Decision-making Contexts around Early Childbearing and Contraception among Young, Married Women in Bangladesh

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Short Abstract

This qualitative study complements the 2014 Bangladesh Demographic and Health Survey (DHS) data on early marriage and childbearing with in-depth interviews among a sub-sample of young, married women age 15-22 in Khulna Division, Bangladesh. This study explores how women who marry as adolescents think about the timing of childbearing and using family planning, the normative environment that shapes their fertility aspirations, how they navigate household decision-making processes to try to achieve their reproductive goals, as well as knowledge, access, and agency-related barriers to using family planning.
Extended Abstract

Introduction

Early age at marriage is socially acceptable in South Asian culture (Riley 1994) and Bangladesh has long been characterized as a country with early marriage and high adolescent fertility. According to the 2011 Bangladesh Demographic Health Survey (DHS), 89% of women age 20-49 were first married by age 20. Despite the legal minimum age of marriage at 18, de facto age at marriage for women remains low; Between 1997 and 2011, the median age increased by a year and a half from 14.2 to 15.8 (NIPORT et al. 2013; Mitra et al. 1997). Many of these marriages are arranged by the parents, involving little participation of the girl (Shrestra 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 almost entirely occurs within marriage. Women’s median age at first birth in Bangladesh is 18.3 years (NIPORT et al. 2013). Adolescent pregnancy poses risks for a range of negative maternal and peri-natal health outcomes, with the risk increasing for the youngest girls (de Vienne et al. 2009; Haldre et al. 2007; Goonewardene and Waduge 2005; Cooper et al. 1995). In particular, girls younger than 19 have a 50% increased risk of stillbirths and neonatal deaths, as well as preterm birth, low birth weight, and asphyxia. 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, being socially isolated, often without partner or family support, and usually unable to complete their education; thus they may perpetuate socioeconomic disadvantage in health outcomes and behavioral risks with 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 her husband or more senior women in the household. 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 girls are less empowered than either unmarried adolescents in their natal home or older married women who have already established childbearing (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 forthcoming) or she 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%) were found to be part of an extended family, of which just over half (51%) claimed that the authority over conception remains with their husband 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. As a result of these potential 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 unmet need for family planning is higher (17%) than among women age 24-49 (12.3%) (NIPORT 2013; MacQuarrie 2014). Contraception is seldom used prior to the first birth (24% of nulliparous women) (NIPORT 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 decision-making context that shapes young women’s fertility intentions, contraceptive, and fertility behaviour in two regional divisions of Bangladesh: Khulna and Rajshahi.

**Methods**

The 2014 Bangladesh DHS, with data collected between July and October 2014, is the seventh DHS in Bangladesh and is a nationally representative sample of about 18,000 ever-married women of reproductive age (15-49 years). The qualitative component comprises 30 in-depth interviews among a sub-sample of Bangladesh DHS respondents in Khulna, specifically women age 15-22 who married as adolescents and who agreed to a follow-up interview on the topic. Study procedures were reviewed by institutional review boards in Bangladesh (Icdrr,b) and the United States (ICF International) and, as with the quantitative Bangladesh DHS survey, the study is supported by USAID/Bangladesh through The DHS Program (contract # AID-OAA-C-13-00095).

The division of Khulna was selected for this study because it has the lowest age at marriage and age at first birth compared to other five divisions. In 2011, the median age at marriage was 15.0 (among women age 20-49 years) and median age at first birth was 17.5. The median difference between the age at first marriage and first birth was 23.1 months (NIPORT 2013).

In-depth interviews are semi-structured and were guided by an interview guide. Data collection occurred in early 2015 and the number of interviews (30) was guided by the principle of saturation (Guest et al. 2006; Patton 2002; Morse 1994). AtlasTi was used to code and manage the data. As qualitative inquiry employs an iterative approach, transcripts were coded per a predetermined list of major themes, and supplemented by codes for new themes and sub-themes that emerged from the respondents’ own narratives. Analysis of qualitative data is complemented by case-specific quantitative data from the main DHS survey. These data are embargoed until their public release, anticipated in January 2016, and so do not appear in this abstract, though they will appear in the full conference paper.

Thematic areas of investigation include: how young, married 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 young 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 their appropriate role in spacing either the first birth or second birth. Finally, but perhaps most importantly, we examine women’s power status within the household and how they navigate household decision-making processes to try to achieve their reproductive goals, as well as knowledge, access, and agency-related barriers to using family planning.

**Preliminary Results**

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1 These data will be replaced with data from the 2014 Bangladesh DHS, embargoed until their public release, which is anticipated to be January 2016.
At the time of interview, our respondents ranged in age from 15 to 22 years, with a mean of 19 years. Their age at marriage was, on average, 15 (range 11-18). Ten girls were married before age 14, 14 girls were age 15-16, and 6 were age 17-18 when they married. Husbands ranged in current age from 18 to 40 (mean 27), meaning that girls were, on average, married to a man 8 years their elder. Girls generally had class 8 or less education. The educational profile of their husbands was similar. Among 8 couples, the wife had more education and in in another 8 couples, the husband had more education. The educational level was the same among 4 couples. Twenty-two of the 30 respondents were living in extended households at the time we interviewed them, though an even greater number began their married lives in this arrangement.

For all but 2 girls, marriages were arranged by their husband’s family alone or both families jointly and frequently occurred within just 1-3 days of being arranged. Most girls 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. Only a couple of girls were able to continue their education following marriage. The swiftness of girls’ marriages afforded little opportunity for the future spouses to become acquainted or to discuss matters such as when they would like to initiate childbearing or whether to use contraception. The only couples that had such conversations were among the very few who married a week or longer after their marriages were fixed.

Married sisters, sisters-in-law, or other older women frequently supplied girls directly or indirectly via their husbands with oral contraceptive pills 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 girls’ desires for initiating or delaying childbearing. 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 decision-making about childbearing and using (or not using) contraception to plan their families.

Upon marriage, the great majority of girls wanted to postpone the first pregnancy. Most wanted a delay of 1-3 years before becoming pregnant; a fewer number wanted a longer delay; and a couple wanted to become pregnant right away. This finding means that, while most wanted to delay the first pregnancy for some time, they nonetheless intended to have a pregnancy during their adolescent years.

Most of the girls had the same or similar desires as their husbands, though for some, this was because their desires were shaped by those of their husband or were the result of a negotiation process with them. Where their desires were discordant, husbands almost always wanted the pregnancy to occur earlier than the girl did. Similarly, when desires between the couple and in-laws were discordant, the in-laws wanted the pregnancy earlier than the couple. Although girls acknowledged they had to defer to their husbands in cases of disagreement, when girls and their marital family disagreed, frequently they were nonetheless able to use contraception to delay the first pregnancy, particularly if her husband’s desires were similar to hers.

Approximately half of those who wanted to delay the first pregnancy changed their minds over time and wanted a shorter delay. Reasons for revising their desires included to strengthen her position or improve relationships in the household, to try to convince her husband to be more responsible and committed to the family, because of growing concerns about fertility or side effects of pill use, or relenting to pressure.

Even considering women’s revised desires, approximately half of girls’ first pregnancies were experienced as mistimed. Reasons for mistimed pregnancies include discordance in desires (and subsequent refusal to adhere to contraception), use failure of the contraceptive method (predominantly
pill), and abandonment of contraception due to side effects. All of the first pregnancies that were not mistimed occurred among (1) women who did not want any delay in becoming pregnant and (2) women with husbands and marital families with concordant desires and who were supportive of using contraception.
References


