Reproductive Health Scenario of Teenage Women: A Study of Budaun District in Uttar Pradesh (India)

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7.1 Introduction

Women in the developing world are at significant risk of poor obstetric and gynecological health. Hence there is need for urgent action. However, leaders and policy makers in the area of public health have been slow to respond to the challenge. The reasons are rooted in cultural biases that put women at a disadvantage regarding awareness of their health needs, as well as the scarcity of resources required to implement effective actions.

Research on women's health issues, as well as interventions to combat the disproportionately higher rates of gynecological morbidity in the developing world, have been few. Studies in Africa, South America and South Asia have shown that more women are suffer from symptoms of gynecological diseases than women in the developed world (Wasserheit,1989). The lack of information on gynecological health makes women in the developing world less likely to recognize symptoms of the disease they may suffer from; and socio-cultural barriers make them less likely to seek help. Consequently, women in the developing world are more vulnerable to serious, chronic complications of their diseases (Bhatti 2002).

The present study aimed at examining the availability of reproductive health services and their utilization teenage women in rural Uttar Pradesh. An attempt was also made to study the factors that influence utilization of these services by adolescent women. The study identified three major constraints in utilization of services by adolescent women: lack of awareness of the importance

of reproductive health, tradition-bound attitudes of the women towards their reproductive health, and programmatic factors.

The lack of awareness—and poor judgment—regarding health is a major obstacle to health-seeking among young women. This is especially true among adolescent women because of lack of education, which is on account of their early marriage. Adolescent women are, generally, poorly informed on matters regarding their sexual and reproductive health. Moreover, their low educational attainment, limited sex education and inhibitions about sex accentuate the ignorance (Jejeebhoy, 2000).

Lack of knowledge and awareness is also related to the adherence to traditions and cultural norms. In turn, this plays an important role in determining their health seeking behavior. Among the programmatic factors, lack of access to health care, poor quality of the delivery system and inadequate response to the needs of adolescent women are important factors influencing utilization of reproductive health care services. This study also aimed to identify the nature of services required by this sub-group of the population. The results of this study point to several target areas for policy and research which should be directed at improved sexual and reproductive and child health services for adolescent women.

According to an estimate, there are around 200 million adolescents in India aged 15–24 years. It is expected that this age group will continue to grow and is likely to reach over 214 million by 2020. The projections also estimate a significant increase in adolescent pregnancies and births over the next 20 years (Gupta, 2003). However, despite the fact that adolescent form such a large segment of the population, there is little focus by policies and programmes on adolescents.

Following the recommendations of ICPD Cairo, the Government of India had launched the Reproductive and Child Health Programme (RCH) in 1997 which prioritized adolescent health

and made it a component of RCH package consisting of maternal and child health, and family planning services. Treatment of RTIs/STD is also an important component of this package. But the needs of adolescent women are integrated with the needs of adult women without adequate appreciation that the needs are different.

Programmes aimed at adolescent women are at an early stage and there is, as yet, there is no clear definition of a strategic approach, and the activities required to provide adolescent health care. Hence, till today, there are very few programmes which distinguish between the special reproductive health needs of married and unmarried adolescents (Gupta 2003). Married adolescents are more vulnerable because of the serious reproductive health risks associated with early marriage and sexual activity, and early child bearing. Postponing marriage would be one way to curb teenage childbearing but for those who are already married and have begun childbearing, some of the health risks associated with adolescent childbearing can be avoided if the reproductive health services are appropriately utilized. Multivariate analysis presented in Chapter-IV of this report clearly shows that women who have greater knowledge of antenatal care are also more likely to use full package of antenatal care services.

Our survey also shows that the lack of knowledge about post-natal care is the most important factor for not obtaining post-partum services. Result shows that an increase in the institutional deliveries also increases the likelihood of receiving postnatal care among adolescent women. It is quite possible that if women deliver in a health facility, they become more aware of the services available as well as the significance of utilization of services.

Place of delivery has emerged as an important determinant of treatment-seeking for obstetric problems after delivery. Results of the study show that those women who deliver in a health facility are more likely to seek treatment for obstetric problems after delivery. Therefore,

measures are also needed to increase the use of professional delivery care to reduce infant as well as maternal mortality and morbidity among adolescent women.

Due to the lack of knowledge on reproductive health issues, women often perceive reproductive health problems as 'normal' and a ‘woman's lot and hence, do not seek treatment unless extremely serious (Jejeebhoy et al., 2003). Results of our study also show that adolescent women do not seek treatment, especially in the case of gynecological and obstetric problems, which they consider as a part of womanhood. Most postpartum complications are considered normal after the birth of a child and no care is sought.

Teenage women are also less open and frank in discussing their reproductive health problems as compared with older women because they perceive their reproductive health problems with shame and embarrassment (CWFP, 1998). Our survey shows that the most common reason for not seeking treatment for reproductive morbidity is embarrassment. Women are embarrassed to seek treatment and are not inclined to discuss their problems with anyone at home. Health personnel also tend to attribute women's non-utilization of reproductive health services to the social stigma attached to these problems. Thus, women prefer to endure in silence rather than seek treatment.

At the time of the interviews, in most of the cases, the mothers-in-law present reported that they were not aware of their daughters-in law's reproductive health problems. Results of multivariate analyses clearly show that an increase in consultation of problems, especially gynecological and obstetric, significantly increases the probability of treatment seeking. Providers should encourage adolescent women to discuss and seek treatment for reproductive health problems. The need is for greater inter-spousal communication, as well as consultation of problems with anyone, at home or with health personnel.

The traditional disposition of women also plays an important role in determining their health-seeking behaviour. This is more so in the case of adolescent women who do not have any autonomy in decision making regarding even their own healthcare (Jejeebhoy et al., 2003).The adolescent women interviewed in our survey reported that the use of reproductive health services is opposed by the parents and elders as they believe that it is not necessary—or customary—to go to a health facility, especially for utilizing antenatal care, natal care and post-natal care services. In some cases, it was seen that the elders even opposed treatment-seeking for reproductive morbidity. An ANM remarked, "it is not enough to educate adolescent women as they do not have any decision-making authority. The target should be their parents, and elders in the society, who need to be educated and made aware about various reproductive health issues". The adolescent women also Suggested that decision-making rests with their husbands and mothers-in-law and hence, for any programme to have the desired impact, they should be included in the target population.

The women's powerlessness and lack of control over resources also plays an important role in their poor treatment-seeking behavior (Jejeebhoy et al., 2003). Although standard of living index in the multivariate analysis has emerged as an important factor, which shows that a better standard of living leads to better treatment seeking, case studies have revealed that even in the households With a better standard of living, the daughter-in-law is accorded the least priority regarding healthcare in the family.

Providers are also of the opinion that economic factor to adolescent women in seeking treatment because they lack control on economic and other resources in the household. An ANM said, *"Adolescent women do not seek treatment as they have to spend on transport and medicines".*

Thus, the findings of the study re-emphasize the need for investment in education and employment opportunities for adolescent women. The draft National Youth Policy of 2000 also calls for a multi-dimensional integrated approach to youth development with focus on youth empowerment, gender justice and youth participation in decision-making.

Finally, programmatic factors including inaccessibility and non-availability of services, and poor quality of care, also hinder utilization of services by adolescent women. The study reveals that limited mobility of adolescent women and the need for male relatives or husband's accompaniment to care facilities also delays seeking treatment. Women do not utilize services, as there is no one to accompany them to the health facilities. Being newly married and young, one of the main constraints of these women is that they cannot go alone for seeking treatment. Moreover, they are also not confident to travel alone to a PHC/CHC in another village, tehsil or district headquarters.

The present study has however, shown that development is not an important factor influencing utilization of services. Rather, it is the distance of a user from a health facility that has important implications for the utilization of reproductive health services among adolescent women. A place may be developed but may not have a health facility; on the other hand, a place may be undeveloped but still has a health facility. Multivariate results indicate that adolescent women living near a health facility are more likely to use the services compared with those living far away from a health facility.

7.2 Objective

Followings were the major objective of the present study:

1. To assess the Utilization of Health Services and RCH Status in Uttar Pradesh

2. To study the knowledge and utilization of maternal health care services among teenage mothers.
3. To study the prevalence of Obstetric Morbidity and treatment-seeking behavior among teenage mothers.
4. To study the prevalence of Gynecological Morbidity and treatment-seeking behavior among teenage mothers.

7.3 Methodology

The study used the following methodology:

The study is based on secondary data. To fulfill the first objective, data from Census of India 2011 (Census of India 2011 & 2011a), District Level Health Survey-3, 2007-08 (IIPS, 2007), Facility Survey 2007 (IIPS, 2007a) was used.

For the other objectives primary data was used. The estimated sample size was 440 women who have ever experienced childbearing before the age of 20. One respondent was selected from each household to maintain heterogeneity.

SPSS software was used to perform univariate, bivariate and multivariate analysis, and the chi-squire test was used to assess maternal and reproductive morbidity among teenage women. Binomial logistic regression model was used to determine the association of different background factors with maternal health, obstetric morbidity, gynecological morbidity and treatment-seeking.

7.4 Major Findings

Of the 440 women, one-third (33 percent) gave birth at less than 17 years. The others had children between the ages of 17 and 19 years. The majority (70 percent) were Hindu and the remaining Muslim. Nearly one-fourth (23 percent) of the sample belonged to the general castes, 31 percent to the Schedule Castes and Tribes, and 46 percent belongs to the Other Backward

Classes. The study found that two-fifths (40 percent) women were illiterate, 43 percent had a primary education and 17 percent of the women had studied up to the secondary level. The proportion of working women was found to be high 58 percent of the women were found to be working at the time of survey. The distribution of women's autonomy index showed that it was low among 38 percent of the women. Exactly half of the women (50 percent) surveyed had medium autonomy and only 12 percent women had high autonomy index.

Thirty-one percent of the women's husbands were engaged in labor work, 52 percent husbands were working in agriculture. Seventeen percent of the women's husbands was engaged in businesses.

Only 38 percent of the women reported availability of toilet facilities in their homes.

Thirty-five percent of the women said that marrying early was traditional practice. Family pressure to bear children and the lack of awareness of family planning. Family pressure and lack of awareness/family planning (32 percent and 26 percent respectively)were the reasons given by the teenage women for their early pregnancy.

While studying the inter-district variation in utilization of health services and the outcomes on reproductive and child health status in Uttar Pradesh, different indices showed different results. However, it is seen that large districts like Lucknow, Kanpur Nagar, Varanasi, Pratapgarh, Agra, Meerut, Baghpat, Ghaziabad, Saharanpur are better off in this respect, while districts Srawasti, Budaun, Barampur, Gonda, Sitapur, Baharaich, Siddharthnagar, Sahjahanpur, Hardoi, Banda are lagging. The northern and eastern districts of Uttar Pradesh have poor social-economic development and poor health infrastructure.

For utilization of maternal health services it was seen that two-fifth of the women had knowledge of antenatal care. The results show that educational status of women, women's autonomy, husbands' education and occupation, and the standard of living index are important predictors of utilization of antenatal care and have significant association with women's knowledge of antenatal care. TT injections, IFA tablets, abdominal examination, blood tests, blood pressure checkups, urine test, measurement of weight measured, and ultrasound examinations are the most widely used components of antenatal care that the teenaged women received.

The educational status of women, autonomy, husbands' educational attainment and occupational category are seen to have significant association with utilization of antenatal care by teenage women. Utilization of natal care has significant association with the women's caste, educational status of women, exposure to media exposure, their husbands' education and the standard of living index. On their perception of Institutional delivery, a high proportion of the women (43 percent) felt that visiting a health facility is not necessary unless there are complications. Furthermore, 21 percent of the women in the sample could not go to care facilities because of lack of time. Only about one-fifth (21 percent) of the teenaged women received post-natal care.

The most common reason for obstetric problems, which were reported by the teenaged women, night blindness and/or blurred vision, swelling of hands and feet, anemia and weakness/dizziness. 58 percent of the women reported at least one complication during pregnancy among whom 76 percent had consulted (or discussed) their symptoms with family members or relatives. The majority of the women (46 percent) shared these complications with their mothers/sisters followed by husbands. Results of binary logistic regression for prevalence of obstetric morbidity show that caste, husbands' occupation, working status of the women and their standard of living index have significant association.

Post-partum obstetric problems reported by teenage women were high fever, pain in the lower abdomen and excessive bleeding. More than two-fifths (42 percent) of the women reported at least one complication during the post-partum period of 42 days. 79 percent of the women consulted (or discussed) their symptoms with family members or relatives and of these41 percent women had discussed these problems with her mothers/sisters. Of concern is the finding that47 percent of the teenage women did not consider these problems as serious enough to seek treatment. Result of logistic regression shows that religion, women's autonomy index, husbands' occupation, SLI and age at birth had significant association.

Vaginal Discharge (white discharge) was one of the most widely reported problems. Other symptoms of gynecological problems experienced by teenage women were itching/irritation/sores in the vaginal area, menstrual disorders, lower back pain, pain in the lower abdomen, pain or burning sensation while urination or blisters. Prevalence of gynecological problems was found to be higher among Muslim women, and those who had no education and whose husbands were engaged in labor. Most of the women reported that they discussed their problems with their husbands; and that personal embarrassment, the perception that treatment is not necessary, and high cost of treatment were the reasons that the women did not seek treatment for gynecological morbidity.

7.5 Conclusion

The finding of this study reaffirms the crucial importance of educating women. Education and timely awareness have significant direct influence on the utilization of reproductive and child health services. To improve Adolescent Reproductive Health, there is a need for not only investment in the provision of health services, but also to fulfill other needs, such as education, jobs, and supportive families and communities. Creating opportunities for adolescent women has

the potential to improve their sexual and reproductive health. There is a need for sensitization and awareness programmes for enhancing married adolescent girls' autonomy in their homes. This can be done by providing better access to education, strengthening girls' life skills and generating employment opportunities. To accomplish these aims, partnerships between government, non-government organizations and the private sector is imperative.

This study also tried to examine the utilization of maternal health care utilization, which included the women's knowledge of ANC, the components of ANC they received, whether they received full or partial ANC; and also of NC and PNC services to determine their bearing on morbidity. Complications of obstetric morbidity during pregnancy and after delivery can adversely affect women's health and pregnancy outcomes. Early identification of these pregnancy complication and timely treatment-seeking are crucial components of safe motherhood programmes.

This study had included 440 women who gave birth before the age of twenty during the last three years preceding the survey. An attempt was made to study prevalence, the tendency to discuss/consult, and treatment-seeking behavior of the women; and to understand the impact of the socio-economic and demographic background characteristics on the reported symptoms of obstetric morbidity during pregnancy and after delivery.

In cases of gynecological morbidity, episodes of white discharge were the highest among the numbers of untreated cases followed by lower back pain, and lower abdominal pain. There were various for not seeking treatment for the reported conditions. The fear of social stigma was a major deterrent to seeking treatment for white discharge. Most women, who suffered from lower abdominal pain and pain in the lower back considered such conditions as normal and hence not requiring treatment.

Another reason for not seeking treatment was financial constraints. The need to be accompanied to health facilities by husband or male relatives was another significant reason for delays in accessing care. Moreover, women tend to ignore such symptoms as they accept them as a normal part gynecological health and reproductive stage of their lives. Also, being daughters-in-law, attention to their health concerns is low on their families priorities. Results of logistic regression show that woman's education, standard of living index, distance from a health facility, level of development and consultation of symptoms with someone are significant predictors of treatment seeking.

7.6 Policy implications

The findings of the study point to an urgent need to evolve targeted and effective policies that address the health needs of teenaged women.

One of the major implications is that health education and studies does not provide proper understanding of the health conditions and needs of women in rural India. There is poor awareness of the causes and potential consequences of gynecological diseases.

The study suggests strict enforcement of the legal age of marriage. In addition, incentives must be provided so that they can benefit those who marry at 18 years or more. More efforts are necessary to promote girls' education with special attention to preventing dropouts and facilitating the return to school of girls who had to discontinue their education. Despite the increase in women's education and the rise in age at marriage over the last few years, the pace of progress is observed to be too slow to have a significant improvement in the health status of adolescent women and their status in the society. To expedite progress, existing laws must be

enforced or improved so that women are empowered to take decisions that affect their health and life.

The emphasis must also be to increase the average number of years women spend in school. This will significantly increase their autonomy. Appropriate strategies should design so that women are sensitized as to their rights and have adequate awareness of the healthcare facilities that they are entitled to and can access. Awareness must also be raised among both men and women in related issues, such as gender equity and shared responsibilities. Health-service delivery interventions need to address married adolescents' lack of decision-making power and social isolation.

Efforts are also necessary to improve knowledge on reproductive health using electronic and print media in a way that the information directly reaches young women. A counseling component should be integrated in RCH programmes to increase knowledge and promote autonomy in decision-making. Improving awareness about self-care practices and care seeking behavior may prevent reproductive morbidities that are usually outcomes of poor personal hygiene. Thus, the urgent need for accessible health services for adolescent girls in rural areas cannot be understated.

In rural areas, a large proportion of young women have their illnesses treated by RMPs or unlicensed practitioners. The costs are high and the outcomes often dubious. This points to the need to strictly regulate the activities of unregistered medical care-givers. Moreover, non-availability of female doctors at public health facilities because, according to service providers in the community, "adolescent women prefer health providers especially a female doctor for treatment of reproductive health problems." Young women prefer private providers, especially female doctors for the treatment of reproductive health problems. In fact, many young women

expressed the need for at least one female doctor at each health facility. The need for a female physician was of ten mentioned during the survey because the women felt shy and diffident while consulting male doctors.

7.7 Limitations of the study:

The present study has some limitations, which are described below:

Gynecological problems are captured on the basis of self-reported symptoms by teenage women. Clinically-tested data would have been more accurate to find out the reproductive health status of the women. Moreover, it should be clear whether women are experiencing abnormal vaginal discharge due to existence of some reproductive tract infections or it is due to some psychosomatic syndrome.

Regarding the symptoms reported during pregnancy and post-partum complications, symptoms could not be classified under 'severe' and 'non-severe' categories. Symptoms such as (weakness, blurred vision, bleeding, and lower abdominal pain, could be manifestations of severe infection so it is difficult to classify them as non-severe. This is a limitation of study.

7.8 Scope for future research

- The study needs to be conducted on a larger sample size.
- The study needs to be conducted on clinical based population.
- Psychological aspects may be explored in more detail because psychological health is a determinant of physical health in many ways. Moreover, hospital based study may be carried out to measure accurately the prevalence and also helping out women who are suffering from reproductive health complications.