Behind the Curtain: When a Adolescent Girl becomes a Married Woman

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Early marriage is common in Bangladesh. Approximately 80 percent of female adolescents get married before they reach age 18 and two third of them experienced pregnancy by age 16. Consequently, fertility is high among adolescent mothers and age specific fertility rate is 144 in the age group 15-19. Data from three consecutive Bangladesh Demographic and Health Surveys were utilized to examine reproductive health behavior as well as other social issues for married female adolescents in Bangladesh. In addition, to understand how married adolescent girls adjusted with the new surroundings, information was collected through in-depth interviews with married adolescent girls from three rural areas of Bangladesh.

It is observed that the mean age at marriage for females continues to be four years below the legal age of marriage (18 years) and most of the girls were married to men who are eight to ten years older than them. Female married adolescents are not involved in marriage related discussions and only being informed about the decisions. Marriage universally plays a major role in discontinuing education, restricted mobility outside and personal freedom.

Newly married women, in general, lose independence and mobility when they move into their in-law's home after marriage. This is due to the fact that they become the new, most junior members of their marital family with little, if any, authority or autonomy, and are under strong social pressure to prove that they are a "good" daughter-in-law and wife. The 1999-2000 BDHS data suggest that only 9.5 percent of married adolescents think that they can go out on their own and another 15.5 percent think that they can go out with their children. In response to a question regarding any possible visits to health centers, about 18.2 percent currently married female adolescents mentioned they could go to health center alone. More than two-third of the married adolescent girls could only go to health center if accompanied by their husband, children or any other relatives. Findings from in-depth interviews suggest that living with their in-laws caused further constraints

on their personal freedom, which they defined as problems in eating, and buying necessary items for themselves. It is interesting to note that more than one third of the respondents experienced non-consenting sex or forced sex by their husbands.

The BDHS also includes questions on household decision-making, another indicator of empowerment. It is observed that only 9.1 percent of married girls (vs. 18.7 percent of slightly older married females) had the final say about their own health care and 5.3 percent (vs. 18.0 percent of 25-29 year olds) had the final say about child health care. Nearly half of the married adolescents did not seek any type of assistance from trained provider during pregnancy. Over half of adolescents mothers had delivery without any skilled attendants.

Married girls have less exposure to electronic media and other sources of mass media than unmarried girls of same age group. Findings indicate that about 28 percent of married female adolescents reported that the last child was unplanned. Knowledge of contraceptive methods among married adolescent girls was universal but only about 38 percent were currently using any family planning methods. About half of the married female adolescents reported that they had never talked with their husbands regarding family planning methods. Approximately 92 percent of non-user intends to use a family planning method in the future. Only one-tenth of married female adolescents had heard about sexually transmitted diseases other than HIV/AIDS.

Majority of the married adolescent girls do not have any future aspirations and desires of their own. Only one-fourth of the married adolescents mentioned that they had some involvement with micro-credit activities. However, none of them received the micro credit for themselves or had any control over that money. Study revealed that married female adolescents are entangled with a wide range of social problems, e.g., mobility, education, personal freedom and participation in conjugal and household decision-making. It is observed that the serious health disadvantages are a result of married girls' younger age and early pregnancy, but also a result of their profound social isolation and lack of power.

An important indication of changing demand for family planning is the extent to which non-users intend to use contraceptive methods in the future. Findings indicate high future demand for contraceptive methods among the non-user female adolescents. Approximately 92 percent of them expressed the intention to use a family planning method in the future. In contrast, greater numbers of married women of 25-29 do not intend to use contraceptives in future. It is not clear how much maternal and child health (MCH) care adolescent married girls receive, and the quality of that care. Providing information on the importance of MCH care cannot alone mitigate their reproductive health problems.

The findings from this study highlight the distinct and often severe social and health vulnerabilities of married adolescent girls. In rural areas, girl had to abide by the family's decision regarding their marriage, and they were forestalled to express their opinion in the marriage process. Married adolescents girls cannot exercise any role in deciding the time of their marriage let alone the selection of partners. In rural areas, parents select the partner and girls are informed about the selection later. In general, married female adolescents do not have any decision making power on most of the issues related to daily life. It is observed that husband plays the major role in the decision making process.