Reproductive Morbidity and Health Seeking Behaviour of Adolescent Women in Rural India

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I Introduction

Prevalence of Reproductive Tract Infections (RTIs) is determined by a number of factors. An association between Pelvic Inflammatory Diseases (PID) among women and husbands' extramarital sexual relations has been well documented (Ooman 2000). Use of contraception especially, IUD, female sterilization, and abortion procedures also increases the risks of RTIs (Gittlesohn et al., 1994; Bhatia and Cleland 1995; Gogate et al., 1998). Also, obstetric experiences of women and certain routine procedures during gynecological examinations may lead to contracting RTIs. Lack of menstrual and personal hygiene are also found to be associated with RTIs. In addition, there are socio-economic and cultural determinants of RTIs. Studies have shown a strong association between women's livelihood, work and their reproductive health. (Ooman 2000).

Generally women with self- reported symptoms of reproductive morbidity do not seek treatment due to existing taboos and inhibitions regarding sexual and reproductive health. They hesitate to discuss about their reproductive health problems especially, due to shame and embarrassment (Bang et al .,1989; Oomman 2000). Even if they seek treatment, a majority of women seek health care from quacks or unqualified private practitioners that also have serious implications for their health. Untreated infections can not only lead to PID, ectopic pregnancy, infertility and cervical cancer but also foetal loss, health problems of new born and increased risk of HIV transmission. In addition to health consequences, women experience social consequences in terms of emotional distress related to gynecological morbidity (Mamdani 1999).

As most of these illnesses progresses to a chronic state and remain with the women for the rest of their lives, the importance of early detection and management becomes evident. Until now, little is known about the prevalence of reproductive tract infections (RTIs) or sexually transmitted diseases (STIs) among adolescent women in developing countries such as India. A recent study of young married women aged 16-22 years in a rural community in Tamil Nadu reports a very high level of morbidity. The study shows that more than half of the

women were suffering from at least one or more RTIs. Clinical examination also confirmed STIs among majority of them (Joseph et al 2000). Similarly, very few attempts have been made to study their health seeking behaviour for reproductive morbidity (Islam et al., 1998; Barua 2000; Joseph et al 2000). Kulkarni and Adhikari in a study of adolescent women in India and Nepal report relatively high rates of gynecological morbidities, especially in the settings where girls have limited access to adequate health care (quoted in Bott and Jejeebhoy 2000).

This study is an attempt to examine adolescent women's treatment seeking behaviour of self-reported symptoms of reproductive morbidity. The study adheres to the WHO (1992) classification of reproductive morbidity into gynecological, obstetric and contraceptive morbidity. Therefore, the study is divided into three sections: gynecological, obstetric and contraceptive morbidity. The section on gynecological morbidity, which includes health problems outside pregnancy, is divided into two parts where prevalence of self -reported symptoms and health seeking behaviour have been studied before and after marriage considering that the health seeking behaviour of adolescent women differs before and after marriage. Obstetric morbidity refers to ill health related to pregnancy. In this section, problems and health seeking behaviour of women during pregnancy, delivery complications and problems experienced after delivery have been studied. The section on contraceptive morbidity includes problems experienced by women due to the use of contraception. The study also attempts to probe the association of the existing socio-economic and demographic factors with prevalence and treatment seeking behaviour of such morbidity. Cross tabulation has been done to examine the effect of the background characteristics on prevalence of morbidity and utilization of services. To assess the significant effect of background characteristics, logistic regression has been used.

II Methodology

2.1 Study Area

The study was conducted in the state of Madhya Pradesh, the state with the highest percentage of currently married adolescent women and consequently the highest adolescent fertility rate in India. According to NFHS-2, the state has the highest level of adolescent fertility rate of the order of 142 births per 1,000 adolescent women and the rate is as high as 162 births per 1, 000 adolescent women in rural areas of the state (IIPS 2000).

2.2 Study Design and Sample Size

The sampling area chosen for the study is the Indore district of Madhya Pradesh. Two Tehsils namely, Depalpur and Indore have been selected on the basis of their level of socio-economic development from the Indore District.

Within each Tehsil a block Primary Health Centre (PHC)/ Community Health Centre (CHC) was selected. At the next stage, three villages, served by each block PHC/CHC were selected for the purpose of the survey. One of the factors which, have been identified to cause disparity in service utilization is the distance of the user from the service facility (Gittlesohn et al., 1994; Sharma and Kumar 1996). This is assumed to be more so in the case of adolescent women who are not allowed to travel alone to a health facility. As the aim of the study is to examine the utilization of reproductive health services, villages in each Tehsil were subdivided according to their distance from the service centre. Depalpur Tehsil has a CHC and three villages namely, Badoli Hauz which is 2-3 kms from this CHC, Murkheda which is 6-7 kms from this CHC (the village also has a sub-centre) and Akasoda which is 10-12 kms from the CHC were selected. Similarly, Indore Tehsil does not have a CHC. Thus, a block PHC of Indore Tehsil was selected and the three villages selected were: Budhania which is 2-3 kms from this block PHC, Jumbudi Hapsi (this village has a sub-centre) which is 6-7 kms from the PHC and Nainod which is 10-12 kms from the block PHC in Indore Tehsil.

Thus, a total of six villages formed the sample. Each village has a population of around 200-400 households. With the help of an aganwadi worker, approximately 45-50 households with a married adolescent woman were selected in each village. Thus, a total of 298 ever-married adolescent women in the age group of 13-19 years were interviewed for the study.

2.3 Tools for Data Collection

For the purpose of data collection, the study has used a combination of both quantitative and qualitative techniques. A structured questionnaire was used to collect information on utilization of reproductive health services by adolescent women. The quantitative phase in which a set of questionnaire was used to carry out the survey was followed by the qualitative phase. Qualitative research is not only helpful in describing patterns of health seeking behavior but it also helpful in examining indigenous beliefs, attitudes and knowledge which influences their choices and

decisions about health care (Gittlesohn et al., 1994). For the qualitative phase, assistance was sought from aganwadi workers in the respective villages to organize the Focus Group Discussions (FGDs) in the villages. A total of 10 FGDs with 8-10 adolescent women in six villages, approximately two in each village were conducted to explore their knowledge and awareness regarding antenatal care, their breastfeeding and menstrual practices, their perception of causes of reproductive health problems, communication of these symptoms, their treatment seeking behaviour and the perception of health care providers. They were also asked to discuss about the interventions, which are required to be introduced to increase the utilization of reproductive health services and their overall status in the society. In addition, 20 case studies were conducted with adolescent women to understand their treatment seeking behaviour of the reproductive health problems. 16 in-depth interviews were conducted with the providers such as ANMs, LHVs, Aganwadi workers, Lady Doctor and Staff Nurse to understand their perception of the utilization of the services by adolescent women and the obstacles in the utilization of services. These in-depth interviews were conducted at the block PHC in Indore Tehsil, CHC in Depalpur, Sub-centres in Murkheda and Jumbdi Hapsi and also during the providers' field visits. A semi-structured interview schedule was used to interview the providers.

III Findings of the Study

3.1 Socio-Economic Characteristics of the Sample Population

This section presents a profile of socio-economic and demographic characteristics of respondents. Table 1 presents percentage distribution of ever married women aged 13-19 years by demographic characteristics of the respondents including their age at marriage, age at cohabitation, percent women ever given birth, number of children ever born, and women ever experienced pregnancy wastage and their socio-economic characteristics such as standard of living index, woman's education, their work status, husband's occupation and woman's autonomy index.

Data reveals that more than half of the women were married below age 13 years. 42.6 percent between ages 14 to 16 years and only 4.3 percent between 17-19 years. More women are married below age 13 years in Dehpalpur tehsil compared to Indore tehsil. But in rural areas, formal marriage is not immediately followed by cohabitation. Cohabitation only starts after the gauna ceremony. Thus, there is a difference between age at marriage and age at

consummation of marriage. Data show that only 29 percent of women began living with their husbands below age 13, 62.6 percent started cohabiting between ages 14 to 16 years and 8.3 percent between 17-19 years of age. Thus, more than 90 percent of adolescent girls started living with their husbands by age 16 years. Data show that more than half of the ever-married women have given a live birth and again the percent is higher in Dehpalpur.

7.8 percent of adolescent women reported more than three children ever born. Not all the pregnancies result in a live birth especially, among adolescent women who belong to high-risk category. Other possible outcomes are spontaneous abortion, induced abortion and still birth. The survey found that 9.0 percent of women reported one or more spontaneous abortions and 2.6 percent still birth. Incidentally, none of the respondents reported an induced abortion this may due to the fact that an adolescent woman is expected to bear a child immediately after marriage and prove her fertility. Thus, due to the fear of social stigma they did not talk about any attempt to abort the foetus. In addition, 7 percent of adolescent women also reported Infant mortality.

Table 1 Socio-Economic Background Characteristics of the Respondents

Socio-economic background characteristics	Dhepalpur	Indore	Total
Age at marriage			
below 13	56.7	49.3	53
14-16	41.3	44.0	42.6
17-19	2.0	6.7	4.33
Age at cohabitation			
below 13	28.7	29.3	29.0
14-16	66.0	59.3	62.6
17-19	5.3	11.3	8.3
Ever given birth			
Yes	60.7	50.7	55.7
No	39.3	49.3	44.3
No.of CEB			
0	40.0	5.0	27.8
1	31.3	60.0	41.3
2	22.0	25.0	23.0
3 and more	6.7	10.1	7.8
Ever has still birth			
Yes	2.7	2.5	2.6
No	97.3	97.5	97.4
Ever had Spontaneous Abortion			
Yes	8.0	10.0	9.0
No	92	90.0	91.0

Ever experienced Infant mortality			
Yes	6.0	8.8	7.0
No	94.0	91.3	93.0
Ever attended school			
Yes	44.0	50.0	47
No	56.0	50.0	53
Work status			
Working	59.3	72.0	65.7
Not working	40.7	28.0	34.3
Husband's Occupation			
Agricultural	72.7	59.3	66.0
Non-agricultural	27.3	40.7	34.0
SLI*			
High	20.7	18.7	19.7
Medium	38.0	33.3	35.7
Low	41.3	48.0	44.7
Women's autonomy			
% women who take the following decisions			
What items to cook	55.3	65.8	60.5
Health care	4.0	0.0	2.0
Purchasing household goods	2.7	0.0	1.3
Staying with parents	0.7	0.0	0.3

*SLI is an average of type of house, fuel used for cooking, source of drinking water, type of toilet facility, ownership of livestock and any vehicle (See Appendix I).

N=298

Socio-economic characteristics of women show that a little less than half of the women have ever attended school. As expected, the percentage of women who have ever attended school is higher in the Indore tehsil. One-third of respondents did not participate in work other than their regular household work. More than two-thirds of women reported that their husbands are involved in agricultural occupation. This percentage is higher in Dhepalpur, being the less developed tehsil in the Indore district. Distribution of women into three categories of standard of living index shows that 19.7 percent of women have high standard of living, 35.7 percent are in medium and 44.7 percent of women belong to low standard of living index.

As regards women's autonomy, data show that most women only had say in the decisions to cook. At least 60 percent of women made this decision on their own. Only 2 percent of women revealed that they had a say in decision making with respect to their health care suggesting that women are not at all involved in the decisions about seeking health care for themselves. The real decision-makers continue to be the husband or mother-in-law. Similarly, newly married adolescent women also do not have any say in purchasing major household items and going and staying with parents or siblings.

3.2 GYNECOLOGICAL MORBIDITY

3.2.1 Prevalence of Gynecological problems Before Marriage

Reproductive health problems are not only the problems of married women but unmarried women also experience gynecological problems. But they often do not discuss about these problems with anyone due to the fear of social stigma attached to such problems. As most of the public sector services generally target adult married women, unmarried adolescents often do not seek health services due to the fear that the services are not confidential, inability to pay, prerequisite of parental/partner approval and negative or insensitive attitude of health providers (Mamdani 1999).

The survey shows that around one-fifth of the women were suffering from at least one symptom of gynecological nature. These women were found to be suffering from white discharge, itching/irritation in vaginal area, menstrual disorders including irregular menstruation and excessive bleeding, lower backache and lower abdominal pain not related to menstruation before marriage.

Table 2 Nature of Illness

Gynecological problems	Percent (episodes)
Vaginal discharge	46.6
Menstrual disorders	22.7
Lower backache	12.5
Lower abdominal pain	13.6

N=88

Among the gynecological problems, white discharge was the most common problem reported by women in this study. A little less than half of the reported episodes were of white discharge. One-fifth of the episodes was reported to be of menstrual disorders, especially irregular menstruation. 13 percent of the episodes were of lower abdominal pain and lower backache.

The mean duration of white discharge and lower abdominal pain was found to be 2.4 years which is high compared to mean duration of other problems such as lower backache (2 years). Women reported that burning sensation lasted for around 2 years and menstrual disorders for more than a year.

3.2.3 Discussion of gynecological symptoms

Women suffer from reproductive morbidity due to their 'culture of silence'. They are reluctant to discuss their problems with either anyone at home or with a health provider (Patel and Khan 1996). In more than half of the episodes of white discharge women did not discuss it with anyone (Table 3). Similarly, in 41.7 percent of cases women suffering with lower abdominal pain did not discuss about their symptoms.

Table 3 Discussion of gynecological symptoms

Gynecological problems	Did not discuss	Discussed with Mother
Vaginal discharge	56.0	44.0
Menstrual disorders	30.0	70.0
Lower backache	27.3	72.7
Lower abdominal pain	41.7	58.3

Focus Group Discussions reveal that women were embarrassed to talk about these problems, as they believed that nobody talked about these illnesses. Most of the women preferred to discuss about their gynaecological problems only with their mothers. Data show that women felt more comfortable in discussing lower backache and their menstrual problems than any other reproductive health problem. A study of married adolescent women in rural Maharastra also shows that problems like burning urination, menstrual disorders especially, if started before marriage were mainly confided by these women in their mothers (Barua 2000).

3.2.4 Knowledge of source of treatment and treatment seeking behaviour

Knowledge about the source of treatment of reproductive health problems among adolescent women was also found to be limited. Most women were unaware of the source of treatment for reproductive health problems.

Table 4 Knowledge about the Source and Treatment seeking behaviour of adolescent women suffering from gynecological morbidity

Gynecological problems	Knowledge about the source of treatment	Did not seek treatment
Vaginal discharge	36.6	82.9
Menstrual disorders	55.0	75.0
Lower backache	54.5	63.6
Lower abdominal pain	33.3	50.0

In a little more than half of the episodes women suffering with menstrual problems and lower backache knew about the source of treatment. Similarly, in only one third of the episodes of white discharge/lower abdominal pain women knew about the source of treatment.

The survey shows that the treatment seeking behaviour of adolescent women before marriage with regard to gynecological problems was found to be poor. Women generally did not seek treatment for white discharge and menstrual disorders. In 82.9 and 75 percent of episodes, women who reported these problems did not seek any treatment. Similarly, in case of nearly two-third and half of the episodes women did not seek treatment for lower backache and lower abdominal pain.

Table 5 Reasons for not seeking treatment

Gynecological problems	Reasons for not seeking treatment					
	Not serious	Did not know the source	Costs too much	No time/long waiting	Facility far off	Embarrassed to seek treatment
Vaginal discharge	26.5	2.9	5.9	2.9	0.0	61.8
Menstrual disorders	20.0	6.7	33.3	0.0	6.7	33.3
Lower backache	85.7	0.0	14.3	0.0	0.0	0.0
Lower abdominal pain	66.7	0.0	16.7	0.0	0.0	16.7

The most common reason for not seeking treatment among adolescent women, especially for white discharge was found to be embarrassment. In case of women suffering with lower abdominal pain and lower backache in more than two-thirds of episodes they considered it normal and did not considered it as serious to be treated. In one third of episodes of menstrual disorders, women did not seek any treatment due to financial constraints as well as embarrassment.

3.2.5 Prevalence of Gynecological problems After Marriage

There are very few studies on prevalence of gynecological morbidity among married adolescent women and their health seeking behaviour (Joseph et al 2000; Islam et al., 1998; Barua 2000). The survey shows that around two-third of women reported any gynecological problem after marriage. As most of the women had multiple symptoms, it indicates a very

high prevalence of gynecological morbidity among married adolescent women compared to unmarried women (Table 6).

Table 6 Prevalence of gynecological morbidity before and after marriage

	Percent women experienced
Before marriage	20.7
After marriage	64.7

N=298

Moreover, perhaps after marriage not only there is an increase in morbidity but adolescent women also perceive the problems better.

Table 7 Nature of Illness

Gynecological problems	**Percent (episodes)**
Vaginal discharge	36.9
Itching/irritation	5.2
Menstrual disorders	20.9
Lower backache	17.5
Lower abdominal pain	12.6
Burning sensation	6.4

N=325

Out of those who reported any gynaecological problems, in more than one-third of cases adolescent women reported to be suffering from white discharge. Around one fifth of the illness episodes were reported to be of menstrual disorders including irregular menstruation and excessive bleeding. 17.5 percent of the episodes were of lower backache and 12.6 percent of lower abdominal pain not related to menstruation. 5.2 percent of episodes were reported to be of itching/irritation including sores in the vaginal area and 6.4 percent of burning sensation while urination.

Mean duration of persistence of symptoms show that itching/irritation continued for 3 years. Similarly, vaginal discharge and pain or burning while urination also persisted for more than 2 years. Menstrual disorders and lower abdominal pain continued for around 2 years and lower backache for 1.5 years.

Percentage distribution of women with self-reported symptoms of gynecological morbidity by background characteristics (Table A1) show that reporting of symptoms is only significantly influenced by pregnancy outcomes i.e. spontaneous abortion. Women who have had ever experienced a spontaneous abortion are more likely to experience gynecological problems. A study of married adolescent women in Tamil Nadu found that RTIs were more common among women who had a greater number of pregnancies, had two or more children, had a tubectomy, whose husbands were transport workers or in the armed forces (Joseph et al 2000).

3.2.6 Discussion of symptoms of gynecological symptoms

Even after marriage, most of the women endured in silence. This is more so in the case of adolescent women who face constraints in expressing their reproductive health problems immediately after marriage.

Table 8 Discussion of gynecological symptoms

Gynecological problems	Discussed	% discussed with*					
		Husband	Mother	Sister	Mother-in-law	Sister-in-law	Doctor/ health wrk
Vaginal discharge	38.3	52.2	30.4	0.0	26.1	8.7	10.9
Itching/irritation	64.7	63.6	9.1	0.0	45.5	18.2	0.0
Menstrual disorders	64.7	59.1	29.5	2.3	54.5	9.1	2.3
Lower backache	66.7	42.1	36.8	0.0	39.5	5.3	5.3
Lower abdominal pain	51.2	52.4	28.6	0.0	57.1	4.8	0.0
Burning sensation	76.2	50.0	31.2	0.0	37.5	12.5	12.5

- the percentage does not add up to 100 due to inclusion of multiple response

The survey shows that in at least 62 percent of cases, women did not discuss about white discharge. Similarly, in half of the cases, women did not talk to anyone regarding lower abdominal pain. In around one-third of cases women never discussed about itching, menstrual disorders and lower backache. Some women who did discuss, discussed about these problems with their either mothers-in-law, husbands or their mothers. Some of the women also reported that they discussed their problems with ANMs. On the other hand, ANMs reported that women contact them for gynecological problems but they were not in position to provide any

help to the women except referring them to higher-level facilities, as they do not get any medicine for the treatment of gynecological problems.

The FGDs revealed that in fact there is a chain of communication of symptoms of gynecological problems adolescent women are suffering with. They first discuss their problems with mothers-in-laws or sisters-in-laws who then communicate this to their fathers-in-law/brothers-in-law and ultimately either fathers-in-law/brothers-in-law or husbands accompany women to the doctor. Some women mentioned that they generally first talk about their symptoms with whoever is in their age group or is closer to them.

Communication of gynecological problems

Woman ⟶ mother-in-law/sister-in-law ⟶ father-in-law/ brother-in-law/husband

But adolescent women talk about these problems only when the symptoms become serious. A 17-year-old young woman during the focus group discussions said, "**if we inform our in-laws in the beginning, they think that we are pretending to be ill, they believe us only when it becomes serious**". Another woman said, "**we discuss about these problems with others only when it becomes serious**".

Similarly, a study of adolescent women in rural Maharastra observed that most women do not talk about white discharge, as they believe that these problems are an integral part of a woman's life. Only a third of girls surveyed ever discussed these problems either with a husband, mother or a friend. The study found that girls preferred to confide in their husbands rather than mothers-in-law but the husbands did not see the need as serious and left it to the girls to handle it (Barua 2000).

3.2.7 Knowledge of source of treatment and treatment seeking behaviour

The findings of the study show that women generally did not know where to seek treatment. Knowledge about the source of treatment was limited in the case of white discharge where in only 30.8 percent of cases women reported knowledge about the source of treatment. Similarly, in the case of menstrual disorders and lower abdominal pain in only half of the cases women had knowledge about the source of treatment. Knowledge about source of

treatment was found to be higher in case of episodes of burning sensation (81 %), itching/irritation (64.7%) and lower backache (64.9 %).

Table 9 Knowledge about source of treatment and treatment seeking behaviour of adolescent women suffering from gynecological problems

Gynecological problems	Knowledge about the source of treatment	Did not seek treatment
Vaginal discharge	30.8	86.7
Itching/irritation	64.7	41.2
Menstrual disorders	50.0	72.1
Lower backache	64.9	71.9
Lower abdominal pain	46.3	70.7
Burning sensation	81.0	47.6

Treatment seeking behaviour of adolescent women for gynecological problems reveals that episodes of white discharge recorded the highest number of untreated cases (86.7 %). In more than 70 percent of cases women suffering with menstrual disorders, lower backache and lower abdominal pain did not seek any treatment (Table 9). Poor treatment seeking behaviour of adolescent women is also corroborated by other studies (Joseph et al 2000; Barua 2000).

In case of treatment for gynecological morbidity, those women who sought treatment depended on private providers (68.2 %). In only 16.5 percent of cases treatment was sought from government providers. 5 percent of cases medicines were bought directly from chemist shop. Similarly, in 5 percent of cases, women relied on home remedy. Few cases of treatment from a faith healer were also reported (3.5 %).

Distribution of women suffering with any gynecological problems by their knowledge about the source of treatment, their treatment seeking behaviour and background characteristics is presented in Table A2. The bivariate analysis reveals a broadly reliable pattern of socio-economic differentials in knowledge of source of treatment and treatment seeking behaviour. Women who have ever attended school are more aware of the source of treatment. Standard of living and women's autonomy index are also positively linked with the awareness regarding the source of treatment. Knowledge of source of treatment also increases with an increase in the number of children ever born.

Similarly, in the case of treatment seeking behaviour, women who have ever attended school are more likely to seek treatment for gynecological problems. As expected, treatment seeking behaviour of women is also positively linked with standard of living index and level of development. Women's work status also influences their treatment seeking behaviour. Result show that working women are less likely to seek treatment compared to non-working women which is perhaps due to the fear of loss of wages.

Table 10 Reasons for not seeking Treatment

Gynecological problems	**Reasons for not seeking treatment**					
	Not serious	**Costs too much**	**No time/long waiting**	**No one to accom pany**	**Embarr assed to seek trt**	**Family/M. I.L not interested**
Vaginal discharge	15.4	15.4	4.8	3.8	57.7	2.9
Itching/irritation	42.9	0.0	0.0	0.0	57.1	0.0
Menstrual disorders	28.6	20.4	6.1	4.1	34.7	6.1
Lower backache	48.8	39.0	4.9	0.0	2.4	4.9
Lower abdominal pain	31.0	37.9	3.4	0.0	20.7	6.9
Burning sensation	20.0	50.0	0.0	0.0	20.0	10.0

Women were asked various reasons for not seeking treatment. Data in Table 10 show that in case of episodes of white discharge, itching and menstrual disorders most of the women were embarrassed to seek treatment, whereas those suffering from problems like lower abdominal pain and pain while urination, financial constraint was a major hindrance in seeking treatment. Women with lower backache generally perceive the problem as non-serious.

Some of the observations made from the case studies conducted with adolescent women reveal that social stigma attached to reproductive health problems is one of the important reasons for non-utilization of health services. Women generally did not talk about reproductive health problems especially white discharge due to embarrassment. A 16 year old young woman said, " **its too embarrassing to go for treatment. I can suffer but I will not seek treatment for such problems**". Another woman said, "**we are embarrassed to discuss these problems such as white discharge and menstrual problems as nobody talks about these illnesses unlike other common problems such as backache etc**".

Moreover, women perceive these problems as a part of womanhood and thus do not consider some symptoms as serious to be treated.

18 years old Reena was suffering from lower abdominal pain for last four years but she did not discuss this with anyone due to embarrassment. After marriage she discussed this with her mother-in-law but did not receive any treatment. Her mother-in-law considered it non-serious and said, " you are suffering from pain because you sit on the wet floor".

17 years old Hema was suffering from white discharge, irregular menstruation, lower backache and burning while urination for last 1-3 years even before marriage. Initially she felt embarrassed to discuss it with anyone but told her mother when she could not bear the pain. Her mother thought that she pretended to be ill and considered her symptoms as non-serious. She did not receive any treatment as her mother was not interested in her treatment due to economic factor and also there was no one to accompany her to a health facility. Hema was embarrassed to tell this to her husband/mother-in-law after marriage as she was not aware about these illnesses and thought that everybody has it.

Lack of money was also a hindrance for seeking treatment.

A 16 years old pregnant girl mentioned that even before marriage she was suffering from white discharge, itching in the vaginal area, irregular menstruation, lower backache and lower abdominal pain. She told her mother about the symptoms except itching which she did not reveal due to embarrassment. But her mother could not provide her treatment for all the symptoms due to the financial constraint. Her mother took her to a private doctor only for lower backache and lower abdominal pain. Even after marriage all the symptoms continued. She did discuss about these symptoms with her husband one year after the marriage except itching, but her husband was not concerned and told her that it was not possible to seek treatment due to lack of money.

17 years old Seema was also suffering from white discharge, irregular menstruation, lower backache, lower abdominal pain and had blisters in the vaginal area after marriage but she did not discuss these problems with anyone except lower abdominal pain and blisters with her mother-in-law due to embarrassment. But in the family no one was interested in her treatment due to the cost factor and told her that they would get all the aliments treated together when they have money.

Even daughters-in-law of households with good standard of living in the village reported financial constraint as a reason for not seeking treatment. A case study revealed that in such families financial constraint was only for women.

A daughter –in – law of a big pucca house in one of the sampled villages who was five months pregnant at the time of interview reported two spontaneous abortions before the present pregnancy. After both the abortions she suffered from lower abdominal pain, vaginal discharge and weakness. Although she discussed this with her mother-in-law, she did not receive any treatment as the mother-in-law viewed the symptoms as normal. She was suffering from white discharge even before marriage. But before marriage she did not discuss

this with anyone due to embarrassment. Now, even after marriage she continued suffering from white discharge for last three years. In addition, for last six months she reported to be suffering from lower backache and lower abdominal pain due to her pregnancy. She told this to her mother-in-law but neither her in-laws nor husband was interested in her treatment. According to them, they did not have money for the treatment. When the woman was asked that if it were her husband, had he got treatment? She replied that "daughters-in- laws get least priority when it comes to health care".

Another reason for non-utilization of reproductive health services was reported to be women's limited mobility. Lack of decision making in the household also made it difficult for them to seek services especially in rural areas where health services are not readily available or accessible (Mensch et al., 1998). Most of the women did not know where to seek treatment for gynecological problems. Even if they knew, as mentioned above, they were dependent on a male member of the household to accompany them. According to an ANM, "**women generally do not talk about these problems. Moreover, they are unable to travel alone for seeking treatment. They are dependent on somebody to take them to the doctor, especially when there is no health facility in the village**".

Being accompanied with males was also one of the reason they were not able to describe their symptoms to the doctor/other health personnel. A Staff Nurse at the CHC reported that "**the adolescent women suffering from reproductive health problems are generally accompanied with their fathers-in-law or brothers-in-law who actually report the problem".** Being adolescent and newly married there is a further disadvantage for these women. They do not speak at all in the front of the doctor. Only the males accompanying them are supposed to talk. Similarly, an ANM stationed at the health centre said, "**adolescent women generally come with their fathers-in-laws who talk about their reproductive health problems**". As mentioned above, as there is a chain of communication of the symptoms of reproductive health problems, it is quiet possible that the symptoms are not communicated properly to the doctor/health personnel. Thus, there are also very high chances of the disease not diagnosed correctly. Thus, findings of our survey are corroborated by the findings of case studies with adolescent women.

3.2.8 Results of Logistic Regression

Table 11 and 12 present logistic regression analysis for prevalence of gynecological problems and treatment seeking behaviour for gynecological problems respectively. In Table 11 the dependent variable is categorized into two categories: those who experienced any

gynecological problems and those who did not. Similarly, in Table 12 the dependent variable is categorized as those who sought treatment for any gynecological problem and those who did not. The odds ratio for each variable indicates the effect of that variable after controlling for the effect of the other variables included in the regression analysis.

Table 11 Experience of gynecological problems

	Odds Ratio			
Predictor variable	**Model 1**	**Model 2**	**Model 3**	**Model 4**
Attended school				
Yes	.730	.843		
No (r)				
Work status				
Working	1.084		1.029	
Not working (r)				
Husband's occupation				
Agricultural (r)				
Non-agricultural				1.036
SLI				
Low (r)				
Medium	.907			
High	1.286			
Autonomy index				
Low (r)				
Medium	1.965**	1.928**	1.963**	1.963**
High	6.570*	6.756*	6.600*	6.578*
Distance from a health facility				
Sub-centre within the village but higher level facility within 6 kms			.924	.920
Higher level facility within 3 kms			1.160	1.167
Higher level facility within 10 kms (r)				
Children Ever Born				
0	1.430			
1	1.737			
2 + (r)				
Spontaneous Abortion				
Yes		12.869**	13.774**	13.890**
No (r)				
-2 Log Likelihood	284.858	287.299	276.039	276.035
N	229	229	229	229

r : reference category ***p< 0.01 ** p< 0.05 *p<0.10

As it is evident from Table 11 that women's autonomy index significantly influences reporting of gynecological problems. In all the four models, woman's autonomy index has emerged as the most important variable. Compared to women, who have low level of autonomy in the household decision making, women with high autonomy are 6.7 times more likely to report a symptom of gynecological morbidity (Model 2). Similarly, as it was found

in the bivariate analysis, pregnancy wastage also influences reporting of gynecological morbidity. Women who have had experienced a spontaneous abortion are 12.8 times more likely to report gynecological morbidity.

Table 12 Treatment for gynecological problems

	Odds Ratio				
Predictor variable	**Model 1**	**Model 2**	**Model 3**	**Model 4**	**Model 5**
Attended school					
Yes	2.401**	2.554**	1.845*		
No (r)					
Work status					
Working			.472**	.490**	
Not working (r)					
Husband's occupation					
Agricultural (r)					
Non-agricultural					1.654
SLI					
Low (r)					
Medium	1.678		2.054*	2.421**	2.073**
High	2.215		2.814**	3.174**	3.958***
Autonomy index					
Low (r)					
Medium		1.046			
High		.936			
Distance from a health facility					
Sub-centre within the village but higher level facility within 6 kms	1.966	1.808	1.639	2.075*	1.832
Higher level facility within 3 kms	2.621**	2.154*	2.447**	2.549**	2.316**
Higher level facility within 10 kms (r)					
Discussed about gynecological symptoms					
Yes				3.981***	
No (r)					
No. of Children Ever Born					
0	.828				
1	1.017				
2 + (r)					
Ever had a spontaneous abortion					
Yes		.390			
No (r)					
-2 Log likelihood	180.389	179.979	223.937	210.077	230.953
N	151	150	194	194	194

r : reference category ***p< 0.01 ** p< 0.05 *p<0.10

Results in Table 12 show that women's education, work status, standard of living index, distance from health facility and discussion of symptoms significantly influences utilization of services for gynecological problems. Women who have ever attended school are more

likely to seek treatment for symptoms of gynecological morbidity. Model 4 shows that compared to women with low standard of living index, women with medium standard of living are 2.4 times and women with high standard of living index are 3.1 times more likely to seek treatment for gynecological problems. Compared to women who are non-working, women who are working are less likely to seek treatment which as mentioned in the bivariate analysis, might be perhaps due to fear of loss of wages.

Unlike in the case of crosstabs, distance from a health facility has emerged as an important factor influencing treatment seeking behaviour for gynecological morbidity. As compared to women who stay far away or even those who are staying in a village with a sub-centre, women staying near higher-level health facilities are more likely to seek treatment. This is due to the fact that diagnosis and treatment of gynecological problems is available only in the higher level facilities like PHCs or CHCs. Discussion of symptoms has also emerged as an important factor influencing treatment seeking behaviour. Women who have discussed their symptoms of gynecological morbidity are 3.9 times more likely to seek treatment.

3.2.9 Summary

To sum up, adolescent women have problems before marriage and same problems continue all their lives starting from their menarche. The study shows a high prevalence of gynecological morbidity among adolescent women. A majority of women do not seek health care till it becomes serious. The continued high prevalence of gynecological morbidity is influenced by the prevailing cultural and traditional relationships regarding health care practices.

A comparison of self reported symptoms of gynecological problems before and after marriage shows that only one-fifth of women reported any problem before marriage as against two-third of women after marriage suggesting that the reporting and incidence of gynecological morbidity increases after marriage. A significant proportion of adolescent women suffer from white discharge and menstrual disorders before marriage whereas in addition to these a higher percentage of women reported lower backache, itching/irritation or sores in vaginal area and also burning sensation after marriage.

Most of the adolescent women did not discuss about the symptoms of the gynecological problems due to embarrassment before marriage. Those who discussed, most of them

confided in their mothers. Even after marriage around two-third of women did not discuss about their problems. Those who discussed, talked mainly with mothers-in-law or husbands. Also, they discussed about it only when it becomes serious.

Their knowledge about the source of treatment was limited but women were less aware of the source of treatment before marriage compared to after marriage. Overall, a lower percentage of women sought treatment before marriage. The treatment seeking behaviour by nature of illness shows that more women have sought treatment for only menstrual disorders before marriage. After marriage, episodes of white discharge record the highest number of untreated cases followed by menstrual disorders, lower backache and lower abdominal pain. Generally, they did not seek treatment especially for white discharge due to social stigma attached to such problems. Most women suffering from lower abdominal pain and lower backache considered it normal and not as serious to be treated. Women also did not seek treatment due to financial constraints. The need for male relatives or husband's accompaniment also delays seeking medical treatment for adolescent women. Moreover, women ignore symptoms as they have accepted them as a part of their gynecological ill health and reproductive life. Also, as a daughter-in-law, a woman's illness is low on the family priority list.

3.3 OBSTETRIC MORBIDITY

Pregnancy and childbirth related complications or obstetric morbidity i.e. “morbidity in a woman who has been pregnant (regardless of site or duration of pregnancy) from any cause related to or aggravated by the pregnancy or management but not from accidental or incidental causes" (WHO 1996) are the leading cause of death for women in the reproductive age in many developing countries.

Complications of pregnancy such as anaemia, spontaneous abortions and eclampsia are significantly higher among adolescent mothers (Mamdani 1999). As adolescent women are not physically fully developed, pregnancy and motherhood expose them to acute health risks during pregnancy and childbirth. A study in rural Maharastra reveals that 64 percent, 47 percent and 24 percent of females aged 14, 15 and 18 respectively were reported to be at obstetric risk (Jejeebhoy 2000). In addition, pregnancy at an early age also damages reproductive tract, increases the risk of maternal mortality, pregnancy complications, peri-

natal and neo-natal mortality and low birth weight (Jejeebhoy 2000). Similarly, other studies on the obstetric morbidity have also shown that pregnant teens are also more likely to suffer from malnutrition, pregnancy-induced hypertension, eclampsia, anaemia and other complications of pregnancy than are women age 20 or older which also raises the risk of dying from pregnancy complications (Ramachandran 1989; Mishra and Dawn 1986; CWFP 1998). In this section on obstetric morbidity, problems experienced by adolescent women during pregnancy, delivery complications and post partum complications have been examined with respect to their health seeking behaviour.

3.3.1 Prevalence of obstetric problems during pregnancy

In this section, self-reported problems faced by the women during the pregnancy have been studied. An attempt is also made to study the treatment seeking behaviour of the women. For the purpose of analysis, problems of currently pregnant women and those who experienced these problems during last live birth have been examined separately assuming there is a difference in the treatment seeking behaviour.

Table 13 Nature of problems

Problems	Current Pregnancy (episodes)	Last Live Birth (episodes)
Night blindness/Blurred vision	20.0	21.3
Convulsions	20.0	18.0
Swelling of hands and feet	14.3	13.1
Anemia	11.4	18.0
Weakness/dizziness	32.9	28.2
Others	1.4	1.3
	N=70	N=305

The survey shows that among currently pregnant women at least 60 percent of women reported some or other problem during pregnancy. Around one-third of the episodes were reported to be of weakness or dizziness during pregnancy and in around one-fifth of cases women suffered from some vision problem and convulsions. 14.3 percent of cases were reported to be of swelling of hands and feet and 11.4 percent of anaemia. In contrast, results of a community based study of pregnant adolescent women in Rajasthan found that 94 percent of women were anaemic (Sharma and Sharma 1992 in pop council). Similarly, Kanani (1994) in her study of adolescent girls living in slum of Gujarat found that 98 percent of girls were anaemic. Similarly, the recent NFHS-2 reports that more than half of the women

aged 15-19 years were reported to be suffering with anaemia compared to other groups of women in reproductive age (IIPS 2000).

In the case of women during last live birth, around 62 percent suffered from any of the symptoms during pregnancy. Out of these, 28.2 percent of cases were of weakness or dizziness and 21.3 percent of episodes were reported to be of night blindness/blurred vision. 18 percent of episodes were reported to be of convulsions and anemia and in 13 percent of cases women reported swelling of hands and feet.

Percentage distribution of women experienced problems during current pregnancy by background characteristics (Table A3) show that none of the factors significantly influences reporting of obstetric problems. Percentage distribution of women who experienced problems during last live birth by socio-economic characteristics (Table A3) show that reporting of obstetric problems is only significantly linked with the pregnancy outcomes. Women who ever experienced a spontaneous abortion are more likely to report the problems during pregnancy. This relationship is statistically significant at .01 percent level.

3.3.2 Discussion of obstetric symptoms during pregnancy

Out of those who experienced any problem, in case of currently pregnant women, more than one-third did not discuss with anyone.

Table 14 Discussion of symptoms

Percent discussed with	Current Pregnancy	Last Live Birth
None	35.5	26.7
% Women discussed with*		
Husband	35.0	33.8
Mother	45.0	39.0
Mother-in-law\ Sister-in-law	45.0	30.0
Doctor/Health worker	10.0	24.7

* the percentage does not add up to 100 due to inclusion of multiple response

N=31 N=105

Out of those who did discuss, most of them discussed either with their mother or mother-in-law/sister-in-law. 35 percent discussed with husband. Compared to currently pregnant women, a higher percentage of women who had problems during last live birth discussed about obstetric problems. The survey shows that a higher percentage of women during last live birth preferred to discuss with their mother (this is perhaps due to the custom of going to

the natal home for the first delivery), followed by husband, mother-in-law and health personnel.

3.3.3 Knowledge of source of treatment and treatment seeking behaviour

The results of the study show poor treatment seeking behaviour of adolescent women for any problem experienced during pregnancy. Among the currently pregnant women, although 77.4 percent of women knew about the source of treatment, only 32.3 percent of them sought treatment. Similarly, in the case of last birth 81 percent knew about the source of treatment but only a little more than half sought treatment.

Table 15 Treatment seeking behaviour for problems experienced during pregnancy

	Current Pregnancy	Last Live Birth
% Women who Know source of treatment	77.4	81.0
% Women who Sought treatment	32.3	57.0
	N=31	N=105

Even for problems experienced during pregnancy a higher percentage of women sought treatment from private (55.7 %) providers compared to public providers (41.5 %).

Table 16 Reasons for not seeking treatment

Reasons	Current Pregnancy	Last Live Birth
Not serious	47.6	64.4
Costs too much	33.3	17.8
No time/long waiting	14.3	2.2
No one to accompany	-	2.2
Family/husband opposed	-	6.7
Facilities/medicines not available	-	2.2
Family/M.I.L not interested	4.8	4.4

Among the reasons for not seeking treatment, in current pregnancy as well as last live birth the most common reason was problem not considered serious by women. Adolescent women perceive obstetric problems as normal symptoms of pregnancy. Secondly, women expressed their inability to seek treatment due to the cost of treatment. In the case of currently pregnant women, time and long waiting was a constraint in seeking treatment. 6.7 percent of women in the case of last birth reported that either family members or husband opposed to seek treatment.

Some of the observations made from the case studies conducted with adolescent women corroborate the findings of the survey.

Durga who was 16 years old and had a four-month-old female child suffered from blurred vision, convulsions and weakness during last pregnancy. Although she discussed this with her mother-in-law, she did not receive any treatment. Her mother-in-law viewed these symptoms, as not so serious to be treated.

Similarly, Lalita who was 18 years old and was 9 months pregnant for the first time was experiencing convulsions and swelling of hands and feet. Although she discussed this with her mother, she did not receive any treatment as she/her mother viewed these problems as normal at the time of pregnancy.

17 year old Rajput girl who was pregnant at time of the survey was suffering from some pregnancy complications such as blurred vision, swelling of hands and feet, weakness and lower abdominal pain. Although she discussed this with her husband and sister-in-law, no one in the family was interested in seeking her treatment due to economic factor.

3.3.4 Results of Logistic Regression

Results of logistic regressions are presented in Table 17 and Table 18. In Table 17, dependent variable is categorized into those who experienced any obstetric problem during last live birth and those who did not. Similarly, in Table 18 dependent variable is categorized into those who sought treatment for any obstetric problems during last live birth and those who did not.

Table 17 Women experienced obstetric problems during last live birth

	Odds Ratio				
Predictor variable	**Model 1**	**Model 2**	**Model 3**	**Model 4**	**Model 5**
Attended school					
Yes	1.717	1.710	1.368		
No (r)					
Work status					
Working		.829			
Not working (r)					
Husband's occupation					
Agricultural					
Non-agricultural					1.587
SLI					
Low (r)					
Medium	.677	.690	.597	.752	.640
High	.421*	.445	.363**	.579	.574
Autonomy index					
Low (r)					
Medium	.829	1.130			
High	3.047	4.440			

Distance from a health facility					
Sub-centre within the village but higher level facility within 6 kms				1.666	
Higher level facility within 3 kms				1.770	
Higher level facility within 10 kms (r)					
Children Ever Born					
0	.311				
1	.489**				
2 + (r)					
Spontaneous Abortion					
Yes		10.038**	8.923*	9.142**	9.090**
No (r)					
Received full package of ANC					
Yes			1.976*		
No (r)					
-2 Log Likelihood	208.845	204.972	206.810	210.219	210.990
N	167	167	168	168	168

r : reference category ***p< 0.01 ** p< 0.05 *p<0.10

As can be seen from Table 17, standard of living index of a household, pregnancy outcome and utilization of antenatal care significantly influences reporting of problems experienced during last live birth. Model 1 & 3 show that as compared to women with low standard of living index, women with high standard of living index are less likely to report problems. Pregnancy wastage also significantly influences reporting of problems. Women who had ever experienced a spontaneous abortion are 8.9 times more likely to experience a problem during last live birth. But reporting of obstetric problems increases with an increase in the number of children ever born. Incidentally, women who received full package of ANC are more likely to report problems during last live birth. This could be a two-way relationship i.e. women who experience obstetric problems are more likely to seek antenatal care.

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Table 18 Treatment for obstetric problems during last live birth

	Odds Ratio				
Predictor variable	**Model 1**	**Model 2**	**Model 3**	**Model 4**	**Model 5**
Attended school					
Yes	2.216*	2.141*	2.020		
No (r)					
Work status					
Working			1.190		
Not working (r)					
Husband's occupation					
Agricultural					
Non-agricultural					.710
SLI					
Low (r)					

Medium	3.065**		2.654*	2.628*	2.125
High	2.687		2.633	4.098	1.333
Autonomy index					
Low (r)					
Medium		.588			
High		.789			
Distance from a health facility					
Sub-centre within the village but higher level facility within 6 kms	7.891***	5.108***	6.412***	6.307***	
Higher level facility within 3 kms	3.218**	1.960	2.840*	3.183*	
Higher level facility within 10 kms (r)					
Discussed obstetric symptoms					
Yes				24.910***	
No (r)					
No. of Children Ever Born					
0	.000				
1	1.250				
2 + (r)					
Ever had a spontaneous abortion					
Yes		.855			
No (r)					
Received full package of ANC					
Yes					.154***
No (r)					
-2 Log likelihood	121.305	129.413	125.988	96.814	
N	105	105	105	105	105

r : reference category ***p< 0.01 ** p< 0.05 *p<0.10

Results of logistic regressions in Table 18 show that women's education, standard of living index, distance from a health facility, discussion of obstetric symptoms and utilization of antenatal care are important determinants of treatment seeking behaviour. Women who have ever attended school are more likely to seek treatment. Similarly, compared to women with low standard of living index, women with medium standard of living are more likely to seek treatment. Distance from a health facility has emerged as an important factor influencing utilization of services for seeking treatment for obstetric morbidity. As compared to women, who reside in villages located at a far away place from a health facility, women staying in village with a sub-centre are more likely to seek treatment. As unlike gynecological morbidity, treatment for obstetric morbidity is readily available even in the sub-centres. Model 4 shows that discussion of the problems with any family member or a health personnel also significantly increases the utilization of services. Women who have ever discussed their problems with someone are 24.9 times more likely to seek treatment. Finally, those women

who received full package of antenatal care are less likely to seek treatment for obstetric problems.

3.3.5 Summary

To sum up, significant number of adolescent women suffer from pregnancy related complications. A higher percentage of women with last live birth were generally reported to be suffering from these symptoms compared to currently pregnant women. As in the case of gynecological morbidity, most of the adolescent women did not discuss about these problems with anyone as they considered it as a part of symptoms related to pregnancy. The results of the study show that a higher percentage of women discussed about their problems during last live birth at the time of the survey. But this is perhaps due to the fact that most of the currently pregnant women were at the initial stage of their pregnancy when they started experiencing the problems. Most of the women had knowledge about the source of treatment but few sought treatment. A higher percentage of women sought treatment for the problems during last live birth as compared to currently pregnant women. Most common reason for not seeking treatment was reported to be non-seriousness of the symptoms followed by financial constraints. Some of the currently pregnant women also did not seek treatment due to long waiting and lack of time to visit a health facility. husband's or other family member's opposition also play an important role.

3.3.6 Prevalence of obstetric problems during delivery

Due to lack of knowledge and negative attitude and restrictions of the family towards health care seeking behaviour, some girls were found to experience adverse pregnancy outcomes and serious complications during delivery (CWFP 1998). In this section, complications of delivery have been examined.

Table 19 Nature of Problems

Item	Percent
Normal delivery	91.6
Some complication during delivery	37.7
Complications at delivery	
Obstructed labour	45.5
Prolonged labour	54.5

Data from the survey shows that at least 9 percent of children to adolescent women were delivered by caesarian section (Table 19). During delivery, more than one third of women experienced some problem during delivery. Out of the total reported episodes of complications 54.5 percent of women reported prolonged labour and 45.5 percent complained of obstructed labour during pregnancy.

3.3.7 Prevalence of obstetric problems after delivery

In this section, problems faced by adolescent women after delivery have been studied. The survey shows that 37.7 percent women reported some problem one-week after the delivery. Out of those who had some problems one-fourth of the episodes were reported to be of lower abdominal pain and in more than one-fifth of cases women complained of fever, excessive bleeding and dizziness or headache. 12.0 percent of episodes were of vaginal discharge.

Table 20 Problems experienced one week after the delivery

Problems	Percent (episodes)
Fever	22.2
Lower abdominal pain	25.0
Vaginal discharge	12.0
Excessive bleeding	20.4
Dizziness/severe headache	20.4

N=108

Similarly, a study in rural Maharastra reports that 24 percent of the girls who delivered reported some problems after delivery such as excessive bleeding, vaginal discharge and fever (Barua 2000).

Percentage distribution of women who experienced problem after delivery by background characteristics (Table A4) show that only level of development is an important determinant of reporting of post partum complications. A higher percentage of women who experience such problems in the less developed tehsil (Dehpalpur) compared to more developed tehsil (Indore).

3.3.8 Discussion of obstetric symptoms after delivery

Out of those who reported a problem, only 16 percent did not discuss it with anyone. Out of those who did discuss, at least half of the women discussed with their mother perhaps due to the custom of delivering the first baby in natal home.

Table 21 Discussion of problems

Item	Percent
Did not discuss	15.9
Percent discussed with*	
Husband	7.54
Mother	50.9
Mother-in-law	17.0
Sister-in-law	1.9
Doctor/health worker	30.1
Friend/neighbour	1.9

* the percentage does not add up to 100 due to inclusion of multiple response

N=63

30 percent with doctor/health worker and only 17 percent discussed with mother-in-law. Very few women (7.5 %) discussed the problems with their husbands.

3.3.9 Knowledge of source of treatment and treatment seeking behaviour

Out of those who experienced any such problems, 80 percent of women knew about the source of treatment and 63 percent sought treatment for any problem experienced one week after the delivery.

Table 22 Treatment seeking behaviour

Item	Percent
% Women Know source of treatment	79.4
% Women Sought treatment	63.5

N=63

Even for complications experienced after delivery women preferred to visit private providers (55 %) compared to public providers (35%). For symptoms after delivery they also reported to be visiting a vaid/hakim (2.5 %), dai (2.5 %) or utilizing a home remedy (2.5 %). Some women also brought medicines direct from chemist shop (2.5 %).

Table 23 Reasons for not seeking treatment

Reasons	Percent
Not serious	60.9
Did not know the source	4.3
Costs too much	26.1
Too embarrassed to seek treatment	4.3
Family/M.I.L not interested	4.3

Most common reason for not seeking treatment was that the problem was not considered serious. Most women thought that these problems are generally associated with the birth of a child and there is no need for seeking medical care. One-fourth of the women also reported financial constraint as a reason for not seeking treatment.

3.3.10 Results of Logistic Regression

Table 24 presents results of logistic regressions for obstetric problems experienced after delivery. The dependent variable is categorized into those who experienced any obstetric problems one-week after the delivery and those who did not.

Table 24 Experience of Obstetric problems after delivery

	Odds Ratio			
Predictor variable	**Model 1**	**Model 2**	**Model 3**	**Model 4**
Attended school				
Yes	1.482	1.723		
No (r)				
Work status				
Working	1.269			
Not working (r)				
Husband's occupation				
Agricultural				
Non-agricultural			.851	
SLI				
Low (r)				
Medium		.867	.862	.874
High		.423	.503	.524
Autonomy index				
Low (r)				
Medium	.999	.971		
High	5.067*	4.725*		

Distance from a health facility				
Sub-centre within the village but higher level facility within 6 kms			.695	.957
Higher level facility within 3 kms			1.323	1.386
Higher level facility within 10 kms (r)				
Children Ever Born				
0	256.248			
1	.741			
2 + (r)				
Spontaneous Abortion				
Yes		1.616		
No (r)				
Received Full package of ANC				
Yes				1.023
No (r)				
-2 Log Likelihood	210.464	209.583	217.903	216.992
N	165	165	167	166

r : reference category ***p< 0.01 ** p< 0.05 *p<0.10

As can be seen from Table 24, reporting of problems is only significantly influenced by women's autonomy index. As model 2 shows that compared to women with low level of autonomy, women with high level of autonomy are 4.7 times more likely to report a problem after delivery.

3.3.11 Summary

Delivery characteristics of adolescent women show that although 90 percent of deliveries were normal, a significant number of women faced complications at the time of delivery such as prolonged labor and obstructed labor. Even one week after the delivery, more than one-third of women has reported problems such as lower abdominal pain, fever, excessive bleeding, dizziness and vaginal discharge.

Unlike in the case of gynecological morbidity and morbidity during pregnancy, women suffering from complications after delivery generally discuss about their problems. Also, in case of problems after delivery a higher percentage of women have sought treatment. At least two-thirds of women has sought treatment for any problem experienced one week after the delivery. Most common reason for not seeking treatment was non-seriousness of symptoms as women thought such problems are generally associated with the birth of a child followed by cost of treatment.

3.4 CONTRACEPTIVE MORBIDITY

Although the use of contraception prevents unwanted pregnancy and in some cases protects against sexually transmitted diseases, it may also raise the risk of infections, resulting in contraceptive morbidity. Therefore, the choice of contraceptives is often influenced by the fear of side effects and perception of morbidity during its use (IIPS 2000) Famous study of Bang and Bang (1989) found negative effects of contraceptive use on the reproductive health of women. The study found that out of 82 women who had undergone sterilization, around 66 percent reported some gynecological diseases. Similarly, Bhatia and Cleland (1995) also found that sterilized women were more likely to report all types of gynecological symptoms. This section focuses on the reported problems of the method use and treatment seeking behaviour of adolescent women.

3.4.1 Prevalence of problems due to the use of contraception

Table 31 shows the percentage of women who have reported problems associated with the method use. 40 percent of women reported some or other problem after the use of contraception.

Table 25 Nature of problems

Problems	Percent
Excessive bleeding	8.9
Headache/Backache/Bodyache	17.9
No menstruation/irregular	16.1
Weakness/Dizziness	21.4
Abdominal pain/Cramps	14.3
White discharge	16.1
Breast tenderness	1.8
Pain in stitches	1.8
Convulsions	1.8

N=56

Among the problems after the use of contraception, most women (21 percent) reported weakness or Dizziness. Women also suffered from headaches/body ache (17.9%), irregular menstruation (16.1 %) and abdominal pain or cramps (14.3 %) and white discharge (16.1 %). 8.9 percent of women also reported excessive bleeding.

Percentage distribution of women who experienced problems due to the use of contraceptive by background characteristics show that women's reporting of contraceptive morbidity only significantly increases with increase in women's autonomy index. (Table A5). Other factors do not seem to affect the prevalence of contraceptive morbidity.

3.4.2 Discussion of symptoms after use of contraception

Out of those who experienced the problems, 32 percent did not discuss with anyone. Generally, out of those who discussed, women discussed with husband or mother. 21 percent discussed with mothers-in-law.

Table 26 Discussion of symptoms

Percent discussed with	Percent
None	32.1
% women discussed with*	
Husband	36.8
Mother	36.8
Sister	10.5
Mother-in-law	21.0
Sister-in-law	5.2
Doctor/Health worker	10.5

* the percentage does not add up to 100 due to inclusion of multiple response

N=28

10 percent of women also reported to discuss contraceptive morbidity with either sister or health personnel and 5.2 percent with sister-in-law.

3.4.3 Knowledge of source of treatment and treatment seeking behaviour

More than 80 percent of women knew about the source of treatment but only 29 percent sought treatment for the problem they are suffering with after the use of any method of contraception.

Table 27 Treatment seeking behaviour

Item	Percent
% Women Know source of treatment	82.1
% Women Sought treatment	28.6

N=28

Unlike gynecological and obstetric morbidity, in the case of contraceptive morbidity women have more trust in government services (62.5 %) compared to private providers (37.5 %).

Table 28 Reasons for no treatment

Reasons	Percent
Not serious	50.0
Costs too much	30.0
No time/long waiting	5.0
Embarrassed to seek treatment	10.0
Stopped using pills	5.0

Regarding the reasons for not seeking treatment, most women (50 percent) consider the symptoms as normal or non-serious and so did not seek treatment. 30 percent mentioned financial constraint as a reason for not seeking treatment. 10 percent were embarrassed to seek treatment. 5 percent either had no time to go for treatment or they stopped using contraception altogether, to get rid of the symptoms which they developed after the use of the method.

3.4.4 Summary

A significant number of adolescent women reported to be suffering from contraceptive morbidity such as weakness, dizziness, headache, body ache, menstrual problems, abdominal pain and white discharge. One-third of women did not discuss about their problems with anyone. Among those who discussed, most of them preferred to discuss the symptoms either with their husbands or mothers. Although the knowledge of source of treatment was universal, only a little more than one-fourth of women sought treatment for problem experienced after the use of contraception. Most of them considered the symptoms as non-serious or did not seek treatment due to economic factor. Some were also embarrassed to seek treatment.

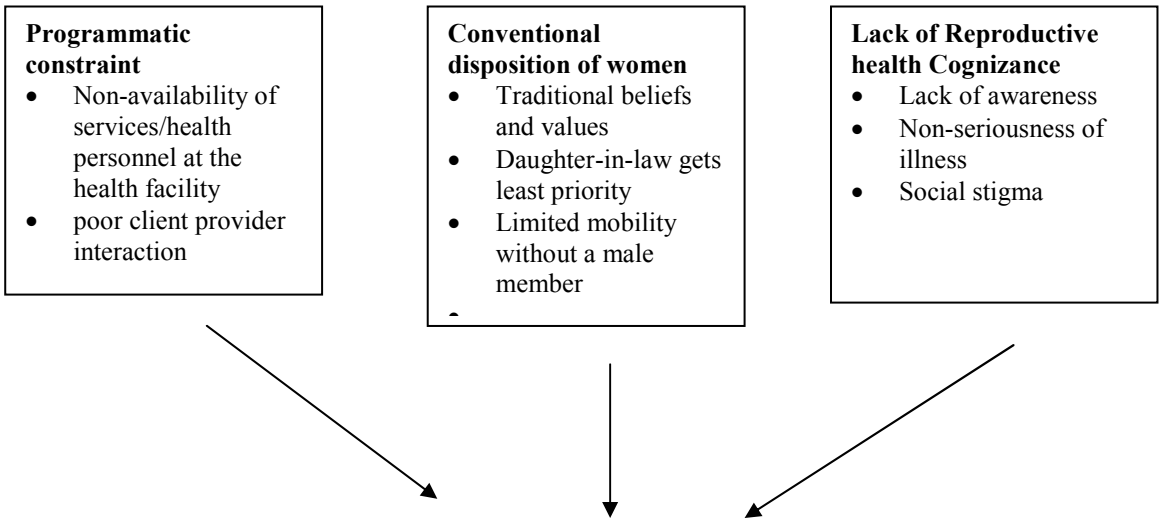
3.5 Conclusion and Discussion

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 reaching over 214 million by 2020. Projections also estimate a significant increase in the adolescent pregnancies and births over the next 20 years (Gupta 2003). However, despite adolescents form such a large segment of the population; policies and programmes in India have focused little attention on adolescents. Following Cairo recommendations Government of India launched Reproductive and Child Health Programme (RCH) programme in 1997 with prioritized adolescent health component as a part of RCH package. But needs of adolescent women are still integrated with the needs of adult women. Even after the implementation of the RCH programme there is no clear definition of a strategic approach and activities to provide adolescent health care. Moreover, very few programmes have been able to distinguish between the special reproductive health needs of married and unmarried adolescents (Gupta 2003).

In-depth interviews with the providers reveal that very few programmes only for unmarried adolescent girls are in existence in the new RCH programme. These include IEC for adolescents which includes information on age at marriage, risks of adolescent marriage, menstrual and personal hygiene, nutrition and RTIs/AIDS for school going adolescents, diagnosis and treatment of STDs in the STD camps, health mela for girls who do not attend school and medical check ups and tetanus vaccination.

But married adolescents are more vulnerable because of serious reproductive health risks associated with early marriage, early 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. Low utilization of reproductive health services, as revealed by the findings of this study is a cause of concern.

Findings of the study show that **programmatic factors, conventional disposition of women and lack of reproductive health cognizance** contribute to very low proportion of women seeking medical care for their reproductive health problems.



Being newly married and young, one of the main constraints of these women was that they could not go alone for seeking treatment. Moreover, they were also not confident to travel alone to a PHC/CHC in another village /tehsil headquarter or district headquarter. One young woman mentioned that "**if there were a health facility in their village itself than we can even go alone without any male member accompanying them or asking permission from the elders**". Women also demanded at least a health centre in each village where a doctor should be available for emergencies. One young woman from low socio-economic status said, "**Being poor I can not go to a health facility, if there were a health facility in the village to conduct delivery I can also avail of the services**". Another woman demanded "**at least ANM should visit their village daily**".

Moreover, non-availability of female doctors at public health facilities is also an important factor. According to an aganwadi worker, "**adolescent women prefer private providers especially a female doctor for treatment of reproductive health problems**." In fact adolescent women suggested that at least a female doctor should be posted at each health facility. Need of a female physician was consistently mentioned irrespective of the type of treatment a woman was seeking. Women felt that they feel more comfortable with a female doctor while discussing their symptoms of reproductive health.

Focus Group Discussions reveal that one of the main reasons for seeking treatment from private providers is better client provider interaction at private health facilities. Among adolescent women, impressions of public health workers were much less positive. Women reported that at government facilities doctors do not give them proper time and attention neither he/she is appreciative and responsive to their problems. A Focus Group study in Uttar Pradesh also documents similar perceptions among women respondents that staff and medical officers in government clinics are often rude and discourteous to clients (Levine et al 1992).

Moreover, women also reported that even at the government facilities they have to spend lot of money from their pocket**.** During the focus group discussions, one of the women said, "**every time we go a public health facility (CHC/PHC) we have to pay Rs 50. At the time of the delivery we have to spend between Rs.400-500**". Another woman said, "**even if we go to the government facilities, we have buy all the medicines**." One young woman said, " **government has trained the Dai but she does not have a kit to conduct deliveries, moreover, she also charges money for conducting delivery"**.

Traditional beliefs and values also play an important role in determining health-seeking behaviour of women. This is more so in the case of adolescent women who do not have any autonomy in decision making with regard to even their own health care. 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 are required to be educated and made aware about these issues**". Even adolescent women also suggested that the programme should target more powerful decision-makers such as husbands and mothers-in-law in the household.

Financial constraint is also an important determinant of health seeking behaviour. Most of the adolescent women reported that they did not seek reproductive health services due to lack of money. Moreover, as daughters-in-law they get least priority in the household with regard to health care. Providers were also of the opinion that economic factor for adolescent women is a hindrance in seeking treatment. An ANM said, "**adolescent women do not seek treatment as they have to spend on transport and medicines**". In addition, limited mobility of adolescent women and the need for male relatives or husband's accompaniment also delays seeking treatment.

Conventional disposition of women is also related to their lack of cognizance on reproductive health matters. Lack of knowledge and awareness regarding source of health care is also a hindrance in seeking health care. Moreover, adolescent women are not able to complete their education, as they are married young. According to a LHV, **"adolescent girls in schools should be provided with health education"**. A BEE said, "**adolescents should be made more aware of various aspects of personal hygiene and legislation of age at marriage**". Another ANM said, "**adolescent women should also be made aware of anemia, menstrual hygiene and antenatal care**". Similarly, an ANM suggested, "**adolescent girls generally do not attend STD camps thus they should be encouraged to attend these camps**". Thus, providers unanimously believed that increasing awareness among adolescent women regarding various aspects of reproductive health is important to increase the utilization of services. Moreover, women ignore symptoms as they have accepted them as a part of their reproductive life.

Due to the lack of knowledge on reproductive health issues, adolescent women are less open and frank in discussing their reproductive health problems compared with older women. They were also embarrassed to seek treatment and did not discuss about their problems with anyone at home. Health personnel also tended to attribute women's non-utilization of reproductive health services to social stigma attached to these problems.

In addition to health services, most of the adolescent expressed their desire for educational and employment opportunities in their village. They thought that educational and employment opportunities would be helpful in improving their overall status in the household in particular and the society in general. Some women also mentioned that the government should strictly enforce the age at marriage legislation so that the people in the village should be aware of the legislation and also elders should be scared to arrange a marriage of an adolescent girl.

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Appendix I

I Standard of Living Index

The standard of living index was calculated adding the scores given to the availability of facilities and consumer durable in the household. The scores are as follows:

Variable		Score
Type of House	Pucca	4
	Semi-pucca	2
	Kachha	0
Main fuel used for cooking	LPG	2
	Kerosene	1
	Cow dung, Wood	0
Source of drinking water	Tube well	2
	Pipe	1
	Hand Pump	1
Type of toilet facility	Own toilet	2
	Open space	0
Ownership of livestock	Owns livestock	2
	Does not own livestock	0
Ownership of vehicle	Tractor, Jeep/Car	4
	Scooter/Motor cycle	3
	Bicycle, Bullock cart	2
	None	0

Index scores range from 1-5 for a low SLI to 6-10 for a medium SLI and 11-16 for a high SLI. Thus, 44.7 percent of households in the sampled villages have a low standard of living, 35.7 percent have a medium standard of living, and 19.7 percent have a high standard of living.

II Woman's Autonomy Index

Women's autonomy index was calculated adding the scores given to the indicators of women's autonomy. The scores are as follows:

Who takes the following decisions in the household		Score
What items to cook	Self	2
	Others	1
Obtaining health care for yourself	Self	2
	Others	1
Purchasing household goods	Self	2
	Others	1
Your going and staying with parents	Self	2
	Others	1

Index scores range from 4 for a low WAI to 5 for a medium WAI and 6-8 for a high WAI. Thus, 39.1 percent of women have a low autonomy, 58.2 percent have a medium level of autonomy, and 2.7 percent have a high level of autonomy in the decision making.

Table A1 Percentage distribution of women suffering from gynecological problems after marriage by background characteristics

Variable	% women reported any problem	Chi square
Women attended school		1.571 (.210)
Yes	61.0	
No	67.9	
Work status		.440 (.507)
Working	66.0	
Non-working	62.1	
Husband's Occupation		.000 (.992)
Agricultural	64.6	
Non-agricultural labourers	64.7	
SLI		1.773 (.412)
Low	67.9	
Medium	59.8	
High	66.1	
Development		.233 (.629)
Less developed tehsil	63.3	
More developed tehsil	66.0	
Distance from health facility		.729 (.694)
Very near	68.0	
Near	63.0	
Far	63.0	
Women's autonomy index		4.767 (.092)
Low	58.1	
Medium	67.8	
High	87.5	
No. of Children Ever Born		2.837 (.586)
0	61.9	
1	70.5	
2	60.4	
3	64.7	
4	100.0	
Ever had a spontaneous abortion		8.366 (.004)*
Yes	95.0	
No	62.9	

*Significant at .05 level ** Significant at .01 level

Table A2 Percentage distribution of women by knowledge of source and treatment seeking behaviour of gynecological problems after marriage and background characteristics

	% women who know source of treatment for any gynecological prpblem	Chi square	% women sought treatment for any gynecological problem	Chi square
Women attended school		8.753 (.003)*		9.726 (.002)*
Yes	64.0		45.3	
No	42.6		24.1	
Work status		.264 (.608)		5.976 (.014)*
Working	50.8		27.7	
Non-working	54.7		45.3	
Husband's Occupation		.641 (.423)		1.557 (.212)
Agricultural	50.0		30.5	
Non-agricultural	56.1		39.4	
SLI		8.927 (.012)*		9.380 (.009)*
Low	41.8		23.1	
Medium	56.3		39.1	
High	69.2		48.7	
Development		.989 (.320)		4.760 (.029)*
Less developed tehsil	48.4		41.1	
More developed tehsil	55.6		26.3	
Distance from health facility		.210 (.900)		3.937 (.140)
Very near	50.0		38.2	
Near	52.4		38.1	
Far	54.0		23.8	
Women's autonomy index		6.669 (.036)*		3.247 (.197)
Low	39.7		25.0	
Medium	57.6		37.3	
High	71.4		42.9	
No. of Children Ever Born		16.367 (.003)*		3.200 (.525)
0	36.1		28.9	
1	59.7		35.8	
2	68.8		37.5	
3	72.7		36.4	
4	100.0		100.0	
Ever had a spontaneous abortion		.045 (.832)		3.558 (.059)
Yes	57.9		15.8	
No	55.3		37.9	

*Significant at .05 level ** Significant at .01 level

Table A3 Percentage distribution of women by problems experienced during current and last pregnancy and background characteristics

Item	% of Currently Pregnant women	Chi square	% of women with last live birth	Chi square
Women attended school		1.865 (.172)		1.004 (.316)
Yes	47.4		66.7	
No	66.7		59.1	
Work status		.736 (.391)		.045 (.832)
Working	63.2		61.9	
Non-working	50.0		63.6	
Husband's Occupation		3.369 (.066)		1.088 (.297)
Agricultural	67.6		59.6	
Non-agricultural	40.0		67.8	
SLI		2.001 (.368)		2.672 (.263)
Low	65.4		68.4	
Medium	61.1		59.7	
High	37.5		51.9	
Development		3.516 (.061)		.462 (.497)
Less developed tehsil	71.4		64.8	
More developed tehsil	45.8		59.7	
Distance from health facility		.795 (.672)		2.423 (.298)
Very near	50.0		66.7	
Near	61.1		66.7	
Far	65.0		54.4	
Women's autonomy index		.891 (.641)		2.304 (.316)
Low	55.0		59.6	
Medium	61.3		62.5	
High	100.0		87.5	
No. of Children Ever Born		.087 (.957)		6.462 (.167)
0	60.0		50.0	
1	57.9		55.8	
2	-		75.5	
3	66.7		58.8	
4	-		100.0	
Ever had a spontaneous abortion		.702 (.402)		6.005 (.014)*
Yes	80.0		92.9	
No	60.6		59.7	

*Significant at .05 level ** Significant at .01 level

Table A4 Percentage distribution of women by post partum complications by background characteristics

Variable	% women experienced problems	Chi square
Women attended school		1.723 (.189)
Yes	43.2	
No	33.3	
Work status		.065 (.799)
Working	38.4	
Non-working	36.4	
Husband's Occupation		.176 (.674)
Agricultural	38.9	
Non-agricultural	35.6	
SLI		2.308 (.315)
Low	42.3	
Medium	37.1	
High	25.9	
Development		4.574 (.032)*
Less developed tehsil	45.1	
More developed tehsil	28.9	
Distance from health facility		1.401 (.496)
Very near	43.9	
Near	34.0	
Far	35.1	
Women's autonomy index		4.899 (.086)
Low	36.2	
Medium	36.0	
High	75.0	
No. of Children Ever Born		2.783 (.595)
0	50.0	
1	34.7	
2	38.5	
3	52.9	
4	0.0	
Ever had a spontaneous abortion		.403 (.526)
Yes	46.2	
No	37.3	

*Significant at .05 level ** Significant at .01 level

Table A5 Percentage distribution of women by problems experienced after use and background characteristics

Variable	% women experienced problems	Chi square
Women attended school		2.188 (.139)
Yes	30.0	
No	47.5	
Work status		.045 (.831)
Working	40.8	
Non-working	38.1	
Husband's Occupation		2.572 (.109)
Agricultural	32.6	
Non-agricultural	51.9	
SLI		2.955 (.228)
Low	50.0	
Medium	36.4	
High	25.0	
Development		1.658 (.198)
Less developed tehsil	46.3	
More developed tehsil	31.0	
Distance from health facility		.294 (.863)
Very near	41.7	
Near	42.3	
Far	35.0	
Women's autonomy index		12.014 (.002)*
Low	18.8	
Medium	39.6	
High	100.0	
No. of Children Ever Born		4.094 (.251)
0	0.0	
1	34.8	
2	50.0	
3	30.0	
4		
Ever had a spontaneous abortion		.003 (.956)
Yes	40.0	
No	41.3	

*Significant at .05 level ** Significant at .01 level