Delaying the First Pregnancy: A Survey in Maharashtra, Rajasthan and Bangladesh

Kavita Sethuraman, Lokesh Gujjarappa, Nandita Kapadia-Kundu, Ruchira Naved, Alka Barua, Prachi Khoche, Shahana Parveen

Childbearing in adolescence, a common practice in south Asia, can adversely affect the health of both mother and child. This qualitative study was conducted in three sites in India and Bangladesh where low birth weight is prevalent to explore the ability of newly-weds to negotiate the timing of their first pregnancy. The pattern in each site generally reflected prevailing social views on contraception, childbearing and couple communication.

In India and Bangladesh, where early marriage remains a widespread practice, adolescent pregnancy is often an immediate sequitur to marriage [Pachauri et al 2002]. Adolescent pregnancy is problematic for the young mother and the foetus, as the mother herself is still growing, causing both to compete for nutrients [Allen et al 2001]. Adolescent pregnancy also carries increased risks of maternal, infant, and perinatal/neonatal mortality [Reynolds et al 2006]. Mothers at this age are more likely to have a lowbirth weight baby, a risk factor that often precedes malnutrition in childhood [Allen et al 2001; Reynolds et al 2006].

In this region, 50 per cent of pre-school children are malnourished. Importantly, with declining fertility rates and little change over the last few decades in the age of marriage, a majority of births are among adolescent girls, whose children face the adverse consequences of mortality and malnutrition [Allen et al 2001; Reynolds et al 2006; Jensen et al 2003]. Delaying the first birth until adulthood (in addition to subsequent birth spacing) is a potential strategy for improving maternal and child health outcomes. However, for various reasons, most young newly-wed couples are unable to postpone a first pregnancy.

Newly married adolescent girls have little power and social status in their marital family and are rarely able to negotiate for a delay in their first pregnancy [Ram et al 2006]. Data show that contraception is rarely used before the birth of the first child in south Asia [Pachauri et al 2002; Ram et al 2006]. It is important for newly married couples to establish their fertility by conceiving early, often within a year of marriage [Reynolds et al 2006; Khan et al 2004]. For men, it demonstrates “manliness”; for women, that they can fulfill the role of mother and provide sons to carry the family lineage forward. Furthermore, as the services of providers and health messages are geared to women who already have children, there is little opportunity or even acceptability, for newly-weds to access contraceptive services [Santhya 2003].

Nonetheless, married adolescent girls in Bangladesh have greater knowledge of and access to temporary contraceptives than their counterparts in India, where family planning services implicitly favour non-reversible methods of contraception [Pachauri et al 2002; Santhya 2003; Pathak et al 1998]. The family planning services in Bangladesh, which emphasise the use of temporary methods, offer couples an opportunity to delay their first pregnancy [Pachauri et al 2002]. Of note, however, the emphasis of family planning programmes in both countries is on using contraception to space and limit the number of births, and virtually no emphasis is placed on delaying a first pregnancy from adolescence to adulthood.

Although in principle, the policies of the national family planning programmes in India and Bangladesh are similar,
implementation at the community level differs in important ways; therefore, the acceptability of reversible versus non-reversible methods of contraception also differs [Pachauri et al 2002; Santhya 2003; Pathak et al 1998]). In India, tubectomies, commonly referred to as “the operation”, have gained popular acceptance and are the main mode of contraception [Santhya 2003]. In Bangladesh, popular acceptance of temporary contraceptive methods is widespread [Pachauri et al 2002; Schuler et al 1996]. In both contexts, service provision, mass campaigns, and increasing media exposure to family planning messages can explain why different methods of contraception have gained such wide acceptance [Westoff et al 1999]. These efforts have in effect legitimised the methods that are socially acceptable in the two contexts. This has created an enabling environment in which women have the space to consider, communicate about, and negotiate for specific contraceptive methods [Gayen et al 2006]. However, the contraceptive behaviour of individual women is influenced by various factors that include realistic access to a range of methods, social status in the family, knowledge of methods, couple communication about contraception and family size, husband’s approval of contraception, and to a lesser extent, in-laws’ approval of contraception [Ram et al 2006; Gayen et al 2006; Mason et al 2000; Hossain et al 2007; Kamal 2000]. In India, social acceptability of temporary methods is less, precluding young couples from being able to consider contraception almost until they have fulfilled their desired family size [Pathak et al 1998; Zavier et al 2000]. In Bangladesh, the emphasis is on spacing and limiting births, their desired family size [Pathak et al 1998; Zavier et al 2000]. In India, social acceptability of contraception, and to a lesser extent, in-laws’ approval of contraception about contraception and family size, husband’s approval of contraception, and to a lesser extent, in-laws’ approval of contraception [Ram et al 2006; Gayen et al 2006; Mason et al 2000; Hossain et al 2007; Kamal 2000]. In India, social acceptability of temporary methods is less, precluding young couples from being able to consider contraception almost until they have fulfilled their desired family size [Pathak et al 1998; Zavier et al 2000]. In Bangladesh, the emphasis is on spacing and limiting births, precluding newly-weds from considering contraception early in their marriage to delay a first birth.

**Theory of Diffusion of Innovation**

The manner in which contraception and family planning have gained social acceptance is explained by the theory of the diffusion of innovations, which suggests that an innovation is adopted by a minority in the initial stages and becomes accepted by the majority over time [Campbell 2006]. In other words, the practice of family planning became acceptable once public opinion reached a tipping point in its favour. In India, this has meant adopting the practice of tubectomies, and in Bangladesh, the use of oral contraceptives. Yet this has resulted in missed opportunities in both countries, where adolescent pregnancy remains widely prevalent, in part due to inadequate services at the community level [Elul et al 2004; Purohit 2006; Rahman et al 2001]. Delaying the first birth could be a potential strategy for improving maternal and child outcomes. Enabling social change to shift in favour of postponing the first pregnancy until adulthood in this context is another innovation that holds promise. This paper presents qualitative findings on the dynamics, patterns, and trends in the acceptability and ability of newly-weds in India and Bangladesh to communicate about and negotiate the timing of their first pregnancy.

### 1 Methodology and Data Collection

This qualitative study on nutrition and gender took place in three sites: two in India (Maharashtra and Rajasthan) and one in Bangladesh. The three study sites were selected because at the aggregate level, the prevalence of low birth weight remains high in each, while the context differs. Each study site had two sub-sites (Table 1). In Maharashtra, the purposive sample consisted of vulnerable groups from Pune’s urban slums and Aurangabad district. In Rajasthan, although Udaipur district is one of the more backward districts, the purposive sample did not consist of the most vulnerable population in the district. Similarly, in Bangladesh, the two sub-sites are not necessarily representative of other parts of the country. Mirzapur is close to Dhaka city and has a somewhat diversified economy and is more modern than many other parts of Bangladesh. Although Matlab is rural and remote, it has been a research site for the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) for decades, so external influences are likely high.

The qualitative methods included in-depth interviews, focus group discussions (fgds), narrative scenarios (participatory group exercises using unfinished stories), and key informant interviews (Table 2). Analyses for this paper was based on the data collected from married adolescent girls and women, husbands, and mother-in-laws. The key informants included health providers, non-governmental organisation (ngo) activists, and community leaders. Checklists used to collect data were developed collaboratively by the research partners and translated into Hindi, Marathi, and Bangla, the commonly understood and used languages in each of the study sites.

Data collection teams of about six to 10 members (male and female) received training in qualitative methods and collected data from participants of the same sex. Opportunistic and purposive sampling was used to identify participants. In-depth interviews and focus groups were conducted in separate villages, as were men’s and women’s focus groups. Each participant was included in the data collection only once and only for one method (i.e., focus group or in-depth interview), and each participant was from a separate household.

Access to the study participants was obtained in different ways. In Maharashtra and Bangladesh, the research partner worked and provided services at their field site; in Rajasthan, access to

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### Table 1: Study Sites and Study Sub-Sites

<table>
<thead>
<tr>
<th>Study Sites</th>
<th>Study Sub-Sites</th>
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</thead>
<tbody>
<tr>
<td>Maharashtra</td>
<td>Pune (urban slums)</td>
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<tr>
<td>Aurangabad</td>
<td>district (Pachod rural)</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>Udaipur district (Salumbar block) (rural)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Matlab (rural)</td>
</tr>
</tbody>
</table>

### Table 2: Study Methods and Participants

<table>
<thead>
<tr>
<th>Method and Participants</th>
<th>Maharashtra Urban</th>
<th>Rural (Pachod)</th>
<th>Peri-Urban (Bhindar)</th>
<th>Rural (Salumbar)</th>
<th>Rural (Matlab)</th>
<th>Rural (Mirzapur)</th>
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<tbody>
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<td>In-depth Interviews</td>
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<td>31</td>
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<td>20</td>
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<td>Focus Group Discussions</td>
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<tr>
<td>Narrative Scenarios</td>
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<td></td>
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<td>1</td>
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</tr>
<tr>
<td>Key Informant Interviews</td>
<td>Mothers-in-law</td>
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<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Key informants</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>8</td>
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</tbody>
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the field site was obtained through a local NGO. The study started in August 2004 and the fieldwork was completed by August 2005. Oral informed consent was obtained, and confidentiality and privacy were ensured for study participants. Field notes were transcribed in the local language and scrutinised by the supervisors for deficiencies and inconsistencies.

Codes were defined and a code list was finalised at a workshop in Mumbai by the research partners. The data were coded using Atlas.ti and analysed. At each site, inter-coder reliability was assessed to ensure reasonably consistent use of the code list within and across study sites.

In the first stage of analysis, each team analysed the data for their site to assess the range of variation and identify patterns. In the second stage of analysis, the data was compared and contrasted across sites. The data was not pooled, so as not to lose the context specificity by study site, permitting identification of important similarities and differences across the three sites. During both stages of analysis, the in-depth interview were analysed first and then triangulated with the data from the focus group discussions, narrative scenarios, and key informant interviews.

2 Survey Results

Across the three sites the study participants were from comparable socio-economic backgrounds, although generally within each site, status varied from low income to lower middle income. The number of years of education completed by the women in the study was also similar across sites as shown in Table 3.

Across the three study sites, most of the married young women interviewed had married by 18 years of age, with the large majority marrying between 15 and 18 (Table 4, p 83). Only a few several girls had married later. The process of marriage was largely similar across sites. Most marriages were arranged by parents and extended family, and various family members played an important role in identifying potential grooms and bringing them to the parents attention. The final decision on marriage was mainly made by fathers. In Bangladesh and Rajasthan, the predominant pattern was to marry non-relatives, but in rural Maharashtra, marriage to relatives was more common. A majority of women across the three sites had a fairly common experience in the initial transition to their marital home. They described these experiences using terms such as fears and apprehensions, and expressed concern about fulfilling expectations and roles as the marital family expects.

Experience around First Pregnancy

Across study sites, the range in the timing of first pregnancy varied (Table 5, p 83). Whereas most of the first pregnancies in Maharashtra took place within a year of marriage, only about half of those in Bangladesh and less than half in Rajasthan occurred in this period. Regardless of the site, the majority of these early conceptions were during adolescence, among women aged 18 years or younger at marriage. Of the 151 women, 95 had their first pregnancy within 12 months of marriage; 33, between 12 and 24 months after marriage; and only 23, after 24 months or more.

Importantly, many couples did communicate about their child-bearing aspirations and often discussed when to have their first pregnancy, but the extent and nature of this communication varied across sites (Table 6, p 83). There was less communication and a higher proportion of early pregnancies in Maharashtra than in the other sites. Among couples who delayed pregnancy, there was variation across the sites in the extent to which they had genuine discussions with their spouses. Less than half the women with delayed pregnancies in Maharashtra and Rajasthan had discussions with their partners, while more than half in Bangladesh had discussions that often resulted in the use of contraception.

Maharashtra

Most girls in Maharashtra who conceived early had little discussion about family size and first pregnancy before the birth of the first child. Several factors appeared to underlie this. At the community level, the data suggested that although there is general awareness and knowledge about contraception, there is little acceptability in promoting its use.

When asked if a young married woman can make family members understand that she does not want a child immediately, a focus group of mothers-in-law had the following exchange:

“P3: Yes, she talks at home, she makes them (in-laws) understand.
P7: She will tell her husband.
P4: She does not tell us (in-law parents), but she talks to her husband ....
P7: But this cannot happen, she can have one child and then she can delay her next conception, that I should not have next child.
P6: If she is well educated and belongs to educated family, then she will surely delay her conception.
P6: And if she is not educated, then everybody at home feels that she should have one child, everyone will have that expectation, then that is her expectation that she should have one child now.”  
–Mothers-in-law FGD

This expectation is driven in part by continued fears of the long-term effects of temporary contraceptives, particularly that they may cause infertility:

“P4: Because of contraceptive use, one of my relatives conceived after 13 years of marriage. They have taken all the treatment, now his wife is three months pregnant.
P5: As per my view, daughter-in-law should have child after one year only. That my relative's daughter has taken tablets to avoid the pregnancy. She had not told us about it.
P7: Taking that tablets is also not good. There is problem due to those tablets also.”  –Mothers-in-law FGD

And at the same time, other family members strongly desire having a new child in the family soon, as newly married women remarked in an FGD:

“P7, P9: Relatives in the family expect a child as soon as possible.
P13: If a child is born soon, then only husband and wife stay
(ghotalateel) at home; otherwise, they will be more interested outside the house.

P9: If they have child, they will remain at home; otherwise, they will do whatever they want.

P1: Relatives in the family expect that newly married women should have a child quickly. If she has a child quickly, she will be thoughtful at home soon. We also get relieved from responsibility (jimmedariton).” –Married women’s FGD

Not surprisingly, women in Maharashtra felt they could not decide these issues on their own, and their ability to delay a first pregnancy was contingent on consent and agreement of their husband and sometimes other family members: “P3: She cannot do anything by her own. If there is consent of both husband and wife, then only she can avoid pregnancy.

P11: It would be avoided with their own consent. How daughter-in-law makes them agree that she does not want to be pregnant?

P7: She will tell her husband and in-laws that she does not want to be pregnant now.

P12: She must tell it to her husband that she does not want to be pregnant now, all these decisions were taken by husband and wife, they do not ask it to parents.” –Married women's FGD

From the husband's perspective, having a child early was partly desire and proof of fertility, but also a natural outcome of having sexual relations with their young wives:

“P7: …When our wives are young, how we can sit quiet, physical relations are bound to happen. Then child is born within one year….

P5: Wife is young, so everyone wants a child because of pressure on woman as well as man. And family members say to young married men that don't use any family planning method. Let it be as early as possible, then let’s see what to do.

P4: Not everyone has same opinion. Many are with the opinion that in order to keep the wives' health properly, they do not want a child when the women's age is less.” –Men's FGD

Within this broader context, women had limited ability to communicate and negotiate for a delay in their first pregnancy (Table 6). Many who conceived soon after marriage had little opportunity to discuss their childbearing desires: “Previously, there was no plan to have child. But after having one child, it was planned that we will not have another child for four years. We both made this decision.” –Chandra, 19 years, married at 18 years, urban.

Importantly, virtually no couples in Maharashtra used contraceptives before the first pregnancy; a few used condoms. Several women, however, tried to convince their husbands to delay childbearing, with mixed results: “They (marital family members – mother-in-law and others) wanted a child immediately. Spouse should decide when to have child with mutual discussion. However, after marriage I did not know anything about the pregnancy and other things. On these issues, I told my husband, 'I do not want child so soon'. That time my husband asked my mother-in-law that she (young married adolescent women – I) does not want child now, what should we do? On that I felt very insulted, I felt like I am nothing. Therefore, everything was decided by them, they have not asked me anything.” –Devi, 18 years, married at 15 years, urban.

Janabhai, who lived in a rural joint family married at 16 years, said: “No, in-laws did not pressure me for early pregnancy. Nobody said anything. In-laws said that they do not want early pregnancy as I am young to have a child. Two years, there was no pregnancy; during the third year, I became pregnant.”

Swati, who lived in a rural nuclear family and was married at 14 years, said: “Nobody pressured me to get pregnant after marriage. Nobody from the family said anything about having a baby. My husband said that we do not want a child so early. Nothing was done for that. My husband used condom (Nirodh) on his own.”

Both Janabhai and Swati had support from their family or husband, which influenced the ultimate decision of when to conceive, consistent with what women shared in the focus group discussions.

Many married adolescent girls stated that they did not experience pressure to conceive, they simply conceived – in many cases early and in a few cases late – but for the most part within a time frame acceptable to the family. For the majority who conceived early, the lack of discussion around first conception reflected both a “willingness” or readiness to conform to expectations, and a lack of decision-making power, as others often made childbearing decisions: “I told my husband we don’t want child now, but he asked his mother about that, then she said, ‘Nothing like that, anybody can have child as soon as marriage, why you will not have, and why don’t you want?’ I had my first child before

<table>
<thead>
<tr>
<th>Table 4: Age at Marriage by Study Site</th>
<th>Age at Marriage</th>
<th>Maharashtra</th>
<th>Rajasthan</th>
<th>Bangladesh*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
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<td>Urban</td>
</tr>
<tr>
<td>&lt;15</td>
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<td>9</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>15 to ≤18</td>
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<td>22</td>
<td>47</td>
<td>15</td>
</tr>
<tr>
<td>&gt;18</td>
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<td>2</td>
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</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>31</td>
<td>61</td>
<td>20</td>
</tr>
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</table>

*Not reported in one case.

<table>
<thead>
<tr>
<th>Table 5: Time from Marriage to First Conception, by Age at Marriage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at Marriage (in years)</td>
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<tr>
<td></td>
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<tr>
<td>Maharashtra</td>
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<tr>
<td>&lt;15</td>
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<tr>
<td>≥15 to ≤18</td>
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<tr>
<td>&gt;18</td>
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<tr>
<td>&gt;18</td>
</tr>
<tr>
<td>Total</td>
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* Nine women in the sample were newly married, three of whom were living at their natal home. None of them had ever conceived at the time of the interview. **Not reported in one case.

<table>
<thead>
<tr>
<th>Table 6: Couple Communication on Contraception and Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Genuine discussion</td>
</tr>
<tr>
<td>Persuasion/pressure/compulsion</td>
</tr>
<tr>
<td>Threat/violence/deception</td>
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<tr>
<td>Guama (practised in Rajasthan)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

* Early conception: ≤12 months after marriage; delayed conception: >12 months after marriage.
† Nine women in the sample were newly married, three of whom were living at their natal home. None of them had ever conceived at the time of the interview. **Not reported in one case.
§ In five cases, initial genuine discussion was followed by persuasion or pressure.
completing one year of my marriage.” – Rohini, 18 years, married at 15 years, urban.

The ability of women to negotiate for a delay in the first pregnancy also appeared to be undermined by their fears and lack of accurate knowledge of contraception: “I used to take family planning pills, but irregularly. I had fear that after taking those pills, I will become infertile and no one will look after me...” – Vanita, 17 years, married at 17 years, urban.

“After marriage, we (husband and I) did not use any contraceptives. After first delivery, my husband himself started using Masti condom ... there is no pressure on me, because I have no information about its use, so my husband uses it.” – Leela, 18 years, married at 16 years, rural.

**Rajasthan**

In Rajasthan, there was widespread awareness and knowledge of contraception and family planning at the community level. Although many couples had genuine discussion about the timing of a first pregnancy, few couples actually practised contraception. Many participants from different focus groups believed that everyone is aware of contraceptive methods and couples can discuss childbearing issues now:

“P3: If Sunita wants to delay her pregnancy, she can use contraceptives like oral tablets, copper-T, condom, or injections. And her in-laws will never know, she will tell only her husband, Sunil.
P1: If she does not want a child, then she will abort the child in Udaipur hospital, for that she can go with Sunil.
P6: For Sunita’s future pregnancy, her family members will make her avoid Mala-D tablets. Because of Mala-D tablets, the child may become handicapped (Lula, langada).” – Mothers-in-law narrative scenario.

“P4: To avoid conceiving, Seema can take pills, use condoms, go to the temple to pray, or go to a doctor.
P1: The decision of not having a child now should be made by her and her husband. This is necessary. If she does not want to have a child, and her husband wants one, then the condom will be of no use.” – Men’s narrative scenario.

However, different family members also expected and desired a child soon after marriage: “The in-laws have various expectations from the daughter-in-law; the main expectation is that a daughter-in-law should perpetuate the family honour.... It is expected that a daughter-in-law should give birth to a child within a year of marriage.” – Men’s narrative scenario.

Many couples engaged in genuine discussion on childbearing early in marriage: of 31 women who talked about communication or no communication with their husband on the first pregnancy, 15 had genuine discussions. But only a few couples used contraception to delay this pregnancy: “I got married at 18 and have three daughters. There was no pressure (Dabav) from anyone for me to get pregnant. The decision to have babies was entirely my husband's and mine. My husband and I decided on this issue after discussion.” – Shanta, 23 years, married at 18 years, rural.

Such dialogue among couples appeared acceptable to families, giving couples space for discussion, consistent with the focus group findings. This enabled couples to agree about when to have their first child, even if their families preferred to have a child sooner: “When I got married, my mother-in-law told me that she now wanted to be a grandmother, but the decision about timing of pregnancy and about which contraceptive should be used was taken jointly by husband and me”. – Meera, 25 years, married at 23 years, rural.

Most married adolescents in Rajasthan felt that they were under no pressure to conceive early; instead, they felt the decision was theirs and their husband's: “I got married at 18 and have a year-old daughter. There was no pressure on me to conceive. My husband and I have the right to decide the number of children we want to have. My husband and I understand each other and there is no tension between us.” – Lakshmi, 22 years, married at 18 years, currently nine months pregnant, rural.

Although discussion among couples was common, many still had a child early and often this was what they decided. For some, these discussions were more an exercise in negotiation and persuasion by husband or wife to have a child either earlier or later. In three cases, women wanted to delay conception; in two of these cases, the husband agreed. “Any decision is made jointly by my husband and me. He does not force me to do anything and respects my wishes. My mother-in-law does not interfere. There was no pressure after marriage on me to conceive. I started using Mala-D right after marriage because at that time, my studies were still going on and my husband too wanted a child after a year because even his studies were going on. I had heard about it on television and my husband also knew about it. People had told me that these pills are safe and do not have any effect on the body. I used the pills for a year. Then we made the decision that I should conceive. Now I am in my seven month. My husband and I want two children, a boy and a girl.” – Monishka, 22 years, married at 20 years, currently seven months pregnant, rural.

In the other case, the husband convinced his wife to conceive early. She said, “I wanted to have first child three to four years after marriage. But my husband was keen to have the child early. I told him my wish to delay. He did not pressure me to agree. He persuaded me through discussions. I did not oppose him and agreed. When my daughter was four to five months old, he started using condoms. He used condoms only on certain days of the month. He told me that on the other days, the chances of my becoming pregnant were less. These decisions were his as my knowledge in these matters is poor.” – Sharda, 18 years, married at 16 years, rural.

In Rajasthan, ‘gauna’ – the practice of keeping married girls at their natal homes until they reach menarche (sometimes longer) before sending them to their marital home – still prevails. In our sample, six married adolescents conceived much later in marriage because of this practice. For example, Buri Bai described her situation: “I got married at the age of 11 but stayed in my natal house till I was 17 years old. ... My parents feel that after marriage, the daughter settles down (Betika ghar bas jata hai). I started my studies two years after marriage and went to my husband’s house six years after marriage.” – Buri Bai, 30 years, married at 11 years, peri-urban.

Some women who denied pressure in fact had little decision-making power on family planning and contraception: “After marriage, there was no pressure on me to conceive. My husband had the right to decide, and he decided the number of children we
should have and whether it would be a boy or a girl. I have been pregnant twice. After the birth of my son, I started using Mala-D. I used these after asking my husband.” – Chandrakala, 23 years, married at 19 years, rural.

And in some cases, women had no opportunity to even discuss the issue: “I never felt pressure for pregnancy. I have a son and a daughter. But how many children I should have, this decision was taken by my husband. We never discussed this issue till now (Per is vishay per abhitak bat nahi hui).” – Santosh, 25 years, married at 16 years, peri-urban.

As in Maharashtra, some women said they had no knowledge of contraception, so they relied on their husbands to make the choices for them: “Neither do I know of such methods (family planning), nor have my family members asked me to adopt any such method. I conceived soon after marriage. There was pressure on me to have a baby. I have a daughter. My mother-in-law has not said anything on the matter to me. I have not adopted any method till date. My husband and I would decide how many children we want, but I have to be careful in my marital home about what I say.” – Mahila, 20 years, married at 18 years, rural.

Bangladesh

The main pattern in Bangladesh sharply contrasted with those in Maharashtra and Rajasthan in some important ways. In Bangladesh, as in Rajasthan, many couples seemed to have genuine discussion on delaying their first pregnancy, but here, most couples went one step further by agreeing on, or negotiating for, the use of contraceptives. Indeed, many couples discussing the matter used contraception to delay their first pregnancy. In most of these cases, husbands decided that their wives should use contraception; in a few cases, wives made the final decision or the couple decided jointly.

It is likely that the widespread acceptability of contraception as a means of family planning allowed couples space early in their marriage to discuss and agree on childbearing before the first conception, and the ability to act on that agreement. The focus group and key informant data support this also. Women and men in focus groups clearly stated that services were widely available and accessible, and that sometimes, health providers could facilitate the family conversation if needed: “Close to our house are hospital A and the family planning clinic. When everything is so close then a woman gets to know everybody within four to six months. There are so many daktars of family planning even within the village from whom the women can take the method. These facilities are available to everybody now.” – Young married women’s FGD, Matlab.

“We tell them don’t try to conceive before you are 18. …Now many understand this (that it is better to conceive after 18). The brides understand this and girls usually get to know all these things after marriage. At first, many feel shy to talk to their husbands about this. Then we advise them to adopt a method. Then they gradually come to learn. …Now everybody understands these things as they watch TV and listen to radio...There are two cases here where both the mother and the child are malnourished. People observe this and they get cautious …We explain these things to girls, brides, and mothers-in-law. If a woman is a mother[of a girl], we talk to them because mothers do understand and they caution their daughters, ‘If you conceive at this age, your child would be malnourished and your health would suffer.’ The fact that a daughter’s health would suffer is something a mother always remembers.” – Key informant, Matlab.

But despite this support and infrastructure, there is also a competing desire to have children soon after a marriage: “I got married at 24. I need to see my children graduate from school and college. So I must have the children right away.” – Men’s FGD.

“The men who go abroad often have a child soon, fearing what could happen if the girl was without a child and then she gets out of control. The question of ijjat (honour) is more important here. Marrying is meaningless if one cannot protect his ijjat. In that case, other things happen and then there is aushanti (no peace) at home. In each and every village, one or two such events occur.” – Men’s FGD.

These competing interests appeared as tensions in several in-depth interviews where, occasionally, the family and the couple disagreed on the timing of births. Overall, the nature and extent of dialogue among couples on first pregnancy in Bangladesh was more progressive than that in Maharashtra and Rajasthan. The high social acceptability and accessibility of family planning and contraception in all likelihood facilitated this trend.

However, the childbearing aspirations of newly weds varied here too. Several husbands wanted a child immediately; their reasons were proof of fertility, fear of infertility from contraceptives (particularly for first conceptions – six of 27 cases), family desire for early childbearing, or husband’s plans to go abroad. Others wanted to delay pregnancy. When girls married in adolescence, the common reason given was that the girl was too young and an early pregnancy would harm her health. Sometimes, a delay was desired to prevent public speculation. Some married adolescents tried to negotiate a delay in their first pregnancy but were unsuccessful. For example, Mala from Matlab married a businessman at age 16. He told her they would have a child right away. She said, “I was not that interested. … when I asked him to bring me contraceptives, he told me they are not needed. If you conceive, we’ll have the child. I used to tell him people would say bad things (khara koi-bo) if a child is born so early – so, bring me pills. He would say to this, ‘Would the people feed it [the child] or I’d feed it? I’ll feed my child. The question is whether it is mine.’ …One day I tried to take pills and he caught me and he slapped me. He said, ‘Why do you take pills? I did not take any more pills after this [incident] and I conceived.’” – Mala, 24 years, married at 16 years, rural.

Several other married adolescents were able to negotiate for a delay in pregnancy. Tomiza married a farmer in Matlab at the age of 16. Her marital family wanted her to have a child immediately, but she decided to use oral contraceptives. At first, she bought the pills; later, she convinced her husband to bring them to her. She argued that both of them were too young to be parents. She was concerned about her husband’s age, about 20 at that time: “He was [very] young when we got married. He was not suitable [for being a father]. He was like a child himself.” – Tomiza, 31 years, married at 16 years, rural.

In this way, Tomiza was able to delay first conception until she had been married for 14 months.

At times, husbands favoured delaying the first conception despite the intention of their wives to have a child. For example,
Polly came from a well-off family in Matlab. She married at 15 but stayed at her natal home for two years to continue her schooling. Her in-laws did not want her to get pregnant early so that she could finish her education. Polly, however, wanted a child, which she did not reveal to anyone. Also, she was afraid of side effects of contraceptives and did not want to take the pills: “On the day of the wedding, they [husband and sister-in-law] asked me to take pills. I couldn’t take the pill out of fear. Then they made me take the pill by scolding me.” –Polly, 22 years, married at 15 years, rural.

Polly first conceived 24 months after the marriage.

Sometimes intentions to postpone a first birth for a long period were modified by a fear of infertility related to using contraception before first conception, as voiced by Bela, a poor girl from Mirzapur married at age 15 whose husband wanted to wait 10 years: “I told [him], what if no child is born due to delay? So, he said, ‘Okay, then we’ll have it five years later.’ [Several months later], my aunt … and others scared me, saying that many didn’t have any children here [because of delaying conception]. If I don’t conceive now, I might never have a child. … So I told my husband that this is why many women don’t have any children. What if this happens to me as well? Then he said, ‘Then let’s have it.’” –Bela, 18 years, married at 15 years, rural.

These negotiations took place over 15 months, and only then did Bela conceive.

Some husbands wanted to delay pregnancy because their wives were too young. Linu married a 21-year-old assistant carpenter at age 16. Her mother-in-law hinted that she wanted a grandchild. But her husband told her: “Don’t get a baby now. You are too young and I am too young too. You won’t survive if you have a baby. He used to tell me that there was a young girl who had a baby and suffered a lot. ‘So don’t you get a baby, hearing what other people tell you.’ … So I said okay, let it [the baby] come later … what can I do if you don’t want to have a baby.” –Linu, 18 years, married at 16 years, rural.

The couple used oral contraceptives for 18 months, but Linu developed vertigo from them and wanted a baby. Her mother-in-law suggested: “If you feel bad, then you stop taking them [the pills]. If he asks you why don’t you take pills, tell him I have taken the shot [Depo-Provera].”

Linu conceived four or five months after she stopped taking the pills.

Some couples agreed to use contraception against the in-laws’ wishes. Tahmina, a 22-year-old woman from a non-poor household in Matlab, married at age 19 after passing the 10th grade and conceived 19 months later. She described how her mother-in-law objected to her taking pills, through others or from a distance: “My mother-in-law always used to chillachilli [raise a hue and cry]: ‘You need not use these methods. … We need grandchildren.’” –Tahmina, 22 years, married at 19, rural.

Her ‘jal’ (husband’s brother’s wife) told her, “Don’t take these pills. You don’t need to. Why would you take them? Get the first child and then use them (the pills). If your narih noshto (uterus/fallopian tube is damaged), you’d lose everything.”

And her father-in-law lamented, “My friends bring their grandchildren to the bazaar and they have a lot of fun. I am not lucky enough to have such fun.” But Tahmina and her husband wanted to delay conception and used contraception. Backed by her husband, she could ignore the opinion of her in-laws until the day (one and half years into the marriage) her husband’s married friends had children, when, as she put it, “He came home and told me, don’t use these (-pills) anymore. So I stopped using them.”

The reverse happened in the case of Modhumoti, from a poor household in Matlab. She married at age 20 and conceived two months later despite her husband’s wish to wait a year. The couple used the safe period method but stopped because of family pressure. In Modhumoti’s words, “They (i.e., the mother-in-law and the aunt of the husband) didn’t let us (delay first conception). They used to rebuke me. They used to say, ‘You are not so young’.” –Modhumoti, 20 years, married at 20 years, rural.

Her grandmother-in-law said to her, “I have seen other grandchildren’s children. Now I want to see yours before I go. So don’t you use that rubbish.”

Cross-Site Findings

The three study sites fall at different points along a continuum when it comes to discussion and negotiation by newly-weds of first pregnancy and contraception. This broad continuum suggests that the acceptability and accessibility of temporary contraception that varies across this region is one factor that defines the space for and drives the nature and extent of discussion on first pregnancy.

The data revealed a set of main pathways favouring early conception or delayed conception. In Maharashtra, most newly-weds do not discuss their childbirth aspirations and conceive early. Here, awareness of contraception at the community level has not transcended to the household level. Therefore, families are not supportive of contraception early in marriage and rarely discuss or encourage it. As a result, not only are the nature and extent of communication around contraception limited among couples, but the lack of community and family support more generally limits the social space in which newly-weds can discuss and decide about contraception. In effect, across the three sites, couples in Maharashtra generally had the least autonomy in the discussions and decisions of contraception.

In Rajasthan, there is more discussion among couples, and the practice of keeping married girls at their natal home until menarche, which in effect delays pregnancy. Nonetheless, many newly-weds still have a child early in marriage. In this study site, the focus group data suggested that there is awareness and knowledge of contraceptive methods along with acceptance that couples should engage in dialogue around childbearing, but no widespread acceptance of delaying the first pregnancy. The acceptance of couple communication appears to have created a social space in which newly-weds can discuss contraception and family planning early in marriage. Here, couples seem to be more autonomous in their decisions about pregnancy and childbearing, but not to such an extent that they frequently use contraception before the birth of the first child.

In Bangladesh, couples commonly discuss and agree on actions to delay pregnancy – mainly use of contraceptives. This site
differs from the others, as is evident from the focus group and interview data, in that some families clearly support a delay in pregnancy, citing reasons such as the girl is too young. Nevertheless, there are tensions in families about when a couple should have children. Some couples are able to overcome these pressures for early conception. Many women do attempt to negotiate the timing of their first birth and use of contraception; some succeed, whereas others do not. In some instances, women make the decisions on contraception but ultimately succumb to pressure from their husband and family.

The data also show certain noteworthy similarities across the three sites. Regardless of site, there appears to be more acceptability of spacing and limiting children than of delaying the first birth, mainly because of the strong desire within families for a child soon after marriage. Continued fear about the possible adverse effects of contraceptives is also common, and lack of accurate knowledge of contraceptive methods among women undermines their ability to discuss and raise the issue of family planning. This was particularly so in Maharashtra and Rajasthan, where it is in part a consequence of the prevailing lack of realistic access to services. In contrast, women in Bangladesh rarely stated that they did not know about contraception, and to a certain extent this was facilitated by the widespread accessibility of contraceptives at the community level. A lack of decision-making power, and power dynamics within the couple and family also limit the ability of some women to partake in decisions about childbearing in all sites. Importantly, the majority of women who ultimately use contraception do so only after obtaining the approval and support of their husbands. Across sites, the approval of husbands appears to be instrumental to enabling their wives’ access to contraception, so much so that it sometimes overrides what the family wants.

3 Conclusions

Adolescent pregnancy remains widely prevalent in south Asia. Given the inter-generational consequences of early childbearing, shifting childbearing into adulthood is a potential strategy for improving the health and nutrition outcomes of mothers and children in this region. However, to date, there has been little research to identify opportunities at the community level to enable such change. In this three-site study, the nature and extent of couple communication across the study sites varied considerably and in important ways. Furthermore, the range of variation seen reflected the local context of each site and suggested that the three sites fall along a continuum – not just one of couples along a continuum of communication, but also one of communities along a spectrum of social change. Although awareness and knowledge of contraception are widespread in each site, the data suggest a gradient in the extent and nature of social acceptability in the use of contraception before the first pregnancy. Across sites, however, families continue to desire a child soon after a couple marries. In Maharashtra, where couples have the least space, time, and opportunity to communicate about the first pregnancy, they appear to be the least autonomous in their decisions and dialogue, and use of contraception is rare. In Rajasthan, couples have more opportunity to discuss and agree on the timing of the first birth, although few in practice used contraception. In Bangladesh, couples are the most autonomous in their discussion and decisions about contraception, largely because of the social context whereby communities have internalised the benefits of contraception, creating social space and acceptability for couples to dialogue. In addition, it is noteworthy that there was considerable variation in these patterns within each site.

The findings presented here are based on qualitative data and as such need to be interpreted carefully. In addition, the study sites are not equivalent to each other in terms of the vulnerability of the populations sampled and are not necessarily representative of the respective states or countries as a whole. In Maharashtra, where one might have expected favourable findings, the sample was drawn from the state’s most vulnerable groups. In Rajasthan, although the sample was not from the most vulnerable populations, the state is nonetheless one of the most backward in India; the findings indicate that even in this context, positive changes are under way. In Bangladesh, Matlab and Mirzapur are parts of the country that although poor, are quite progressive in terms of contraception and family planning.

Despite these differences, important similarities across the data suggest that there are some common issues in all sites. Such data help to shed light on the social transformation that is under way, particularly in terms of the ability of couples to delay their first pregnancy. Not surprisingly, as noted elsewhere in the literature, husbands’ approval of wives’ contraceptive use is instrumental in enabling women to gain access to contraception early in marriage [Mason et al 2000; Hossain et al 2007; Kamal 2000]. Similarly, fears of the adverse effects of contraceptives prevail in all three sites, as has been noted in other studies [Santhya 2003; Zavier et al 2000]. Even in Bangladesh – the most progressive site in terms of acceptability of contraception – this remains a barrier to expanding use and acceptability. The lack of decision-making power among women, particularly in early marriage, combined with their fears and lack of accurate knowledge of contraception, further undermines their ability to negotiate for contraception, as others have noted [Ram et al 2006].

In Bangladesh, a main thrust of the national family planning programme historically has been to make oral contraceptives widely available and accessible; in the programme’s early days, couples were taught about the use of contraceptives as well. Today, this has translated into popular knowledge and acceptance of contraceptives [Schuler et al 1996]. Interestingly, the emphasis of the family planning programme has been to promote contraception as a means to space and limit children; there has been no emphasis on delaying the first pregnancy. The pattern we observed shows in a sense an innovation on an existing technology, whereby a few community members are using these services for purposes not originally intended by the programme. In contrast, the data from India suggest that communities, families, and individuals are still at the early stage of accepting temporary contraceptives and are not fully convinced of their benefits. The theory of the diffusion of
innovations suggests that there are five stages to adopting innovations: knowledge, persuasion, decision, implementation, and confirmation. In this study, with regard to temporary contraceptives, India appears to be at the first stage of this transition, where there is limited knowledge and a minority group use contraception. However, a barrier to the increased acceptance of temporary contraceptive methods is the considerable variability in access to family planning services across India [Santhyana 2003; Campbell 2006; Purohit 2006; Bhasin et al 2007]. Realistic access to services has been previously shown to be a pre-requisite to shifting values and behaviours around contraception [Campbell 2006]. Bangladesh is at the other end of the spectrum (confirmation), where people have accepted and use temporary contraceptives, and a majority are convinced of their benefits. The findings from Bangladesh indicate that knowledge, practices, and services have permeated to the local level, even though use of contraception before the first pregnancy varies. In contrast, the data from Maharashtra and Rajasthan suggest that acceptability of temporary contraceptives is low, and the parallel infrastructure of realistic access to services is not fully in place yet, as noted in other literature [Elul et al 2004; Purohit 2006; Bhasin et al 2007].

Taken together, these findings can be used to design effective interventions for newly-wed couples to delay first pregnancy. These findings suggest that promoting couple communication to delay the first pregnancy is an important strategy that could be incorporated into existing family planning programmes, and broader social programmes, such as adolescent life-skills programmes and women’s self-help and micro-credit groups. Importantly, given that most newly-wed women first conceive within a few months of marriage and during adolescence, there is a need to provide unmarried adolescent girls with accurate knowledge of contraception and communication and negotiation skills while still in their natal homes to prepare them for their future. In addition, concerted efforts are also needed at the family and community levels to promote the acceptability of delaying the first pregnancy into early adulthood, and to create an environment that gives couples social space to communicate and negotiate about these issues early in marriage. Programmes also need to work with men to increase their knowledge and understanding of family planning, and convey to them the rationale for using contraception to delay the first pregnancy into early adulthood.

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