“MY MOTHER-IN-LAW FORBADE ME TO TAKE PILLS”

FACTORS DRIVING ADOLESCENT PREGNANCIES AMONG YOUNG WOMEN CLIENTS FROM HEALTH CLINICS IN BANGLADESH

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Preface

The Resilience through Information on SRHR & Empowerment (RISE) project (2021-2022) aims to strengthen the capacity of NGO (health) professionals to meet the sexual and reproductive health and rights (SRHR) needs of vulnerable groups in Bangladesh. It is a collaboration between KIT Royal Tropical Institute, RedOrange, and Simavi. RISE works with the Family Planning Association of Bangladesh (FPAB) and Integrated Social Development Effort (ISDE). The project is part of an Orange Knowledge Programme Tailor-Made Training course. The Orange Knowledge Programme is funded by the Dutch Ministry of Foreign Affairs and managed by Nuffic, a Dutch non-profit organisation for internationalisation in education.

ABOUT KIT ROYAL TROPICAL INSTITUTE

KIT Royal Tropical Institute is an independent centre of expertise and education for sustainable development. We assist governments, non-governmental organizations and private corporations around the world to build inclusive and sustainable societies, informing best practices and measuring their impact.

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Acronyms

FPAB	Family Planning Association of Bangladesh
GBV	Gender-based Violence
IDI	In-depth Interview
ISDE	Integrated Social Development Effort
IPV	Intimate Partner Violence
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraceptive
MR	Menstrual regulation
MRM	Menstrual regulation management
RISE	Resilience through Information on SRHR & Empowerment
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights

Executive Summary

Although Bangladesh has made strides in decreasing the total fertility rate, the country still sees the highest rates of adolescent pregnancy in South Asia. In such a context, this study aims to explore the socio-cultural context influencing the reproductive outcomes, experiences and decision-making ability of young women (15-19 years) who were recently pregnant in Barisal, Chittagong, Cox's Bazar, Cumilla and Dhaka in Bangladesh. Data was collected through 51 interviews with (recently) pregnant female clients of health clinics and their family members, as well as key informant interviews with health-care providers and managers. The study was conducted as part of the Resilience through Information on Sexual and Reproductive Health and Rights & Empowerment (RISE) programme[1].

The findings are consistent with previous qualitative and quantitative research conducted in Bangladesh, suggesting that adolescent pregnancy is strongly influenced by entrenched social norms around sexuality and gender roles, and driven by child marriage. Newly-married young women face pressure to prove their fertility to extended family members (particularly in-laws) through early childbearing. This pressure is exerted despite widespread awareness of government advice to delay childbearing until age 20. The findings suggest that stigma associated with (fear of) infertility also influences this. Young women (both married and unmarried) are unable to make informed decisions about their own family planning and use of menstrual regulation services. This is due to a lack of knowledge of contraceptives and male-dominated partner dynamics, which limit their ability to control the timing and frequency of pregnancy. This is also related to the stigma associated with adolescent sexuality and relationships, which widens the already existing inter-generational gap between parents, or in-laws in discussing reproductive health needs. Both formal and informal barriers to accessing sexual and reproductive health (SRH) services and information for young people remain. The findings will contribute to an improved understanding of SRH service user needs among policy-makers and practitioners working in the field, especially those at Family Planning Association Bangladesh (FPAB) and Integrated Social Development Effort (ISDE). The findings will also support evidence-based advocacy at both community and policy levels.

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1 Introduction

1.1. Adolescent pregnancy in Bangladesh

The high rate of adolescent pregnancy in Bangladesh is a major concern from health, rights, and development perspectives, as adolescent pregnancy affects both girls and their children (Shahabuddin et al., 2016). It has negative consequences on adolescents' physical, mental, and economic outcomes. Adolescent pregnancy increases the risk of maternal complications, including eclampsia, postpartum haemorrhaging, systemic infections, and preterm delivery) (Chen et al., 2007; Ganchimeg et al., 2014). It is highly correlated with low birth weight and early neonatal deaths (Ganchimeg et al., 2014; Mukhopadhyay et al., 2010). Adolescent pregnancy also increases school dropout and reduces employment opportunities in the labour market (Kamal & Hassan, 2013).

Bangladesh is often considered a role model among developing countries due to its success in reducing both adolescent fertility rates and the total fertility rate per woman, largely through increased use of contraceptives (Islam et al., 2020; NIPORT, 2020). Family planning programmes have succeeded in increasing the contraceptive prevalence rate (CPR) of this Muslim-majority country which is characterised by high poverty and low literacy rates, and relatively low levels of women's autonomy (Streatfield & Kamal, 2013; Islam et al., 2017). As a result of these efforts, the CPR in Bangladesh increased to 62% in 2018 from a mere 8% in 1975 (NIPORT, 2020). The success of family planning programs has contributed to the decline of the total fertility rate (TFR) to 2.3 children per woman in 2018, from 6.3 children per woman in 1975 (ibid.). In addition, the family planning programme has also facilitated a significant decline in maternal mortality from 574 per 100,000 live births in 1990 to 196 in 2016 in Bangladesh (Sultana, 2019).

The adolescent pregnancy rate has also reduced dramatically, from 33% in 1993 to 28% in 2017. However, it remains the highest in South Asia (NIPORT, 2020). The median age at first birth among women aged 20 to 49 years has increased to 18.6 years in 2017 from 17.7 years in 1993 (NIPORT, 2020). It is evident that despite remarkable progress in the country's socio-economic development, adolescent pregnancy is highly prevalent in Bangladesh and is closely linked to the high prevalence of child marriage (Islam & Gagnon, 2014; Islam et al., 2017).

The evidence available to provide in-depth understanding of the context of adolescent pregnancy is scanty. Several studies conducted in Bangladesh

have adopted a quantitative approach, primarily using Demographic and Health Survey data. Given the complexity of an issue such as adolescent pregnancy, we need a deeper understanding which can be offered through a qualitative lens. Existing qualitative studies have often had a limited geographical focus, which can influence the generalisability of these findings. Hence, this study aims to fill these gaps. The findings of this study will support NGOs and policy makers to design effective, targeted and contextualised programmes to reduce adolescent pregnancy to ensure adolescents' health and developmental rights.

1.2. About the RISE project

The Resilience through Information on SRHR & Empowerment (RISE) Tailor-Made-Training Plus (TMT+) project aims to strengthen the capacity of NGO (health) professionals to meet the sexual and reproductive health and rights (SRHR) needs of vulnerable groups, especially those affected by conflict and the climate crisis in Bangladesh. RISE (2021-2022) is implemented by KIT Royal Tropical Institute in the lead, along with RedOrange and Simavi in collaboration with Family Planning Association Bangladesh (FPAB) and Integrated Social Development Effort (ISDE). This study was conducted as part of the research trajectory of this project wherein staff from ISDE and FPAB were trained on conducting research. More information on their role in the study can be found in section 2 (Methodology).

1.3. Study objectives

The study aims to explore factors associated with adolescent pregnancy using a qualitative lens and focuses on five different geographic regions in the country, namely Barisal, Cumilla, Chittagong, Cox's Bazar, and Dhaka.

The research objectives of this study were:

1. To explore perceptions and attitudes of young women and their family members around adolescent pregnancy
2. To understand decision-making processes regarding the use of family planning among young women who were (recently)[2] pregnant
3. To identify socio-cultural norms and values that influence adolescent pregnancy
4. To identify family planning (FP) information and service needs of young women (in relation to contraception, awareness, and menstrual regulation management (MRM))
5. To make recommendations to ensure programmes can be more responsive to the needs of young women

[2] *In the 6 months prior to data collection*

2 Methodology

The study adopted a qualitative research design. Accordingly, data was collected through in-depth interviews (IDIs) with adolescent girls who recently experienced an adolescent pregnancy, husbands and parents or in-laws of recently pregnant adolescent girls and key informant interviews (KIIs) with health workers and managers.

2.1. Study areas

The study was conducted in five geographical locations: Barisal, Cumilla, Chittagong, Cox's Bazar, and Dhaka. These study sites were chosen based on the physical presence of the two implementing partners of the RISE project, namely ISDE and FPAB's as well as accounting for environmental variations between regions including fragile settings[3].

Hence, these geographical locations have different characteristics—for example, some locations are considered fragile as the site is either in a coastal region or in an area hosting large displaced populations[4]. A short description of the contexts of each study area is given below.

Dhaka: Dhaka is the capital of Bangladesh and the only megacity of Bangladesh. It is the sixth most populated city globally with a population of 8.9 million, and there are 21.7 million residents in the greater Dhaka area (as of 2011) (Bangladesh Bureau of Statistics, 2011). Dhaka is bounded by the Buriganga, Turag, Dhaleshwari, and Shitalakshya rivers.

Barisal: Barisal city is situated on the bank of river Kirtankhola in the south-central parts of Bangladesh. This city is the administrative headquarter of the Barisal division. Barisal is one of the oldest river ports in the country and the third-largest information technology and financial hub. This city consists of 328,278 population according to the 2011 national census, with 30 wards and 50 mahallas (Bangladesh Bureau of Statistics, 2011). The city is located in a coastal area with frequent exposure to natural disasters.

Cumilla: Cumilla city is situated in the Chattogram division of Bangladesh. It is the administrative centre of the Cumilla districts. Gomoti and the little Feni River pass through the Cumilla beside other rivers. Cumilla's climate is marked by high temperatures, monsoons, considerable humidity, and heavy rainfall (Rahman et al., 2016).

[3] *Fragile settings were a considerations as the RISE programme aimed to focus on training health and social NGO workers on SRHR in these settings. Moreover, the literature on fragile settings, particularly in settings affected by climate change is limited.*

[4] *It should be noted that it was not possible to include study participants who were themselves part of displaced communities as part of this study, due to bureaucratic, security, and logistical challenges.*

Chittagong: Chittagong (also known as Chattogram) is the second-largest city in Bangladesh. It has the busiest seaport on the Bay of Bengal. Chattogram is located on the banks of the Karnaphuli River between the Hill Tracts and the Bay of Bengal. The city has a population of more than 5.1 million (Bangladesh Bureau of Statistics, 2011). After the partition of British India, Chittagong expanded and become industrialised. In 1971, during the Liberation war of Bangladesh, Chittagong was the site of the Bangladeshi declaration of independence. The city is also located in the south-eastern part of Bangladesh with exposure to climate vulnerabilities (Barua et al., 2020).

Cox's Bazar: Cox's Bazar is the tourism centre, fishing port, and district headquarters of the southeastern part of Bangladesh (Miah et al., 2022). It is famous for its long natural sandy beach. The district hosts 1.1 million Rohingya people, who are spread over 34 refugee camps (Sakib et al., 2021). These refugees lack access to services, education, food, clean water, and proper sanitation, and they are also vulnerable to natural disasters and infectious disease transmission (ibid.). The Bangladesh government, NGOs, and INGOs are providing humanitarian support to this refugee population but they remain stateless and one of the world's most persecuted refugee groups (Milton et al., 2017). It should be noted that due to bureaucratic and safeguarding policies, it was not possible to include any Rohingya participants as part of this study.

2.2. Study team

The study team consisted of lead researchers from KIT Royal Tropical Institute (2) based in Amsterdam and the University of Dhaka (1). The team also included a designated researcher for quality assurance based at KIT Royal Tropical Institute. All team members have extensive experience conducting research on SRHR-related topics and are knowledgeable about feminism, gender equality and SRHR. While one researcher is Bangladeshi, the other two are South Asian or have South Asian heritage. RedOrange, based in Dhaka played a role in coordinating logistics for the data collection. Four staff from FPAB and ISDE were selected to work on this study based on their skills, motivation and their professional duties in their respective organisation. These included 3 staff who identified as male and 5 staff who identified as female, of which some worked as medical doctors while others were social workers. The staff from ISDE and FPAB along with the lead research team co-wrote the proposal for the study, co-developed the topic guides and conducted the data collection. Data analysis and report writing was conducted by the lead researchers. All team members were involved in study dissemination.

2.3. Selection of study topic

Priority setting exercises were conducted online in January 2022 with FPAB and ISDE each. to prioritise a study issue that was of relevance and urgency to both parties. With support of management of both organisations, the study topic of adolescent pregnancy was chosen by FPAB and ISDE. In a hybrid workshop in Dhaka and online in February 2022, the team was trained by the lead researchers on proposal development, research methods and ethics, and a proposal was co-developed.

2.4. Study methods

In-depth Interviews: In-depth interviews (IDIs) were conducted among pregnant or recently pregnant young women, their husbands, and their in-laws/parents. The topic guide for these IDIs covered the following issues: adolescence and related challenges, causes of or reasons for adolescent pregnancy, knowledge and information about family planning/ contraception, consequences of adolescent pregnancy, menstrual regulation services, contraceptive use and choice, gender-based violence, family planning service access and use, and preventing pregnancy. Three separate topic guides, one each for (recently) pregnant young women, their husbands, and their in-laws/parents were developed. Forty-five IDIs were planned among (recently) pregnant young women (25), their husbands (10), and their in-laws/parents (10). The topic guide used for interviews with young women can be found in Annex I. Due to challenges encountered during data collection (discussed further in the section 2.10 Limitations, below), 42 IDIs were carried out (25 with young women, 7 with husbands, and 10 with in-laws/parents).

Key Informant Interviews: Key informant interviews (KIIs) were conducted among health care providers and managers. The topic guide for KIIs broadly covered the following issues: adolescence and related challenges, causes of adolescent pregnancy, contraceptive use and choice, consequences of adolescent pregnancy, menstrual regulation services, family planning services access and use, and community interventions to prevent pregnancy. The topic guide can be found in (Appendix II). Ten KIIs were planned among health care providers and managers, but due to the difficulty in securing permission from the appropriate authorities in one area, 9 KIIs were conducted.

All topic guides were developed in English and then translated into Bengali[5], a widely spoken language in Bangladesh.

Study Participants and Data Collection Methods	Dhaka	Chattogram	Cumilla	Cox's Bazar	Barisal	Total
IDIs	**8**	**9**	**9**	**7**	**9**	**42**
Young women	5	5	5	5	5	25
Husband	1	2	2	0	2	7
In-laws/Parents	2	2	2	2	2	10
KIIs	**1**	**2**	**2**	**2**	**2**	**9**
Health worker/Manager	1	2	2	2	2	9
Total Interviews (IDIs and KIIs)						**51**

Table 1: Distribution of sample across the study area

2.5. Selection of study participants and sampling

The primary study population was adolescent girls living in the selected study area aged 13-19 years, who were currently pregnant or had delivered a baby in the previous 6 months. However, young women sampled who fulfilled the eligibility criteria were between 15-19 years[6]. Young women meeting the above criteria were sampled from clinic client lists. They were randomly sampled and contacted for an interview. IDIs were also carried out with husbands and in-laws/parents[7] of (recently) pregnant girls; where possible these were the family members (husbands or parents/in-laws) of the young women who were also interviewed as part of the study but this was not always feasible. Health workers at the same clinic and managers of the clinic or those at district-level were also interviewed.

2.6. Data collection

Data collection was conducted in the months of June to August 2022. Although the data collection team consisting of FPAB and ISDE staff were collecting data from FPAB clinics, efforts were made to ensure staff working in the chosen clinic were not interviewing clients from that clinic. Data collection per area took place in teams of two, with two pairs of FPAB staff and two pairs of ISDE staff conducting interviews per area. Although efforts were made to ensure that female researchers interviewed female participants, this was not always possible in every study area. Although participants were sampled from the clinic, they were interviewed outside the clinic in a private area or in some cases inside the clinic but in a separate room. Interviews were recorded upon consent of the participant. Interviews

[6] *Since the age group sampled was between 15 to 19 years, we refer to this group of participants as 'young women' and not adolescent girls. However, the term 'adolescent' is used when citing quotes if participants used the term.*

[7] *As part of this group, one grandmother who was a recent care-giver of one of the pregnant young women was interviewed. For the sake of brevity, this group of respondents will be referred to as parents/in-laws throughout the report*

were transcribed by students from the University of Dhaka and were directly translated from Bengali into English during the transcription.

2.7. Data analysis

A coding framework based on the topic guides was developed by the lead researchers which they used to thematically code the transcripts. Narratives were written which were used to contribute to the final report writing. Data analysis was conducted by the three lead researchers to prevent introduction of bias by FPAB and ISDE whose organisations were implementing programmes in the study areas. However, to ensure capacity building addressed all aspects of the research process, the 8 FPAB and ISDE staff came together for a workshop where participants developed skills to code transcripts thematically and deliberate on the preliminary findings.

2.8. Quality assurance

During data collection, a researcher based in Bangladesh ensured regular check-ins and discussed quality of preliminary interviews with the data collection team. Transcripts were checked by one of the lead researchers for consistencies. Since data analysis was conducted in a team, it afforded the team opportunity to discuss any queries, discrepancies and clarify doubts, hence reducing any potential bias. Moreover, during the research workshops, translation facilities were also available and the team composition lent itself to discussion in Bengali. The final report was peer reviewed by a quality assurance team member based at KIT.

2.9. Ethics

The research team was trained in ethics and principles of qualitative research extensively prior to data collection. Ethical approval was granted by the University of Dhaka's Health Economics research board in May 2022. All participants were asked for their verbal and written consent and the research team ensured that the study participants knew the study objectives and were aware of their right to withdraw their participation at any time without consequences. For minors, assent was taken by the young women and consent from their parents/guardians.

2.10. Limitations

While the initial study proposal also included a focus on fragile settings- both around climate-change affected areas and areas occupied by the Rohingya refugees in Bangladesh, this focus did not emerge in the findings. This is further explained in the section 5 outlining the discussion.

Although FPAB and ISDE staff members (8 staff) were trained in conducting research, this was one of their first times conducting data collection. This meant that during some interviews, personal opinions or their role as medical doctors or social workers would take precedence over their role as researcher. In cases where there was clear interview bias, these interviews were discarded. Moreover, due to varying capacities between members of the team conducting data collection, the quality of transcripts also differed to some extent. In addition, given the relatively small number of interviews per areas the study does not include an extensive comparative analysis between the different study sites. However, in cases where clear contextual differences emerged, these are clearly highlighted to the reader.

Moreover, it was difficult to conduct interviews with health managers in Dhaka due to additional permission processes and hence fewer KIIs were conducted than planned. Although a considerable number of participants from the same family are interviewed, an extensive analysis comparing the differences between the views of these participants is not conducted due to the limited scope of the study.

3 Demographic characteristics

As outlined above, 51 participants provided interview data for this study. Of these 51, 25 were recently or currently pregnant young women, 7 were husbands of such women, while 10 were mothers or mothers-in-law of a (recently) pregnant young woman. In addition, 9 health-care workers participated in key informant interviews.

While the age eligibility criterion for inclusion in the study was 13-19 years for the recently or currently pregnant women, the 25 young women who participated in this study were all were aged 15 – 19 years. Most (18 participants) were aged 17 - 18 years. Three were aged 15, one was 16 years old, nine were 17 years old, eight were 18 years old and four were 19 years old. The husbands interviewed were between 25-33 years, while mothers and mothers-in-law were between 32-62 years.

Of the participants who were able to provide more detailed demographic information, most were lower middle class or working class, and common forms of employment for male participants and the husbands of young women participants included daily labourer and rickshaw puller. One young woman participant whose family were described as upper middle class had a husband who was a banker. None of the young women was currently in employment, while only two were still in education.

The health-care workers represented a range of different types of facilities and roles, and included service providers and managers at government health facilities. Of the nine health-care workers interviewed, three identified as women while six identified as men.

4 Findings

This section presents the study findings, beginning with a discussion of the socio-cultural context and norms around adolescence, including the study participants' understanding of adolescence as a life stage, gender (in)equality, and young people's aspirations (section 4.1.1 - 4.1.2). We then present the findings that emerged in relation to child marriage and gender-based violence (GBV) in sections 4.1.3 and 4.1.4, which cover both personal experiences of these issues that participants chose to share, as well as reflections on wider cultural attitudes towards child marriage and GBV, including perceptions of driving factors, survivors and perpetrators.

Section 4.2 follows which discusses the SRH service and contraception needs of young people, including their knowledge, perceptions, and sources of information, as well as the views and beliefs of parents and husbands which improve our understanding of the context in which young women make decisions about SRH services and contraception. The final section (4.3) discusses the experiences of participants in relation to adolescent pregnancy, specifically the causes and consequences as well as how and by whom decisions are made in relation to early childbearing.

4.1. Socio-cultural context and norms around adolescence

4.1.1 Changes during adolescence (Puberty, Menstruation, Relationships)

Participants universally recognised adolescence as the transitional phase of human life from childhood to adulthood. However, the reported age span of adolescence varied for girls and boys. The majority of the participants mentioned that adolescence ranges between eight and eighteen years of age for girls while it was ten to eighteen years for boys. Participants also highlighted various changes they underwent during adolescence. These changes are presented below in four sub-themes i.e., puberty, menstruation, and relationship along with challenges faced by young people.

Some parents, health-care workers, and husbands (but less frequently young women) discussed the impact of technology and felt that this had changed how young people now experience the period of adolescence compared

to previous generations. Some felt that access to the internet and (social) media had a positive impact on young people's knowledge and awareness of the world, whereas others felt that it increased their access to pre-marital sexual relationships and content which they disapproved of.

4.1.1.1. Puberty

Most participants mentioned that both boys and girls underwent physical changes during early adolescence. Puberty was acknowledged as a period when adolescents – both girls and boys – reach sexual maturity and become capable of reproduction. However, it was commonplace to find that younger participants (young women and husbands) were too shy to talk openly about changes during puberty. The participants predominantly mentioned physical changes including getting taller and healthier, changing voices, growing a beard, etc. for boys while initiation of menstruation for girls.

> *Girls start having menstruation; many kinds of feelings are expressed. Boys start having moustaches- bread, and their voices change. They feel like adults, they wish to do everything according to their own decisions and give priority to that. (Young woman, 16 years old, Dhaka)*

However, many participants mentioned that as they underwent these changes, it was difficult to talk about them with their family members. The majority of the young men and women mentioned that they felt too shy to fully discuss these changes. Girls usually shared some questions and experiences with their mothers, elder sisters, or other female family members, while boys shared with their friends or, in some rare cases, with their fathers. The findings also highlight that while changes during puberty were considered natural, many puberty-related issues were considered taboo and thus should not be discussed openly among family members.

> *During my puberty, I was curious about how a baby was born or how they come. But how can I share it with my parents? I mean when I will ask the question, won't they feel ashamed? Could we know about these before marriage? I have known these only after marriage. (Young woman, 18 years old, Chittagong)*
>
> *I shared my issues and other things with my friends. We used to watch adult films together. If I had any wet dreams, I would share that with my friends only. Because we should not talk about it with anyone other than friends, should we? (Husband, 28 years old, Chittagong)*

4.1.1.2. Menstruation

The majority of the young women interviewed stated that they did not know about menstruation before experiencing it themselves. They mentioned that it was a “horrible” or “fearful” day when they found that they were bleeding, sometimes because they had such limited knowledge, they thought their menstrual blood was the result of an unseen injury. Many of the young women participants were nervous or even felt mentally traumatised during their first menstruation.

The majority of the young women mentioned that they received support and information on menstruation from their mothers, elder sisters or cousins, maternal aunts, or other female family members. However, they also discussed various myths around menstruation that were shared with them by these family members, many of which were then used to justify restricting their movements (including advising against attending school) or diet while they were menstruating. These seemed to relate to a general view of menstruation as an unclean, inauspicious or arduous process, during which young women should be kept away from others and avoid exerting themselves.

In some cases, mothers were not the first source of support for girls and young women experiencing menstruation. Some young women also mentioned how fathers usually do not take part in these discussions.

> *No, later on I heard it [menstruation] from my cousin sister. Then she told me about the situation. I told her that I didn’t understand anything and she told me everything about what happens. (Young woman, 18 years old, Cox’s Bazar)*

Interestingly, we found that there is a change in mindset among the later generations of participants. The younger women, in comparison with the mothers or the mothers-in-law, were more open and supportive towards their (future) daughters. Some young women mentioned that they did not want their daughters to go through the difficult experiences during menstruation that they underwent where this topic was not discussed with their mothers.

4.1.1.3. Romantic relationships

The majority of the participants mentioned that romantic affairs among adolescents and youth were on the rise in comparison with earlier times. They mentioned that it was commonplace to see boys and girls under eighteen engaged in romantic relationships in communities.

> *Now the children are more digital and they mature faster than our times. At our age, we have seen that people fell in love at the intermediate level or the metric level. Now children of class 7-8 are involved in this kind of relationship. (Husband, 26 years old, Barisal)*

The majority of husbands and young women mentioned that along with natural attraction towards the opposite sex during adolescence, the availability of digital technologies including the internet, social media platforms, and mobile phones have created an enabling environment for adolescents and youth to engage in romantic relationships more easily. They also opined that these are not always long-term relationships. Some of the participants explicitly mentioned the reasons behind engaging in such affairs were to satisfy the need for physical attraction or sexual urges among adolescents and youth (particularly boys, who were considered to have higher levels of sexual desire).

> *Now girls fall in love with a boy only if he has a bike and a boy tries to own a bike and a smartphone. Girls are very weak to these nowadays. It doesn't matter whether she knows the boy or not. Even she doesn't want to know the condition of that boy. The same is true for the boy too. He also doesn't care about the family background of that girl. They just have the intention to involve in a relationship. As if their purpose in life is this. (Young woman, 19 years old, Cumilla)*
>
> *I am talking about my point of view. As it is now, in this situation all boys are busy thinking about sex. Normally I am seeing this at college and school, many boys go to college. But they don't attend class. They are involved in many things. There are also many girls, even we see at our Chandgaon, who gossip while sitting at the pond's edge. But they are still very young. They are not yet of marriage or love age. But what do they think? Sex. It became one of the parts of their personal life. You will be bad to them if you tell them anything. If say something, I will be bad too. (Husband, 28 years old, Chittagong)*

Some of the participants (including young women, husbands, and parents/parents-in-law) mentioned that romantic relationships among adolescents and youth also lead to child marriages in Bangladesh. They mentioned that oftentimes it was seen in the communities that young men and women fell in love and when their families came to know about it and didn't approve of their relationship, they eloped and got married.

Some participants opined that such incidents bring shame to the families, especially to the girl's families. It was commonly discussed by all types of study participants that in order to avoid this, parents often marry off their daughters early which also increases the incidence of child marriage in the country.

> *Seeing our economic hardship my daughter said that she would go to work. So, we increased her age to 15 years in the certificate to send her to a garment factory. While working there, she met a battery-tempo driver and fell into a relationship with the boy. When we heard about this, we convinced her not to continue the relationship. But she did and one day she fled from the house and married the boy. (Mother of (recently) pregnant 15 year old, Cumilla)*

Many respondents (both young people and parents) reported that parents commonly restricted children's movement (particularly girls and young women) and contact with others in an attempt to stop them engaging in romantic relationships. Some respondents reported severe physical punishment from relatives in a response to this, including beating and burning. For example, one mother-in-law in Cumilla reported that when her uncle suspected her younger sister of having a relationship he "used to cauterise [burn] her using a candle." as a form of punishment/deterrent.

4.1.2 Challenges during adolescence

Participants predominantly mentioned two types of challenges faced by adolescents and youth: 1) communication challenges about the changes during adolescence and 2) the risk of child marriage, especially among girls and young women (this is discussed at length in section 4.1.5 Early and child marriage). In terms of communication challenges, as explained in 4.1.1.1, the majority of the young women and husbands either felt shy when talking about changes or vulnerabilities during puberty with their family members, or they could not do so since their families lacked knowledge about these topics. They also felt that their voices and opinions were not duly regarded by their families.

> *I could not share anything with my parents at home. If I told anything, they told me to shut up. They were in charge of every decision and that is what I had to follow. I felt like there is no value in any of my words. I was a child then. They told me I won't understand anything. (Young woman, 17 years old, Dhaka)*

The majority of the participants mentioned that girls and young women face the added challenge of child marriage during their adolescence. Due to a myriad of reasons, participants indicated that parents belonging to lower-educated and poorer families tend to marry off their daughters before the age of 18.

> *Many parents especially those who are uneducated and poor think they can get rid of their social and religious obligations by getting their daughters married. So they tend to marry off their daughters as reach puberty. They don't wait for girls to become 18 years. (Health worker, Male, Government facility, Barisal)*

4.1.3 Gender (in)equalities

Participants mentioned a wide array of issues they experienced or witnessed that highlighted highly prevalent gender-biased attitudes and practices at community level.

The majority of all types of participants opined that boys and girls were not treated equally in their families or in wider society. According to some participants, that the supremacy of men starts from birth and is manifested in every sphere of life.

> *Male children are assumed to be superior to female children in all aspects. Even from the birth of a child. When a girl is expecting her child, not only her mother-in-law but also her mother desire to have a male grandchild. (Young woman, 19 years old, Cumilla)*

4.1.3.1. Gender-biased attitudes; perceptions regarding 'good/bad' girls vs. 'good/bad' boys

Gender-biased attitudes emerged from the majority of participants when they were asked about ideas of 'good' and 'bad' girls and boys. According to the participants, a good boy studies attentively, is well-mannered, obedient to his parents and elders, abides by religious practices (e.g., performs prayers five times a day and fasts during Ramadan, if Muslim), and so on. For a good girl, the criteria were similar, but involved additional expectations and restrictions. Specifically, a girl had to dress 'decently', wear a veil or Purdah, and stay at home to be called a good girl.

> *If I do all my household chores, study properly, and help my family like I'm helping my mother...To people, this is a good version of me. But if I mistreat my mother, and always hang out with my friends and pass time with boys, then people would say I'm bad. (Young woman, 17 years old, Barisal)*

Similarly, the definitions or attributes of bad boys and bad girls also varied reflecting gender-biased societal constructs. While the dominant characteristics of bad boys centred around their own habits, such as being disrespectful to elders, smoking cigarettes in public places, having an addiction to drugs (e.g., Yaba, Weed, etc.) or alcohol, and so on, bad girls were characterised by their behaviour towards members of the opposite sex i.e. having male friends, having romantic affairs, eloping with their lover, getting pregnant before marriage, and so on.

> *Bad boys hang out all day and don't look after the parents. They don't care for their siblings. They live as their own. They smoke cigarettes, take Yaba, or use drugs like these. They don't say salam and have respect for the elder people. They tease girls in public. They do all bad things. (Young woman, 17 years old, Cox's Bazar)*

Another recurrent theme was labelling girls as "bad" based on their dress code. The majority of the participant opined that people judge the character of a girl/woman based on the dress she wears. More specifically, "bad" girls do not wear a veil or adhere to Purdah, they smoke cigarettes, and wear "western dresses".

> *Bad girls go out without having "orna" [scarf/veil], wear short dresses, or show their figure. On the contrary, virtuous girls perform Salat [prayers], fasting, etc., and wear veils. These girls do slutty things and are tagged as bad. (Young woman, 17 years old, Barisal)*

4.1.3.2. Gender discrimination in mobility

We also found evidence of gender discrimination between women and men in terms of their mobility. Participants universally mentioned that girls cannot move freely and independently as boys do. Familial and societal restrictions tend to limit the mobility of women, particularly at night. They also mentioned that a girl is often labelled as "bad" if she comes home late frequently.

> *A boy can go outside whenever they want just telling his mom that he's going out. But if a girl says so, she has to answer many other questions like where and why she is going, when she'll be back...They ask her to take along her brother or even want to come along on their own. There are no restrictions for boys. Sometimes they don't even need to seek permission. They roam around as per their wish. Girls do not have this Independence. (Young woman, 19 years old, Cumilla)*

Some men justified the familial and societal restrictions imposed upon women's mobility with notions such as "it's for the safety of women". However, such gender-biased norms and practices seemed to be so deeply rooted within the community that the young women themselves became active supporters of those norms.

> *If you are a girl, you have to stay inside the house. Our society does not see girls in another way. For this reason, if you are a girl, you have to stay indoors. It's also beneficial for us. (Young woman, 16 years old, Dhaka)*

4.1.4 Young people's aspirations & opportunities

The majority of the young women and men discussed their strong desire to continue their education. Becoming a doctor or a teacher was the most common career goal for young women. However, despite there being ample opportunities in terms of the availability of educational institutions (e.g., schools, colleges, etc.), they mentioned that due to financial insolvency they had to terminate their education. All participants spoke highly of educational aspiration and attainment, and many parents and young women in particular were very regretful if they or their children were unable to pursue education as far as they wished.

> *If I could go to school, I would have learned many other aspects, I could be educated. I had an immense desire to go to school. But my mother sent me to earn money when I was too young. (Young woman, 17 years old, Barisal)*

Some young women also mentioned that due to the COVID-19 pandemic-induced economic hardship and school closure, their parents thought it would be best for their daughters to get them married.

> *My father had a dream that he would educate our three sisters and raise us as good human beings. I also had the wish to fulfill my father's dream. I had a dream to be a teacher. But suddenly lockdown has been started in the country. That's why our study has been paused then. I was at home. Then I got married. So, my dream didn't be fulfilled. (Young woman, 17 years old, Cox's Bazar)*

The majority of the husbands also validated the findings that poverty was the key reason why families could not afford continuing education for their children. They stressed that although both boys and girls are affected by poverty, it was girls who had to drop out of schools disproportionately in comparison with boys.

> *Because of financial insolvency, parents cannot educate their daughters. If you want her to study, you will have to pay. They cannot continue their study if they can't pay the fee for the exam. I couldn't take TC for money. So, I had to left study. If I got some financial support, then I could have continued my education. (Husband, 28 years old, Chittagong)*

However, some young woman participants mentioned that parents in the community (including sometimes their own) were not willing to educate their daughters not because of financial insolvency, but because of gender-biased attitudes. They believed girls didn't need to be educated as they would be married off and then they would look after the domestic affairs (e.g., household chores, caregiving to children and family members, etc.). Those participants also mentioned that they could not materialise their aspirations due to the lack of support from their parents.

> *There are many primary and high schools for girls where they are acquiring knowledge. But not every parent is willing to let their daughter study. According to them, there is no necessity to send a girl for education as ultimately she has to focus on domestic chores after getting married. People often mention household activities sarcastically as 'Dag Mastery' (to become an expert in domestic chores). (Young woman, 19 years old, Cumilla)*

4.1.5 Early and child marriage

4.1.5.1. Setting the scene

Participants of all types were aware that child marriage (under age 18) is illegal in Bangladesh, but most suggested that despite this the practice was still prevalent and were able to describe ways in which legal restrictions were ignored or evaded. A health worker and a husband from Barisal suggested that the practice is becoming less common.

Despite this, most of the study participants (among the young women, and mothers/mothers-in-law) had been married underage (e.g. under age 18). Early marriage (i.e. of girls aged 18-19) was also reported to be common (including among participants themselves). Their husbands were usually in their early to late 20s when this happened, while no one had married a boy who was underage. One husband from Barisal said that girls generally get married after finishing their Higher Secondary Certificate examination (Grade 12), suggesting this can be below age 18, while a 17 year old girl from Dhaka stated that most girls get married at 15-16 years old. Another husband (aged 28 years) from Chittagong suggested that marrying young women and underage girls is socially acceptable or even desirable among young men:

> *I married an 18 year old girl. This is because, it's a matter of luck. Right? And marrying a girl of 18 is not a bad thing. I married that girl with my choice. Right? And there is no problem to marry a girl of 18 or 14 nowadays. Is there?... So, when they arranged my marriage, I think it would be better for me. I didn't think about her age. (Husband, 28 years, Chittagong)*

Many of the young women interviewed spoke very negatively about the circumstances leading to their marriage, stating plainly that that they felt they had been forcibly married, often expressing extreme distress or regret about this. This was not echoed by any of the husbands who participated in this study. This was particularly apparent where the marriage had led to either school drop-out or job-loss, and many young women clearly stated the causal link between their (early/child) marriage, and this loss of economic and/or educational opportunities. Unsurprisingly, those girls who had experienced violence and/or mistreatment from their husband or his family following their marriages were also particularly likely to express extreme distress (including suicidal ideation) or regret.

4.1.5.2. Causes

Social norms regulating young women's sexual and romantic relationships

A major driver of child marriage that emerged from the interviews was the social unacceptability of pre-marital sexual or romantic relationships in all study sites, and the corresponding view that young people's sexual desire or activity was both shameful and sinful. Marriage was understood by all types of study participants as a way of regulating young people's sexuality and relationships, and avoiding the stigma associated with GBV, pre-marital sex/pregnancy, or socially unsuitable relationships:

> *My mother said I was in a relationship with a guy. Then my mother decided that I have to get married to the guy she would choose for me. And I had to do the marriage (Young woman, 17 years old, Barisal)*

The desire among parents to arrange marriages for their daughters before they are seen or suspected to be engaging in sexual or romantic relationships was therefore a major cause of early marriage. Many participants seemed to elide or almost equate pre-marital sex with GBV, often implying that girls who engaged in sexual activity or who became pregnant outside of marriage were probably pressured in some way (discussed further below in section 4.3.2.5).

Elopement

Young people who were romantically involved with each other faced intense pressure to end the relationship if their families disapproved of the match (e.g. for reasons such as unequal social status of families, or perceived unsuitability of the partner due to, for example, drug or alcohol dependency, or poor career prospects). This was reported by young women, husbands, and parents. Marriage in the form of elopement was viewed by both young people and parents as a way of ensuring that families were unable to intervene and force them to end the relationship:

> *They've only one house, we've got three [alluding to class differences]. My father said that I wouldn't be able to survive there. He [my husband] used to tell me from the [wealthy] family I belong, my family won't let me spend my life with him. I replied to him that once I've been married to you, I've no other way except staying. (Young woman, 19 years old, Cumilla)*
>
> *When my daughter was 15 years of age, her attitude changed a little. I asked her what had happened. She gave me explanations … So, I was convinced, but later I became to know that she got married. We accepted that as there was nothing else to do. (Mother of a (recently) pregnant 15 year old, Cumilla)*

The effectiveness of elopement as a tactic enabling young people to avoid arranged marriages was related to the social unacceptability of divorce; it was acknowledged that once a couple has married, there is little that family members can do to break up the match even if they are strongly disapproving of it. This also relates to the social norm that once someone (particularly a woman) is divorced, her re-marriage prospects are damaged, while remaining unmarried is very socially undesirable.

Relatedly, parents who suspected their daughter to be engaged in a relationship with a partner they deemed unsuitable may rush to marry them to someone of their (the family's) choosing rather than risk their continued involvement and potential pre-marital sexual activity (or community suspicion of this), or elopement. Young women and mothers-in-law reported this first-hand, while health-workers were also aware of this.

Such parents sometimes therefore viewed the early marriage as a negative or unfortunate outcome, but still viewed it as preferable to allowing children to engage in relationships with unsuitable partners. As one mother from Barisal stated: *'I had no other way except this. Otherwise, there is no mother who wants her young child to get married at such an early age'.*

This view also was also reportedly shared by marriage registrars (also known as Kazis / Qazis), as suggested by a young woman from Dhaka who explained that they were easy to convince to officiate underage marriages:

> *They say that girls should get married as early as possible. Otherwise they'll fall in love and elope with someone. (Young woman, 17 years old, Dhaka)*

As a result, in some cases both parents and young women reported a sort of race between parents and children to enter children into the match of their respective choosing – this appears to be a push factor for early marriage from both sides in all study sites.

Study participants also reported the extreme social pressure placed on couples to marry following an out-of-marriage pregnancy, due to the unacceptability of giving birth outside of marriage. While none of the young women in the study had a pregnancy outside of marriage, all participants agreed that such women, their children, and their families faced intense stigma and shame, and that the only means of somewhat ameliorating this was for the two parents to marry.

Lack of opportunity and protection for women

Marriage was reportedly seen by (particularly poorer) parents as a way of shifting the costs of caring for and educating daughters (who are often viewed as financially/economically unproductive family members) elsewhere. Partly as a result, early marriage was closely linked to class by several participants:

> *Parents feel relieved to marry their daughters off. They don't think that their daughters can earn and be financially profitable for them. They mostly prioritise their sons. Sons will earn, but the daughters won't, that's what they think (Health worker, Male, Government facility, Barisal)*
>
> *Those parents with economic solvency don't want to marry off their daughters soon and they keep the girls in education… And those who are very lower class, they see that they cannot afford the education for girls, how they will bear the girls growing up. The parents marry the girls off while it is time (Young woman, 18 years old, Cox's Bazar)*

Girls reported having limited agency in this decision; even where they reported that they strongly expressed their desire to stay in school and/or not get married, this was overridden where it was felt to be in the interests of the wider family (for economic and/or social reasons). Many participants,

youth and adult alike, also spoke of the relationship between early marriage and school drop-out.

> *I wished to study more and get a job to support my family. That didn't happen...I thought to get married after completing HSC. My parents didn't want to give me married. But due to the COVID-19 pandemic, I fall back a lot from the study. Schools and colleges were closed for a long period of time. I was staying at home. I was visiting my neighbours often. So, my mother arranged my marriage. (Young woman, 17 years old, Cumilla)*

As demonstrated above and indicated in section 4.1.4, COVID and related lockdowns exacerbated this here and for other young women. This was reinforced by gendered expectations that young women do not need to work as they need to be taken care of the home.

> *Then the lockdown started. As soon as it happened I had to get married. They told me that there will be no more schools to open in that time. That's why they got me married. (Young woman, 16 years old, Dhaka)*

Closely related to these issues of economic precarity and poverty, parents and in-laws often discussed marriage as the only way of ensuring long-term social and economic security for girls/women. This was a result of a general view of women and girls as socially and economically dependent on family members (first parents, then husbands and in-laws). This resulted in a desire to ensure that girls are married quickly in case of illness in the family. This seemed to be related to parents/grandparents wanting to ensure that they could be confident they had done all they could to ensure a stable future for girls in case they passed away or became otherwise unable to support them.

It should be noted that this wasn't simply related to immediate economic security (i.e., who would provide food for girls), but to a wider sense of long-term economic and social status and protection that encompassed aspects such as GBV. For example, many participants, including a government health worker from Barisal reported that 'eve-teasing' is a factor in this, as marriage is seen as a way of protecting girls and young women from sexual harassment.

Marriage was viewed as a way of becoming *'tension free'* of the stresses of raising girls as explained by a male governmental health worker from Barisal. This same health worker viewed this as problematic: *'This is a problem of our social structure. We've failed to give our daughters a healthy social structure where they can live freely, safely and in well condition.'*

Inadequacy of legal prohibitions

Study participants expressed a general lack of confidence in legal measures to tackle child marriage, which was attributed mainly to the strength of social pressures and the prevalence of traditional/religious marriage which flies under the radar of official detection:

> *No one has the power to stop someone from getting married if he decides to do so. Only a Kazi and 2 witnesses are needed for it. They know that in Islamic way to do it if they want. They can get a Kabin[8]. There is no such way to stop it, not even the Kazi. (Health worker, Male, Government facility, Barisal)*

This was also related to the approval of child and early marriage among community leaders. For example, one 17 year old girl from Dhaka suggested that social authority figures approve of child marriage and therefore are not motivated to tackle the issue. She suggested that even if they have some misgivings about the practice, they can be bribed to turn a blind eye:

> *What would they ['important people of society'] do? They think marrying off young girls is the right solution… If you give them money, they won't say anything at all. (Young woman, 17 years old, Dhaka)*

Marriage registrars are also easily bribed according to several participants. For the marriage of one of the young women, the Kazi initially left because she was underage, but then her birth certificate was fabricated and he returned (though it was not fully clear why he returned, or if any money was offered).

> *They can manage it [arranging a child marriage] by paying bribe to the Kazi [registrar of marriages under Muslim Law]. You can increase the age in Kabin-nama[9] by giving money to Kazi. Same was done in case of my daughter. (Mother of (recently) pregnant young woman, Chittagong)*

4.1.5.3. Consequences

Early pregnancy

Early marriage was very closely linked to adolescent pregnancy, the interlinkages of which are discussed at length in section 4.3 below.

[8] *A Kabin (Kabin-nama) is a written document signed by two Muslim partners that is legal evidence of their civil union and lays out the rights and obligations of the bride and groom, including dowry arrangements*

[9] *A Kabin-nama is a written document signed by two Muslim partners that is legal evidence of their civil union and lays out the rights and obligations of the bride and groom, including dowry arrangements*

School drop-out and negative impact on employment opportunities

Of the 25 young women interviewed, two reported that they were in school (in Barisal, and Chittagong). Early/child marriage and dropping out of school were closely linked. Both were also frequently linked by study participants to poverty. Many young women discussed how they had been unable to continue in education after marriage due to their in-laws' or husbands' disapproval.

Education stopped upon marriage for one 17 year old from Dhaka, despite the girl's desire to continue studying, her parents' approval of this, and her in-laws' initial agreement that she could. She suggested that her parents agreed to the match partly because they felt that this would allow her to continue her education, but reported that her in-laws will now not let her study. It was not clear from her interview why her in-laws initially said she could keep studying and have now reneged on this.

Where the views of in-laws and husbands differed from those of the girl and her parents, in-laws and husbands appeared to hold final decision-making power about girls' access to education and employment following marriage. In many cases, young women's in-laws alone reportedly had ultimate control over their access to education (in addition to other aspects of life), particularly where husbands have lower status in the family due to, for example, unemployment.

Additional responsibilities that led to loss of 'care-free' earlier life.

After marriage, young people (both men and women) reported the pressure to maintain a separate family life, and a lack of time to spend on their relationship with parents (due to responsibility for chores etc). They also experienced anxiety about money, which was particularly common for young women who worried about their husband's drug/alcohol use or lack of job prospects.

> *When we don't have thinking of money in mind, we dream many things. So, there happens a chaos on this. Wife can pinch saying that you told me to take me to Cox's Bazar after marriage, but still, you couldn't.... So, in such situation, husband mistreated her and even could beat her. It can happen in society. We also mistreat with them sometimes which we realise later. But there are these two mistakes. (Husband, 28 years old, Chittagong)*

Poor treatment (including GBV) of some wives after marriage

Several young women described experiencing intimate partner violence (IPV) and abuse from in-laws (including verbal abuse, beatings and rape) after marriage, and denial of nutritious food during pregnancy. This was

corroborated by mothers-in-law and health-workers. The experience of violence during pregnancy is further described in section 4.1.6.

> *I was very happy and joyful before marriage. But I suffered a lot after marriage. They [In-laws] told me that you take baby, but all the time it becomes miscarriage. They don't realize that I am suffering more than anyone else. They don't bother about my sickness, about my bleeding and admitting in medical. They are busy with scolding me. (Young woman, 17 years old, Cox's Bazar)*

One husband from Barisal suggested that the dynamic runs equally both ways between husbands & wives, and wives & mother-in-laws. He suggested that common reasons for disagreement between wives & mothers-in-law are that wives don't provide food or basic necessities to their in-laws, or mistreats them, or that mothers-in-law were manipulative.

Loss of childhood support networks

The majority of the young women interviewed spoke about a loss of freedom following marriage (discussed further in section 4.3.3 below), as well as how moving away from their familial home (as is customary in the context) resulted in them feeling cut off from their usual support networks. However, one husband suggested that the reverse was true, and that young women's support networks could grow after marriage, as well:

> *A married girl can share her problems with her husband and also with her family. She can travel to her father's house if she doesn't feel well. On the other hand, an unmarried girl has to live with her family. She cannot go very far during her moods-off. (Husband, 28 years, Cumilla)*

However, this view was not echoed by any of the young women interviewed, who all suggested that the opposite was a more common experience. If there was a disagreement between parents over the match, then this could also cause a rift between parents and children.

4.1.5.4. Decision-making

Finding a preferred partner or elopement

Young women generally reported a lack of agency in relation to both the timing of their marriage, and choice of husband.

> *I suddenly heard that people were coming to see me. And, later that day I got married. I also came here on the same day. I was very hurt. (Young woman, 18 years old, Cumilla)*

As this quote illustrates, many of the young women in the study were surprised by the speed at which their marriages were arranged, which heightened the sense that these decisions were made without them.

Within this limited decision-making space, there were two ways in which young women were able to exercise some agency. Firstly, by themselves independently finding a preferred partner who they then introduced to their families for approval. This was ultimately effective for several of the young women, though sometimes led to anxiety that the pre-marital relationship would be the subject of gossip and stigma within the community, or intervention from family members.

The decision to disclose a relationship and suggest marriage was often triggered by the suspicion on the part of young women that their families were arranging other marriages for them, to non-preferred partners.

The second way that young women exercised agency before marriage was in eloping with partners of their choice, where their chosen partners were not approved by family members.

Both of these tactics resulted in young women being able to exercise some decision-making power over their marriage partner, but not the timing of their marriage. It is possible that other young women in this context *are* able to exercise greater agency in relation to the timing of their marriage, but due to the selection criteria of the study only young women who had already begun childbearing were interviewed. This meant that all had been involved in early marriages, due to the close causal link between pregnancy and marriage.

None of the young women in the study discussed the possibility of reporting those involved in arranging a child marriage to legal authorities. This suggests not only the widely perceived (and perhaps actual) inadequacy of legal mechanisms available to young people wishing to avoid or escape child marriages, but also that this is not even a mechanism that young people consider to be available to them.

Love marriages vs arranged marriages

Marriages were described as either arranged, or as love marriages. However, the distinction between the two was not always clear; where young people were interested in each other, or romantically involved before their marriage and had then requested their family's approval to marry, this was sometimes reported as an arranged marriage:

> *I used to do a job in market. We met there … I have shared the matter of my relationship with my mother. Then, my mother informed this to my uncles and they also accepted this…Then it happened in the family too. I mean it was arranged marriage too. They [husband's family] came to our home and saw me. They talked to our family. They liked me too. (Young woman, 19 years old, Chittagong)*

It is therefore evident that the term 'arranged marriage' is used to refer to marriages with a high degree of variation in terms of the level of agency that the married couple had over the relationship. It may be that arranged marriages are seen as more respectable, and this is why young people tended to use the term to refer to their own marriages in most cases. The term 'love marriage' seems to be reserved only for those marriages where one or both families disapproved of the match, but the young people had got married anyway. Relatedly, the line between arranged and love marriages was not always clear. In some cases, young women felt they had little other choice but to marry a specific person in order to escape other, worse, situations. One young woman (aged 18 years) in Dhaka who had experienced pressure to marry attempted suicide and was beaten by her as her brothers suspecting her of being sexually assaulted by strangers in the community. She stated that, *"It was neither love marriage or mostly like that. I actually don't know if it was a love marriage or not"*.

Several of the marriages were viewed as love marriages by the young women and husbands (indicating that they had eloped despite the wishes of their parents), and/or as a means of escape from unhappy family situations or forced marriages. Many of the young women clearly expressed that they had not wished to get married, and that the reason for their early marriage was family pressure.

> *My parents were very eager for my marriage that's why I got married (Young woman, 18 years old, Cumilla (married age 17))*

Mothers, fathers, siblings, aunts, uncles, and grandparents were all commonly mentioned as being involved in arranging marriages for young women, and it was often stated plainly by young women and their mothers/mothers-in-law that the decisions of family members would override those of young women (where there was disagreement).

One young woman who had experienced intimate partner violence and neglect during her marriage reported that she had attempted to intervene in order to delay the marriage of her younger sister (though whether she will be successful in delaying this marriage is unknown):

> *[Girls in my area] are getting married very early. My elder sister got married at the age of 14 and I got married at the age of 16. Now, my mother wants to give marriage of my younger sister. But we don't want it. I said she should at least complete S.S.C. (Young woman, 17 years old, Dhaka)*

There was a change of attitude on the part of one young woman towards child marriage before and after being married: at the time of marriage, this girl from Cumilla (18 years) was willing to get married, partly due to problems in her family home (arguments with stepmother/father, and a sick father) but now wishes she had delayed. Another 17 year old woman from Cumilla reported something similar, due primarily to the fact she had been denied the opportunity to continue studying or working after marriage.

Lack of agency among mothers

A lack of agency was experienced not just by the young people who felt forced into marriages, but also by parents who would have preferred to delay a child's marriage but felt unable to due to financial precarity within the family, social pressure, or the belief that by marrying their daughter they were protecting them from far worse fates (such as pre-marital relationships or GBV, which would ruin their prospects of later marriage). This was also the case for mothers who had themselves been married very young (which was the case for almost all the mothers/mothers-in-law/grandmothers interviewed), and felt that this had negatively affected their lives:

> *Actually, the main reason of my marriage was the sickness of my grandmother. At that time, she was going to India to have treatment. So, my marriage started from that source. Otherwise, none of my parents were ready to give me in marriage. My mother was completely displeased. She said that my daughter is still young. I have only one daughter. (Mother-in-law, Chittagong, reflecting on her own early marriage)*

This was also reportedly experienced by fathers:

> *There was a bit trouble for this reason. My father didn't want to give my marriage because I was below 18. Then people said, "your son's wife is below 18, if you can accept her why not your daughter". And many more things were being told to convince my father. (Young woman, 18 years old, Cumilla)*

Limited freedoms and leisure after marriage

When asked about the differences between married and unmarried women, many of the young women looked back on their unmarried childhoods with a great deal of nostalgia, particularly related to aspects of decision-

making and autonomy. It was discussed by many of the young women that unmarried girls experienced a level of independence that married girls had lost, and were able to 'roam around' without anyone else's permission.

> *[Unmarried girls] can study, roam around with friends. But we can't do this [...] Unmarried can go for walking, roaming at the park. (Young woman, 15 years old, Chittagong)*
>
> *[Unmarried girls] are still independent. They can lead their lives as their own. But it is not possible for a married girl. They [married girls] can't go anywhere without the permission of husband. The difference is here between them. (Young woman, 19 years old, Chittagong)*

Educational and employment opportunities

Marriage led to school-dropout for several of the young women who wanted to continue schooling, even where in-laws had promised they could continue education after marriage. It was apparent that young women were not the primary decision-makers in regard to this, but rather their in-laws made the final decision about their access to education.

Young women faced intense pressure from in-laws to begin childbearing (discussed in section 4.3.2)

Financial dependence on husbands

As two of the drivers of early marriage among (young women and mothers/mothers-in-law) study participants was seen to be poverty and school drop-out, it is unsurprising that many of these young women reported financial dependence on their husbands after marriage, often with little recourse to family support. This was related to both lack of autonomy and decision-making ability for young women, and disputes over dowry terms. Both of these led to abuse and mistreatment of some young women. In-laws appear to have a lot of leeway to arbitrarily dictate dowry terms, even where these were unrelated to pre-existing customs. One case of a girl from a poor family in Dhaka who reported being threatened by her in-laws (mother-in-law is mentioned specifically) that her family must provide either a cow or jewellery after the birth of her child (regardless of gender). She acknowledges that this is not a custom, but a new demand made of her family after marriage.

In the most distressing cases, young women reported being denied access to various goods (including food) as a form of abuse by their husband and/or his family members and feeling helpless in relation to this:

> *I used to ask him to buy me a cell phone as I feel lonely at home … He said that they could not give me one. He uses a phone and spends time with his friends. But he did not have time for me. I told him this and he thumped me. At that time I was expecting. He tortured me when I had stitches. I had stitches in my abdomen….He did not buy me one as his mother disagreed. She forbade me to buy myself a phone, as she thinks I will be busy with it all the time. (Young woman, 17 years old, Barisal)*

4.1.6 Gender-based violence

4.1.6.1. Settings of violence

Intimate partner violence

The prevalence of intimate partner violence (IPV), including experiences of physical, sexual and emotional abuse and controlling behaviours by an intimate partner, was confirmed by many participants. Most frequently, participants spoke of intimate partner violence. Slapping, often also violent beating, of wives by their partners was mentioned by young women, husbands, mothers as well as mothers-in-law.

As demonstrated by the account below, some young women interviewed also experienced sexual violence by an intimate partner who pressured them into non-consensual sexual intercourse.

> *Interviewer: When you both involved in physical intercourse, was there consent of both always?*
>
> *Participant: Sometimes, I didn't want sometimes. I used to get angry sometimes…I didn't like this sometimes. [When I didn't want] his behaviour, he will [still] do [alluding to sexual activity and intercourse]. (Young woman, 18 years old, Chittagong)*

What emerged clearly from all experiences of IPV shared in all study sites is that gender-based violence (GBV) in relationships was considered purely in the context of husbands as perpetrators and wives as survivors of violence.

Violence from family members

We found that young women in all study sites also experienced violence inflicted by various other family members, or reported being aware of this happening in the community. Participants particularly addressed the violence young women experience in the families of their husbands. Being hit or beaten by the woman's mother-in-law hereby was frequently mentioned by young women and also acknowledged by some husbands and mothers – whereas mothers-in-law interviewed reportedly had better relationships with their sons' wives.

While the husband and mother-in-law and seem to be the most common perpetrators of violence experienced in the family, young women also face GBV in their own families. Common experiences relate to the gendered beliefs and expectations of and interactions with their parents, reportedly restricting their decision-making power in comparison to their male peers. However, young women interviewed also mentioned physical violence, for instance by their own brother, as the account below illustrates:

> *I got beaten at night; my elder brother kicked me on my head and chest. All these were seen by my husband from his window looking at my residence that both of my brothers were beating me. He got sad while seeing that was happening to me. He let go of it thinking that those were my brothers and they could do it...And for me it was like I didn't do anything yet I got beaten for nothing. If anything happens I am the one who gets beaten, everything was on me. (Young woman, 19 years old, Dhaka)*

In line with this quote, overall we found that violence inflicted by other family members often is accompanied by the witness and acceptance of young women's husbands.

GBV in the community

GBV not only happens in young women's intimate relationships or family situations, but as some participants pointed out, gendered expectations towards girls and women in how they dress and behave are perceived as widespread in their communities.

Several interviewees referred to the harassment of women witnessed as eve-teasing, whistling or hurling abuses at women. A girl's way to school or commuting back home was hereby several times mentioned as a time and space where street harassment, attempts of as well as cases of rape happen.

Although participants often described GBV in the community as situations where the perpetrator violently abducts the girls or young woman, an account from Cox's Bazar also shed slight onto how sometimes manipulation is being used to take sexual advantage.

> *Yes, [men] abducts and takes them through love telling them I will marry you, I will not marry you if you do not have physical intercourse with me. So if this is the girl's danger. So it should be explained to the girl not to get pregnant. (Mother-in-law of (recently) pregnant young woman, Cox's Bazar)*

Another space where manipulative behaviour and unequal power relations make girls and young women vulnerable to experiencing GBV reportedly is

young women's workplace. This was particularly stressed by young women from Barisal who had experienced beating and having to do excessive physical work, as well as having to deal several times with sexual advances during work:

> *Son and son-in-law of the house owner. They used to touch my body and breasts. The son tried to undress me and I ran from there pushing him back. When I complained against him, the owner blamed me and rebuked me saying that her son and son-in-law would not do such things, I must be lying. One night I ran off from there. (Young woman, 17 years old, Barisal)*

4.1.6.2. Circumstances of GBV

Overall participants regarded that GBV can happen to girls and women of all ages. However, some participants reportedly believed that IPV occurs more among couples from lower educational, socio-economic backgrounds and living in rural areas.

Drawing from stories from their communities, some interviewees also considered that girls and young women with mental disabilities tended to experience heightened risks of sexual assault.

Emerging as a common factor, several young women, husbands, mothers and mothers-in-law interviewed in this study shared that often physical and emotional abuse of women, including pregnant women or young mothers, are related to frustrations and conflict around the dowry.

When reflecting more on the circumstances of experiencing GBV, the majority of participants stressed unequal power dynamics, particularly women's financial dependence on their husbands and limited decision-making power, as contributors to increased risk of GBV. A young woman from Dhaka also shared how the gambling and drinking behaviour of her husband strongly affected his behaviour toward her becoming more physically aggressive.

> Lastly, young women interviewed from Barisal, Cox's Bazar and Cumilla reported that they perceived a heightened risk of GBV in fragile settings, such as during the aftermath of cyclones or floods. Next to experiencing verbal abuse, participants shared several stories of rape happening in shelters:
>
> *The boy said that I have a need. Then the boy took the girl in a side and then he raped her. A man saw that incident. Then all the people beat the boy. And people asked the girl, "why did you go there with him? If you didn't go there, this would not be*

> *happened. now your life became destroyed. It happened in front of many people. Who will marry you? if somehow you will marry with someone, he will catch you one day. then what will happen? (Young woman, 17 years, Cox's Bazar)*

As per some participants who did not reside in a fragile setting, the fact that people in shelters after natural disasters are being crowded together and the consequent lack of privacy, for instance in washing areas, were regarded crucial factors contributing to higher prevalence of GBV in these settings..

4.1.6.3. Perceptions of GBV (survivors)

The overall perception of young women, husbands, mothers and mothers-in-law interviewed was that GBV, in the form of physical, sexual and emotional abuse, were quite common in their communities.

Referred to as "the danger of girls" by a mother-in-law from Cox's Bazar, the majority of participants perceived GBV as a problem rooted in unacceptable behaviour of boys and men that causes harm for and therefore fear of social stigma for girls and women as well as their families. Although interviewees acknowledged driving factors for GBV being gender inequality, the abuse of power and harmful norms as discussed in the previous section, we found that overall the perception remains that it is the women's responsibility to protect herself from gendered violence.

Social stigma and pressure therefore weigh heavily on survivors. Some accounts, like the one below, also illustrate how young women themselves assume narratives that assault and abuse can be their own fault, for instance when not adhering to principles of what may be considered respectable clothing in the community.

> *It [eve-teasing] was very common back then. I thought they take girls and sell them in other countries. Sometimes it was due to our faults. We can't have proper dress-up even in school. We should use the hijab in such a way so that men don't get attracted. If we maintain 'Purdah' then boys don't see us much. As we don't maintain these boys get more attracted towards girls. (Young woman, 19 years old, Cumilla)*

At the same time, some participants also shared how society's expectations around GBV can affect how girls and young women approach relationships shaped by fear:

> *I was scared of boys.. of getting involved in a relationship with a boy. I was avoiding this from the fear of having a sexual relationship with a boy during that period. We hear many things*

> *like girls being raped or killed by men. That's why relationships create fear in my mind. Though my elder sister got married after her affair. When she was getting married, people told my parent many bad words. So, I thought that I wouldn't hurt my parents like my sister. That's why I avoided any relationships. (Young woman, 19 years old, Dhaka)*

In a few cases, however, young women reported that they had exercised agency to bring about change in relation to their experiences of GBV, for instance by confronting their mothers-in-law or involving the police and community members when dealing with a stalker. While turning to the policy or local chairmen was mentioned as one potential solution to address GBV, some young women also considered that their parents, some specifically mentioning the mother, could play a stronger supportive role.

4.1.6.4. Consequences (perpetrators and survivors)

Consequences for the survivor

The majority of young women, husbands, mothers and mothers-in-law interviewed among all study areas confirmed victim blaming and stigmatization of girls and women who experienced GBV.

> *I think the boy who raped the girl must be hated and punished. But in reality, our society looks down upon the girl who was the victim. They say many bad things to her. She cannot lead a normal life. (Husband, 30 years old, Cumilla)*

Consequently, girls and young women experiencing GBV face consequences in their private, but also educational and work lives. Several participants mentioned a relationship between eve-teasing or rape and school drop-out of girls, which in return reportedly affects their willingness to report what has happened to them because they fear having to pause their education. Similarly, young women shared accounts of being threatened by their employer to speak up as well as feeling a dilemma themselves to report GBV in the workplace fearing the repercussions, such as being fired. Young women interviewed who experienced or witnessed GBV at school or in the workplace stressed that not disclosing violence to their families because of fear they would not let them go to work or go to study anymore.

Lonely suffering and social exclusion reportedly frequently result from society's response, "*because people would satirise her for not being able to protect herself. That's why she won't share her sorrows with others*." - as a young woman from Barisal reasoned.

Furthermore, in the case of unwanted pregnancy resulting from rape, several participants regarded that the burden would lie with the girl or woman unless, in the words of a young woman from Barisal: "(*If) the rapist gets married to the girl, then there will be no issues for the child.*" Furthermore, while overall we found attitudes towards menstrual regulation/ abortion to be mixed as discussed in section 4.2.3.2, several participants mentioned that abortion in cases of rape, particularly if the perpetrator would not "*accept the child*", was a commonly accepted and practiced response. As shared by some young women interviewed, in some cases GBV can lead to self-destructive behaviours with tragic consequences as far as committing suicides.

Consequences for the perpetrator

Some interviewees suggested that in response to sexual assault committed by strangers or non-family members, reports should be made to the local chairmen or the police and - in the case of an underage perpetrator – the parents of the perpetrator. Participants did not make similar remarks with regard to responding to intra-familial violence. While this suggests that there are few consequences to husbands' and family members' violent and abusive behaviours, some young women, husbands and mothers-in-law also shared that in their experience, there was also little repercussion for perpetrators in general, particularly if they were wealthy or well-connected, even if they are officially denounced.

> *[Girls] become silent because that boy who is the culprit he might be powerful or have money. They give some money to the girl victim's family and they become silent. And those who doesn't keep silence after given money, they would go for filing case. Then the boy's family would go there and wrap up everything with money… Many girls don't want to talk or bargain about this issue… They feel shy, embarrassed… Or they think they won't be able to get married in future, for unmarried girls. (Young woman, 19 years old, Dhaka)*

So while communities seem to have little systems in place to prosecute and initiate behaviour-change programmes for perpetrators or challenge minimization and victim-blaming, we also found that with regard to service provision in response to sexual GBV, there was limited reported knowledge and practice of young women on where and how to access sexual and reproductive health or mental and psychosocial support services. Adding to the impact of social stigma as discussed above, some participants also

addressed practical issues, such as hospitals being too far away for survivors to access, which was reportedly a problem even in the urban context of Dhaka.

4.2. SRH service and contraception needs of young people

4.2.1 Knowledge and perception of contraception (community attitudes etc.)

The majority of young women who were pregnant with their first child did not know about contraceptives before their marriage. They mentioned that their husbands also had limited or no knowledge of family planning methods. Many young women only came into contact with services after beginning childbearing.

A minority of the participants who knew about FP methods before their marriage could name only 1-4 modern contraceptives including pills, condoms, implants, and IUDs. However, their knowledge about contraceptives (e.g., dose or usage) was not accurate in a few cases which also led to unintended pregnancies.

> *A neighbour living next door handed over me that (pills) to take. I thought of it as some kind of chocolate. I didn't understand. I had it for 7 days like chocolates with mixing white and chocolate colour. I had it as I wished. Then suddenly someone asked me how I take that pills and why my pills looked disorganized... Then I was told to stop taking those pills as it might create problems ... After I stopped taking pills I conceived the baby in the first place. (Young woman, 19 years old, Dhaka)*

The majority of the young people including both husbands and wives predominantly had negative perceptions towards contraceptives. They mentioned myths and rumours that contraceptives cause infertility, intestinal burning, complications during pregnancy, etc.

Such views were also prevalent among other family members, especially mothers and mothers-in-law who often also had religious grounds for their beliefs. Some of the young mothers mentioned that their mothers-in-law didn't let them use contraceptives.

> *I had taken methods (pills). But my mother-in-law found the pills and threw them away. (Young woman, 17 years old, Dhaka)*
>
> *Interviewer: Sahanaz (the daughter-in-law) is pregnant now, right? How did she conceive so early?*

> *Participant: Allah knows best....I hadn't educated my [other] daughter on anything. When Allah will be willing, she will have children. That's it. (Mother-in-law of (recently) pregnant 18 year old, Barisal).*

However, some educated mothers and mothers-in-law were very positive in terms of the use and benefits of contraceptives. Healthcare providers also mentioned that many mothers-in-law nowadays accompany their daughters-in-law to healthcare centres and support them in receiving family planning methods as per their choices.

> *Many times mothers-in-law come to the facility with their daughters-in-law here at our facility. They encourage the daughters-in-law to have children at a later time period and promote contraceptive use. It is not like in earlier times; many things have changed now" (Health-care worker, male, NGO facility, Barisal)*
>
> *As a mother, I did wrong for myself. Now, I have 4 children and my family is going through economic hardship. After the birth of the first child, I will suggest to her (her daughter) a birth control method by which she can have a 3 years gap before the second birth. (Mother of (recently) pregnant 15 year old, Cumilla).*

4.2.2 Sources of information on contraception

We found a clear distinction in the sources from which young women and men get family planning-related information. Young women who knew about at least one modern method of contraceptives received this information from their mothers, elder sisters, sisters-in-law, neighbours, or husbands. On the other hand, young men (husbands) reported knowing about contraceptives from the internet through YouTube, TV advertisements, or from a friend.

> *I learned about contraceptives, particularly condoms, from YouTube. Also, there are vlogs and pages of different medical professionals on Facebook and other social media sites. We can learn many things from those pages. (Husband, 25 years old, Barisal)*

4.2.3 Barriers to access and use of services

4.2.3.1. Contraception

Participants highlighted several barriers that prevented them and others in the community from accessing and utilising FP services. These barriers were mainly socio-cultural, or related to policies around eligibility criteria for

services. Some mentioned the costs of family planning products/services but generally they were described as financially accessible for all but the poorest people who might struggle to afford costs associated with accessing services such as bus tickets. A key barrier was the inability of unmarried people to access services or to only access them while accompanied by guardians, as well as young people feeling uncomfortable or shy about discussing their SRH service and product needs. A small number of health workers, young women, men, and family members including their mothers and mothers-in-laws mentioned that the use of contraceptives to limit childbirth is prohibited in Islam, but they also stated that this prohibition was not generally adhered to. No one discussed that this was being actively preached by religious leaders. One health-worker from Cumilla mentioned a religious superstition that restricted use of long-acting contraceptives, specifically that some people believed that if a woman died while having an IUD or implant, her funeral would not be considered religiously valid.

Shyness among the young married women also restricted them from accessing family planning information as well as utilising family planning services. They mentioned that contraceptives are taboo in society and they could not talk about it with anyone.

Another universal finding regarding barriers to access to and use of FP services was the marital status of the adolescents and youth. The majority of the participants unanimously mentioned that it was more challenging for unmarried girls and boys to access FP services or information because of the fear of getting a *"promiscuous"* tag. They mentioned that people spoke badly about them, especially about unmarried girls.

> *It is difficult to ask. If I would ask anyone about it (FP methods) prior to my marriage, it would be disgraceful for me. If I did ask my cousins or sisters-in-law, they would think I'd become promiscuous. That's why I didn't go to anyone. (Young woman, 17 years old, Cox's Bazar)*

The healthcare providers also highlighted the structural barrier that one needs to be married to avail the family planning services from the healthcare centres. One health-worker mentioned that unmarried people were able to access some services if they were accompanied by a guardian, but acknowledged that in practice this presented a considerable barrier, as *'if we ask them [unmarried people] to bring guardians, most of them don't return'*. As they are asked about their marital status, many unmarried adolescents or youth avoid visiting healthcare centres.

> *If we go to doctors to consult about family planning measures, they ask if we are married or not. They consult the married couple with a positive mind. But that unmarried couple cannot deal with the queries or cannot confess that they've conceived before getting married. In our society, married people are privileged in terms of retrieving information whereas unmarried people are treated to be unaccepted. (Young woman, 17 years old, Barisal)*

In reference to unmarried young people's access to contraceptives, a husband summarised some of the barriers to include shyness, prohibitive costs of contraceptives and desire to have intercourse with 'more pleasure'.

> *In case of using condom, there are two reasons why they don't use condom. Firstly, there is a matter of age and shyness in buying condom. Secondly, the price of the condom is high. The price of a condom nearly 70 or 80 taka which is which is beyond the affordability of many. But the main thing is the shyness. And I think there is another thing that the movement or speed is reduced while having sex with condom [...] They try to have sex with more pleasurable way. Then they don't have patient to use condom. It seems the natural feeling doesn't come while using condom. So, there are three reasons, shyness, feelings and money. These three reasons work together. (Husband, 25 years, Chittagong)*

Lastly, as mentioned in 4.2.1, there was a misconception that contraceptive use led to infertility.

4.2.3.2. Menstrual regulation services

Most of the young women who participated in this study across all study sites did not know about menstrual regulation services. Some participants mentioned that they had just heard about it and did not know anybody in their social circle who had utilised menstrual regulation (MR) services. However, those who knew about MR opined their positions for and against abortion. Some believed that killing the foetus through MR would be a "grave sin" and God would question those parents, which was one main barrier to accessing services. Another group mentioned that MR can be utilised in the following circumstances: if the girl/woman is a rape victim; if the mother has a severe health threat or is going under heavy medication; and if the girl conceived before marriage and the man rejected to marry her.

However, all the participants including young mothers, young husbands, family members (e.g., mothers and mothers-in-law), and healthcare providers unanimously highlighted that accessing MR services was far more

challenging for women whose pregnancies occurred outside marriage. They mentioned that the burden of shame predominantly falls on the pregnant girl and their families. Community members oftentimes label the girl as a "bad girl". Thus, the girl had to secretly undertake MR services.

> *You see, it is not open in our society. So, they may go to the pharmacy secretly. And the pharmacist may say that we can't give you such risky medicine. But we have communication with such maternity centre, you can go there. So they may go there to do this. Many times, it is seen many girls take a man to the hospital making him a fake husband to do these things. (Mother-in-law of (recently) pregnant young woman, Chittagong)*
>
> *For out-of-wedlock pregnancy, she will not come to us so easily. They will prefer to go to any private hospitals instead of coming here outdoors. If their parents are aware of this, they take them for abortion. But if teenagers go for an abortion by themselves, they don't go to someone well qualified. They terminate their childbearing by going to cheap places or to nurses or midwives. (Health-care worker, male, Dhaka)*

One participant shared her experience of being pressurised by healthcare providers not to undergo menstrual regulation.

> *I couldn't get the [MR] service ... I and my husband went to the doctor first. I clarified our challenges to them (service providers). But they were forcing us to keep the baby. I felt sick due to stress after going to that medical hospital. They were literally doing mental torture....I didn't get supportive behaviour from the service providers of the medical hospital. They're pressurising me instead of providing the service. (Young woman, 17 years old, Barisal)*

The young woman quote above was eventually able to access MR services, and was supported by her husband, who was also interviewed for this study, in this. She mentioned that her husband was supportive at every stage, which seems to have been a decisive factor in her eventual success in accessing services. Besides, we also found that systematically unmarried girls/women face added challenges while accessing or using the MR services. The healthcare service providers mentioned that according to the government provision, MR services should only be provided to married women accompanied by their husbands or guardians.

> *They [unmarried girls] cannot have it [menstrual regulation].. They provide fake identities to have this service. The government has regulations to provide MR services to women who had*

> *unwanted pregnancies. It can be due to method failure or unavailability of contraceptives during a sexual relationship. But, in that case, she has to provide proof of her reason for getting MR and a legitimate identity for eligibility... because there are some juridical matters for this ... after getting an MR, if the boy rejects the girl to marry, then she will file a case against him. Then the doctor who has done the MR has to go through some legal procedure. Moreover, there are more legal issues related to this service. That's why unmarried girls cannot have MR services. (Health worker, Male, Government facility, Cumilla)*

4.2.4 Decision-making

We found that married young women had very limited say in decision-making processes regarding family planning, while husbands or mothers-in-law were the main decision-makers. The majority of young women mentioned that they were forced not to use any contraceptives so that they would get pregnant and fulfill the desire of their in-laws by giving birth to a child. In most cases, husbands, as well as women's family members (e.g. mothers), also ask them to follow what they are told by their mothers-in-law.

> *I had that pill once only. Later my mother-in-law asked me not to take any childbirth preventive measures. She had the desire to have a grandchild. I have a sister-in-law, who was constantly telling my mother and mother-in-law why I wasn't conceiving despite being married for quite a long time. He [my husband] told me to do what his mother wants. (Young woman, 17 years old, Barisal)*

Young men also validated the findings that their wives are usually the followers of the decisions taken by them or their in-laws, not the decision-makers themselves.

> *Previously, my mother took the familial decision but now she has aged. So, now I take the decisions...my wife listens to whatever I tell her. (Husband, 30 years old, Cumilla)*

We found that if the husbands and wives were educated, it was more common that they made decisions jointly. Those young women mentioned that their opinions were valued, and they actively participated in both family planning and general household decisions within the family.

> *My husband is educated, always respects my choices, and never dominates me for anything. According to them [in-laws], as grown-ups and married, we are allowed to do whatever is beneficial for us; they don't have any objections. (Young woman, 17 years old, Barisal)*

4.2.5 Perceptions and roles of health-care providers

We found the healthcare providers were very positive and welcoming of the needs and challenges faced by the young people, but predominantly towards those who were married (or focused on abstinence for unmarried young people). They also shared elaborate descriptions of the ways they provide information and services required by adolescents and young people.

> *We do yard meetings with adolescent boys and girls… We make them understand many physical and mental changes and issues. From education to nutrition and vaccination programs, we talk about everything with them openly. In a month, we do 3-4 court-yard meetings." (Health worker, female, Cox's Bazar)*

The service users e.g., young men and women, expressed their satisfaction with the services received from the healthcare centres. They mentioned that it is convenient for them to visit healthcare centres. They also highlighted their satisfaction with the quality of services, responsiveness, attitude, and behaviour of the healthcare providers.

> *The service of that place is good. Many women go there for service. When we go there, everything is explained to us properly. They come to the home to see the patient. If anyone faces any problem, they (health workers) come to the home to observe or treat the patient. They also treat people who go to their centre. It is convenient in every way. (Young woman, 19 years old, Chittagong)*

However, some participants mentioned that door-to-door service provision was declining in recent times. They mentioned that healthcare providers do not visit their households or localities as they did previously. A government health worker from Cumilla also acknowledged that there was a health worker shortage.

> *It has been 3 months yet there are no signs of them (healthcare providers). They don't come to provide any family planning methods or any other medicines as well. If they would visit us frequently, as they used to do earlier, it would be better for us. (Young woman, 17 years old, Dhaka)*

4.3. Adolescent pregnancy

4.3.1 Community knowledge and attitudes

Most participants of all types were familiar with government advice to delay conception until age 20. This was discussed as a sensible benchmark, after which childbearing became less dangerous for young women. No

participants believed there to be any (physical) health benefits for either mothers or babies associated with early conception apart from vaguely expressed beliefs (particularly among some mothers/mothers-in-law) that early childbearing of one child could protect against infertility. Despite this, both intended and unintended adolescent pregnancy was described as very commonplace – but only within marriage.

Pregnancies occurring outside of marriage were reported to be extremely uncommon, and a topic of huge shame and community disapproval, linked to social norms which view sexual desire and activity as sinful. This is reflected in the marital status of the young women who participated in the study, all of whom were married. Most participants claimed to have never come across any unmarried pregnant women, perhaps partly due to a desire not to be associated with such 'disreputable' behaviour. Even health-workers claimed they had only heard about such cases through the media[10]; as one government health-worker from Barisal stated *"I have not personally dealt with any pregnancy cases outside of wedlock. But it's not that these kinds of things don't happen. They do. I have seen a lot of news like this".*

Some participants suggested that in-marriage early childbearing was also looked down upon by more educated groups:

> *I mean if you take baby or not, it is fault in both cases. I you take baby at an early age, then educated people will say that you have taken baby at early age, you will have trouble to move, will be tough to stand on own feet. But elders who didn't study much say that it has been good that you have taken baby. Because you could not have baby in future, if you are late. (Young woman, 18 years, Chittagong)*

4.3.2 Causes

The main cause of adolescent pregnancy was seen to be child marriage in conjunction with pressure exerted on young women by in-laws to demonstrate fertility following marriage. Only two of the young women in the study reported actively wanting to become pregnant themselves. It is possible that the implicit disapproval of adolescent pregnancy in the context of a healthcare setting[11] (where the interviews were conducted) may have impacted these participants' willingness to share this.

[10] *The very fact that this is considered a news-worthy issue is an indication of how shocking such events are seen to be in the context.*

[11] *As noted above, the vast majority of participants were aware of the government advice to delay childbearing until age 20*

The immediate cause for most adolescents and youth who had experienced unintended pregnancies was incorrect use of contraceptives, linked to a lack of access to SRH information and services before and immediately following marriage. Adolescents also lacked sources of informal advice in relation to pregnancy prevention, partly due to the shyness that (both young and older) people felt in discussing issues relating to sexuality with each other, both within and between generations. As with marriage, the distinction between intended and unintended pregnancies was not always clear due in part to community/family pressure, and misinformation.

Religious beliefs did not appear to be a factor preventing young people from using contraceptives, but seemed to have some bearing on usage of abortion or menstrual regulation (MR) services.

4.3.2.1. High social value placed on in-marriage childbearing

Families (particularly in-laws) of married young women reportedly placed huge pressure on these young women to conceive shortly after marriage – as one health-worker from Cox's Bazar stated, *"our society thinks of having children right after getting married",* even at the age of 13 or 14 years.

This was reported by almost all the young women and health-workers within the study, many of whom suggested it as the major driver of adolescent pregnancy, particularly when considered in the context of the lack of agency and low status within the family experienced by many married young women.

Husbands and some parents had a slightly different perspective, which suggests that they may not be aware of the pressure experienced by young women, or were unwilling to report such pressure as they feel it reflects badly on the way that young married women are treated in their own families. Instead, according to one husband, a lack of education/ information as the main cause, only somewhat agreeing that family pressure can play a role after probing, but downplaying the influence of this factor.

Another husband (26 years) from Barisal also dismissed pressure as a major factor leading to adolescent pregnancies, insisting only after probing that *"It is an issue that happens, but not all families do that".*

Many interviewees discussed the widely held view that, while adolescent childbearing places a lot of strain on the physical health of the mother, it was desirable to have one baby soon after marriage and then take a break from childbearing following this.

This was often discussed in relation to pressure placed on married adolescents and youth to prove their fertility by bearing their first child soon after marriage, and various myths about infertility. For example, one husband from Cumilla (30 years) stated that *"I heard that if you don't have a child after your marriage, then you can have complications in conceiving one. That's why they take children as early as possible"*. Infertility was also linked to hormonal contraception (discussed further below), and abortion/MR, which discouraged young women from using these. Infertility was highly socially stigmatised, as described by one young woman from Cox's Bazar:

> *People ask them [childless married women] that they have been married for so long and why they still don't have children? …Due to this reason, quarrelling happens between husband and wife, between wife and parents in law. People pinch her saying that you are sterile … The husband also says that I have been married for so long. But still, we can't have a child. Everyone including family members insult and tease her. (Young woman, 17 years old, Cox's Bazar)*

Families were particularly pressurised to give birth to boys, which was a driver of short birth spacing for adolescents and youth who had already given birth, but to a girl,

> *Some people think that I have a baby girl already, so if I will have another one, that baby might be a boy. (Husband, 28 years, Chittagong)*

4.3.2.2. Desire to solidify marriages

Many study participants discussed the role that children played in permanently binding together, or solidifying new marriages. This could be particularly important for husbands who were engaged in migrant work and had to leave the family home for long periods of time (which appeared to be fairly common).

> *Some women take baby due to the husband, they think that if I take two babies, my husband could not go anywhere. Many women have such kind of thinking on their mind … And husband takes the baby so that wife also cannot go anywhere … , I am thinking that if I am not here or maybe I could go abroad, then I would take a baby so that my wife couldn't go anywhere and I could be tension free (Husband, 28 years, Chittagong)*

Particularly where parents disapprove of partners, having a baby together was seen as the next stage in ensuring that the couple could not be broken up:

4.3.2.3. Lack of access to SRH/R information and services

It clearly emerged from the interviews that accessing both information and services relating to contraception was extremely difficult, if not impossible, for unmarried adolescents and youth (as discussed in section 4.2.3). This was due to both formal barriers (such as policies within health services, and costs) and informal or social barriers, namely the extreme judgement of the need for such access, and shyness on the part of young people.

Interestingly, few interviewees (even health-workers) described this in itself as problematic. Instead, many chose to characterise the *need* for contraception among unmarried adolescents and youth as the issue, and related this to 'poor morals' or general societal moral decay, leading to pre-marital sexual activity. This lack of access to services and information must therefore be understood within a context of extreme disapproval of pre-marital sexual activity as explained in section 4.1.5. Such views were very frequently expressed by health-workers, which is indicative of the barriers faced by young people who might want to access services:

> *Before it was seen as a sin to have sex before marriage but now people are getting far from that type of view. That's why unmarried adolescent girls are getting pregnant. This is very alarming for us and we should address this as early as possible [...] There were a lot of unwanted pregnancies in the previous two years. The main reasons behind this are lockdown, shutdown, unavailability of work and staying home. Poor class people of our country see sexual intercourse as a source of entertainment (Health-worker, male, Cumilla)*

As mentioned above, even among health-workers, romantic relationships were often described as a standalone cause of pregnancies outside of marriage, rather than relationships in conjunction with a lack of access to family planning services. Many participants were taken aback and seemed shocked by the suggestion of such need:

> *Why should unmarried youths learn this [about contraception]?.... They don't need to be aware of this while being bachelor. This should be known after getting wedded. Neither they need this [girls and boys being friendly with each other]. Even this is shameful to say so. (Mother-in-law of (recently) pregnant 18 year old, Barisal)*

Even where participants mentioned the value of knowledge or education about sex before marriage, this often appeared to be a reference only to the need to educate young women (more than young men) on the importance

of avoiding pre-marital sex. However, some young people (both pregnant women and husbands), stated that they felt it *would* be better for unmarried people to also have access to this information. The findings suggest that the consequences of the low levels of knowledge (and subsequent use) of contraception was felt once young people were married, hence calling to attention the need to improve awareness among unmarried youth as well.

While one health-worker suggested that communities *'don't know well about the proper time'* to begin childbearing, the interviews suggested that most participants and their families were at least aware of the advice to delay this until age 20 - even though they themselves had not adhered to this, often for reasons relating to misconceptions about contraception, and general pressure from family members to conceive.

There was a general perception among young women that married adolescents or youth were unaware of the availability of family planning services/methods and this was a major cause of adolescent pregnancy. It was apparent from the interviews with young women and husbands that they had not received adequate (or any) sexuality education at school.

> *It's all my fault [referring to an accidental pregnancy]. It happened only because I misunderstood the processes...In our time we didn't study anything...I don't know whether it is a part of the curriculum or not. But in our times, it wasn't. (Husband, 25 years old, Barisal)*

As mentioned in section 4.2.4, many young women described their own incorrect use of contraception given to them by family members who had not provided proper instructions. A young woman who conceived due to incorrect use of contraceptives went on to conceive again 40 days after having her first baby. She stated that due to her home delivery, she had not seen any health-workers and therefore was still unaware about family planning. However, she then miscarried this second pregnancy, after which she went to hospital and was *"was told about all these [contraceptives] by the authorities. They made everything understandable for me"*. After this, she stated that she had started using contraception. Other young women stated that they didn't use contraception, even though they knew about birth control.

4.3.2.4. Misconceptions about hormonal contraception and abortion

As discussed in section 4.2.1, most young women participants were familiar with condoms and contraceptive pills, and some with injectables, but very few mentioned knowledge or usage in the community of other long-acting

reversible contraceptives (LARCs) such as the implant or the IUD. This was corroborated by health-care providers. This resulted in non-usage of LARCs in favour of forms of contraception that are far more susceptible to user-error and disruption of availability, such as the combined oral contraceptive pill (taken daily) or condom. This leaves girls and women at much higher risk of both accidental pregnancy, as well as forced interruption of contraception usage due to pressure from family members (as reported by many of the young women participants).

Many participants of all types and genders discussed the widespread belief that (hormonal) contraception and abortion were causes of infertility, which was a direct driver of adolescent pregnancy. Many participants did not state directly that they held these views, rather they were discussed as commonly heard arguments used to discourage use of birth control.

> *We encourage them to adopt 'Implant' which restricts pregnancy for 3 years. But the percentage is very low. The girls think that if they don't have children as soon as possible then the marriage won't survive. They also think taking children will prove her capacity to reproduce. (Health worker, Male, Government facility, Cumilla)*

4.3.2.5. Pregnancy as a result of rape

Some participants also discussed a few pregnancies in their communities as a result of rape, but only in the context of pregnancies that occurred outside of marriage. It was often assumed, especially by husbands and mothers/mothers-in-law, that pregnancies occurring outside of marriage were largely caused by pressure and/or violent assault of women by men. One mother discussed the case of an unmarried girl with learning disabilities who conceived due to sexual assault. Attitudes towards GBV survivors and the consequences for both survivors and perpetrators are discussed at length in section 4.1.6.

4.3.3 Consequences

4.3.3.1. Impact on physical and mental health

Young women experienced negative effects on both their physical and mental health, which were frequently interrelated. Study participants both young and adult spoke of the adverse impacts early pregnancies had on young women's bodies, and explicitly linked these to early childbearing. Many of the young women in the study discussed firsthand the effects that their pregnancy had on their own physical health including that of weakness and possibilities of miscarriage. For many these effects on their

physical health heightened their feeling that they were not yet prepared for parenthood.

> *The situations I am facing, I am physically so sick. I feel so unwell sometimes and I feel like dying often..I can't do much. If I do any work, I feel dizziness. I fall down in dizziness...If I was pregnant at the age of 20, it would be much better for me. Or it would be more better 21 years old. (Young woman, 17 years old, Dhaka)*

All of the young women interviewed as part of this study were married, and many spoke of the extreme distress that resulted from their experiences of early marriage and adolescent pregnancy. While no unmarried pregnant women were interviewed, participants of all types suggested that these young women would likely face even higher levels of stress caused by the stigmatisation of such pregnancies (discussed further below in section 4.3.3.2).

While some participants were neutral or excited about the prospect of parenthood (a sentiment which was far more common among husbands), many pregnant women and some husbands experienced anxiety in relation to their perceived lack of emotional and financial preparedness for this stage of life. With regards to young men (husbands) who were interviewed, the main anxiety they experienced related to increased tension within the marital home, including heightened pressure to earn an income to support their growing family.

> *At that time, actually, I didn't feel that good thinking the family is getting bigger gradually. Maybe I will feel better after the delivery of the baby. But I didn't feel good thinking the poor situation of the family. Because we are far behind with money (Husband, 25 years, Chittagong)*

4.3.3.2. Social shame & stigma for unmarried women

In general, as discussed above, unmarried young women who became pregnant faced shaming and stigma. If the prospective father would not marry them, young women were reportedly pressured to give away or abort their children to try and avoid passing on this stigma to them. In these circumstances it was stated that they would likely not be able to have contact with the child as it grew up. Young men however, did not face similar consequences.

> *If an unmarried girl gets pregnant she faces a lot of social issues and problems. Our society doesn't want to accept these cases...And that girl may face many shaming, harassments and*

> *judgments and she may became mentally upset ... she suffers from mental trauma and may commit suicide. That is why they must be given mental support in such situations. (Health worker, female, Cox's Bazar)*

4.3.3.3. Improved reproductive autonomy and access to contraception

Many participants suggested that once young women had given birth to their first child, they were then better able to make their own decisions about contraception and birth spacing as they had satisfied their in-laws' wishes and therefore faced less pressure from them. However, as the young women participants in this study had all very recently begun childbearing no one was able to confirm this from personal experience, rather it was often expressed as a hope or expectation. As explained in section 4.2, young women were also more easily able to opt for contraception after they had their first baby, partly as a result of increased contact with SRH services.

4.3.3.4. Early marriage

Participants of all types strongly asserted that the most socially acceptable solution to a pregnancy that occurred outside of marriage was for the couple to marry, thus putting young people at risk of early/child marriage. This was often considered the primary solution for the girl; however, for the boy, one participant suggested they could refuse but that this refusal would be a reflection of his 'bad character'. The limited decision-making space available to women in such circumstances is starkly evidenced by the fact that in cases of sexual assault, marrying her rapist was seen as the best available option for her, and even in these cases she would have little ability to influence this outcome.

4.3.3.5. Pressure to abort

Although there is some stigmatisation of use of MR services (as discussed in section 4.2.3.2), the findings suggest that unmarried young women may face pressure to undergo MR or abort their pregnancy. A woman in Cox's bazar also spoke of some young women who abandon babies conceived outside of marriage.

4.3.4 Decision-making

As discussed above, for young married couples the decision about when and how many children[12] to have was seen as an issue that concerned the whole family rather than just the prospective parents.

[12] *The question of whether couples wanted to ever have children was not something discussed by any participants*

Where young women wished to delay pregnancy but family members wanted them to begin childbearing, there were several ways in which pressure was applied to the young women, but also some evidence of ways in which (few) young women (and their husbands) resisted. One of the means of applying pressure was to accuse young married women of having fertility issues, and to suggest that they might have caused this or cause this in the future if they begin/continue to use contraceptives:

> *After passing 8 months, I thought to have baby. I got afraid if I could not take baby in future due to this delaying. Everyone used to say that if you take medicine too much, you will not have baby. Then I have left having medicine. Then, I saw that I was not being able to have baby. So, everybody suggested to consult with a Kabiraj (Ayurvedic practitioner). But I didn't consult with kabiraj. I thought that Allah will do what he wants, we are still young and we have enough time to have baby later. If I could not have baby at older age, then we will consult with the doctor. (Young woman, 18 years old, Chittagong)*

The cultural practice of couples living in the family home of the husband following marriage gave families of husbands a great deal of influence and control. For example, one health worker from Cox's Bazar described how the parents-in-law of a 13 or 14 year old girl she had seen were threatening to kick the couple out of their home unless they conceived.

Key decision-makers included mothers-in-law, sisters-in-law, husbands, and young women themselves.

The wishes of in-laws (i.e. families of husbands) were generally given far higher priority than those of young women and their parents. Some young women did describe themselves as wanting to conceive, but usually as this quote illustrates, in reference to their agreement with their husband or family's wishes:

> *Everybody has a wish. I have this wish [to have a child]. My husband [has this wish]. I had also but my husband wanted the most. (Young woman, 15 years old, Cumilla)*

Some women who attempted to assert their own wishes in regard to pregnancy were beaten by husbands and their wishes were ignored. Even where young women wished to delay due to physical health problems and their husbands were sympathetic to this, their wishes were sometimes ignored and overridden by parents-in-law:

> *I told my husband. He said that if you feel bad, then you can take [conceive the baby] later. But my parents-in-law and others*

> *said that you are the eldest. So, you will have to take baby now. (Young woman, 17 years, Cox's Bazar)*

While unusual, some couples reportedly took factors such as a woman's desire to continue education into account when deciding to delay childbearing. In this case, a young man whose wife planned to have an abortion reported:

> *We aren't ready to have a child now. My wife is studying now...Yes. Also my income source is not so good. And so, we're not prepared to bring a new life. (Husband, 25 years old, Barisal)*

Abortion

Contrary to all other aspects of decision-making, unmarried pregnant women appeared in some respects to have more decision-making space available to them in relation to abortion. Participants generally discussed abortion/MR as an understandable and socially acceptable response to an unmarried girl's pregnancy (where the prospective father refused to marry her). However, given the stigma around pre-marital pregnancies, it could also be suggested that unmarried young women were sometimes encouraged to abort. It was also acknowledged that despite greater social acceptability to abort, there may be formal barriers (e.g. eligibility requirements restricting access to married people) to accessing these services.

Where young married women had become pregnant entirely unintentionally, there was a generally expressed view that aborting one's first child in particular was unacceptable, despite a somewhat ambivalent or tolerant attitude towards early abortion/MR in other circumstances. This limited the decision-making ability of young women, and was a driver of continuation of unintended adolescent pregnancy:

> *Yes...Actually my son-in-law decided to have this child as termination of the pregnancy might cause complications later... This is their first child. Abortion might dissatisfy Allah (Mother, of (recently) pregnant 17 year old, Dhaka)*

One young woman reported that this pressure was exerted not just by family members, but also by service providers. However, some young couples, supported by doctors, were able to make the decision to abort their unintended pregnancies:

> *At first my wife discussed this to the doctor that we are not willing to conceive now. So, what can we do? Then we've been suggested to feticide the foetus [referring to MR]. (Husband, 25 years old, Barisal)*

As with timing of birth, education appeared to be a factor which strengthened the decision-making ability of young couples in relation to abortion. While we cannot draw broader conclusions from such a small group of participants, the only young woman in the study who was able to make the decision to terminate her unwanted pregnancy was also one of the only two who was still in education.

> *No. He [referring to her husband] prioritised my decision. As I didn't want to give birth...He is [also] just a freshman and I'm a running student. It will take him at least one year to get a job. If we have a baby at this time, we would be in trouble as he has no job. Whatever we did [referring to the MR] was our own decision. My husband is educated and whatever I am he always respects my choices and never dominates me for anything. (Young woman, 17 years old, Barisal)*

4.3.5 Violence experienced during pregnancy

Only a few interviewees considered that the level of husbands' aggression changed with the woman's pregnancy or shortly after childbirth, suggesting that also pregnant women and young mothers are frequently exposed to physical violence at home.

> *"My husband beat me once, when I said that I wouldn't take the baby. When I conceived baby, he beat me. He said, don't talk like this ever, it should be taken as Allah gives it." (Young woman, 18 years old, Chittagong)*

Some young women also shared how their husbands abused them verbally, for instance by yelling or scolding, but also by insulting their cooking skills or calling them lazy or voicing regrets for marrying the woman. Thinking back of the emotional abuse experienced during pregnancy, some young women mentioned that they felt lonely being left home alone and not being allowed to leave the house for significant times.

A few young women further reported that their mothers-in-law also emotionally and verbally harassed them before, during and after their pregnancy. Such abuse can take the form of restricting their free movement outside the house, not providing them with (enough) nutritious food, expecting them to do harder labour than their physical state allows, as well as blaming them for wrong doing after giving birth with a caesarean. Some of these experiences are captured in this conversation with a young mother from Barisal:

After having the initial check-up to confirm my pregnancy, the doctor prescribed me to avoid heavy tasks, not carry bulky jars, or wash clothes. Still, I had to clean heavy clothes, and carry heavy pitchers. I did have severe stomach aches sometimes, they did not even care. In terms of food, the doctor suggested I have milk, eggs, and fruits. But they did not provide me with anything...They had money. It is just that they did not waste their money on me.... they [mother-in-law and husband] still barb me saying did my parents have given a penny, nothing. (Young woman, 17 years old, Barisal)

It was also frequently acknowledged that between partners, GBV did not occur from day one but started a little later into the relationship. Out of the young women interviewed who had experienced physical violence before their pregnancy, some shared that their husbands' behaviour did not change during or after pregnancy, while, a young woman and her mother-in-law, at least in a few cases participants had the feeling that husbands reduced the physical violence upon pregnancy or when they had children.

4.3.6 Prevention activities

In conversation with several young women, husbands, mothers, mothers-in-law, and health workers, preventing adolescent pregnancy was discussed - mostly in relation to young people's, but also the older generation's, perceived lack of information and knowledge about sexual and reproductive health and family planning in particular (also see section 4.2.1). Interviewees advocating for or engaging in prevention activities focused mostly on the perceived need for strengthening young women's agency and participation in pregnancy-related decision-making, as well as awareness raising and education around contraceptive use to prevent or space pregnancies.

As discussed in section 4.3.2, we found that community members were perceived as vocal in what they considered 'the right time' for a young woman in their neighbourhood to conceive as well as often negatively influencing prevention activities through spread of myths about infertility as a result from using contraceptives. At the same time, many young women interviewed stressed that family members, teachers, health workers and religious leaders had the necessary positioning to influence change and should therefore contribute to advancing sexuality education.

School and college teachers [can educate about the negative aspects of adolescent pregnancy]. If they provide us the information about having children at a particular age which is good for us, then we would be more careful. Also, if the doctors

> *and health care providers give the message, it will be more helpful. In the religious gathering, the religious leaders can provide this information about the bad sides of adolescent pregnancy. People would be careful and free from shaming. (Young woman, 18 years old, Cumilla)*

4.3.6.1. Role of parents and in-laws

While a few participants reportedly had no open conversations about pregnancy prevention in their family homes, those that regarded parents and in-laws a role in preventing adolescent pregnancies suggested that talking about it with a girl or young woman was the responsibility of women in their lives: mothers, sisters, if applicable, or - particularly once they got married - their mothers and sisters-in-law. Accounts like the below also suggest that the role of parents and in-laws in pregnancy prevention is increasing:

> *Yes. They [parents] didn't use to do it [discuss family planning with their children] before. But nowadays mothers are more aware. Fathers also go to places, have discussions and get to know about these things from the meetings at shops or other places. Mothers discuss the issues with family planning officials. Also they learn information from TV and make their kids aware by discussing with them. (Mother-in-law, Cox's Bazar)*

Some accounts suggest that female family and in-law members indeed supported young women in preventing early pregnancy by organising family planning methods for them. However, they did not communicate accurate information on how to use the contraceptives.

Acknowledging a lack in SRHR knowledge among adults, a health-worker interviewed suggested that existing pregnancy prevention programmes focusing on young people should include guardians:

> *We need to provide the information through trained personnel. Though the school health education program is running, I think it should include the guardians. A guardian meeting can be arranged monthly to give information regarding pregnancy and other adolescent problems. Also, we can train the teacher to give motivation to their students about it. Overall, all types of people need to work together to prevent adolescent pregnancy. (Health worker, female, Government facility, Cumilla)*

With regards to parents' role in educating boys and young men about preventing pregnancy, participants' views varied. While some suggested

that fathers would talk about pregnancy (prevention) with their sons, others considered that boys and young received most information on this topic from brothers, if applicable, or their friends as well as via (social) media (see section 4.2.3).

4.3.6.2. Role of public health services

Overall, participants acknowledged that the government played an important role in offering pregnancy prevention activities, such as awareness raising campaigns, educational and counselling offers and SRH services (also see section 4.2.6). Several accounts of young women interviewed sharing that health workers have encouraged them to postpone pregnancy.

According to health workers interviewed, prevention activities focus mostly on girls and young women who have married at an early age, aiming to sensitise them in relation to the option of postponing their first pregnancy. In the words of a health worker from Cumilla, *"the motto is 'No marriage before 18 and no children before 20'"*.

> *Yes. I, myself, suggest them. If I get anyone age under 20 among the women who come here for [family planning], I advise them not to take baby before 20. Move freely few more years. Develop yourself and if you are in education, then study. I try to understand first whether she is student or housewife. Considering her condition, I advise her accordingly. I advise everyone not to take baby before 20. (Health worker, female, Chittagong)*
>
> *There [in pregnancy prevention activities] we tell them that an adolescent girl is the future mother. So from the beginning of having menstrual periods, we tell them about the hygiene, sanitation, vaccinations, having iron tablets and folic acids, having nutritious meals and all the issues. This is what I tell them at 1st. After that I tell them what complications they can face if they become mothers before a specific age, and what are the benefits of getting pregnant and the right time or the other sides of it. We make them understand about these issues. (Health worker, female, Cox's Bazar)*

As illustrated in the account above, most health workers reportedly also considered it their responsibility to educate girls and young women about the physical, financial, and educational impacts of early pregnancy.

Some pregnancy prevention programmes from health workers are being offered during school visits, both in junior high schools as well as the

example from Cox's Bazar shows, at times also in madrasas involving religious leaders:

> *We are connected in schools, mainly in the junior high schools where the children are at 12, 13 or 14, 15 years old. After the 10 years old to 19 years old children are given advices from us. We even go to the Madrasa and provide them health educations and advices. We show them things in projectors, we show them dramas on these issues. And also at the Madrasa, Masjid those who are Imams there, we encourage them to talk about these issues in those shows there. We also tell the Chairman and the members to promote awareness. This is how from the governmental level we take measures. (Health-care manager, female, Cox's Bazar)*

As the majority of prevention activities take place at health facilities or schools, in line with the quote below, some participants highlighted the importance of offering more campaigns, information sharing and prevention activities to girls and young women who lack opportunities to leave their homes:

> *Girls don't go outside often, so information should be carried to them. The family planning service provides can give better services to share the knowledge of family planning methods. (Young woman, 17 years old, Cumilla)*

Also, to counteract social and religious norms that restrict young people's access to prevention activities (see more on barriers to access to services in section 4.2.3.), some health workers interviewed in this study stressed the importance of door-to-door services for young women as well as their husbands and families where they share knowledge about a nearby facility or engage in counselling services directly. According to a mother-in-law from Chittagong, public awareness raising on pregnancy prevention has also been initiated at least in some parts of the country:

> *The government gave us all types of facilities already. Even they left its campaign. So, now if you don't take it, it's not the fault of the government. They already preached a slogan in the country that "Duiti Sontaner beshi noy, Ekti hole valo hoy" (Not more than two children, one is better). So, now, it depends on you that what you will do. (Mother-in-law of (recently) pregnant young woman, Chittagong)*

Some participants stressed a need to increase the number of health workers to increase reach.

4.3.6.3. Role of teachers

Overall, the majority of participants agreed that for school-going children and young people, teachers can play a crucial role in preventing adolescent pregnancy.

> *They haven't been to school, that's why they lead their lives in their own ways. Whereas school-going kids learn from their tutors. They can generate acquired knowledge when they are grown-ups. They will be able to differentiate between right and wrong. Teachers would guide mothers about dos and don'ts, and accurate and inaccurate facets. (Mother of (recently) pregnant 17 year old, Barisal)*

However, sexuality education from school may not only cascade to parents as suggested in the quote above, several participants in this study particularly have highlighted the perceived benefit of school-based prevention activities over often girl-focused activities in health facilities given that boys and young men would also be educated on the topic.

Officially, teachers for classes 9-12 are responsible for covering sexuality and pregnancy-related topics in their teachings. However, as the quote below illustrates, neither a curriculum nor teacher training materials have been developed.

> *Teachers don't usually have ideas about this [sexuality education]. We don't ask them to attend even if they do. But our population policies dictate that there should be collaboration among all the departments and use them when necessary. But our SACMOs[13] or secondary school representatives are instructed to make a school education curriculum...We don't have any curriculum with the secondary school teachers yet. We haven't yet trained them or used them for our programs. (Health worker, male, government facility, Barisal)*

A few participants have also questioned whether sexuality education in schools should start – in an age-appropriate manner – earlier in the curriculum. Some accounts suggest that school-based prevention activities focused on encouraging young women not to have more than two children, while the physical education curriculum guides teachers primarily in educating about physical changes that children and young people observe while growing up.

[13] *Sub-Assistant Community Medical Officers*

> *Family planning as in the books of secondary and higher secondary level have information. Like not to have more than two children or this type of information. (Husband, 26 years old, Barisal)*

While our findings overall are too limited to draw conclusions about the level of quality and comprehensiveness of sexuality education in the study areas, young people shared different experiences with sexuality education at school. While some young women interviewed suggested that teachers in their experience sometimes skipped or insufficiently covered topics related to sexuality education, one interviewee felt teachers went over the physical education chapter on sexuality in detail.

Representative of several responses from young women, husbands and health workers, a male health worker from Barisal reasoned: *"One reason [why teachers do not teach about pregnancy prevention] is they somewhat feel shy. They may feel shy to talk about these issues with the children."*. Some participants also suggested that young people themselves might not feel at ease to talk about family planning with their teachers. Further, a participant also suggested that teachers might also feel differently equipped or comfortable to implement sexuality education, depending on whether they are teaching in a co-educational or sex-segregated teaching environment.

4.3.6.4. Civil society-led youth activities and youth clubs

In addition to government-led health service and education activities around pregnancy prevention, some participants, including young women from different study areas also highlighted the role that civil society organisations play in their communities.

> *They [adolescents] get training on this issue nowadays. There are NGOs in different areas, they spread awareness in neighbourhood. They spread awareness about modern birth control methods, and how to avail those methods. They encourage them to use modern family planning methods. (Mother-in-law of (recently) pregnant young woman, Cox's Bazar)*

While door-to-door services are reportedly offered by some health workers and civil society organisations, some young women interviewed also flagged that they never got in contact with such initiatives (see potential barriers to access and use of services in section 4.2.4).

Some interviewees, including young women suggested that particularly youth clubs or youth-led activities had the potential to cascade learning

about preventing pregnancy from school-going youth (girls) to out-of-school youth.

Overall, perceptions of the role of youth clubs varied among participants. Some shared that youth clubs in their experience did not focus much on topics around pregnancy prevention, while a health worker from Barisal argued that they present an opportunity as young people can have a lot of influence on each other when discussing pregnancy in safe spaces.

4.3.6.5. Role of religious leaders

When discussing pregnancy prevention activities with study participants, religious leaders were generally not regarded as playing a significant role and seemed to be rather neutral in their discourse around use of contraceptives.

One male health worker from Barisal suggested, that religious leaders in recent times have gotten more open to speak about adolescent pregnancy prevention: "*The Imams also try to make them [adolescents] aware now. I don't see any problem in that.*". Overall, among interviewees advocating for more pregnancy prevention activities in the communities, the perception persisted that religious leaders would be a core target group to engage more due to their influential role in the community.

4.3.6.6. Alternative (online) pregnancy prevention activities

As shortly touched upon in section 4.2.2, some young women and husbands interviewed confirmed that (social) media was a growing opportunity for engaging young people in pregnancy prevention activities, being used to self-study and exchange:

> *Yes. Via YouTube...Not like...There are vlogs of different medical professionals on social networking sites. We can learn many things from these pages. (Husband, 25 years old, Barisal)*

Different media platforms may reach other groups. According to a mother-of-law from Dhaka, *"People have learned a lot about these things [pregnancy prevention] from TV."* TVs therefore seems to be an effective awareness raising and educational method, because "*almost every household has one.*" When asked about pregnancy prevention activities in fragile settings, for instance in situations after natural disasters, in political instability or during pandemics, a young woman (17 years) from Barisal further suggested to introduce a toll-free tele-service for family planning, inspired by the already-existing 999 government hotline.

5 Discussion and Conclusion

Adolescent pregnancies are closely **linked to child marriage** in the context of Bangladesh, both of which are related to gendered norms which encourage a view of girls and women as economically unproductive, and dependent on relatives for financial as well as social security (Acharya et al., 2010). As a result, women are often denied access to education (seen by parents as a squandered investment) and relegated to the domestic sphere, while their **value is attached to their reproductive functions**. Financial precarity and the belief that women and girls are financially burdensome mean that early marriages are often hastily arranged for young women as soon as possible, usually with little regard to their own wishes. **Poverty and lack of/interruption of education** exacerbate these issues (Hameed et al., 2014), and have been described as the immediate cause of many of the participants' child marriages. These were often entrenched by death or sickness in the family, and school closures related to the **COVID-19 pandemic**.

These risk factors closely related to **social norms that aim to regulate young women's sexual and romantic relationships.** Young women's ideas of what society and often, they themselves consider a 'good girl' meant that they changed their own behaviour (for eg. going out too much or fraternising with boys) to ensure they were not perceived negatively by their parents or society (as this 'bad behaviour' could potentially lead to marriage) (Naved et al., 2022). (Child) **Marriage was hence, also positioned as a form of protection** against pre-marital sex (perceived as both sinful and frequently non-consensual) and sexual assault.

Contradicting discourses on the acceptability of adolescent pregnancy co-existed in the communities. Family and societal members pressurised young women to give birth soon after marriage to prove their fertility and fulfil familial desires, one of which was to extend the family line by giving birth to a son. In parallel, there was widespread awareness of slogans such as 'no marriage before age 18, no baby before age 20', and community members recognised adverse health effects of an adolescent pregnancy. This idea, however, was often expressed regarding 'other young women' and often did not apply to women in their households.

In general, while many young women were able to clearly express their own desires and ambitions, these were frequently ignored by those around them. Prior research by Rahman et al. (2014) found that only a third of Bangladeshi women were involved in making decisions for their own health and according to Haque et al (2012) and Acharya et al. (2010), this

depended on one's employment status, educational levels among other factors (Haque et al., 2012; Acharya et al., 2010). In a patriarchal context such as Bangladesh, age and gender intersect to give power to certain household members. **Young men and particularly mothers-in-law dominated the conversation and decisions around family planning on behalf of young women**. Our study findings highlight the role mothers-in-law played in deciding if contraceptives would be used. Similar to other South Asian societies, elder women such as the mother-in-law in the household are responsible for pregnancy-related decisions since male involvement is not common (Shahabuddin et al., 2016; Simkhada et al., 2010). Living with in-laws also resulted in increased dependence on them which meant that young women were compelled to obey their (particularly mothers-in-law's) demands, regardless of whether violence was used. As found in Pakistan, this obedience also comprises of the daughter-in-law's 'good' behaviour (Mumtaz & Salway, 2007). Interestingly, **mothers-in-law asserted and negotiated their authority in similar ways, perhaps to retain their position in the household, but also because they went through similar experiences**.

Due to misconceptions about contraceptive use and menstrual regulation leading to **infertility,** young people and parents had an overwhelming belief that young women should and **need to give birth to one child**, only after which it was acceptable for them to consider family planning or potentially MRM services. Young people had **low levels of knowledge on contraceptives and SRHR was prevalent** due to the **lack of (comprehensive) sexuality education in school (Islam et al., 2018)** and the barriers in accessing SRHR information and services prior to marriage such as shyness and **lack of youth-friendly health services, and a refusal to consider unmarried youth as being sexually active by health workers** and society in general. **contraceptives** among others. Some health workers also that felt access should be differentiated by marital status. In this regard, unmarried youth face clear barriers as they are asked for their marital status to avail such information, but also services. In fact, some young women in the study suggested that young people would prefer to have this information prior to marriage so that they can avoid pregnancy immediately after marriage. However, as Haque et al. (2012) indicate, since seclusion and limits on mobility are part of women's reality in Bangladesh, a guardian-often male is needed even to gain access to health services- also for married women. Due to the above reasons, contraceptive and family planning-related information and services was therefore far more easily accessible to young people once they were married and even more so once they had already given birth (Shahabuddin et al., 2016).

When young women interviewed were given contraceptives by their family members such as their sisters-in-law, it was often inaccurate information which led to incorrect use of contraceptives and consequently an intended pregnancy. To tackle **misinformation about hormonal contraception and increasing its uptake**, contraceptive counselling offered to the woman alongside the husband and the mother-in-law offer an opportunity.

The above referred norms regulating women's sexuality result in widespread acknowledgement of the **stigma and shame** experienced by unmarried pregnant women and their prospective children. Men who were involved in out-of-wedlock pregnancies were not subject to the same censure, though they were seen as being of 'bad character'. Marriage was viewed as the only socially acceptable response to such pregnancies, representing another link between child marriage and adolescent pregnancy. Since no unmarried pregnant young women participated in this study, we were not able to hear firsthand from any women who had experienced this. On the other hand, married young women expressed regret with their experiences of child marriage and consequently early childbearing. Mistreatment and violence at their in-laws' homes, restrictions on mobility and other freedoms indicate the **impact on mental health** experienced and narrated by young women. A study conducted in parts of Mymensingh district in Bangladesh revealed that antepartum depressive and anxiety symptoms were prevalent in many of the women in their last trimester of pregnancy, which were in turn associated with their poor financial situation, partner dynamics and violence in the household.

The study also highlights the wide-ranging incidents of **gender-based violence** experienced in general by young women, as well as during pregnancy. Known in South Asia by the term 'eve-teasing' or more accurately what is **street sexual harassment** is a common occurrence which is **normalised for both women and men**. In addition, many young women reported violence in the in-laws' household, either in the form of intimate partner violence or violence inflicted by the mother-in-law. During pregnancy, this took various forms- that of non-consensual sex within marriage, increased amount of care work, lack of nutrition as well as physical beatings. While increased household decision-making is associated with lower likelihood of IPV, there is mixed evidence on this in Bangladesh (Alam et al., 2021; Rahman et al., 2011). However, increased educational and economic equality for women and men both have been associated with lower levels of IPV (Alam et al., 2021).

Our study set out to explore the reasons for adolescent pregnancy among

unmarried and married young people in Bangladesh from their own perspectives. However, it became increasingly clear that this would be limited to married young people. Even though the research team attempted to recruit and invite unmarried young women to participate in the study, they faced several challenges. The one unmarried participant who did agree to participate decided to withdraw her consent partway through due to the taboo nature of the subject and her own negative experiences surrounding pregnancy.

Prior research has highlighted the challenges including of child marriage and increased barriers to SRH services faced by young people in fragile settings in Bangladesh (Ainul et al., 2018). While we did interview persons residing in Cox's bazar, explicit focus on the camps was not possible due to bureaucratic, security and logistic challenges. In addition, although we did interview persons from climate-change affected areas as explained in the study sites above, and while fragility-related considerations were integrated in the data collection tools, study participants did not explicitly mention any such factors as impacting their SRHR. It is possible that some of the findings alluding to lack of outreach services and more clearly incidence of GBV is linked to fragility. However, due to limited probing, a direct relationship between the two is not possible to ascertain.

6 Recommendations

1. Conduct **community and intergenerational dialogues** among community members to bridge the communication gap between young people and adults.

2. Implementing **quality implementation of current reproductive health education** in Bangladeshi schools. This can include **teacher support groups** to ensure that teachers can exchange challenges or lessons learnt on teaching these chapters in schools. Simultaneously, **continued lobbying for comprehensive sexuality education which is age-appropriate and includes referrals to existing Adolescent-Friendly Health Corners in Bangladesh**.

3. Promoting the use of **online sexuality education resources** (particularly on contraceptives) especially given lack of teacher training, poor attitudes of health workers towards unmarried young people SRHR needs and given young women have limited mobility. This may not include young women who cannot borrow or own a cell phone, but still can offer some avenues, also for young men to be informed.

4. Health workers should provide **contraceptive counselling (including of LARCs) to all newly married women and close family members, including the mother-in-law, and husband.** This can promote male engagement and tackle misconceptions about contraceptives.

5. Conducting **regular value clarification with health workers** to separate personal values and professional responsibilities. This can help health workers navigate their person beliefs which may be conservative about pre-marital sex and timely use of contraceptives. This can also be useful for **teachers**.

6. Ensure continuous t**raining of health workers on implementing youth-friendly services**. Health workers should be trained to treat young people above 18 years as independent adults without the need to know their marital status.

7. Engaging Family Welfare Visitors, SACMOs and community clinics as well as their supervisors at the district and upzailla level to ensure continued **outreach activities in communities in activities in school**

8. Setting up **follow-up systems in schools** which target girls and their parents that are potentially 'at-risk' of dropping (poor financial situation, sickness in the family etc), and targeting those homes where girls have dropped out or have been married. This can help harness the clear gains from increased education in aspects of decision-making in the household and avoiding early marriage or early childbearing.

9. **Championing supportive marriage registrars** that are against child marriage as role models

10. Develop specific strategies to **engage potential allies on gender-based violence such as teachers, religious, and community leaders.** These stakeholders are well placed to conduct **community-based activities that engage and sensitise men and boys** on the forms, causes and harms of GBV, and mainstream this topic into existing community activities.

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8 Annex

A. Topic guide used for in-depth-interviews with (recently) pregnant young women[14]

Area of Inquiry	Questions	Probes
Gender	1. What is a good girl/boy?	• Characteristics • Role differences • Decision making power of women and men • Gender (in)equality
Adolescence and related challenges	2. What are the some of the issues that adolescent girls and boys face during this period? 3. When do adolescents start engaging in love and relationships here? 4. What are young people's desires and hopes in this community in relation to marriage, children and parenting?	• Feelings experienced during physiological changes? • Feelings experienced during mental changes? • Is there any difference between boys & girls? • Do young people usually agree/disagree with their parents about these topics? • What happens if they disagree?
Causes of adolescent pregnancy	5. How common are adolescent pregnancies here? 6. Why do unmarried young women become pregnant before the age of 20? 7. Why do married young women become pregnant before the age of 20?	• Social norms of the community • Religious beliefs • Beliefs around contraception and service use • Links to education or economic opportunities • Due to floods/ conflict when on the move? • Stigma of infertility • Presumptions of infidelity • Improved status of Girls' and Boys' (wife and husband) after birth • Lack of girls' individual agency • Misconceptions around contraception

[14] *This was developed in English and translated into Bengali for use in the interviews*

Area of Inquiry	Questions	Probes
Knowledge and information about family planning / contraception	8. How can someone prevent pregnancy? 9. Where or whom do you go to, to get information about family planning methods? 10. What barriers do young people face when trying to get family planning information?	• Contraceptive methods, traditional methods • Teachers, health workers, TV, social media • Is there a minimum age for pregnancy? • Difference between married and unmarried women
Consequences of adolescent pregnancy	11. If an unmarried girl is 15 and turns out she is pregnant, what usually would happen? 12. What are the consequences for the young woman once she is pregnant? 13. What are the consequences for the young man after the pregnancy, and when he becomes a father?	• Do these kinds of pregnancies happen a lot? Why do they usually happen? • Who would she ask for help- family members/ teachers, health workers • Role of the boy/boyfriend • Schooling, jobs, health • How does the community look at the young woman • How does the community look at the man that got her pregnant • Difference in consequences for married and unmarried women • Social stigma
Menstrual Regulation services	14. How easy is it for pregnant unmarried or married girls in this situation to access menstrual regulation services? 15. What are the barriers (religious/social) to accessing MR services	

Area of Inquiry	Questions	Probes
Pregnancy-related experiences (for those who experienced TP)	16. How did you find out that you were pregnant? 17. Do you want to continue your pregnancy by your own decision or by any pressure from your husband/family member/society? 18. If you have ever sought out menstrual regulation services, how did you find this experience?	• Was it your choice to become pregnant? • Support from partner/ boyfriend
Contraceptive use and choice	19. Who decides whether young women or men can use a contraceptive method or not? 20. Who decides which contraceptive method to use? 21. What role do religious/ community leaders play in promoting or discouraging contraceptive use?	• Mother-in law, role of husband/boyfriend • Role of schools/teachers • Role of healthcare workers • Are women pressured to have sex without contraception? • Difference between married and unmarried women
Gender based violence	22. Do girls and women experience (sexual) violence in (refugee or cyclone/flood) camps? 23. Do girls and women experience (sexual) violence when they are 'on the move', before arriving in camps? 24. How does the community view women and girls who become pregnant as a result of sexual assault?	• Violence from husband/ boyfriend/ host community/ anyone else • On the move refers to displacement due to extreme weather or conflict • If so, what happens to them e.g. are they encouraged to stay silent, is any support available, can they speak to anyone?

Area of Inquiry	Questions	Probes
SRH services access and use	25. What type of services are available for young women's SRHR in this community/ camp? 26. What are the challenges that young women face while accessing or using these services? 27. What is the role of health workers in the community/ camp in helping young women prevent adolescent pregnancy?	• What services you think need to be made available at doorstep or within communities • Services provided by NGOs, governments? • Long distances and mobility • Costs for service use or transport • Challenges related to displacement if relevant (e.g. language barrier, no provision, no knowledge of local area) • Any impact of extreme weather? • Stigma / religious or social disapproval
Preventing pregnancy	28. What role do community members play in relation to adolescent pregnancy (both married and unmarried)? 29. What can help young women and men have a better future in this community?	• Difference for married and unmarried women • Both positive and negative roles • Role of teachers, religious leaders • Role of parents / in-laws • Role of youth clubs, schools etc • Sexuality education, life skills, provision of contraceptives, education or economic empowerment interventions
Educational and economic opportunities	30. What are the schooling options for young people in the community? 31. What are the employment opportunities for young people in the community?	

B. Topic guide used for in-depth-interviews with husbands of (recently) pregnant young women

Area of Inquiry	Questions	Probes
Gender	1. What is a good girl/boy? 2. What is a good husband/wife?	• Characteristics • Role differences • Decision making power of women and men • Gender (in)equality
Adolescence and related challenges	3. What are the some of the issues that adolescent girls and boys face during this period? 4. When do adolescents start engaging in love and relationships here? 5. What are young people's desires and hopes in this community in relation to marriage, children and parenting roles?	• Experienced feelings during physiological changes? • Experienced feelings during mental changes? • Is there any difference between boys & girls? • What are the concepts of love, affection, communication, relationship, conflict/ conflict management, empathy, sympathy, healthy behavior. • Do young people usually agree/disagree with their parents about these topics? • What happens if they disagree?

Area of Inquiry	Questions	Probes
Causes of adolescent pregnancy	6. How common are adolescent pregnancies here? 7. Why do unmarried young women become pregnant before the age of 20? 8. Why do married young women become pregnant before the age of 20?	• Social norms of the community. • Religious beliefs. • Beliefs around contraception and service use. • Links to education or economic opportunities. • Due to floods/ conflict when on the move? • Stigma of infertility. • Presumptions of infidelity. • Lack of girls' individual agency. • Misconceptions around contraception.
Decision-making about pregnancy and contraception	9. How do you and your wife make decisions about getting/not getting pregnant? 10. Who decides whether or not you and your wife use a contraceptive method, and which method? 11. Where or whom do you go to, to get information about family planning methods? 12. When you found out your wife was pregnant, who/how did you make a decision about whether or not to continue with the pregnancy?	• Contraceptive methods, traditional methods • Is there a minimum age for pregnancy? • Difference between husbands and wives in decision-making • Influence of healthcare workers • Any issues accessing FP services
Expectations of parenthood	13. What was your reaction when you found out your wife was pregnant? 14. How did your wider family and community respond? 15. What expectations did you have of fatherhood? 16. What expectations did you have of your wife as a mother?	• Reactions/ influence of wider community and family (e.g. married couple's parents) – did they have any expectations • Influence of cultural beliefs about father/motherhood • Improved status of Girls' and Boys' (wife and husband) after birth

Area of Inquiry	Questions	Probes
Consequences of adolescent pregnancy	17. If an unmarried girl is 15 and turns out she is pregnant, what usually would happen? 18. What are the consequences for the young woman once she is pregnant? 19. What are the consequences for the young man after the pregnancy, and when he becomes a father?	• Do these kinds of pregnancies happen a lot? Why do they usually happen? • Who would she ask for help- family members/ teachers, health workers • Role of the boy/boyfriend • Are there any barriers (religious/social) to accessing MR services • How does the community look at the young woman • How does the community look at the man that got her pregnant • Difference in consequences for married and unmarried women • Schooling, jobs, health • Social stigma
Contraceptive use and gender-based violence	20. Are young women pressured to have intercourse without using any contraceptive methods? 21. How does the community view women and girls who become pregnant as a result of sexual assault?	• Pressured by husband/ boyfriend/ anyone else

Area of Inquiry	Questions	Probes
Family planning service access and use	22. What type of family planning services are available in this community? 23. Where do people go to access these services? (who is providing these services) 24. What are the challenges that people face while accessing or using these services?	• What services you think need to be made available at doorstep or within communities • Experience with any services accessed • Are husbands encouraged to be involved in family planning • What services you think need to be made available at doorstep or within communities • Services provided by NGOs, governments? • Long distances and mobility • Costs for service use or transport • Stigma / religious or social disapproval
Preventing pregnancy	25. What role do men have in relation to adolescent pregnancy? 26. What can help young people have a better future in this community?	• Difference for married and unmarried women • Role of youth clubs, schools etc • Sexuality education, life skills, provision of contraceptives, education or economic empowerment interventions
Educational and economic opportunities	27. What are the schooling options for young people in the community 28. What are the employment opportunities for young people in the community?	

C. Topic guide used for in-depth-interviews with mothers and mothers-in-law of (recently) pregnant young women

Area of Inquiry	Questions	Probes
Gender	1. What is a good girl/boy?	• Characteristics • Role differences • Decision making power of women and men • Gender (in)equality
Adolescence and related challenges	2. What are the some of the issues that adolescent girls face during this period? 3. When do adolescents start engaging in love and relationships here? 4. What are young people's desires and hopes in this community in relation to marriage, children and parenting roles? 5. What are parents' desires and hopes for their children in this community? 6. Do parents in this community discuss pregnancy, relationships, and parenthood with their children?	• Experienced feelings during physiological changes? • Experienced feelings during mental changes? • From what age? • Is there any difference between boys & girls? • What are the concepts of love, affection, communication, relationship, conflict/ conflict management, empathy, sympathy, healthy behavior • Do young people usually agree/disagree with their parents about these topics? • What happens if they disagree?

Area of Inquiry	Questions	Probes
Causes of adolescent pregnancy	7. How common are adolescent pregnancies here? 8. Why do unmarried young women become pregnant before the age of 20? 9. Why do married young women become pregnant before the age of 20?	• Social norms of the community • Religious beliefs • Beliefs around contraception and service use • Impact of sexual violence • Links to education or economic opportunities • Stigma of infertility • Presumptions of infidelity • Improved status of girls and boys (wife and husband) after birth • Lack of girls' individual agency • Misconceptions around contraception
Family planning information	10. Where do adolescents get family planning information from? 11. What barriers do young people face when trying to get family planning information?	• Teachers, health workers, TV, social media
Knowledge about pregnancy and contraceptive methods	12. Are adolescent girls in the community aware of how to prevent pregnancy? 13. Where or whom do young people go to, to get information about family planning methods? 14. Do parents in this community discuss family planning with their children?	• Differences between advice given to girl and boy children • Contraceptive methods, traditional methods • Is there a minimum socially acceptable age for pregnancy? • Difference between married and unmarried women

Area of Inquiry	Questions	Probes
Consequences of adolescent pregnancy	15. If an unmarried girl is 15 and turns out she is pregnant, what usually would happen? 16. What are the consequences for the young woman once she is pregnant? 17. What are the consequences for the young man after the pregnancy, and when he becomes a father?	• Do these kinds of pregnancies happen a lot? Why do they usually happen? • Who would she ask for help- family members/ teachers, health workers • Role of the boy/boyfriend • Schooling, jobs, health • How does the community look at the young woman • How does the community look at the man that got her pregnant • Difference in consequences for married and unmarried women • Social stigma
Menstrual Regulation services	18. How easy is it for pregnant girls in this situation to access menstrual regulation services? 19. What are the barriers (religious/ social) to accessing MR services	
Contraceptive use and choice	20. Who decides whether young women or men can use a contraceptive method or not? 21. What role do schools/teachers play in promoting or discouraging contraceptive use? 22. What role do religious/ community leaders in promoting or discouraging contraceptive use?	• Mother-in law, role of husband/boyfriend • Role of schools/teachers • Role of healthcare workers • Difference between married and unmarried women
Gender based violence	23. How does the community view women and girls who become pregnant as a result of sexual assault?	• Pressured by husband/ boyfriend/ anyone else

Area of Inquiry	Questions	Probes
Preventing pregnancy	24. What is done to prevent young women from becoming pregnant before 20 years 25. What is the role of other members of the community in relation to adolescent pregnancy (both married and unmarried)? 26. If you had to give advice to your government on how young women can prevent adolescent pregnancy, what would your advice be? 27. What can help young women and men have a better future in this community?	• Difference for married and unmarried women • Both positive and negative roles • Role of teachers, religious leaders • Role of parents / in-laws • Role of youth clubs, schools etc • Sexuality education, life skills, provision of contraceptives, education or economic empowerment interventions
Educational and economic opportunities	28. What are the schooling options for young people in the community 29. What are the employment opportunities for young people in the community?	

“MY MOTHER-IN-LAW FORBADE ME TO TAKE PILLS”

FACTORS DRIVING ADOLESCENT PREGNANCIES AMONG YOUNG WOMEN CLIENTS FROM HEALTH CLINICS IN BANGLADESH