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ADOLESCENT REPRODUCTIVE HEALTH: CHOICE OR CHANCE?

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Abstract

Reproductive health in general and adolescent reproductive health in particular has not received concerted attention in our country so far. The traditional view of marriage as "protection" to girls in puberty from premarital sexual exploitation thrusts them into conjugality even before physical maturity is attained. This paper presents hospital-based data of 51 married adolescent girls in their antenatal phase, consulting a local hospital in the city of Visakhapatnam. This qualitative study included a personal data sheet and a semi structured interview schedule to assess sexual and reproductive health knowledge of the respondents. Findings from the study revealed that two-thirds of the adolescents were married before the legal age of marriage, one-fourth of the sample were undernourished and 98% were anaemic. Themes from content analysis revealed knowledge of sexual and reproductive health to be minimal. Contraceptive knowledge, HIV awareness, negotiating reproductive decision-making and fertility issues were found to be low.

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Introduction

Reproductive health is relatively a new phenomenon for gendered concerns in the area of reproductive behaviour. Reproductive choice can be defined as "one that requires as a precondition the existence of a feasible set of acceptable options on matters relating to reproduction and sexuality that is available to the individual woman. It also assumes as a prerequisite, a certain capability and access over the resources and information, as well as decision making power of the individual for making informed choices" (Mukhopadhyay & Savithri, 1998). In this context, reproductive choice in India is synonymous with fertility regulation. In other words it has been centered on issues such as number of children a woman would want to have, when she wants them and her need to access to contraceptive devices in order to operationalize that want.

Fertility control measures concerned with population momentum left women with no rights and very little control in the domain of reproduction; reinforcing the secondary status of women in the family and society (Hussain, 2003; Datta, 2003). As Petchesky (1980) remarks, "Women's reproductive situation is never the result of biology, but mediated by social and cultural organization." Gender inequalities evident through structural factors constrict women's well being, social power and ability to set the terms of sexual relations and childbearing (Datta, 2003).

In a rapidly changing world, confronted by HIV/AIDS, "adolescence"- a period of critical capability building (Sen, 1997)- is now recognized as central to the social and economic development. Within the age and gender stratified patriarchal family system in India (Karve, 1965), women are less empowered to exercise their sexual and reproductive choices, but young and newly married women are powerless, invisible and voiceless. In India adolescent brides comprise one of the largest groups of vulnerable women, whose special needs have gone unnoticed (Jejeebhoy, 1998). With the onset of puberty, the gender role differentials existing in childhood become widened for girls as restrictions are placed on education, social and physical mobility. While marriage is observed as a social and cultural event, reproductive behaviour and reproductive choices are segregated into the private domain mostly controlled by men. According to the National Family Health Survey-2(NFHS-2, 1998), the median age of marriage among women in India is 16 years for the country as a whole (less than legal age of 18 years), while in states like Andhra Pradesh the median age is 15 years or less. It is reported that 36% between 13-16 years of age and 61% of girls below 19 years have already begun childbearing (Jejeebhoy, 1998).

The consequences of early marriage and childbearing include acute health risks such as maternal mortality, complications during labour, spontaneous abortions (United Nations Population Fund, 1998), low birth weights in infants and neonatal mortality (Population Reference Bureau, 2006; Jejeebhoy, 1998); and contracting reproductive and sexually transmitted diseases. In addition, factors such as limited opportunities for education (Llyod, Mensch & Clark, 1998; Mensch & Llyod, 1998) and skill development further compromised their economic standards of living (Prakasam & Upadhyay, 1985; Tripathy, Rao & Pradhan, 1992; Ganiger, 1992) leading to lack of empowerment including inability to exercise decision-making power (George & Jaswal 1995; Pachauri & Santhya, 2002; Ramsubban, 2000).

There is a dearth of information about the sexual and reproductive knowledge among married adolescents (Jejeebhoy, 1998; Mensch, Bruce & Greene, 2003). There is therefore a need for better understanding of the factors that constrain married adolescents in making sexual and reproductive choices as they form one of the most vulnerable sections of the population.

This paper examines issues relating to reproductive choice among married adolescent girls in their antenatal phase and the coping mechanism adopted by them in the context of their transition from childhood to childbearing. It seeks to understand and explore the relationship of gender inequity in making reproductive choices.

Method

Setting and Sample

The study was conducted in the outpatient clinic of the Department of Gynaecology in the Government Victoria Hospital in the city of Visakhapatnam in Andhra Pradesh. This hospital was chosen for the study as it is as a government hospital that caters exclusively to the gynaecological needs of the city's population and also extends its services to the population in the district of Visakhapatnam. The sample consisted of 51 married adolescent girls in the age group of 13-19 years in their second and third trimesters of the antenatal phase, attending the Out-Patient Department of Gynaecology in Government Victoria Hospital for Women.

Tools of Data Collection

The tools for collecting socio-economic and demographic data and reproductive health data included

i. Personal data sheet with details of the respondents such as information on the age of the respondents, education; income; occupation; and type of family,

caste and religion. Considering iron deficiency anemia (Hemoglobin (Hb) <12g/dl)* as the criteria physiological well-being of the sample was assessed. Information about these measures was taken from the hospital case sheets of the participants

ii. Information on reproductive concerns such as age at marriage and conception; duration of marital life; consanguinity and use of fertility measures and HIV status

iii. Goldberg's General Health Questionnaire (GHQ-28) to screen for psychological wellness in the four dimensions of somatic symptoms, anxiety and insomnia, social dysfunction and depression. A cut off point of 3/4 was used to identify cases with psychological illness. Since many of the respondents either had no formal education or did not know English, the Telugu version of GHQ-28 was used. This translated version had earlier been used by Sachi Devi (2003) and Mrudula and Vindhya (2005)

iv. A semi structured interview schedule was used to assess reproductive and sexual health knowledge of the respondents. This included issues such as consent to marriage, dowry, preparedness for pregnancy, negotiation in fertility issues, contraceptive use dynamics, the context of induced abortions, sexually transmitted infections, including HIV and the infertility situation.

v. Information about coping strategies the respondents employed to deal with their reproductive concerns was also obtained through the semi-structured interview schedule.

Information for the socio-demographic sheet was obtained in the beginning of the interview. All interviews were in Telugu, the language of the respondents, and were transcribed verbatim and then translated into English. The medical staff at the hospital identified adolescent married girls in the Out Patient Department and referred them to the interviewer. Interviews were conducted in the space provided by the hospital authorities after obtaining consent from the respondents. Each respondent was interviewed in a single session lasting approximately an hour. Privacy was ensured during the session.

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* Haemoglobin concentration of less than 7.0g/dl is considered severe, 7.0-9.9 g/dl as moderate and 10.0-10.9 g/dl as mild if they are pregnant and 10.0-11.9 g/dl if they are not pregnant (Centre for Disease Control and Prevention, 1998).

Findings

Socio-demographic characteristics of the sample

Table 1 shows the socio-demographic profile of the sample in terms of age of the respondents, education, income, occupation, residence, caste, and religion.

Table 1 Socio-Demographic Characteristics of the Sample

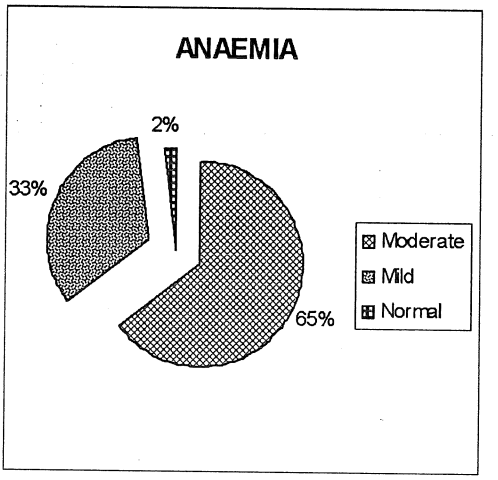
Demographic variables	Numbers	Percent
Age of the respondent		
13-17	11	21.6%
18-19	40	78.4%
Education		
No formal education	18	35.3%
Primary	7	13.7%
Secondary	9	17.6%
High school and Inter	10	19.6%
Intermediate	6	11.8%
Graduation	1	2.0%
Residence		
Rural	11	21.6%
Semi-urban	15	29.4%
Urban slum	19	37.3%
Urban	6	11.8%
Type of family		
Nuclear	13	25.5%
Joint	38	74.5%
Religion		
Hindus	48	94.1%
Christians	1	2.0%
Muslims	2	3.9%
Caste		
Forward caste	13	29.5%
Backward caste	30	68.2%
Scheduled caste	1	2.3%
Scheduled tribe	None	

This socio-demographic profile constructed from the sample of married adolescent girls is in line with research evidence that suggests that factors such as age at marriage; early child bearing; limited education, compounded with lack of gainful employment and limited income adversely affect the social wellbeing of adolescent girls. When education that can shape reproductive behavior leading to effective decision-making (Caldwell, 1979), is abridged due to early marriage, it has particularly detrimental implications for the empowerment opportunities of young girls.

Physical Well-being

Figure 1 represents the status of the adolescent pregnant girls on the dimension of physical well being as represented by anaemic condition.

Physical well being as indicated by Anaemic Condition



Taking iron level in haemoglobin (Hb< 12g/dl indicates Anaemic status) as criteria for physical wellbeing, the study focused on the presence of nutritional impairment during pregnancy. The present study found that a strikingly high percentage of the respondents (98 percent) were anaemic. Of them, 33 percent were moderately anaemic and 65 percent were mildly anaemic. These results are in line with earlier research findings that one of every five ever-married adolescent women has moderate or severe aneamia (NFHS – 2, 1998). It has been well documented by now that

socio-economic factors such as poverty and gender discrimination affect the nutritional status of young girls (National Family Health Survey—2, 1998; Datta, 2003; Agarwal & Agarwal, 2006).

Reproductive Health Issues

Table 2 presents the findings on age at marriage, duration of marital life, consanguinity in marriage, fertility measures adopted by the respondents that include history of Medical termination of pregnancy (MTP) and HIV status.

Table 2 Reproductive Health Issues

Age at marriage		
< 18 yrs	32	62.7%
>18 yrs	19	37.3%
Duration of marriage		
> 6months	33	64.7%
7-12 months	10	19.6%
<1 year	8	15.7%
Type of marriage		
Consanguinity	13	25.5%
Non-consanguinity	38	74.5%

Age at marriage

A significant finding is that nearly two-thirds of them (62.7 percent) were married before the legally sanctioned age for marriage i.e., 18 years while 37.3 percent of them were married at 18 years or later. These figures drive home the fact that a large proportion of adolescent girls become wives and mothers before they become adults that are typically driven by poverty, parental concerns about premarital sex and economic and cultural reasons (Population Reference Bureau, 2006). This situation reflects adolescent girls' limited power to make their own marital and reproductive choices.

Duration of marital life

In this sample, 64.7 percent of the girls were married and in the process of childbearing within 6 months of marriage. A high proportion of married girls i.e.,

85.3 percent were pregnant within one year of marriage. In this regard Mensch, Bruce & Greene (2003) remark that in many developing countries "the females 'traditional mandate' to begin childbearing soon after marriage enhances their respectability and economic security" reflects the lack of reproductive choices for adolescent girls in marriage.

Fertility measures

None of them reported use of any methods of contraception. Two of them currently pregnant resorted to termination of pregnancy using oral contraceptives, which however did not give the desired result, and they were continuing to full term.

Sexually Transmitted Infections - HIV

All the respondents in the sample had undergone HIV test, as it is mandatory in the hospital. None of the respondents in the sample were infected with HIV/AIDS. However, information on the modes of HIV transmission and measures required in protecting oneself from such infections were minimal.

Psychological Well-being

Table 3 Psychological Well-being in Relation to Demographic Characteristics

Background characteristics	Psychological well-being					
	Non-cases		Cases		Total	
	Number	Percent	Number	Percent	Number	Percent
	29		22		51	
Current Age						
Below 18	7	23.3%	4	19.0%	11	21.6%
18 and above	23	76.7%	17	81.0%	40	78.4
Age at marriage						
Below the legal	23	76.7%	9	42.9%*	32	62.7%
Legal age for marriage	7	23.3%	12	57.1%	19	37.3%

Marital life						
Below 6 months	19	63.3%	14	66.7%	33	64.7%
7-12 months	5	16.7%	5	23.8%	5	10.0%
Beyond 12 months	6	20.0%	2	9.5%	8	15.7%
Education						
Illiterate	9	30.0%	9	42.9%	18	35.3%
Primary	4	13.3%	3	14.3%	7	13.7%
Middle school	6	20.0%	3	14.3%	9	17.6%
High school	7	23.3%	3	14.3%	10	19.6%
Intermediate	4	13.3%	2	9.5%	6	11.8%
Graduation			1	4.8%	1	2.0%
Residence						
Rural	7	23.3%	4	19.0%	11	21.6%
Semi-urban	10	33.3%	5	23.8%	15	29.4%
Urban slum	8	26.7%	11	52.4%	19	37.3%
Urban	5	16.7%	1	4.8%	6	11.8%
Type of family						
Nuclear	6	20.0%	7	33.3%	13	25.5%
Joint	24	80.0%	14	66.7%	38	74.5%
Consanguinity						
Consanguineous	6	20.0%	7	33.3%	13	25.5%
Non-consanguineous	24	80.0%	14	66.7%	38	74.5%
Religion						
Hindu	30	100%	18	85.7%	48	94.1%
Christian			1	4.8%	1	2.0%
Muslim			2	6.5%	2	3.9%
Caste						
Forward caste	10	33.3%	3	21.4%	13	29.5%
Backward caste	19	63.3%	11	78.4%	30	68.2%
Scheduled caste	1	3.3%			1	2.3%
Anaemic status						
Moderate	21	70.0%	12	57.1%	33	64.7%
Mild	8	26.7%	9	42.9%	17	33.3%
Normal	3.3%			1	2.0%	

* Significant at $p < 0.05$

Of the 51 respondents, 22 could be identified as "cases", that is, those who scored higher than the cut off point of 3/4 on the GHQ and 29 of them were considered as "non cases". Interestingly respondents whose age at marriage was below the legal age of marriage (i.e. 18 years) were found to have adverse psychological health ($x^2 = 6.041$, df = 1, $p < 0.05$). No other difference in socio demographic features of the 'cases' and 'non cases' emerged in the analysis of the data. The findings of the present study show that early marriage does result in poor psychological health.

An item-wise analysis of GHQ data revealed a significant presence of somatic symptoms, and anxiety and insomnia. The respondents scored high on complaints that included pain, physical distress, headache and a general feeling of illness. Nearly one-third of the sample expressed a need for a good tonic for symptom reduction.

On the anxiety and insomnia dimension, one-fifth (10 percent) of respondents scored on the questions, "had difficulty in staying asleep once you are off" (item number 9 of GHQ). This is however to be expected since sleeplessness in later stages of pregnancy due to difficulty in finding a comfortable position is a common occurrence (Dutta, 1994).

The responses on the dimension of social dysfunction indicated that most of them were well adjusted. Since pregnancy and motherhood are valued positively, this was not surprising. However, all the respondents responded to the issue of decision making i.e., item 21 of GHQ, (felt capable of making decision about things) in the negative, reflecting lack of autonomy and personal choice in the realm of domestic and marital relationships.

Most of the respondents did not report any significant depressive and suicidal tendencies. Only one girl had elevated score on the depressive scale. Her husband abandoned her after marriage and she did not want to face her relatives in this state. It was in this condition that she contemplated suicide. However she reconciled with the situation, as she was pregnant and felt life was worth living for the sake of her unborn baby.

In the following sections, an exploration of sexual and reproductive health issues of adolescent girls such as consent to marriage, dowry, preparedness for pregnancy, negotiation in fertility issues, contraceptive use dynamics, the context of induced abortions, sexually transmitted infections, including HIV, and the infertility situation is done. Certain cross cutting issues such as gender inequities, power imbalances, exercise of informed choice, male involvement that are central to each topic have been addressed within the discussion of each subject rather than as separate sections.

Consent to Marriage

Choices in marriage are very much linked up with economic, demographic and cultural conditions. Fundamental to early marriages is the 'precariousness of girls status' and the fear of premarital sexual activity, which is linked to the 'honour' of the family. Thus attainment of menarche is mostly viewed as a sign of girls' readiness for marriage. In the present study most of the participants reported that they had no choice in deciding their partners. It was mostly the family members who chose the groom and the girls accepted irrespective of whether liked the boy or not. Poverty and gender roles expectations were prominent themes that were elicited in the interview data

"....my parents decided on whom I should marry based on the means (wealth) they can give.."

"...unmarried girl in the house calls for unnecessary attention....doubts on character... so parents incur debts and arrange for marriage..."

There has been enough evidence from demographic and health surveys in developing countries indicating adolescent girls' lack of control regarding choice of partners (Population Reference Bureau, 2006).

Dowry

An integral feature of marriage is the contract of taking dowry from the bride's family. Though none of the respondents evaded the issue of dowry they did not want to discuss the details of payment. In this regard respondents expressed their inability to go against the system. Excerpts from the respondents' interviews of how they felt are provided below

"...My in-laws were quite demanding, my parents yielded because I am the eldest and there are other siblings to be married after me..."

"...If we refuse a proposal when the girl is young ... the older she grows it becomes difficult to arrange for the dowry..."

Preparedness for Pregnancy

Most of the respondents reported lack of preparedness and planning for pregnancy. They held the view that since they were married they were expected to fulfill the reproductive role as an inevitable consequence. The respondents reported that the lesser the gap between marriage and conception, the more they were accepted in

the conjugal family. The findings reflect the restricted autonomy adolescent girls face in the sphere of marriage wherein child bearing dominates their life choices.

Negotiation in Fertility Issues

It was evident from the responses of the respondents that they were unaware of their vulnerability as 'teenage mothers'. The adolescents had very low level of knowledge about several reproductive health matters and were not aware of the risks of early sexual debut and other sexually transmitted diseases such as HIV. In fact demographic and health surveys from 51 countries reveal that young age of girls hinders their capacity to negotiate sex and reproduction including aspects of domestic and public life (Nugent, 2006).

".....My in-laws insisted that we have children immediately and not use any contraceptives"

".....as a woman one has to bear a child at some time or the other, the sooner the better, was what my husband said....."

Contraceptive Use Dynamics

In his report on the 'Youth in a Global World', (Nugent 2006) states that, "adolescents are less likely to use modern contraceptives because of lack of access to desired family planning methods" (p 149). Most respondents revealed that the elderly women in their family guided them and allayed their fears regarding pregnancy and childbirth, indicating that the main source of information about sexual and reproductive issues was the family. Excerpts from the respondents in the present study also suggest there was an unmet need for contraception because they did not have adequate knowledge of contraception. Even when they vaguely knew of contraception, all of them voiced their apprehensions regarding use of contraception. The misconceptions that these girls have regarding contraception are illustrated in these statements given below

"... I would consider abstinence as a better method of contraception..."

".... My in-laws forewarned that using contraceptive pills might lead to infertility as a relative in our family never conceived after taking oral contraceptives"

The Context of Induced Abortions

Interestingly almost all the respondents indicated that they were aware of ultrasound scan techniques that are used to detect foetal anomalies and a majority of them knew that this device can be used in determining the sex of the foetus. It is ironical that they do not know measures of contraception, while they were aware of technological developments used in detecting foetal anomalies and for sex determination of the foetus. This stark difference reinforces the fact that reproductive health issues have primarily been centered on fertility issues so far.

There is social approval for measures such as sex determination technology although knowing the sex of the child is legally banned now according to the Pre-natal Diagnostic Techniques Act (1996). While the girls expressed a desire for a healthy child they did report a desire for a male child as it is assumed that giving birth to a male child enhances the woman's social worth. The statements below indicate this attitude

> *"...for the first pregnancy it doesn't matter if it is a girl but at least the second one should be a boy or else my family members would humiliate me..."*
>
> *"...if I give birth to male child, my husband's family would rejoice as the other daughter-in-law has only daughters.*

For some it was insignificant as it was their first pregnancy and the sex of the child was not a cause of concern. Some respondents attributed the sex of the child to the "will of God or divine providence".

Sexually Transmitted Infections, Including HIV

All the respondents had been tested for HIV and all of them tested seronegative indicating that there were no cases infected with HIV in the present sample. Most of the respondents had heard about HIV from the Parent to Child Transmission Counselling and Testing Centre (PPTC) located in the hospital premises, as it is mandatory for all registered cases in the hospital to undergo counselling and testing for HIV. A significant and alarming finding in this context was that married adolescents were not aware of the male contraceptive devices such as condoms that prevent transmission of HIV due to sexual contact. Owing to their low education levels, most of them were unable to comprehend the information given in the testing centre at the Hospital. The typical responses noted from the narratives are

"...HIV is an illness one gets if he/she indulges in relationships outside marriage..."

"....I heard about this disease, it spreads through mosquito bite...."

These statements support the findings from Demographic and Health Survey in the recent years (from 2000 to 2003) that the knowledge of HIV risk is low among the adolescent group (ORC Macro, Measure DHS+, HIV/AIDS, cited in PRB 2006).

Stigma of Infertility

In the present study, for most of the girls pregnancy was welcomed as a means to avoid the stigma of infertility. The respondents placed a great value on motherhood and felt that infertility is primarily because of 'some defect' in the female reproductive system and that they were not aware of any other causes of infertility. From the narratives of the adolescent mothers it could be discerned that these girls had little negotiating power in child bearing and were mostly fraught with fears regarding their own fertility that are captured in the following statements:

"...irrespective of young age I wanted to go through this stage for fear of being ostracized as an infertile woman...."

"... not all women are blessed to be fertile and privileged for childbearing....."

Coping Strategies

Another important variable that was studied in the context of adolescent reproductive health was coping strategies. Though pregnancy and motherhood were viewed as positive life events they entail some amount of stress, considering the age of the mother, low level of education, lack of employment and lack of awareness about reproductive health and limited or no power in negotiating fertility issues. Most of the adolescent girls looked for external resources for coping, while few of them had internal resources of strength that had helped them to adjust to their situation. The predominant themes that emerged from the interview data included positive appraisal of pregnancy, existence of social support, faith in God and acceptance of their situation ungrudgingly.

Positive Appraisal of Pregnancy

An overwhelming majority of the respondents reported that they viewed pregnancy as a pleasant event. As one respondent puts it "pregnancy is a unique experience that every woman may not have the good fortune of receiving it". Though they had

interpreted pregnancy as a positive event a majority of them accepted childbearing as an "inevitable experience in a married woman's life", and also indicated a strong external locus of control in matters related to fertility. It can be discerned from these responses as to how gender stereotypes of women as nurturers and care-givers are internalized.

Social Support

Support from natal families is not unusual and it is a prevalent cultural practice to bring girls to their natal family for childbirth. Traditional practices compel the girl's parents to shoulder the expenses for marriage, give dowry, and take the responsibility of her prenatal care and delivery of the child. Husbands were also considered as source of strength by some of the girls who would console them and also ease the tension between the girls and their in-laws. Some of the girls expressed that friends and other members in the family also provided support in adjusting to their life situations.

Faith in God

Some of them accepted their situation that nothing could be done and sought to find solace in God. These statements reflect their faith.

"....what is there in our hand, everything is predestined....I would pray to god, so that all my problems would be solved..."

Passive Acceptance

Many of them knew that they had limited power in the family and so they chose to suffer in silence. Interview data regarding coping styles illuminated these aspects of passivity.

"....I would not react and try to keep my feelings to me and hope that problems would reduce on their own...."

"... I would keep my feelings of hurt to myself because if I express them there might be adverse reactions..."

Viewed from the western models of family dynamics and gender roles, the current situation appears oppressive and stifling to the growth of the married adolescents with adverse effect on their well-being. Research has documented that despite the range of adversities experienced by women across the life span in India, women

negotiate for spaces for themselves within the permissible range of deviation from norms, maneuvering their own fertility outcomes without overthrowing either patriarchy or the ideology of motherhood (Patel, 1999).

To conclude this discussion, the present study focused on the knowledge of reproductive health issues and on the physical health measures such as status of anaemia and BMI of 51 married adolescent girls consulting a local hospital. Although reproductive conditions are not life threatening, they do have a considerable impact on daily life (Sadhana, 2002) and in the case of India, mirror the vulnerabilities and disempowering conditions of lives of young women.

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