

# Reproductive health-seeking by married adolescent girls in Maharashtra, India

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*In India, most adolescent girls 15-19 years old are married. A study was conducted in 1995-97 in Ahmednagar district of Maharashtra, India to gain insight into whether and how their reproductive health needs are met, especially for gynaecological problems, family planning and perceived fertility problems. It included a survey among 302 married girls of this age, and in-depth interviews with 74 girls, 37 husbands and 53 mothers-in-law. Girls were treated quickly for illnesses interfering with domestic work and were expected to conceive in the first year of marriage. Menstrual disorders and symptoms of reproductive tract infection often went untreated. There was an emerging need for delaying and spacing pregnancies; limiting the number of children was well established. Household work, protection of fertility and silence arising from embarrassment related to sexual health problems were the strongest factors influencing care-seeking. Husbands made the decision whether their wives could seek care and mothers-in-law sometimes influenced these decisions; girls had neither decision-making power nor influence. This study provides valuable input for the new reproductive and child health programme in Maharashtra.*

**Keywords:** adolescent girls, marriage, reproductive health, India

**I**N India, adolescent girls aged 15-19 constitute about 10 per cent of the population. About 40 per cent of adolescent girls are married before the age of 18, at a median age of 16, in contravention of the minimum legal age (18 years).<sup>1</sup> Information about health issues among unmarried adolescents in India has recently been highlighted,<sup>2,3</sup> but little is known about married adolescent girls and whether and how their reproductive health needs are met.

Adolescence is a time of sudden transition for girls in India. Newly married girls leave their natal home to take up residence with their husbands' family, where as strangers, they find themselves in a subordinate position relative to all the members of his family.<sup>4-6</sup> These girls confront social and familial pressure to begin childbearing soon after marriage, which is often welcomed by them as a way to improve their status.<sup>6,7</sup> Marriage and childbearing bring new health problems, however, especially those relating to reproductive health. Yet married

adolescent girls rarely seem to seek treatment,<sup>4,8</sup> a fact which cannot be explained by the lack of services alone.

While it is true that health care services are lacking in some areas, it is also true that Indian women often do not use available services. It is unclear why they seek care for some ailments but not others, or which health concerns are more quickly addressed. Several studies have documented a greater inclination to seek curative care, but relatively low use of preventive services.<sup>9-11</sup> Some women delay or forego seeking treatment because of household duties,<sup>10,12-14</sup> but may seek care promptly when their condition prevents them from performing household tasks.<sup>9,11,15</sup> Certain conditions, reproductive tract infections in particular, may receive inadequate attention because sexual matters and related gynaecological problems are shrouded in a culture of silence, embarrassment, shame and blame.<sup>16,17</sup> Alternatively, symptoms like vaginal discharge

may be considered 'normal' and therefore not in need of care.<sup>17</sup>

Women are not the primary decision-makers when it comes to seeking health care in many parts of India.<sup>5,11,18</sup> Other family members dictate whether a woman's condition warrants treatment and what type of care she receives. This is particularly the case for adolescent girls, for whom treatment is often delayed while they navigate the familial decision-making process.

In India, the role of the husband has been noted in decisions related to the use of contraception and expenditures for health care.<sup>7,19,20</sup> However, the mother-in-law also plays a dominant role, sometimes even determining the reproductive behaviour of a young couple.<sup>5,6</sup> In one study of 100 pregnant women of reproductive age in Uttar Pradesh, 56 per cent of the women deferred decision-making about health issues to their mothers-in-law and 15 per cent to their husbands.<sup>18</sup>

This paper reports on research conducted in 1995-97 into patterns and motivations of health-seeking behaviour for general and gynaecological illnesses among married adolescent girls 15-19 years old in a rural area of Maharashtra in western India. It further explores whether married adolescent girls are best able to access health care when their health concerns coincide with those of their mothers-in-law or husbands, or both. Given the interest of mothers-in-law in their daughters-in-laws' fertility, it explores whether the husband's family is responsive to the girls' reproductive health needs, including symptoms of gynaecological problems, family planning and problems getting pregnant. Needs of an obstetric nature will be described separately.<sup>21</sup> Needs in relation to general illness are included for comparison.

### Study site

The study was conducted in Parner block of Ahmednagar district in Maharashtra. Maharashtra is regarded as one of the progressive states in India in terms of its economic and social development (Table 1). Ahmednagar, 120 kms to the northeast of Pune city is one of the largest and better performing districts in Maharashtra (Table 2).

Parner, the selected block in the district, is a

**Table 1. Socio-economic indicators<sup>22</sup>**

Indicator	India	Maharashtra state
Households with electricity	60%	82%
Households with safe drinking water	78%	82%
Women's literacy	51%	61%
Employed women	39%	56%
Mean age at marriage (girls)	19.7	19.8

**Table 2. Reproductive health indicators<sup>23</sup>**

Indicator	Maharashtra state %	Ahmednagar district %
Girls marrying <18 yrs	35	41
Birth order 3+	35	34
Pregnant with ANC	89	91
Institutional delivery	53	60
With RTI	27	21
Contraceptive prevalence rate	59	65

predominantly rural area with a population of 210,000 in 131 villages. All villages have electricity and at least one source of safe water. Agriculture is the mainstay of people's livelihood but lack of irrigation, frequent drought-like conditions and few employment opportunities lead to male migration to the neighbouring district of Pune and further to Mumbai.

The health infrastructure in the block includes seven primary health centres (PHCs), 38 subcentres, and one rural hospital with 30 beds, apart from several private health facilities. There is a distinct dichotomy in service delivery by the government and the private sector. Government facilities largely focus on primary health care through the three-tiered service delivery system, of which the auxiliary nurse midwife (ANM) is the most peripheral health provider, catering to about 5,000 population. The private sector consists of allopaths and practitioners of alternative systems of medicine such as Ayurveda and homeopathy, and mainly deals with curative care.

Since 1994 the Foundation for Research in Health Systems has helped the Maharashtra Directorate of Health Services to test the feasi-

bility of introducing a reproductive and child health programme in Parner block. This study arose from that work.

### Participants and methods

A quantitative survey was conducted among 302 married girls 15-19 years of age who were randomly selected, based on the population of married adolescent girls in the area, and from 33 villages. The villages were selected from the 1991 census with the probability of selection being proportional to population.

The survey was supplemented by in-depth interviews which asked general information about the household, health-seeking behaviour during illnesses, care during antenatal, delivery and post-natal periods, gynaecological problems and STDs, infertility, family planning practices and induced abortion. The interviews were semi-structured and focused on the perceptions of and decisions made by the respondents. The sample for in-depth interviews came from the same villages as the survey. Interviews were held with 74 girls, 37 husbands of adolescent girls, 53 mothers-in-law of adolescent girls, 7 medical officers and 37 ANMs in all seven PHCs. In addition, 20 private doctors were interviewed whose health services were most often utilised by the girls, including practitioners of alternative medicine. The respondents were selected purposively: those who were more vocal and willing to give interviews. The husbands and mothers-in-law were not necessarily those of the girls covered in the survey. All but one of the husbands interviewed were 20-29. One was 35 years old. Similarly in the survey, 87 per cent of girls reported that their husbands were aged 20-29, 7 per cent 30-38, and 6 per cent were 18-20.

Five trained interviewers aged 20-22, four women and one man, who were qualified medico-social workers with data collection experience, collected data. All were from the same district, and therefore fluent in the local language and dialect.

### Profile of married adolescent girls

More than 80 per cent of the girls in the quantitative survey reported being married before the age of 18 (mean age 17). Twenty-eight

percent were married to cousins on their fathers' side of the family, and so were not near their natal homes. Almost one fifth were not literate. Economic status was described as poor by 16 per cent and not so poor by the rest. Some 60 per cent had become full time housewives after marriage, 35 per cent worked in their own fields and 5 per cent were employed. About 67 per cent of the girls had experienced at least one pregnancy with an average age at first conception of 17. Of the pregnancies, 14 per cent ended in miscarriage, 5 per cent in stillbirth and 4 per cent in infant death.

Of the girls who participated in the in-depth interviews, the age distribution, age at marriage, number of pregnancies, and obstetric history were similar to girls in the survey. The level of education was marginally better, with 14 per cent not literate.

### Utilisation of health services

In the survey, 118 girls (39 per cent) reported suffering from general illnesses in the previous month, e.g. coughs, colds and fever with chills and headache, of whom 97 per cent availed of formal medical care (Table 3). Half of the 302 girls in the survey reported ever suffering from gynaecological problems, some even before marriage. The most common were menstrual problems (27 per cent), lower backache (25 per cent), lower abdominal pain (12 per cent), vaginal discharge (6 per cent), burning urination (5 per cent) and prolapse (2 per cent). Only half of those with gynaecological symptoms actually went for treatment.

The felt needs for spacing and limiting the

Table 3. Health service utilisation (n=302)

	Felt need		Services sought	
	No.	%	No.	%
General illness	118	39	114	97
Gynaecological problems	153	51	75	49
Spacing between children	24	80	40	17
Limiting number of children	243	80	3	1
Problems of fertility: non-pregnant, non-contracepting girls	-	-	7	8

number of children were high at 80 per cent. Among those girls who were not pregnant or sterilised at the time of the survey, however, only 17 per cent were using a spacing method.

Regarding fertility problems, the survey found 89 girls who were co-habiting with their husbands and who were not contracepting but who had not conceived since marriage. However, they were not asked whether they considered themselves infertile. Health service utilisation for infertility was calculated based on these 89 girls, instead of on the smaller number who perceived themselves to be infertile. Of the 89, seven girls had sought treatment to help them to conceive. There was no length of time of not having conceived that was considered a cut-off for infertility, because it was the perception of infertility that was of interest.

Thus, the degree of treatment-seeking varied widely depending on the perceived health problem: as high as 97 per cent for minor, general illnesses and as low as 8 per cent for failure to conceive. The in-depth interviews with the girls, husbands and mothers-in-law and some additional survey data provided reasons for this variation.

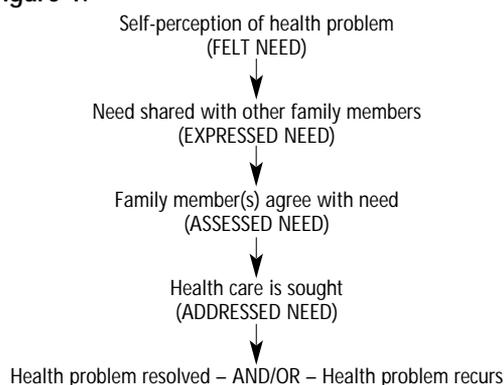
### Needs framework

The data indicated that the occurrence of a symptom or condition triggered a four-step process to determine the need for and access to health care (Figure 1). This begins with a symptom being identified by the girl, creating a felt need for treatment; telling a family member about the need; agreement on the part of family member(s) that it is worth seeking treatment; and action taken by the family and health providers to seek and provide treatment. At each step, no action might be taken, stopping the process. How far a health need progressed towards treatment differed by symptom or condition and among the participants, as described below.

### General illnesses

Among women who experienced general illness in the month prior to the survey, 97 per cent sought formal health care to treat it. The in-depth interviews with the 37 husbands revealed that they all perceived a need for and

Figure 1.



encouraged their wives to seek immediate medical care for general illnesses so that household routine would not be affected.

*'If my wife ever falls sick... we take her to a private doctor. Her sickness does affect the daily routine of all the household members. Not only does her own work get affected but also work of the person who accompanies her to the doctor also gets affected. It also upsets our monthly budget.'*

Initially, when a girl feels the first symptom, she generally informs both her mother-in-law and husband about it. Sixty-nine percent of symptomatic girls informed their family on the day the symptoms began.

The proportion seeking care is high despite scepticism by the mothers-in-law about the credibility of these symptoms. One third of the mothers-in-law who participated in the in-depth interviews described the illnesses as due to carelessness or a pampered lifestyle in their own mothers' homes that they said made these girls incapable of coping with a little extra physical exertion in their husbands' household. To them, minor illness in their daughter-in-law was 'escapism' to avoid household work.

*'Sunita falls ill almost every month... She just remains in bed during this period. I think she fakes all these complaints. Maybe she is not able to cope with the work and this is her way of getting rest.'*

Two other mothers-in-law said they let the daughter-in-law take treatment only to quell rumours, as illnesses usually led to a lot of

gossip about the health of the daughters-in-law in the neighbourhood.

While the scepticism of the mothers-in-law was ultimately overruled, it often delayed treatment seeking by a few days. Mothers-in-law, as well as the girls themselves during in-depth interviews, believed that any relaxation from domestic routine was an ill-afforded indulgence. Girls tried home remedies first and sought care only when their routine became difficult. Thus, with domestic work as a motivating factor, the framework of needs was traversed fairly quickly with general illnesses.

### Gynaecological problems

Half the girls in the survey reported ever experiencing gynaecological problems (51 per cent). Painful, scanty or irregular menstruation were perceived as minor inconveniences. White and red discharges, on the other hand, were seen as serious, as they were thought to lead to cancer, weakness or death. As one mother-in-law said:

*'Women with white and red discharge should either get 'curetting' done or get the uterus removed at the earliest. Otherwise the germs grow in the blood during the periods and women get cancer...'*

According to the survey, two-thirds of the girls who reported experiencing a gynaecological problem did not discuss it with anyone initially. Some thought these problems were chronic and were part of being women and of bearing children. Others expressed shame:

*'I have had copious white discharge ever since I got married. It gets worse after coming in contact with my husband. I have told my husband about it, but not my mother-in-law. I am ashamed of talking about it.'*

A third of girls turned to their mothers for problems like burning urination and menstrual disorders, especially if the problem had started before marriage. They turned to their husbands for problems of vaginal discharge, itching, bad odour, and pain experienced during intercourse. They did not, however, mention the problem to their mothers-in-law.

Most husbands (33 of 37) in in-depth interviews were not convinced that their wives

needed medical care if a gynaecological problem arose and did not think they were important overall. They believed these problems could be resolved through better personal hygiene:

*'I am not aware of any special illnesses in her age group. She doesn't have any. Even if they have, nobody bothers about these illnesses. There are major things like daily sustenance to worry about.'*

The few husbands who acknowledged these problems as symptoms of illness felt that their wives should not talk about them and should seek care on their own. Even fewer husbands wanted to accompany their wives to the health centre, and yet the girls did not want to attend by themselves.

For problems like red or white discharge, girls did not express their need to their mothers-in-law though mothers-in-law who were interviewed indicated they would have been receptive to requests for seeking treatment. For the mothers-in-law, gynaecological problems represented a threat to fertility and fertility was of prime concern to them, as their daughters-in-law needed to conceive and have a baby within a year of marriage:

*'... baby binds the woman to her new house.'*

Mothers-in-law felt that prompt medical treatment should be sought as some gynaecological problems have serious consequences for later fertility:

*'Women have problems like white and red discharge, cancer and rotting of the uterus. My elder daughter-in-law after her operation started getting white discharge. She told me about it. We went to a doctor. He gave her some ointment and two injections along with some tablets. Nowadays, girls feel shy to talk about these things. They hide their symptoms. They should not do that. They should consult a doctor at the earliest.'*

Almost half the girls in the survey (49 per cent) who had experienced gynaecological problems had sought treatment. Half of these, however, had sought this care before they were married, with the assistance of their mothers. Gynaecological problems among unmarried girls are one instance in which the girls were treated promptly, even though they were minors,

because any gynaecological problem is perceived as limiting marriage prospects. Among the married girls, however, some only sought treatment when their symptoms were strong enough to impede their domestic work; others were blocked from moving through the framework of needs at each stage.

### Delaying the first child

A small number of couples were practising family planning before the first pregnancy (11 per cent of the 100 girls in the survey). Seven couples were using modern spacing methods for the first one to six years of their marriage.

However, delaying the first pregnancy played out quite differently from spacing a subsequent child, in that concern about fertility was predominant. The mothers-in-law were adamant and girls strongly felt the pressure to conceive a first time. One-third of husbands, however, wanted to delay their wives' first pregnancy. Reasons given included health problems, the babies would be weak and reduced physical pleasure following repeated births. One man mentioned financial reasons:

*'I think that the first child should be delayed, especially when the woman is below 19 years of age. Also in my case the family is not that well off. We have a financial crunch at home. In such a situation we will not be able to give my wife the necessary medicines and diet... But my wife does not agree. She wants a child immediately.'*

Health providers suggested that induced abortion to delay a first birth was also sought, at least occasionally. All seven government doctors interviewed said they discouraged termination of first pregnancies. In contrast, 15 of the 20 private doctors interviewed claimed that while they did not encourage termination of first pregnancy, they made exceptions if they felt that the couple was too young and incapable of supporting a child.

### Spacing between pregnancies

From the survey, 80 per cent of girls expressed a desire to space their children. In the in-depth interviews, all the girls and husbands mentioned that they wanted to space their next child. Ideal spacing between the birth of two

children, according to most married girls and husbands, was three years.

The majority of the mothers-in-law, on the other hand, were opposed to using modern methods of spacing (30 of 54). They felt strongly, however, that to achieve several years' spacing between children, 'natural spacing' or abstinence was best. One mother-in-law expressed the views of many:

*'I had a natural spacing of four years between my children and expect my daughter-in-law to have at least three years' spacing. I have advised her about two years' abstinence. I am aware of the various methods of family planning like the cork [diaphragm] that is fitted by doctors, Copper T, pills, bags [condoms] and tubectomy. I have seen about these on the TV. But I am against them as they cause problems. I will not allow my daughter-in-law and son to use them.'*

How girls and their husbands addressed the felt need to space the next pregnancy is more difficult to quantify, in part because spacing can happen naturally. According to one girl:

*'I myself did not use anything as I have a long natural spacing (palna). I got married one month after menarche and conceived seven months after marriage. After the first child I had menstruation two years later. And then I conceived again. So I did not have to use anything in the intervening period.'*

However, only 15 per cent of girls in the in-depth interviews felt certain that natural spacing worked long enough to allow sufficient space between their children without using modern methods. Interestingly, none of the interviewees mentioned breastfeeding as a form of natural spacing. Still only 17 or 18 per cent of couples used modern family planning methods, as reported by girls in in-depth interviews and the survey respectively. The low use of modern methods is also explained in part by most girls not discussing child spacing with their husbands because they found it embarrassing.

The husbands of all 40 girls who reported using a modern spacing method knew their wives were using a method. In fact, the husband either made the decision himself (12) or made it jointly with his wife (23), leaving only five girls who reported making the decision to use a method on their own. In addition, many

of the girls who used a spacing method (21) said their family members approved of it.

The qualitative data also suggest that some husbands were prepared for their wives to use induced abortion as a spacing method, though the proportion could not be clearly established from our data. Husbands seemed to be the ones to take the decision regarding induced abortion.

*'I don't want her to have a child for another two years. If she does conceive in between, I will make her abort the baby.'*

The method for induced abortion was often referred to as 'curetting' (from the dilatation and curettage procedure, or D&C). D&C, however, is also the technique used to stop bleeding after a miscarriage. While 16 of the 28 girls interviewed who reported a spontaneous abortion said they did not feel the need for medical attention afterwards, the remaining 12 went for a D&C. While many of the 12 were probably spontaneous abortions, some may have been induced.

That induced abortion was an option for married adolescent girls and their husbands seemed to be understood by some of the mothers-in-law, who did not approve and were anxious about it. As one girl said:

*'I did not want a child so soon after marriage. My mother-in-law told me to have the child. For six months she did not take me to a doctor. Actually my mother-in-law was scared that I might go to the doctor for termination of pregnancy. That is why she does not even allow me to go to a doctor...'*

### Limiting family size

The felt need for limiting the number of children was as high (80 per cent) as for spacing between pregnancies, and usually meant having female sterilisation (tubectomy). As long as one child was male, it was expected that the mother would be sterilised after two or three children. In the in-depth interviews, all the girls and husbands mentioned that they wanted to limit their number of children to two or three by sterilising the mother thereafter, and mothers-in-law concurred. Three girls in the survey had already undergone tubectomies by the age of 19, as they had already achieved their family size.

### Perceived infertility

Some girls and their mothers-in-law became concerned if the girls did not conceive within a year of marriage despite regular unprotected sexual contact with their husbands.

The need to conceive within the first year of marriage is felt keenly by girls, mothers-in-law, and some husbands. However, only seven girls in the survey (eight per cent of those who were not yet pregnant) sought treatment. Some who had not conceived did not feel they could be treated because fate, spirits, witchcraft or the 'evil eye' determined their ability to conceive; some expressed embarrassment at the idea of seeking treatment.

*'We don't do anything to prevent pregnancy. Everybody in the house wants me to conceive early. But the conception will happen only when it is destined to happen. It is not in our hands.'*

Most girls raised their fertility concerns with their husbands. Husbands whose wives had not conceived (4 of 37) maintained that their wives were more anxious about conceiving than they were. And in in-depth interviews, girls who had not conceived (7 of 74) confirmed this. Husbands expressed differing levels of concern:

*'We have been married for two years but my wife has not yet conceived... As I am not very keen to have children for another two years, I have not been worried. I have therefore not taken her anywhere for a check-up. She is very keen to get examined and treated...'*

*'We have been married for a year and come in contact everyday but she has not yet conceived. Both of us want a child. We do not know where to go and whom to consult. We are very ashamed of the problem.'*

Mothers-in-law preferred their daughters-in-law to seek the care of faith healers because they also believed that the inability to conceive was caused by spirits and fate. If there was no pregnancy for two to three years, allopathic treatment was ultimately sought, although this treatment was thought to be long drawn-out and expensive, and success uncertain.

### Discussion and recommendations

The results suggest that maintenance of young married girls' ability to carry out household

work, protection of fertility and the silencing influence of embarrassment and feelings of shame surrounding sexual matters were the strongest influences on whether the reproductive health needs of young married girls were addressed or not.

When husbands, mothers-in-law and girls agreed on the importance of a health need, it would be addressed quickly. Prominent examples from this study were general illness and female sterilisation for limiting family size. With regard to female sterilisation, the decision effectively seems to be taken well ahead of time now that small family size is becoming the social norm.

Other reproductive health needs were usually not addressed as quickly, and in some cases, not at all. In some cases a need was not felt because symptoms were perceived to be 'normal', e.g. certain symptoms of reproductive tract infections. Even where a need was felt, it might not be expressed because of shame or embarrassment. Even if the need was expressed, husbands might decide it was not a condition requiring health care, e.g. their common belief that some gynaecological problems could be resolved through personal hygiene. Finally, even if husbands sometimes agreed that care should be sought for their wife's gynaecological problems, they preferred her to seek care on her own, which some married adolescent girls felt they could not do.

Thus, apart from feeling a need for care to begin with and then expressing it, young married girls in this study had almost no role in deciding whether they could seek treatment for gynaecological symptoms. Sometimes their health needs were met and sometimes not, but it was their husband who made the decision. Mothers-in-law did not seem to have decision-making power in this area, but they did have a fair amount of influence on their sons. Putting pressure on the young wife to become pregnant in the first year of marriage was the strongest influence mothers-in-law exhibited in this study. Delaying a first pregnancy was the one issue on which many more husbands felt a need than took action, largely due to the influence of their mothers.

The emerging social norm that families should be limited to two or three children was strongly expressed in this study by young married girls,

their husbands and their mothers-in-law, and sterilisation is routinely carried out with no apparent constraints. Sterilisation may seem surprising for married girls at such young ages, but childbearing and completion of desired family size are occurring at young ages in India, as was also shown in a study in Kerala.<sup>24</sup>

The desire for spacing between pregnancies was also widely felt by girls, husbands and mothers-in-law, but there seemed to be some disagreement about whether its natural occurrence in very young girls should be relied upon alone or whether modern methods should be used. Mothers-in-law were often against modern methods, but some girls and their husbands were using them anyway and a few husbands mentioned that they would get their wives to have an abortion if necessary to ensure spacing between children.

Not delaying the first pregnancy was the subject on which the most intransigent views were expressed in this study. Mothers-in-law strongly objected to any delay and the girls were willing to have a child in their first year of marriage to meet this social expectation, which husbands usually had to go along with. In an area where many married adolescent girls have little education and the majority are at home full-time, alternatives to early childbearing are few. Despite this, however, there were 11 girls in this study who were using modern methods and had been doing so for up to six years.

The Government of India is implementing a national Reproductive and Child Health (RCH) programme through the existing primary health care (PHC) system. This programme is meant to include emergency obstetrical care and management of reproductive tract infections, as well as respond to new users' groups such as adolescents of both sexes. The Maharashtra state government is also in the process of implementing these changes.

This study provides valuable input for new programme design by offering insights into the ways families approach the health system in relation to married adolescent girls' health and the timing of and reasons for seeking care for them. For spacing of pregnancies, health workers could do more to promote the use of modern methods and inform young women of the contraceptive effects of breastfeeding in the first

months after childbirth. Appropriate messages and adapting the choice of methods to girls' needs are crucial, and perhaps some messages could be tailored to husbands as well. We did not ask where married adolescent girls in this study obtained abortions, but the provision of abortion services should be considered an important aspect of the new RCH programme. In spite of being legal, abortion is not always safe, as shown in South India, and poorer women often seek abortions from untrained providers using substandard procedures, especially in rural areas.<sup>25</sup> Given that some young couples are using modern contraception to delay first births, as well as spacing between births, the new RCH programme could give more attention to providing appropriate methods for this. Almost half the married adolescent girls in this study had experienced menstrual disorders, vaginal discharge, itching and bad odour, or pain during intercourse, and only half of them had ever sought treatment. The new RCH programme should offer more information and make treatment more available to young women for

these problems (and for their husbands in many cases); community-based education programmes for both young women and their husbands would also seem to be appropriate in this regard.

Finally, it is worth pointing out that young married girls should have the right to make their own decisions about seeking treatment for gynaecological problems when they feel they need it. This is not a matter for health services to resolve but for social action.

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## Résumé

En Inde, la plupart des adolescentes de 15 à 19 ans sont mariées. Une étude a été menée en 1995-97 dans le district d'Ahmednagar, au Maharashtra, pour savoir dans quelle mesure et comment leurs besoins de santé génésique sont satisfaits, particulièrement pour les affections gynécologiques, la planification familiale et les problèmes perçus de fécondité. Elle a réalisé une enquête auprès de 302 épouses de cet âge et des entretiens approfondis avec 74 adolescentes, 37 maris et 53 belles-mères. Les jeunes femmes étaient rapidement soignées pour les maladies entravant le travail ménager et on attendait d'elles qu'elles conçoivent pendant la première année de mariage. Les troubles menstruels et les symptômes d'infections gynécologiques étaient rarement traités. Il existait un besoin émergent de méthodes pour retarder et espacer les naissances; la limitation du nombre d'enfants était bien établie. Le travail ménager, la protection de la fécondité et le silence gêné entourant les problèmes sexuels étaient les facteurs contrariant le plus la recherche de soins. Les maris décidaient d'envoyer leur femme se faire ou non soigner et les belles-mères avaient parfois de l'influence sur eux; les jeunes femmes n'avaient ni pouvoir de décision ni influence. Cette étude constitue une précieuse contribution au nouveau programme de santé génésique et infantile du Maharashtra.

## Resumen

En la India, la mayoría de las mujeres de entre 15 y 19 años están casadas. Entre 1995 y 1997, se realizó un estudio en el distrito de Ahmednagar en Maharashtra, India, para comprender mejor las necesidades de salud reproductiva de estas mujeres y determinar hasta que punto, y de qué manera, dichas necesidades estaban atendidas, especialmente en lo tocante a los problemas ginecológicos, planificación familiar y problemas de fecundidad percibidos. El estudio abarcó una encuesta a 302 muchachas casadas y entrevistas en profundidad a 74 muchachas, 37 esposos y 53 suegras. Las muchachas recibían tratamiento oportuno para enfermedades que les impedían cumplir con el trabajo doméstico, y se esperaba que ellas quedasen encinta durante el primer año de matrimonio. Los trastornos menstruales y síntomas de infección del aparato reproductor a menudo no se trataban. Se notaba una necesidad emergente de postergar y espaciar los embarazos; el limitar el número de hijos ya estaba bien establecido. El trabajo doméstico, la protección de la fecundidad, y el silencio surgido del pudor en relación a los problemas de la salud sexual eran los factores principales que incidieron en la decisión de buscar atención de salud. Los esposos decidían si sus esposas podían buscar tratamiento, y las suegras a veces tenían influencia sobre ellos; las muchachas carecían de poder de decisión y influencia sobre sus esposos. Este estudio aporta insumos valiosos al nuevo programa de Salud Reproductiva e Infantil en Maharashtra.