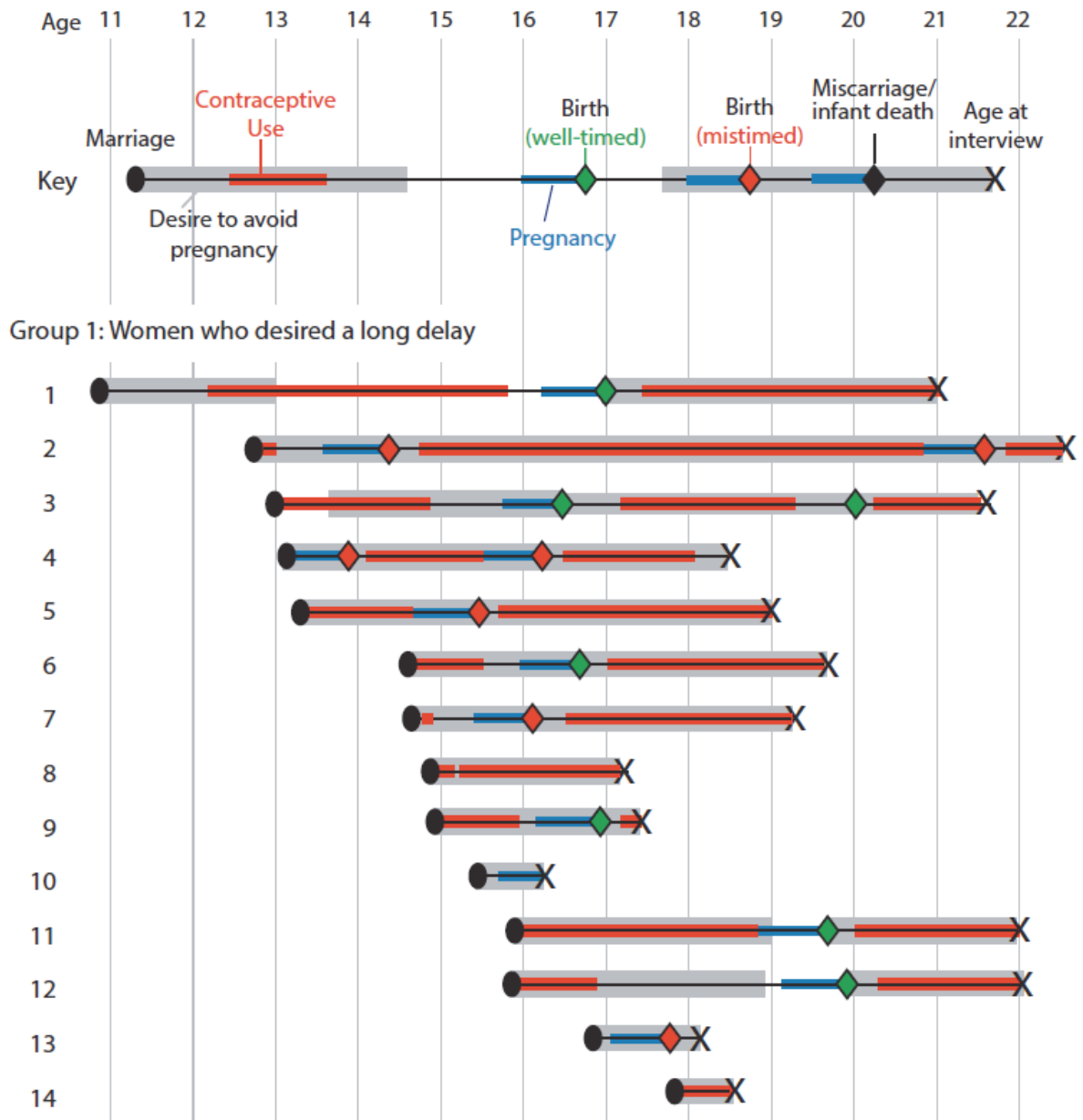
“Then my sister-in-law gave me two government pills, named ‘Maya bori’ and told me to take it. She also told me to take pill every day; she taught me how to take the pill. From then I could understand. Before that I couldn't...she said that menses will be stopped then.” (Informant #28, age 16, age at marriage 12)

In summary, girls do not exhibit any agency in marrying, engaging in sexual intercourse, or using contraception in the early days of marriage. Because first sex frequently occurs before recently married couples discuss their desires about having a child, contraceptive use at first sex is disconnected from broader decision-making about childbearing and using (or not using) contraception to plan their families.

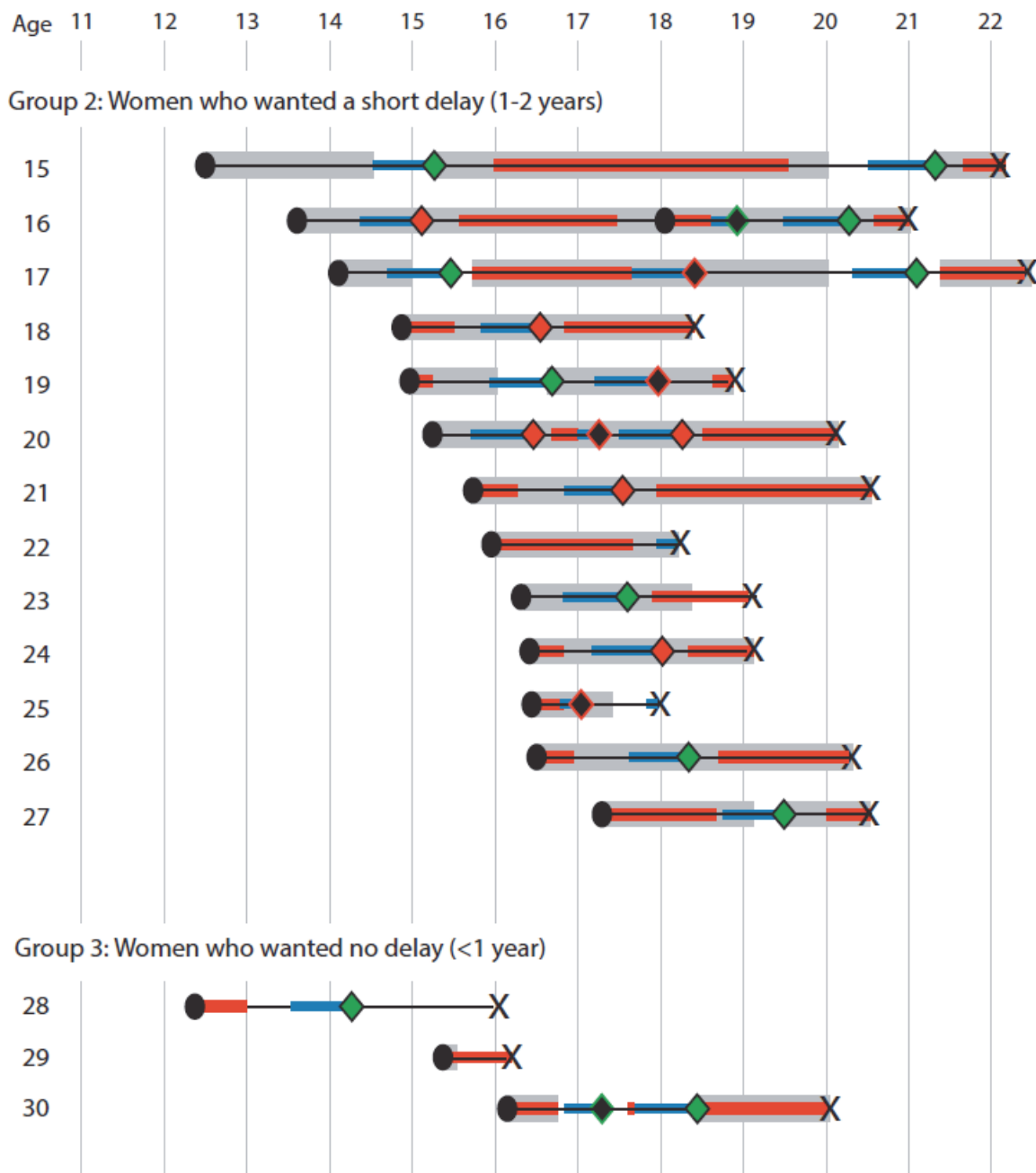
3.5. Fertility Desires at Time of Marriage

Figure 2 presents the reproductive timelines of all 30 women in our sample. This figure serves as a companion guide for the narrative data presented in the following sections. Each timeline begins with

Figure 2. Women's reproductive timelines



a woman's marriage and extends to the time of the in-depth interview, with age indicated along the top axis. Women are grouped according to whether, at the time of marriage, they wanted a long delay (>2 years), a short delay (1-2 years, inclusive), or no delay (<1 year) before experiencing their first pregnancy and, within each group, are listed in ascending order according to their age at marriage. A thick, gray bar shadowing the timeline indicates the portion of women's timelines in which they wanted to avoid a pregnancy; the absence of a bar indicates they would like to become pregnant. A thin, red bar placed on the timeline indicates episodes of contraceptive use. Pregnancies are indicated with a blue bar on the timeline and end in either a red diamond, for births that were mistimed at the time of birth, or a green diamond, for acceptably-timed births. Pregnancies that end in a miscarriage, termination or infant death are indicated by a black diamond. Black diamonds are outlined in red or green depending on whether the pregnancy was mistimed or acceptably timed. A pregnancy concluded by a green diamond symbol can follow a gray bar either if (1) a woman became pregnant at precisely the time she



intended to, or (2) if she initially wanted to postpone pregnancy but at some point preceding the pregnancy she changed her fertility intentions toward wanting a pregnancy sooner.

3.5.1. Young women's fertility desires

Not surprisingly in this social context, none of the women expressed a desire to remain childless. Nonetheless, upon marriage, the great majority of girls wanted to postpone the first pregnancy. As shown in Table 2 on the following pages and by the grey bars in Figure 2, only three women wanted to become pregnant within the first year of marriage: one right away, one within a month, and the third wanted to wait 6-7 months after marriage before becoming pregnant. Almost an equal number of the

remaining (majority) of women wanted a short delay as wanted a longer delay. Thirteen women wanted to wait 1-2 years before becoming pregnant; 14 women wanted to delay pregnancy for more than 2 years. None wanted to delay more than 5 years.

This finding is striking in that, while most want to delay the first pregnancy for a number of years after marriage, they nonetheless intend to have a pregnancy during their adolescent years. Given the age at which the women married, the time that they wanted to postpone childbearing would put women, on average, at about 17 years of age at the time of their first pregnancy. Only three women would be 20 or 21 years old at the time they wanted their first pregnancy. Ten women would be 15-16 years old and twelve would be 17-18 years old at the time they wanted their first pregnancy.

Most women express their desired wait time as a range, not an exact time. The single most common response reflects a desire to delay pregnancy for 2-3 years. Most informants express the desired timing of pregnancy as a period of time (usually several years) following marriage, while some relate their desired time of pregnancy to achieving a key milestone (sitting for an exam, as one example). One informant offers her rationale for desiring a pregnancy later as follows:

“I want to take child one and a half years later [from the time of interview]. By this time my exam will be completed. Then I will stay one year at my in-laws’ house and by this time my body will develop more. I will be fat and then I will take child.” (Informant #14, age 18, age at marriage 17)

It was exceedingly rare that a woman gave an age—or age range—as a targeted time to become pregnant. It appears that, generally, the benchmark of biological age plays less of a role than the life stage and circumstances of one’s life in forming fertility desires.

3.5.2. Young women’s reasons to delay pregnancy

For the three women who continued their studies after marriage, pursuing their education through their next exams or certificate was their primary motivation to postpone a pregnancy, as illustrated here.

I want to continue my study and I don’t want to take child immediately... We will take 2-3 years later.” (Informant #14, age 17, age at marriage 15)

“My husband asked me, ‘What if we would take a child then?’ Then I said as I had been in my study, it would better to not to conceive...My intention was I would wait 5 years...everyone used to tell me I was very young.” (Informant #5, age 19, age at marriage 13)

The other women offer a range of reasons for postponing a pregnancy. Prominent among them are concerns about their physical health and development and effects on child health. Most of the young women in our study believe they were not yet fully physically matured and hold notions of when the body would be physically fit for pregnancy or childbearing. This informant explains.

“Both of us want to take baby after 2 years. After 2 years my body will be fit... Now 2 years passed...Now I am 18 years. For that reason I have taken baby.” (Informant #22, age 18, age at marriage 16, currently pregnant)

One woman specifically worried about having a difficult delivery at such a young age.

“I was young that’s why I didn’t want to take child, I thought I couldn’t bear the child. But my husband wanted to take any time.” (Informant #26, age 22, age at marriage 13)

Several informants clearly relate the physical problems of early childbearing to the social phenomenon of early marriage:

“They gave me marriage before 18 years. And before 18 marriage is child marriage, before 18 one cannot take child...Mother’s health and child health will be malnourished” (Informant #14, age 18, age at marriage 17)

“If I got pregnant from the very beginning of my early marriage, I will lose my physical fitness and I will be sick then...In that time I should take care of myself but as I would have a baby then and I would not be able to manage time for myself...This will affect the baby and it would not get proper care and love for me.” (Informant #8, age 17, age at marriage 15)

Another common motivation, albeit a little less frequently articulated, derives from the cumulatively shifting roles that come with marriage and parenthood. Women are concerned about taking on the responsibility of childcare and role of parenthood while still familiarizing themselves with the new, marital household. The concerns are about both social acclimation and practical aspects of childcare, as reflected below.

“I had the desire to settle in my in-law’s house, come to understand the family environment of them. Then I would take child.” (Informant #19, age 18, age at marriage 14)

“He [husband] sometimes asked me to take baby after 2 years of our marriage...But I was not prepared for that as I had no fascination on baby. I told him that I will take baby while my time would be to take it.” (Informant #11, age 22, age at marriage 16)

“No, I disagreed [with husband about having a baby right away] as I was worried about how could I take care of the child. I was so young to feed, bathe, or take all the care of a baby.” (Informant #18, age 18, age at marriage 14)

Several women also wanted to get to know their husband before becoming a parent. One woman reports that her husband agreed that they should first spend time enjoying each other’s company and, in particular, fulfilling their sexual desire before taking on the added responsibilities of parenthood.

A few informants raise concerns about instigating rumors or developing a bad reputation if they were to become pregnant quickly upon marriage:

“People will say cutting remarks if someone becomes pregnant within 2-3 months of marriage.” (Informant #30, age 20, age at marriage 16)

“My mother-in-law said to take child. Father-in-law also said; but we planned to take child 1-2 years later. As we were just newly married, it will be not comfortable to go here and there with child [pregnant] and also think of what people would say if we take child so early?” (Informant #27, age 20, age at marriage 17)

Finally, several women suggest that it would appear inappropriate to have a child before other members of their extended family who were older or who had been married longer than they were, as these two women describe.

“My husband said that my elder brother has no baby. How could I take baby? How would you be pregnant and how you would go in front of them with your pregnancy?”
(Informant #8, age 17, age at marriage 15)

“Besides, I also explained to him [husband], till then my elder brother-in law-had not taken any child. So as we are younger to them, it would not look good. Then he agreed.”
(Informant #5, age 19, age at marriage 13)

3.5.3. Women’s reasons to not delay pregnancy

Only three women wanted no delay after marriage before becoming pregnant. There are too few cases to draw conclusions about this group as a whole. One woman could not continue taking pills due to the side effects she experienced (Informant #28) but gave no reason for wanting a child right away. She did not articulate her own childbearing desires separately from those of her husband. Rather, she simply accepted her pregnancy when it occurred. A second woman (Informant #30) similarly offered no opinions for why she wanted to become pregnant 6-7 months after marriage. She miscarried her first pregnancy and viewed the idea of becoming pregnant again quickly as an opportunity to allay concerns she feared her in-law family might have about her fertility, since she also had an older married sister who had had problems conceiving since her marriage 4-5 years earlier. The third woman (Informant #29) had a very tumultuous and traumatic entry into marriage and saw becoming pregnant as a way to secure her position in her new home. She was raped prior to marriage and compelled to marry her rapist as a way to resolve the incident, a solution which displeased her in-law family. With a child, she hoped it would be more difficult for elder family members to try to split up the couple or for her husband to abandon her. She explains,

“There are many men who become good after having child. They thought that I do not have any land property and living house, I have to earn this for my son, I have to do this for the future of my son.” (Informant #28, age 16, age at marriage 12)

Several other women who wanted a short delay (1-2 years) before becoming pregnant also mentioned having a child as a way to solidify their position in a new family, or to compel better behavior from their husband or a more hospitable attitude from the in-law family. This is the case for one woman whose husband provided little emotional and financial support.

“Suppose my parents take me away and give me marry again. Do anyone give me assurance that I will not be ill-treated by my new in-laws’ family? Hence I took child so that it would be hard for my husband to leave me.” (Informant #19, age 18, age at marriage 14)

In summary, women’s interests in the timing of their first child are about achieving life goals, such as education, position in their home, becoming established in their new home, and concerns about their health and physical maturity to bear a child.

3.5.4. Concordance with husbands’ fertility desires

Table 2 also shows, for each woman in our study, her fertility desires, concordance of those desires with those of her husband and with those of other family members, and the resulting timing of the first

pregnancy. As this table shows, one-third of our sample had fertility desires that were exactly concordant with those of their husbands, including two of the women who wanted no or a very short delay (<1 year) before becoming pregnant. Another six couples had overlapping fertility desires with, for example, one person wanting a pregnancy in 1-2 years and the other in 2-3 years, or one person wanting 2.5 years and the other 2-3 years. There was no difference in which party wanted to wait longer (3 each). This finding means that just over half our sample had the same or similar fertility desires as their husbands.

Table 2. Fertility desires, concordance of desires, and resulting timing of first pregnancy

ID	Age at marriage	Wife's desire for timing of 1st pregnancy	Wife/husband concordance	Family concordance	1st Pregnancy mistimed
1	11	>2 years	concordant	concordant	no
2	13	2-3 years	husband wanted sooner	concordant	yes
3	14	3 years	concordant	natal family concordant in-law family wanted sooner	no
4	13	2-3 years	husband wanted sooner	concordant	yes
5	15	5 years	concordant	in-law family wanted sooner	yes
6	14	2-3 years	loosely concordant	in-law family wanted sooner	no
7	15	2-3 years	concordant	in-law family wanted sooner	no
8	15	3-4 years	concordant	concordant	--
9	15	2-3 years	loosely concordant	in-law family wanted sooner	no
10	15	2-3 years	husband wanted sooner	concordant	yes
11	17	3 years	husband wanted sooner	natal family concordant in-law family wanted sooner	no
12	16	3 years	loosely concordant	natal family concordant in-law family wanted sooner	no
13	18	4-5 years	husband wanted sooner	natal family concordant in-law family wanted sooner	yes
14	17	2-3 years	loosely concordant	concordant	--
15	12	2 years	husband wanted sooner	in-law family wanted sooner	no
16	15.5	1.5 years	husband wanted sooner	no opinion	yes
17	13	1 year	husband wanted sooner	concordant	no
18	14	2 years	husband wanted sooner	natal family concordant in-law family wanted sooner	yes
19	14	1 year	loosely concordant	in-law family wanted sooner	no
20	15.5	1-2 years	husband wanted sooner	in-law family of mixed opinion	yes
21	15	1 year	loosely concordant	in-law family wanted sooner	yes
22	16	2 years	concordant	in-law family wanted sooner	no
23	16	2 years	husband wanted sooner	in-law family wanted sooner	no
24	17	2 years	husband wanted sooner	in-law family wanted sooner	yes
25	18	1-2 years	concordant	in-law family wanted sooner	no
26	16	1.5-2 years	husband wanted sooner	in-law family wanted sooner	no
27	17	1.5-2 years	concordant	in-law family wanted sooner	no
28	12	no delay	concordant	no opinion	yes
29	14.5	1 month	wife wanted sooner	no opinion	--
30	16	6-7 months	concordant	in-law family wanted sooner	no

Fourteen women, however, were at odds with their husbands about when to get pregnant. In thirteen of the fourteen couples, women wanted to postpone a first pregnancy longer than their husbands did. In ten of these cases, the husband was not interested in delaying childbearing at all and an eleventh husband wanted a delay of just 3 months. For the couple (Informant #13) with the largest discrepancy, the woman wanted to wait 4-5 years before becoming pregnant, but the husband wanted a child right away. In three other couples, the wife wanted a 2-3 year delay and the husband, no delay. Thus, for many couples, there is a sizable gap in the desired timing of childbearing.

Only one woman wanted a pregnancy sooner than her husband. This is the woman (Informant #29) who was forced to marry her rapist.

Among the 14 women wanting to delay pregnancy more than 2 years, nine women were in concordance with their husbands and five were not. Couple discordance was more common among women wanting to delay pregnancy 1-2 years. Only five women in this group agreed with their husbands, while but nine did not.

3.5.5. Husbands' reasons to delay pregnancy

Among the 14 couples who agreed it was desirable to delay the first pregnancy, the woman sometimes reports her husband having a different rationale than her own. However, as a group, husbands hold a similar set of reasons for postponing childbearing as did women. For example, women report that husbands are also concerned about the health effects of early childbearing for young women and children. This perspective is less prevalent among husbands than among women, but present nonetheless, as explained here.

"He said...we will take baby after 3-4 years as I am not fit enough for a baby."
(Informant #8, age 17, age at marriage 15)

"He said that if we take child immediately the child will be malnourished...He said to me to take child after 3 years, not before that." (Informant #12, age 22, age at marriage 16)

Several women report a new reason for postponement among husbands that was not as present among their own concerns: economic considerations. As one woman details,

"Our economic condition is not that sound. My father-in-law has limited land. He [husband] has a small jewelry shop...That's why he was interested to earn more before take child. He said, 'We have to bring up child, more over we have to support the family, so it will be good to spend time on earning before taking child'." (Informant #12, age 22, age at marriage 16)

3.5.6. Husbands' reasons not to delay pregnancy

As wanting a pregnancy soon after marriage is more common among husbands than among young women,³ women report that husbands emphasize reasons for not delaying a pregnancy over reasons for delaying a pregnancy. According to their wives, some husbands who wanted a pregnancy early extolled the benefits for childcare of having a child while grandparents were living or before an extended household separated.

"He said, "It will be good to take child now, as we all live together. Taking care of the child will not be a problem, rather it will be a problem if the family separates. Everybody will take care of the child." (Informant #18, age 18, age at marriage 14)

Other husbands made it clear, women say, that having a child was their motivation for getting married and so becoming pregnant soon after marriage was expected. No women mentioned this motivation for marriage. This is consistent with women's lack of control over the decision to get married: women did not accept a marriage proposal because they wanted a child soon.

³ This includes 13 husbands who wanted a pregnancy sooner after marriage than did their wives and two couples who agreed it was desirable to have a child right away.

Finally, women report that husbands also expressed a concern with their wives' health as a reason for not delaying a pregnancy. Husbands suggested that becoming pregnant soon after marriage was a practical alternative to using contraception, which may have harmful health effects. This finding is elaborated in a later section on contraception.

3.5.7. *Decision-making and couple discordant desires*

When a couple's fertility desires were discordant, as was the case for 14 women, women face substantial challenges to pursuing their reproductive intentions to postpone a pregnancy. A number of women with discordant goals note the futility of articulating an independent opinion when her husband wants a child soon. Such a desire is bound to go unfulfilled.

"I never said anything. I said to him, as your wish. As he is the male person I have to follow his word. I said to him what you want to do, you do." (Informant #1, age 21, age at marriage 11)

*"He said that it will be good if we take child after 6-7 month. Then we took child."
"That was your husband's opinion, what did you want?"
"What will be my opinion? If he wants then I have to take it."* (Informant #30, age 20, age at marriage 16)

One woman who did have concordant desires to delay for more than 2 years remarks on this fortuitous happenstance upon which her opportunity to pursue her desires hinged.

"He could say that he wants to take a child. If he said like that, then my desire will not be fulfilled. So it was a positive side that he had the same desire and he also agreed to take child later." (Informant #14, age 18, age at marriage 17)

Other women make it clear that she would have to defer to her husband when their desires disagreed, as this informant describes.

*"So you didn't want to take child, but your husband wanted?"
"Yes, later on I also became convinced, as he wanted the child most."* (Informant #18, age 18, age at marriage 14)

Women also demonstrate this deference to their husbands even if she has other members in her family network who support her desires to delay a pregnancy, as described by these informants.

"He told me to take the child; I said that I will not take so early. My natal family also forbade taking a child...But he said to take the child." (Informant #18, age 18, age at marriage 14)

"My mother-in-law forbade us to take a child so early. My mother also didn't agree that I would take child immediately. I had to take child only because of him. I took child as he wanted." (Informant #10, age 16, age at marriage 15)

On the other hand, if he agrees with his wife on the timing of pregnancy, the husband can be a powerful ally against family pressures, as this woman who faced pressures from her sisters-in-law found.

"I think that if my husband and mother-in-law don't want baby now, so I also need not to have desire for a baby." (Informant #8, age 17, age at marriage 15)

In summary, the husband's desires exert strong influence over women's ability to achieve her reproductive intentions. When husbands want to delay pregnancy, women believe they are able to delay per their wish, even if they face pressure from other sources to become pregnant quickly. When husbands do not want to postpone pregnancy, those intentions override her own.

3.5.8. Family and community attitudes toward fertility

Women were much more likely to disagree with their in-law family than with their husbands about the timing of the first pregnancy. As seen in Table 2, 20 women report discordant desires with their in-law family, while seven women report that their in-law family supported their desire to delay the pregnancy. (Three women reported that their in-laws expressed no opinion.⁴) As with husband-wife discordance, the in-law family most often wanted the young woman to become pregnant sooner than she wanted to. This includes one case (Informant #30) where the woman wanted to become pregnant just 6-7 months after marriage.

Women who wanted to delay pregnancy for 1-2 years following marriage most frequently experienced disagreement with their in-law family: 11 women in this group had in-laws who wanted the woman to become pregnant sooner. Just one woman in this group (Informant #17) had in-laws who agreed with her desire to delay pregnancy for one year. This division was more balanced among the women who wanted to delay the first pregnancy for more than 2 years: six women had in-laws who agreed with their desired timing while eight had in-laws who wanted the pregnancy sooner. This finding perhaps confounds expectations that there would be more discordance with in-laws among the group of women who wants to postpone pregnancy the longest.

Only four women had both a husband and in-law family who agreed with her desired pregnancy timing (including one woman, Informant #28, who wanted to become pregnant right away). In the cases of eight women (two wanting to postpone pregnancy more than 2 years; six who wanted to wait 1-2 years), both their in-laws and their husbands wanted the woman to become pregnant before she did. In six cases, the woman's husband held discordant desires but her in-law family agreed with her desires. In 12 cases, husbands agreed with the women's wishes but in-laws did not.

In most instances, the natal family's opinion agreed with the in-laws or they expressed no opinion. In five cases, the natal family agreed with the woman's desired timing while the in-law family wanted her to become pregnant sooner than she wanted.

Women seldom report attitudes from neighbors and community members. Where they do, neighbors generally expressed a preference for earlier childbearing. Community attitudes are frequently invoked either by the woman to reinforce arguments in support of her desired timing or by the husband or family member in support of their perspective. They are seldom described as having a separate and independent effect on women's attitudes or behavior.

3.5.9. Family and community reasons to delay pregnancy

When in-law and natal family members preferred that a young woman postpone a first pregnancy, it was universally in situations when the woman, herself, wanted to postpone the pregnancy. The rationales family members offer mimic women's own reasons for delaying pregnancy. One of the few women who continued her education for a time after marriage described her studies as a source of pride among her elder brothers-in-law:

⁴ This includes one couple who lived with her mother (*ghor jamai*) and one woman whose in-laws died within months of her marriage.

“I was studying. I got A+ in class eight. My brothers-in-law were very happy with that. They used to say I would shine the family’s name as a youngest wife. The suggested me not to take child. They wanted me to become SSC pass [secondary school certificate]. I also wanted that.” (Informant #5, age 19, age at marriage 13)

Protecting women’s health and the baby’s health is the most common reason families favored postponing pregnancy. Women report that this concern was more common among their natal families than their in-law families. In-law families more frequently were concerned with protecting the woman’s potential fertility. The following two quotes illustrate the differences between natal and in-law families:

“My mother also told [mother-in-law] to advise me not to take child immediately as I was young. In our caste, older women suggest to take child when a married woman has perfect figure to carry child. Otherwise children may have problem.” (Informant #26, age 22, age at marriage 13)

“My mother and parental relatives told me...that if I get pregnant at that age, it would be harmful to me and so they suggested to take time in getting pregnant. On the other hand, my marital relatives...told me that if I take time in taking baby it might happen that I would not be pregnant in future.” (Informant #11, age 22, age at marriage 16)

Issues of settling into the new household and childcare are expressed with less frequency, though present nonetheless, as these informants describe.

“They [in-law family] told that you are not a matured girl since you can’t take care of yourself. How would you take care of a baby?” (Informant #8, age 17, age at marriage 15)

“My sister forbade taking child. She said, you just got married, both of you should enjoy your time.” (Informant #18, age 18, age at marriage 14)

3.5.10. Family and community reasons not to delay pregnancy

As described above, one particular concern in-law families (and, to a lesser extent, community members) express is with the young woman’s childbearing capacity. This interest in young women’s fertility took a particular expression that is perhaps surprising. In contrast to much of the narrative around early childbearing in Bangladesh and South Asia generally, there was no emphasis on having young girls prove their fertility as an essential part of becoming a woman or gaining status within the family. To the extent those sentiments exist, they were not expressed as such. Rather, elder family members’ concern with girls’ fertility assumed that girls themselves were interested in having a child at some point and was expressed—perhaps with paternalistic overtones—as a concern for preserving their reproductive capacity, at a time when it was seen particularly vulnerable. As this woman explains,

“My aunt in law also expressed her anxiety that if I make delay, there is a possibility to not to have baby in future.” (Informant #8, age 17, age at marriage 15)

While this sentiment was certainly common, it did not apply equally to all women. It was often prompted by an adverse health event. For example, one woman reports that her in-laws advised her to try to become pregnant only after she experienced a miscarriage. A widespread belief among in-laws and women in the community is that long-term pill use or side effects during contraceptive use could impair fertility. Informants report these fears influenced their thinking about contraception.

“Everyone used to tell that it [pills] harms placenta. Placenta will be dried by using it.” (Informant #19, age 18, age at marriage 14)

“We hear people say if women delay to take baby and use pill longer, they do not become pregnant. In village many women do not conceive.” (Informant #22, age 18, age at marriage 16)

Another, albeit less common, rationale for hastening a first pregnancy is to improve a husband’s or in-laws’ behavior and attachment to the young woman, as these two informants explain.

“My aunt-in-law said to me to take child urgently because of having bad manner of my in-law family members towards me...I thought that a child can change their manner.” (Informant #19, age 18, age at marriage 14)

“My husband lived at Dhaka. Hence my brother-in-law also advised me to take a child to get remedy from loneliness and also to keep husband in touch always...so that my husband starts to live at home.” (Informant #15, age 22, age at marriage 12)

3.5.11. Decision-making and family discordant desires

Informants’ accounts reveal that the power of in-law families and community attitudes to influence their fertility desires and behavior to be mixed. For a number of women, the in-law family’s opinions and instructions clearly hold sway over women’s fertility desires. This influence is exhibited more frequently when the woman’s husband also does not want to postpone pregnancy. One reason women are influenced by their family members and neighbors is because of their youth and inexperience, as these two women describe.

“When all the family members said the same, I thought I have to take child soon.” (Informant #30, age 20, age at marriage 16)

“I took child as everybody [in-law family and neighbors] suggested taking child soon...That time I was young, that’s why I followed whatever they said. Now I am matured.” (Informant #21, age 20, age at marriage 15)

In contrast, some women could resist when in-laws suggested an early pregnancy and hold to their own desires, as this informant explains.

“They [in-law family] told me that I should take contraceptives only after having a baby... But I didn’t listen to them... I told all of them I had no plan for that and I will take time.” (Informant #11, age 22, age at marriage 16)

Our data indicate that a woman is more frequently able to pursue her own desire to delay the first pregnancy when a woman and her in-law family disagrees, compared to when she and her husband disagrees. This resistance in the face of discordance with family members is easier when the husband and woman’s desires align. However, a minority of women note how this is not easily accomplished.

“I was not afraid of not listening of my husband, because he is my husband. But if you are living with other people, you need to listen to them. I am very afraid their talks.” (Informant #7, age 19, age at marriage 14)

“People said it is not wise to take child so early age, but I have to stay there. And if I were to take child, they wouldn’t behave badly with me.” (Informant #29, age 15, age at marriage 14)

3.6. Changing Fertility Intentions

Approximately half of the 27 women who originally wanted to delay the first pregnancy changed their minds over time and decided to get pregnancy sooner. This is perhaps not so surprising given the high proportion of women living with at least one other person—either husband or in-laws—who held contrary views on her fertility. The reasons women give for changing their minds are similar to those given by women who initially did not want to delay a pregnancy for long. These reasons include: strengthening her position in the household; improving relationships with family members, trying to convince her husband to be more responsible and committed to the family; growing concerns about fertility or side effects of pill use; and relenting in the face of ongoing pressure. One woman describes the increasing pressure she experienced as time passed.

“After one year, everyone started to ask me whether I use any family planning method...My sisters-in-law told me that ‘if you haven’t used anything then why didn’t you get pregnant yet?...’ My mother-in-law didn’t say anything to me but when they saw 2 years passed of my marriage they again started to tell me to take child.” (Informant #15, age 22, age at marriage 12)

Similarly, concerns with the possible effects of contraceptive pill use on fertility do not always emerge at the moment when women are first deciding whether to use pills. They frequently intensify as pill use continues over time or are triggered when women experience side effects.

“Pill didn’t suit me. I had vertigo...Then she [mother-in-law] said take a baby.” (Informant #22, age 18, age at marriage 16)

Other women change their fertility desires in response to changing living situations. The timing they desired when first married is no longer suitable as the circumstances of their lives unfolded. This type of change in desired timing is equally likely to occur of women’s own initiative and at the behest of another person.

“Later on he changed his decision...He said, ‘look all of them [neighbors] took child...Let’s take a child.” (Informant #12, age 22, age at marriage 16)

“I need the child. I didn’t get love from him; initially I thought I will take child 6 months or one year later. But as he started bad behave I took the child immediately.” (Informant #26, age 20, age at marriage 16)

3.7. Experiences with Contraception between Marriage and the First Pregnancy

More than two-thirds of our sample—23 women—used contraception at some point before their first pregnancy, as shown in Figure 2. This includes two of the three women who have not yet had a pregnancy and all three who are currently pregnant. All three women who continued their education after marriage were also able to use contraception for some time. Surprisingly, all three women who wanted to become pregnant soon after marriage also used contraception for at least several months.

The widespread use of contraception stands in contrast with the broad discordance women experienced with their husbands or in-law family and concerns they have with side effects and fertility impacts of

contraception. However, seven women did not use contraception before their first pregnancy; for six of these women, their husbands wanted the pregnancy sooner and for the sixth, her in-laws wanted the pregnancy sooner than she wanted.

3.7.1. Methods used

The contraceptive pill is by far the most commonly used method before the first pregnancy and among never-pregnant women, adopted by 19 women. Three women used a combination of withdrawal and periodic abstinence and two used condoms.

Given the limited nature of discussion occurring at the time of first marital sex and the spouses' lack of familiarity with one another, it is no surprise that the contraceptive behavior in the early days of marriage differs from that later on. Most women used some method of contraception during first sexual intercourse. Some informants who did not use anything at the first sexual encounter adopted a method soon after. Conversely, several of those who did use contraception only during this first encounter or for a few days before stopping when they learned of opposition to its use, as this woman describes.

“I had one pill that night [first sexual intercourse]. But further he did not allow me to take any pill...my husband did not let me take it after that saying that we need to have a child first.” (Informant #23, age 19, age at marriage 16, non-user)

Others shifted methods as they made decisions—or experienced coercion—about their fertility goals. Frequently, condoms or withdrawal were used as a short-term method as women transitioned to another method for an ongoing sexual relationship.

“He said that he has some friends at the bazaar, one of them said, ‘you got married, you can use condom and ask your wife to explore pills which one is appropriate for her.’ Then he used condom first...After marriage he told me to take pill so that he needs not to use anything...Later on we alternately use methods, one month I took pill and another month he used condom.” (Informant #12, age 22, age at marriage 16, pill and condom user)

However, other couples settled on condoms as the method of choice. The following woman recounts how her husband gladly used condoms when pills posed problems for her.

“Many men don’t like to use condom and order wife to take pill...But my husband told me, my wife is a little girl and I don’t want to make any problem to her. I will use condom. It may happen that I can’t enjoy the relation fully but I am not unhappy with that since my wife is mine and she is not leaving me.” (Informant #8, age 17, age at marriage 15, condom user)

3.7.2. Method choice and desirable attributes

Since it is the dominant method in Bangladesh's method mix, the majority of women know someone who is currently or had recently used the pill. Women prefer the pill because of the faith they place in the protection it affords.

“I always preferred to take pill as it is the most secure method. Pill is safe and sound. Pill avoids pregnancy.” (Informant #12, age 22, age at marriage 16, Femicon user)

However, women acknowledge that among the various pills on the market, each person needs to find the one suitable for her. Additionally, while pills are viewed as being unsuitable for extended use, some formulations are believed to be poorly suited for young, nulliparous women at all.

“I: Why you avoid taking Femicon?”

R: I heard that only after having a child should Femicon be taken. As I was newly married I shouldn't take it, as I hadn't any child. There is chance of infertility if I take Femicon before have the first pregnancy.” (Informant #14, age 18, age at marriage 17, Ovastat user)

“I don't take government pill [Shuki] as I was not sure whether it would suit with me or not from the beginning. I heard from neighbors that they couldn't take government pill due to side effects. That's why I even didn't try that.” (Informant #12, age 22, age at marriage 16, Femicon user)

Women are generally accepting of condoms, but see them as less reliable than pills and worry about their disposal.

“I have no problem to take pill. But there is a possibility of getting pregnant if the condom leaked. So I prefer pill.” (Informant #14, age 18, age at marriage 17, pill user, occasional condom user)

“Condom is kind of a problem...problem means, in the village everything is so open, so it is a problem to drop the used thing.” (Informant #12, age 22, age at marriage 16, Femicon user)

“I felt ashamed to drop off the used condom...otherwise there was no problem at house, nobody will find it if I put it in to the drawer or under the mattress.” (Informant #18, age 18, age at marriage 14, pill user)

In general, pills and condoms are viewed as suitable methods for young, nulliparous women. Withdrawal and periodic abstinence are acceptable substitutes when these other options are not feasible. However, injections and long-acting reversible contraceptive methods like implants and IUDs are less favorably viewed for this population. Fear of side effects was a consistently expressed concern.

“I heard that woman has to have minor operation in their hand to insert the capsule [implant]. I also heard that this method is harmful to woman... I heard that it may cause cancer.” (Informant #11, age 22, age at marriage 16, Femicon user)

“Maybe, I could feel dizzy by using injection that's why I never thought about injection.” (Informant #15, age 22, age at marriage 12, non-user)

3.7.3. Discussion and contraceptive decision-making

The data from our informants clearly show that husbands are deeply involved in deciding whether and what method of contraception to use. In some cases, couples rely on information about specific methods from elder women to make this decision. Sometimes, both husbands and wives work together to determine the most suitable course of action, while other women defer to their husbands, as they do with the timing of pregnancy.

“My sisters-in-law informed me that I should take pill and if we don’t have that we should use condom...Then I told it to my husband and he bought the condom.” (Informant #11, age 22, age at marriage 16, pill user)

“Then I gave up using the injections thinking that since he is wanting a baby, I should be taking too. What’s the point of going against him while I will have to carry out this family?” (Informant #16, age 21, age at marriage 13, injection user)

When husbands and wives agree on postponing a pregnancy, husbands can be supportive partners in effective contraceptive use, as these women’s examples describe.

“He is very much cautious about it. Even if I sleep before he sleeps, he awakes me and asks me whether I have taken the pill. If I don’t, then he helps me to take that.” (Informant #5, age 19, age at marriage 13, pill user)

“From the beginning he said that we will take child later...He is very careful, he is careful more than me.” (Informant #12, age 22, age at marriage 16, pill and condom user)

In contrast to incidents of agreement, men who want a child earlier than their wives easily have the authority to prevent contraceptive use in pursuit of her desired timing, as one woman explains.

“My husband wanted to have children... He said first we will have a child and so he did not allow taking any pills.” (Informant #23, age 19, age at marriage 16, non-user)

3.7.4. Side effects

Out of concern for young women’s health, husbands and sometimes in-laws rule out certain methods for fear of side effects. This is particularly the case when long-acting reversible methods are under consideration.

“They [natal family] asked me to take pill, but my husband didn’t allow me to take pill. He said that pill may cause cancer, it is not good to take pill.” (Informant #15, age 22, age at marriage 12, non-user)

“My husband said that you need not to take implant or injection since those have side effects, from which my sister-in-law is suffering. He told me that what we are using [condoms], that is right.” (Informant #8, age 17, age at marriage 15, condom and withdrawal user)

This concern for protecting women’s health and fertility sometimes takes a paternalistic tone, as women are often not the ones driving the decision about whether to adopt or discontinue a given method. Other family members make this decision on her behalf.

“Did you ever discuss with your husband about the method for 5 years [implant]?”
R: Yes. He said, ‘you can do what you want’ but my family members forbade taking that.” (Informant #28, age 16, age at marriage 12, pill user)

“I heard, if you take injection next 3 months you need not to take anything...My husband forbade taking those...As he is the head of the family, I have to obey him.”
(Informant #30, age 20, age at marriage 16, pill user)

Fears of side effects are not unfounded. Women frequently experience side effects, which sometimes interfere with their ability to accomplish their daily work. In total, nearly one half (11) of the women using contraception before their first pregnancy experienced side effects. Of those experiencing side effects, six women discontinued using contraception altogether and five switched to condoms, withdrawal, or periodic abstinence.

When the husband and wife agree on the timing of pregnancy, women are often able to parlay their husband’s concern into support to minimize the side effects or to seek a new, better suiting method. Again, the expertise of women in their social network who have more experience with contraception is a valuable resource.

“Initially I had head spinning and vomiting tendency. Then I told it to my grandmother... she said that initially these will happen and gradually it will be ok. So I continued to taking pill and now it is ok for me.” (Informant #14, age 18, age at marriage 17, Ovastat user)

“They discussed about me with that woman. They informed her about my sickness due to having pill. So they preferred condom for us and that woman provided that method and still we are using that... He [husband] said that ‘I should take this method to keep [his] wife healthy’.” (Informant #8, age 17, age at marriage 15, condom and withdrawal user)

An interesting facet of the last example is how absent the woman, herself, is from discussion about a matter that impacts her life; others make the decision for her.

The experience of side effects is a common reason for stopping contraception or changing methods. However, only a few methods are perceived to be suitable for nulliparous women, limiting women’s options if they experience side effects and need to switch. Often, women are advised to cease contracepting altogether. Other women switch to a less effective method. One woman, for example, switched from using the pill to condoms, and then from condoms to withdrawal. This pattern leaves motivated women at risk of unintended pregnancy.

3.8. Experience with the First Pregnancy

3.8.1. Timing of the first pregnancy

While Figure 2 presents the details of each woman’s contraceptive use and pregnancy timing, a summary of these data across all women is found in Table 3. Of the 30 women in our sample, 27 had experienced a first pregnancy (including three who were currently pregnant). Eighteen women became pregnant within one year of marriage;⁵ another five women became pregnant within 2 years of marriage. Only four women experienced their first pregnancy after 2 years of marriage or more.

Sixteen women report that their first pregnancy was appropriately timed,⁶ while 11 report that it was mistimed. An additional seven women became pregnant sooner than they had wanted to at the time they

⁵ This figure refers to pregnancies in the current marriage.

⁶ This figure refers to pregnancies in the current marriage.

married; however, these pregnancies were not mistimed at the moment that they experienced them because their fertility desires had changed. One woman, who initially wanted to wait longer than 2 years before becoming pregnant, experienced her first pregnancy after more than 5 years of marriage, later than she had wanted.

Table 3. Summary of women’s contraceptive use and pregnancy timing

Contraceptive use ¹	Mistimed	Appropriately Timed	Not yet pregnant	Total
yes	5	5	2	12
no	6	11	1	18
Total	11	16	3	30

¹ Contraceptive use at the time of pregnancy, or at time of interview for those who have not experienced a pregnancy

Seventeen women were not using contraception at time they became pregnant, including six women who experienced mistimed (too early) pregnancies. Six had previously used contraception but stopped because they wanted a pregnancy. Nine women had previously used contraception but discontinued while still in need, before they were ready to become pregnant.

“That time we hadn’t any plan to take child. In fact I want to take child more later. But I don’t know how it happened. He said take a child, take a child. Then I stopped taking pill and then had the baby.” (Informant #18, age 18, age at marriage 14)

“Actually I was feeling sick for using pill for 3 years. I was feeling vertigo, headache and I had to take rest all the time. So I stopped taking pill for one month and then I got pregnant within that month. ...I have a problem which they called “Badhok”. Women who feel pain during menstruation they have the disease of Badhok and those women can’t be get pregnant easily. That’s why I thought that I also have the disease and I would not be pregnant if I don’t use any contraceptives.” (Informant #11, age 22, age at marriage 16)

Ten women were using contraception up until their pregnancies, including five women who experienced mistimed pregnancies and five women who accepted the timing of their pregnancy. These women seem to have experienced contraceptive failures, although we cannot distinguish use failure from method failure in this study.

“After 2 years I got pregnant. I was using a method. But still with the will of Allah this baby came to my womb.” (Informant #5, age 19, age at marriage 13)

“We were conscious [about using pill consistently] but how did it happen, we don’t know.” (Informant #26, age 22, age at marriage 13)

Another six women had stopped using contraception in the month immediately preceding their pregnancy; for four women this was because they desired a pregnancy, but two women became accidentally pregnant with a mistimed pregnancy upon stopping contraception in anticipation of switching methods.

“None of us wanted a child during that time. However, I did not understand that I will be getting pregnant so easily. He thought that I was taking pill, which I was not.” (Informant #10, age 16, age at marriage 15, pill user, temporarily stopped (8 days) due to side effects)

It was rare that a few women had pregnancies later than they wanted. One woman (Informant #1) experienced her first pregnancy much later than she initially wanted. Two others decided after some time that they wanted to become pregnant earlier than first planned, but had trouble becoming pregnant immediately when they tried. One woman who stopped pill use 3 months after marriage, but took another one and half year to become pregnant, told her story.

“He had gonorrhoea (Dhatu vangto otirikto). That’s why it took time for my pregnancy...I came to know it after marriage. One of my sisters-in-law informed me about his disease....I advised him to take medicine. Then he took medicine. He cured after 2 months of taking medicine. [then got pregnant]” (Informant #19, age 18, age at marriage 14)

3.8.2. Termination

Three women who experienced an unintended pregnancy contemplated terminating it,⁷ but were refused, either by family members or doctors. In each case, the reason was that they did not already have children.

“He [husband] phoned me and then I told him I had not gotten my period. Then after 2 months I saw a doctor and doctor confirmed I had conceived. Then I asked the doctor whether I could terminate my pregnancy. But doctor said as it was the first baby so I could not terminate.” (Informant #5, age 19, age at marriage 13)

“My mother-in-law was very angry. She told me that the marriage just took place and I got pregnant! She took me to terminate the pregnancy but by the grace of Allah, it could not be terminated.” (Informant #4, age 18, age at marriage 15, non-user)

In the third case (Informant #24), everyone in the woman’s family opposed her desire to terminate, as it was the first pregnancy. Her mother and in-law family members assured her they would help to care for the child so she could continue to study.

More frequently, women do not consider termination when they experience a mistimed pregnancy, as this informant succinctly describes.

“No, nobody thought to abort it. I also didn’t want to abort. As the baby came why we would abort it?” (Informant #26, age 22, age at marriage 13)

In summary, even considering women’s revised desires, approximately half of girls’ first pregnancies are mistimed. Reasons for mistimed pregnancies include couple discordance in wanting a pregnancy (and subsequent refusal to continue contraception); use failure of the contraceptive method (predominantly the pill), and discontinuation due to side effects.

3.9. Fertility Desires for Spacing a Subsequent Pregnancy

Following the first pregnancy, women generally want a long interval before a subsequent pregnancy, much longer than the spacing between marriage and first pregnancy. A response of a desirable gap of 5-7 years is particularly common, as shown in Table 4. Only one woman wanted a gap of less than that,

⁷ While women often used a term like *baccha nosto* to refer to either menstrual regulation or terminating a pregnancy, we did not probe to distinguish between these events/procedures. Therefore, we use the term “termination” to refer to all such procedures.

at 3 years. Three women wanted a gap of 10 years or more and one woman did not want a second child. By the time of our study, nine women had progressed to at least a second pregnancy.⁸

Table 4. Fertility desires, concordance of desires, and resulting timing of second pregnancy

ID	Wife's desire for timing of 2nd pregnancy	Wife/Husband concordance	Family concordance	2nd Pregnancy mistimed
1	>10 years	concordant	concordant	--
2	5-6 years	discordant	concordant	--
3	7 years	concordant	discordant	no
4	no more	concordant	concordant	yes
5	10 years	concordant	no discussion	--
6	3 years	--	--	--
7	8-9 years	--	--	--
8	10-12 years	--	--	--
9	6-7 years	concordant	concordant	--
10	5 years	no discussion	--	--
11	7 years	no more	concordant	--
12	no more	concordant	discordant	--
13	5-6 years	no discussion	concordant	--
14	4-5 years	--	--	--
15	5 years	concordant	concordant	no
16	6-7 years	discordant	--	no
17	unspecified delay	concordant	no opinion	no
18	10-12 years	concordant	--	--
19	7 years	concordant	concordant	yes
20	unspecified delay	discordant	concordant	yes
21	8 years	concordant	--	--
22	5-7 years	--	--	--
23	5 years	concordant	concordant	--
24	7-8 years	concordant	--	--
25	10 years	concordant	--	--
26	5-7 years	no more	--	--
27	7-8 years	concordant	--	--
28	10 years	concordant	concordant	--
29	unspecified delay	--	--	--
30	4-5 years	concordant	concordant	--

Concordance around timing of the second pregnancy is also much more likely. Women's husbands and in-laws also favor a longer spacing between pregnancies than they did before first pregnancy. In one of only two exceptions (Informant #12), the couple concurred that they did not want any more children, but the woman's mother-in-law encouraged them to have a second child 3-4 years after the first child's birth. In another (Informant #3), the couple wanted to wait 7 years before another child but the mother-in-law did not want them to use any contraceptive methods. These examples contrast with the general pattern of support for an extensive delay.

The reasons given for postponing a second pregnancy are also different than for postponing the first. Few women refer to age, physical development, or emotional maturity as some had expressed as a factor in the desired timing of the first pregnancy. This is in spite of the fact that many women are still adolescents following their first birth. Rather, the factors encouraging spacing include the health benefits to mother and to child and the ability to provide and care for children that are well spaced. A desire not to have the second child until the first is grown is a common theme. Women report that they, their husbands, and their in-laws, alike, express this view.

⁸ This figure refers to pregnancies within the current marriage.

“If the older child is very young, then isn’t that a problem if I take another child? If I do that, it would appear that I would not be able to take care of this child properly. Therefore, the ideal way is to properly raise this child and then take another one.” (Informant #27, age 20, age at marriage 17)

One woman was concerned about the health risks and economic costs of a second delivery following a C-section.

“I had C-section; I might need C-section again if I become pregnant. Where will I get money? This time my parent bore the cost. I will take another child when this child is grown up, by this time if his father’s [economic] condition improves!” (Informant #28, age 16, age at marriage 12)

However, these other concerns are infrequent compared to the notion of allowing the first child to grow up before having a second child.

3.10. Experience with Contraception after the First Pregnancy and Subsequent Pregnancies

3.10.1. Patterns of contraceptive attitudes and use

Contraceptive use is much more acceptable after the birth of the first child than before the first pregnancy and more options are made available. Having had a child (all but one pregnancy resulted in a live birth), women also now have access to more contraceptive knowledge and confidence to participate in discussion of these topics. Widespread preferences for long spacing between births, as described in the previous section, mean more women are supported in pursuit of their individual goals. Approximately 20 of 24 women have used contraception since the birth of their first child.

Parous women have an expanded range of methods from which to choose, including methods like injections, implants, and IUDs that had been off limits for nulliparous women. Women discuss long-acting reversible contraception with their husbands, sisters-in-law, and health workers more readily than before the first pregnancy, and the advantages of these methods align better with their lengthened desired spacing. While the pill is still a dominant method, more women are using injections, and a few use implants.

Many of the preferences (and myths) that women had held about methods before the first birth still persist. One woman described her fear of side effects with the injection:

“One of my brothers-in-law suggested I take injection but I didn’t agree to have that method and I took pill again. Women become fat after taking that method!” (Informant #11, age 22, age at marriage 16, Femicon user)

Women continue to believe that long-term pill use carries a risk of fertility problems. However, while experiencing infertility is highly problematic for nulliparous women, it is less problematic if experienced by women who already have a child.

After the first pregnancy, the concerns women express about long acting methods shift from their potential side effects to concerns about their invasive nature and religious proscriptions against altering the body. These two women remark on implants and tubal ligation:

“What if I die with ‘kathi’ [implant] in my hand. That person will not be going to heaven and therefore, why would I do something like this?” ... “What if I have a problem

while doing [ligation]? Why would I cut something? Won't God be unhappy that I have cut the body so that I don't have a child?" (Informant #3, age 21, age at marriage 13)

"These methods should not be used. What if you die with these? What would you say to God?...When you would die, the kathi [implant] will be in your body." (Informant #21, age 20, age at marriage 15)

Another attribute of the implant and injections that women dislike is suppression of menstruation.

"She (health worker apa) said there is nothing to be afraid if there is no 'menses'. But it is good to have it, otherwise it will be problematic for the body if the dirty blood couldn't go outside from the body." (Informant #28, age 16, age at marriage 12, injection user)

Other women, who were generally satisfied users of some of these methods, expressed displeasure with the difficulty of accessing injections or implants. This same woman who liked to use the injection described the issues she has with accessibility.

"She gave the date on a paper, when I need to go for [next] injection. Many days passed away but I couldn't go...3 months already over...if they don't go [sisters in law who also use injection], how can I go there alone? It will be good if they provide this at home." (Informant #28, age 16, age at marriage 12)

Another concern when deciding on contraceptive methods that emerged at this point of the life course is the effect of contraception on breastmilk supply and child health for mothers who are currently breastfeeding. Women discuss this issue amongst each other, with health workers and doctors of varying expertise, and seek a method or formulation of the pill that is most compatible with breastfeeding for them. Rather than discontinuing contraceptive use, as was the case with health concerns before the first pregnancy, women are more likely to switch to another brand of pill or switch to condoms while breastfeeding.

Some women continue to experience the same types of difficulties using contraception, e.g., side effects, as they did before the first pregnancy. Women still experience opposition or discordant fertility desires in a few cases, but, as Table 4 indicates, this is much diminished. Yet, some women are still not using contraception in a way that corresponded with their fertility desires. One woman describes the obstacles she still faces. She had experienced a mistimed first pregnancy that was miscarried. Her second pregnancy—the first resulting in a live birth—aligned better with her desires for the timing of a first child. Although she wants a gap of 5-7 years before the next child, her husband is not supportive of using contraception and she worries that she is at risk of another mistimed pregnancy that she would need to carry to term.

"If I do get pregnant, I have nothing to do but keep the pregnancy and raise the child with hardship. I don't like that [terminating the pregnancy]." (Informant #16, age 21, age at marriage 13)

Another woman, however, describes how opposition to contraception is not the same barrier to use that it once was. Husband's approval isn't as critical to a woman's ability to use contraception as it was before the first pregnancy.

"One day my sister in-law said that she was going to do that [have implant inserted] then I also went with her...I didn't take permission from [her husband], as I knew that

he will not agree. After I came back to home when I inform him, he became angry... 'Why didn't you ask me before? How dare you do that without my consent.' I said, 'So what should I do? You didn't allow me to take pill, so I would have to deliver child in every month?' We were quarreling, and then he became calm." (Informant #26, age 22, age at marriage 13)

3.10.2. Increasing knowledge

In contrast to their descriptions of the early days of marriage, women's accounts of contraception after the first child clearly show an expansion in knowledge, as exemplified by one woman's detailed description of pill use.

"Every day before sleep you have to take the pill. And if you forgot one day, you have to take the pill immediately when you could remember next day. And at night you have to take the regular one...There are iron tablets there,⁹ There are three rows of white tablets and a row of iron tablets on the strip of the pill. After taking the white colored pill then you need to take iron pills." (Informant #12, age 22, age at marriage 16)

Other accounts show the process by which women learn of more methods.

"Many women use vaccine [injection]. I didn't know about all these...Now I visit at hospital and come to know many more things like capsule [implant]. After having a child my sisters-in-law advised me, not to take another child urgently. Hence I came to know about methods." (Informant #15, age 22, age at marriage 12)

"Everybody took pill here. Nobody took injection here. I didn't know that there is a capsule for 5 years; you cannot know everything at a time. Gradually you can understand many things; I also understood many things gradually." (Informant #28, age 16, age at marriage 12)

Nonetheless, some incorrect knowledge persists, as evidenced by the mistaken notion that red pills cause menstruation to start rather than menstruation coinciding with when white pills cease:

"At the last month I started with white pill then took all the red pills but my period didn't start. Then I took some more red pills from another strip to have period but it didn't work out." (Informant #26, age 22, age at marriage 13)

Six women in our sample of 30 had experienced a second pregnancy. Of these, about one half were mistimed. Whereas family opposition to postponing a pregnancy or using contraception played a major factor in the occurrence of mistimed first pregnancies, mistimed subsequent pregnancies were largely the result of contraceptive failure or accidental pregnancies due to interruptions in contraceptive practice.

⁹ Several of the most popular pill formulations include red, non-hormonal pills that contain iron rather than being entirely inert placebos.

4. Discussion and Conclusion

This study adopted qualitative methods to complement quantitative data of the Bangladesh DHS and sought to answer questions about why young, married women bear their first child at a young age. We find that women enter into marriage suddenly and with no advance preparation. This rush to marriage proves to be a strong deterrent to successfully planning childbearing. Women have no opportunity to adjust to the idea of being married, let alone to discuss with their husbands their desired timing of pregnancy or decide on and acquire contraception. Furthermore, women's lack of agency in the marriage process sets the tone for their early reproductive lives, with young women lacking empowerment to implement reproductive intentions. Like others, we find that early and sudden marriage is, therefore, associated with low decision-making and poor fertility control, as evidenced by unintended pregnancy (Godha, Hotchkiss, and Gage 2013).

The women in our study want to postpone their first pregnancy until 2-3 years following marriage on average. Our finding contrasts with that of earlier studies in Sylhet, Bangladesh and elsewhere in South Asia which indicated that a majority of newly married women wanted a child immediately (Sharma et al. 2002; Henry et al. 2015). Our finding that women want to delay childbearing is particularly positive for those wanting to shift childbearing from the adolescent years and into the early twenties, an age attended by lower risk of negative maternal health and birth outcomes. It suggests a strong basis for programmatic efforts that support women to achieve their fertility desires.

Women primarily are motivated to postpone a pregnancy to protect their health and secondarily to allow for a period of adjustment into an unfamiliar household and role. This latter finding contrasts with other studies in Bangladesh that found having a child soon after marriage facilitates integration into the unfamiliar, marital household (Rashid 2006; Henry et al. 2015). Only a few women in our study express this perspective. Only a very few women continued their education after marriage; finishing school is particularly strong motivation to postpone pregnancy among these women. Education has long been identified as a factor influencing fertility and the timing of childbearing, however the typical mechanism posited is delaying marriage (Bates, Maselko, and Schuler 2007; Abedin 2011; Bhatti and Jeffery 2012).

While the young women in our study want to postpone the first pregnancy, they are often influenced by their husbands and in-law family, who frequently have opinions about timing of childbearing that conflict with their own. Husbands and in-law family members are more likely to prefer an early pregnancy than the woman, herself. Husbands and in-law family members who do want to postpone pregnancy often share the same motivations as do newly married women. Women clearly understand that bearing a child too young can be harmful both to herself and to her baby.

Husbands and in-laws often share this concern. However, their interest in protecting her health, particularly in preserving her fertility capacity, can be a powerful motivation to stop contraceptive use if she experiences side effects, thereby running the risk of pregnancy. This motivation is particularly strong among in-law family members. Thus, the health motivation operates differently for in-law families and husbands than it does for young women and leads to early childbearing. Programs to support women in achieving their fertility desires must be designed to address the different motivations of husbands and in-laws and their influence on women.

The women in our sample have a mean age at marriage of 15 years and, on average, a preference to postpone a first pregnancy for about 2 years. This finding means that most women desire a first pregnancy that falls within their adolescent years. This finding warrants emphasis. One implication is that if the aim is to move first births beyond the adolescent years, it may be advisable for programmatic and policy efforts that assist women in achieving their fertility intentions to be complemented by continued efforts to delay marriage beyond the legal minimum marriage age.

This study shows women enter into marriage with little practical contraceptive knowledge; many lack even basic body literacy and understanding of reproduction. Taboos against talking about sex and contraception with unmarried girls bolster this lack of knowledge. Older sisters-in-law and other female relatives often step in at the time of marriage to provide young women with some cursory information about contraception. Yet, women do not know how to use contraception effectively in the early part of their marriages. Their need for education and information on sex, their bodies, and contraceptive options is clear. Results from the 2014 BDHS indicate that less than one third of women age 15-19 have seen or heard anything about family planning in the media or from health workers in the preceding month (NIPORT, Mitra and Associates, and ICF International 2016), suggesting a role for the media to fill this knowledge gap.

One striking finding from this study is how many young women attempt to use contraception to postpone the first pregnancy. Twenty-three of 30 women used contraception for some time before their first pregnancy. This finding contradicts the conventional wisdom that contraception is seldom used until after the first child is born (Godha, Hotchkiss, and Gage 2013). Unfortunately, most women were unable to use contraception continuously and effectively to realize their desired pregnancy timing.

The women in our study consistently defer decisions related to the timing of pregnancy and contraceptive use to others in the marital home. Our finding that women exercise little influence over reproductive decisions echoes the relative powerlessness of recently married women identified in other studies (Sharma et al. 2002; Gipson and Hindin 2007; Acharya et al. 2010; Huda et al. 2013). Husbands and in-law families exert influence over the timing of childbearing. Their opinions both shape women's own desires at the outset of marriage or over time sway women to change their plans to have a child sooner than they first planned. Targeting interventions to husbands may be particularly useful in delaying first pregnancies.

Female relatives continue to be sources of information—and sometimes misinformation—about contraception throughout the early years of marriage. This result is consistent with other studies that point to female in-laws as the primary source of reproductive knowledge and guidance (Mumtaz and Salway 2009). The contraceptive experiences of sisters-in-law and mothers-in-law strongly influence young women's own behavior. Newly married women are limited to a narrow range of contraceptive methods (pill, condom, or traditional methods) because female relatives believe other methods such as injections and implants are unsuitable for young, nulliparous women. From among this limited set of contraceptive options, husbands often determine whether and which method will be used, a pattern of contraceptive decision-making that is consistent with existing studies (Acharya et al. 2010).

The experience of side effects while using contraception (predominantly pills) was commonplace in our study. Fear of and experiences with side effects of contraceptive methods compel some husbands to insist that their wives stop using contraception and conceiving a child. Similarly, mothers-in-law believed myths that long-term pill use and other methods could cause infertility, a finding not unique to this study (Char, Saavala, and Kulmala 2010; Henry et al. 2015). In-laws' interests in protecting a young woman's fertility potential influence young women to discontinue contraceptive use before they are ready to become pregnant.

Nearly two-thirds of the women in our study experienced their first pregnancy earlier than they had desired when they married. Discordant fertility aims and side-effect-induced contraceptive discontinuation are the two major factors contributing to mistimed pregnancies. Efforts to support current users, minimize discontinuation (Jain et al. 2013), and to correct misperceptions about contraceptive methods are critical for this population of young, inexperienced contraceptive users. Targeting this information not only to newly married women but to men and older women as well could also be beneficial.

In summary, this study has complemented the quantitative findings of the Bangladesh DHS 2014 in its investigation of how young, married women make and implement decisions about the timing of childbearing. It found that entry into marriage is an unexpected disruption of unmarried girls' lives. Spousal communication and women's decision-making are low. Women want to delay a first pregnancy, but still want a birth within 2-3 years of marriage, leading to childbirth while they are still young. Women's abilities to meet their fertility aspirations are challenged by discordant childbearing aims, limited options for contraceptive methods, and discontinuation due to side effects and concerns about infertility.

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Appendix 1. Socio-demographic profile of study informants

ID	Women's information							Husband's Information				
	Age	Education	Age at marriage	No. preg.	No. of living children	Age of last child	Current pregnancy status	Type of family	Age	Education	Occupation	
1	21 yrs	Class-8	11 yrs	01	01	4 yr	Not pregnant	Extended	28 yrs	Class-9	Electrician	
2	22 yrs	Class-6	13 yrs	02	02	5 m	Not pregnant	Extended	35 yrs	Class-8	Business of iron	
3	21 yrs	Class-8	13 yrs	02	02	1.6 yrs	Not pregnant	Extended	30 yrs	Class-10	Business (fruit)	
4	18 yrs	Class-5	13 yrs	02	02	3 yrs	Not pregnant	Extended	26 yrs	Class-6	Small business (row material)	
5	19 yrs	Class-8	13 yrs	01	01	16 m	Not pregnant	Extended	27 yrs	Class-7	Van driver	
6	19 yrs	Class-9	14 yrs	01	01	3 yrs	Not pregnant	Extended	26 yrs	Class-5	Farmer	
7	19 yrs	Class-9	14 yrs	01	01	3 yrs	Not pregnant	Extended	25 yrs	Class-7	Small business (vegetable seller)	
8	17 yrs	Class-8	15 yrs	0	0	0	Not pregnant	Extended	27 yrs	Class-7	Farmer	
9	17 yrs	Class-6	15 yrs	01	01	5 m	Not pregnant	Extended	26 yrs	No school	Farmer	
10	16 yrs	Class-8	15 yrs	1	0	0	9 m. Pregnant	Extended	18 yrs	Class-5	Farmer	
11	22 yrs	Class-8	15 yrs	01	01	2 yrs 9d	Not pregnant	Nuclear	26 yrs	Class-9	Farmer	
12	21 yrs	Class-10	16 yrs	01	01	2 yrs	Not pregnant	Nuclear	32 yrs	HSC	Jewelry maker	
13	19 yrs	Class-9	17 yrs	01	01	43 d	Not pregnant	Extended	25 yrs	Class-9	Business	
14	18 yrs	Class-12	17 yrs	0	0	0	Not pregnant	Extended	27 yrs	B.A	Madrasa teacher	
15	22 yrs	Class-5	12 yrs	02	02	9 m	Not pregnant	Extended	30 yrs	SSC	Nochimon driver	
16	21 yr	Class-5	13 yr	03	02	11 m	Not pregnant	Nuclear	26 yr	Class-6	Carpenter	
17	22 yrs	Class-7	14 yrs	03	02	19 m	Not pregnant	Nuclear	30 yrs	No school	Small business	
18	18 yrs	Class-6	14 yrs	01	01	2 yrs	Not pregnant	Nuclear	26 yrs	Class-4	Farmer	
19	18 yrs	No school	14 yr	02	01	3 yrs	Not pregnant	Extended	22 yrs	No school	Butcher	
20	20 yrs	Class-7	15.5 yrs	03	02	2 yrs	Not pregnant	Extended	27 yrs	Class-7	Farmer	
21	20 yrs	SSC	15 yrs	01	01	3 yrs	Not pregnant	Extended	40 yrs	M.A	Teacher	
22	18 yrs	SSC	16 yrs	1	0	0	4 months pregnant	Extended	28 yrs	Class-7	Worker of jewelry shop	
23	19 yrs	Class-5	16 yrs	01	01	2 yrs	Not pregnant	Nuclear	30 yrs	No school	Imam and also a farmer	
24	19 yrs	SSC	16 yrs	01	01	1 yrs	Not pregnant	Extended	28 yrs	HSC	Small business of fertilizer	
25	18 yrs	Class-9	16 yrs	1	0	0	Pregnant	Extended	22 yrs	Class-8	Farmer	
26	20 yrs	No school	16 yrs	01	01	2 yrs	Not pregnant	Nuclear	40 yrs	No school	Auto driver	
27	20 yrs	Class-3	17 yrs	01	01	11 m	Not pregnant	Extended	24 yrs	No school	Farmer	
28	16 yrs	Class-4	12 yrs	01	01	18 m	Not pregnant	Nuclear	20 yrs	No school	Seasonal day labor and auto driver	
29	16 yrs	Class-4	15 yrs	0	0	0	Not pregnant	Extended	19 yrs	Class-1	Day labor	
30	20 yrs	Class-10	16 yrs	02	01	2 yrs	Not pregnant	Extended	32 yrs	SSC	works in a co-operative	