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Reproductive health issues among married Adolescent girls

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Abstract
Marriage as a social institutional arrangement in India is still intact and marriage is a precondition for reproduction almost universally. Girls who marry early begin sexual activity when they are physiologically more vulnerable to infection. Adolescent females are more prone to pregnancy related complications and to having low birth weight babies or premature babies or still birth. In India, early marriage for girls receives religious and social sanction. Despite laws rising the legal age of marriage to 18 for girls, there are strong cultural pressures on parents to marry their daughters early. This study deals with the factors related to married girls and issues related to reproductive health.
The sample selected for this study is from the urban and rural areas of Thiruvananthapuram district in Kerala, India. Data was collected through in depth interview using questionnaire.
In the rural areas 6.15 percent of the girls complaint about problems during intercourse. Before bringing any change in menstrual practices, girls should be educated about the facts of menstruation and its physiological implications. The girls should be educated about the significance of menstruation and development of secondary sexual characteristics, selection of a sanitary menstrual absorbent and its proper disposal. Also they should be educated about the reproductive health issues, which affect them without proper hygiene, nondrinking of water, lack of menstrual hygiene etc.

Keywords: Marriage, Sexual Intercourse, Autonomy, Abortion, Contraception, Intra Uterine Device, Infertility, Reproductive issues, Health issues

Introduction
Marriage as a social institutional arrangement in India is still intact and marriage is a precondition for reproduction almost universally. It is a universal human institution that forms the foundation of family. Marriage offers an environment for cultivating love between two people and their fulfilment. It is recognized as economically, spiritually, legally and socially as the primary social arrangement for upbringing of children. Girls, who marry early, begin sexual activity when they are physiologically more vulnerable to infection. Society often places strong pressures on young women to prove their fertility, and in many settings, bearing sons is the only means by which young women can establish social acceptance and economic security. Lack of autonomy within their marital homes often means that married girls have limited access to health care or participation in taking decisions about their own health.
In India, early marriage for girls receives religious and social sanction. Despite laws raising the legal age of marriage to 18 for girls, there are strong cultural pressures on parents to marry their daughters early. The median age at first marriage among women aged 20-49 years in India is 16.7 with a two-year difference between urban and rural women (18.7 versus 16.0).
In most cases, of course, psychological immaturity is a factor, but the major factor that needs more concern is the incapable nature of the body to accommodate the early onset of childbearing. There are over 10 million pregnant adolescents and adolescent mothers in India, with one in six girls age 13-19 beginning childbearing. The National Family Health Survey (1998-1999 (NFHS-2) found that 56 percent of adolescent girls are anaemic and only 7.4 percent of married girls age 15- 19 use contraception. According to the NFHS-2, among mothers less than age 20, only 68.7 percent received prenatal care from a health worker or professional, 79.9 percent received a 3+ month-supply of iron and folic acid, 67.6 percent received two or more doses of Tetanus Toxoid, and only 41.6 percent were assisted at

delivery by a skilled birth attendant. Statistics show that 50 percent of maternal deaths in girls 15-19 are due to unsafe abortions.
But when we look into the issues of married adolescent girls certain other points like age at marriage, age difference between spouses, residential background etc are also to be taken into account. The objectives of the study are to find out the factors related to married girls and the issues related to reproductive health.
352 married adolescent girls were considered for this study. Indepth interview was conducted during house visits. The girls were selected from the rural and urban areas of Thiruvananthapuram district. The areas selected are Vazhuthacaud, Poonthura, Bheemapally, Manoorkonam, panacode, malayadi, Amboori, Kuttichal etc.

Age at Marriage
The study reveals that girls got married at the age of 14 years onwards. The mean age at marriage was 17.4 years. The age at marriage was 14 years for a negligible percentage of the girls in urban areas. It is also observed that 17 and 18 years of age are the most preferred age for marriage in the rural and urban areas.

Table 1: Percentage distribution of girls by age at marriage and residential background

Age at marriage	Rural	Urban	Total
14	-	0.90 (2)	0.57 (2)
15	6.15 (8)	3.15 (7)	4.26 (15)
16	18.46 (24)	10.81 (24)	13.64 (48)
17	34.62 (45)	26.58 (59)	29.55 (104)
18	36.15 (47)	41.89 (93)	39.77 (140)
19	4.62 (6)	16.67 (37)	12.22 (43)
Total	100.00 (130)	100.00 (222)	100.00 (352)

Age difference between husband and wife
In contradiction to the western culture, marriage is not for fun or experience in our society. It is a lifelong relationship to be maintained in healthy manner. This, of course, gives a social status to a certain extent, to the family.
There are many reasons that affect the strong relations between the spouses. Various studies conducted all over the world shows that the difference in age of spouses too has a major role in maintaining this relationship. The age difference that is generally accepted by modern society varies directly with the age of the individuals involved in the relationship; larger differences are more acceptable with older individuals. For example, while a seven-year difference might be considered unacceptable (even illegal in some places) between a 22-year-old and a 15-year-old, it is less remarkable between a 30-year-old and a 23-year-old, and unnoticed completely between a 78-year-old and a 71-year-old.
While looking at the age difference between spouses among respondents of the study, it is seen that 13 girls had an age difference of less than 5 years and 67 girls had an age difference of 5 to 6 years.

Table 2: Distribution of married girls by age difference with their spouse

Girls' Age at marriage	Age Difference with Husband and Wife								Total
	<5	5	6	7	8	9	10	>10	
14	-	-	-	-	-	-	-	2	2
15	-	-	2	1	3	2	6	5	19
16	7	3	3	6	8	1	6	13	47
17	2	7	13	20	9	19	12	19	101
18	4	3	23	30	32	24	11	16	143
19	-	5	8	7	6	6	-	8	40
Total	13	18	49	64	58	52	35	63	352

The age difference between spouses is less than 10 years for 209 girls. An age difference of greater than 10 years is seen among 63 girls. The notable feature is that there are 13, 19 and 16 girls respectively who have more than 10 years of age difference with their spouse and they got married at the age of 16, 17 and18 years respectively.
This large difference in age indicates so many factors. The girls are adolescents, less educated and belong to poor families. They may not be aware of most of the matters related to reproductive health and because of the age difference they may not be able to communicate with their husbands. All these show the helplessness of the adolescent girls.

Pregnancy status and related matters of the married adolescent girls
Adolescent females are more prone to pregnancy related complications and having low birth weight babies or premature babies or still birth. In some countries 60% of all those hospitalised with abortion complications are issues with adolescents.
Abortion is, of course, a poor substitute for contraception, but it can play a significant role as a backstop measure to prevent unwanted births caused by contraceptive failure. We do not know whether or not contraceptive failure is primarily responsible for abortions. What is important is to understand the extent to which women have adopted contraception after abortion.
The study shows that only 17.69 percent of the rural girls and 25.23 percent of the urban girls are currently pregnant. As reported by them in rural areas 5.38 percent and in urban areas 9.91 percent of the girls had spontaneous abortion. It is also found that, 14.62 percent of the total rural girls and 8.11 percent of the total urban girls are using family planning methods. Only one rural girl had inserted Intra Uterine Device and the remaining are using condoms. Majority of the girls are not using any family planning methods because they are not at all aware of any of the methods. It is very interesting to note that only 73.08 percent of the rural girls and 77.93 percent of the urban girls are having sexual intercourse during pregnancy.

Table 3: Percentage distribution of married girls by features and residential background

Particulars	Response	Rural	Urban	Total
Currently Pregnant	Yes	17.69 (23)	25.23 (56)	22.44 (79)
	No	82.31 (107)	74.77 (166)	77.56 (273)
	Total	100.00 (130)	100.00 (222)	100.00 (352)
Abortion	Yes	5.38 (7)	9.91 (22)	8.24 (29)

	No	94.62 (123)	90.09 (200)	91.76 (323)
	Total	100.00 (130)	100.00 (222)	100.00 (352)
Family planning (Everusers)	Yes	14.62 (19)	8.11 (18)	10.51 (37)
	No	85.38 (111)	91.89 (204)	89.49 (315)
	Total	100.00 (130)	100.00 (222)	100.00 (352)
Intercourse during pregnancy	Yes	73.08 (95)	77.93 (173)	76.14 (268)
	No	26.92 (35)	22.07 (49)	23.86 (84)
	Total	100.00 (130)	100.00 (222)	100.00 (352)

Issues related to sexual intercourse

There are so many issues related to intercourse. In the rural areas 6.15 percent of the girls complaint about problems during intercourse. The percentage is a little higher in urban areas (8.56 percent). It is to be noted that 10.81 percent of the urban girls have not at all responded to this question. These girls are shy to expose their problems related to sex. Pain/bleeding during or after intercourse is a major problem affecting reproductive health. This condition is seen serious in the urban area compared to rural. In urban area 23.87 percent of the girls suffer from pain/bleeding during intercourse. But in rural areas only 6.15 percent of the girls have such experience. Also equal percentage of the girls in both the area suffers from pain/bleeding after intercourse.

Table 4: Percentage distribution of girls by issues related to intercourse and residential background

	Rural	Urban	Total
Any problems during intercourse			
Yes	6.15 (8)	8.56 (19)	7.67 (27)
No	89.23 (116)	80.63 (179)	83.81 (295)
Not responded	4.62 (6)	10.81 (24)	8.52 (30)
Total	100.00 (130)	100.00 (222)	100.00 (352)
Pain / bleeding during intercourse			
Yes	6.15 (8)	23.87 (53)	17.33 (61)
No	93.85 (122)	73.87 (164)	81.25 (286)
Not responded	-	2.25 (5)	1.42 (5)
Total	100.00 (130)	100.00 (222)	10000 (352)
Pain / bleeding after intercourse			
Yes	6.15 (8)	6.31 (14)	6.25 (22)
No	93.85 (122)	91.44 (203)	92.33 (325)
Not responded	-	2.25 (5)	1.42 (5)
Total	100.00 (130)	100.00 (217)	100.00 (347)
Cleaning of organs			
Yes	41.54 (54)	98.2 (218)	77.27 (272)
No	58.46 (76)	0.45 (1)	21.88 (77)
Not responded	-	1.35 (3)	0.85 (3)
Total	100.00 (130)	100.00 (222)	100.00 (352)
Intercourse during menstruation			
Yes	10.77 (14)	4.5 (10)	6.82 (24)
No	89.23 (116)	95.5 (212)	93.18 (328)
Total	100.00 (130)	100.00 (222)	100.00 (352)

Cleanliness is very much essential before and after each intercourse. A question was asked as to whether the couples clean their organs before and after intercourse. It is seen that 58.46 percent of the rural girls and 0.45 percent of the urban girls answered "No". The answer clearly indicates the ignorance of the rural couples. This lack of awareness may lead to problems later in life. Intercourse during menstruation leads to infection. It can affect the reproductive health very badly. The study reveals that 10.77 percent of the rural girls and 4.5 percent of the urban girls have intercourse during menstruation. This shows that the rural girls are not much aware about the consequences.

Infertility treatment

Infertility is a phenomenon, which shows the incapability of the couples to reproduce. The conditions explained above may result finally in infertility.

Table 5: Percentage distribution of girls who undergo infertility treatment by residential background

Infertility treatment	Rural	Urban	Total
Yes	9.23 (12)	3.60 (8)	5.68 (20)
No	90.77 (118)	96.40 (214)	94.32 (332)
Total	100.00 (130)	100.00 (222)	100.00 (352)

In the study 9.23 percent of the rural girls and 3.60 percent of the urban girls reported that they have the fear of becoming infertile and that is the reason stated by them for undergoing infertility treatment.

It is understood that people are aware about the consequences of irregular menstruation. But only very few are undergoing treatment for menstrual regularity. Problems that may affect the reproductive health are seen more in some girls. Absence of effective mechanisms to make them

aware on the consequences of such issues and helps them to take appropriate measures to solve these issues, are noted.

Before bringing any change in menstrual practices they should be educated about the facts of menstruation and its physiological implications. The girls should be educated about the significance of menstruation and development of secondary sexual characteristics, selection of a sanitary menstrual absorbent and its proper disposal. This can be achieved through educational television programmes, school nurses / Health personnel, compulsory sex education in school curriculum and knowledgeable parents, so that she does not develop psychological upset and the received education would indirectly wipe away the age old wrong ideas and make her to feel free to discuss menstrual matters without any inhibitions.

Patterns of menstrual hygiene that are developed in adolescence are likely to persist into adult life. Data suggests that young girls should be taught more effective procedures of washing their menstrual clothes, as well as careful, more sanitary, storage of the pads, or preferably using new clothes for each monthly cycle. Sanitary napkins for menstruation are advertised in television commercials, and the use of commercially available pads has increased. Some simple procedures are likely to be available to most young girls, even in relatively poor families. Some of the traditional beliefs and practices could be linked to new forms of dissemination of hygiene information. The teaching of hygienic practices related to menstruation should be linked to an expanded health education in which young girls can learn about reproductive physiology and functioning, as well as practical information about reproductive tract infections, sexually transmitted infections, and other useful knowledge. Some of this knowledge is spreading into the adolescents, but the dissemination is slow and uncertain. In view of the fact that issues surrounding puberty and menstrual hygiene are extremely sensitive and conventional sources of health information such as popular media or brochures do not generally include them, more informal means of dissemination may be needed. Community groups, peer groups, school curriculums, and other such channels are likely to be more effective means of transmitting important health messages and advice to young girls entering puberty. More effective education about hygienic menstrual practices could be a major contribution to improving women's reproductive health, including reduction of reproductive tract infections.

Social situations have strong influence on adolescent sexual behaviour. Many young people need support in delaying sexual intercourse; others need to know how to protect themselves from pregnancy and infection, others require comprehensive services (including maternal health care). But little research has been carried out into how adolescents view their sexuality and how their views differ from those of adults. Research should also investigate how laws and official policies influence adolescent reproductive health.

Adolescents need a package of services/ facilities and awareness which will enhance their capacity for advancement and enable them to become capable citizens.

Adolescent girls may also be involved more actively in designing and implementing programmes help them to understand about their own health. The lack of knowledge about reproductive health including the emerging threat of HIV / AIDS, reproductive tract infections etc may affect the reproductive health of the adolescents very badly.

During the study it is found that there are NGOs who are putting sincere efforts for improving awareness among women on the reproductive health issues, Sexually Transmitted Diseases, RTIs etc. by conducting various programmes like counselling services, awareness programmes, orientation programmes, etc. NGOs are found to be working sincerely by conducting health programmes along with other services on a periodical basis even in the tribal settlement area where transportations are yet to reach.

With regard to services, we must ensure access to quality youth-friendly, integrated services, provided by healthcare workers who have been trained to work with adolescents. Sex education programs should be scaled up and offer accurate, comprehensive information while building skills for negotiating sexual behaviours. Healthcare workers should be equipped to provide accurate, balanced sex education, including information about contraception and condoms so that young people have the means to protect themselves, provided within a context of healthy sexuality, without stigma or judgment.

Healthcare workers are also well placed to influence policy and ensure service provision for those who need it. For example, healthcare workers can work to ensure young pregnant women receive early and tailored prenatal services to address their high risk and specific problems of anemia, malaria, HIV, and other STIs, as well as giving them special attention during obstetric care, given that they are most at risk of complications and death. Many improvements require political and legal maneuvering and healthcare workers can be advocates for legal abortion, adequate post-abortion care services for young people where abortion is restricted or adolescents have difficulty in accessing legal abortions, contraception provision for all who have unmet need, as well as other ASRH initiatives that can have a direct and strong impact on adolescent health.

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