Chapter 8: Findings and Analysis of Data on Pregnant and Non-pregnant Adolescent Women (Category B):

8.1: Socio Economic Profile

From Chapter 3 we know that there are 59 adolescent women who were admitted in the hospital during my field visit. 47 of them are married (80%) and 12 (20%) of them are unmarried. Figure 11 shows the age of respondents at the time of admission in the hospital. 8 women are of 17 years, 18 women are of 18 years and 21 women are of 19 years. It can be very well understood that they are married very early. Most of them did not complete their educational degree which they were pursuing, they got married while studying and could not continue with their schooling or college.

8.1.1: Age: The age of married respondents is described in Figure 19

![Age of Married Adolescents](chart.png)

Figure 19. Source: Computed from Survey Data

8.1.2: Marital Age: The marital age of unmarried adolescents can be explained from Figure 12. 14 women have got married before attaining adulthood or the marriage age of 18 years. 6 of them got married at 16 years and 8 of them got married at 17 years. It has been
found that 17 women got married at 18 years and 16 women got married at 19 years. Thus we found that around 70% of women are married at 18-19 years and the rest of them are married before attaining marriage age. There is lack of awareness among the respondents regarding reproductive and sexual health. They are married early and are forced by their family members to become pregnant just after getting married.

8.1.3: **Age of Unmarried Adolescents:** The number of unmarried adolescents is 12 which is 20% of the total number of adolescent women. It shows that unmarried girls are admitted less compared to married adolescents. The reasons are shame, embarrassment and fear caused due to gynaecological and sexual issues. (Detailed description of the health problems of married and unmarried adolescents can be found in the Section Nos 8.2 and 8.3). Out of 12 unmarried adolescents 2 of them are 15 years old, 2 of them are 16 years old, 5 of them are 17 years old, 2 of them are 18 years old and 1 woman is 19 years old.

![Figure 20. Source. Computed from Survey Data](chart)
8.1.4: Religion: iv The religion of the respondents has been described in the following diagram.

It shows that 33 (56%) of the adolescents are Muslims and 22 (44%) are Hindus. Out of the 33 Muslim adolescents only 4 are unmarried. It means that out of the 12 unmarried adolescents 8 women are Hindus. It raises some questions that whether the unmarried Muslim women or their families are hesitant to go to doctors before marriage. Since the neigbouring
area is Muslim dominated there could have been more unmarried Muslim girls as there are many married Muslim girls among the respondents. The awareness level and social, religious taboos can be the reasons. It is not really possible to conclude so easily and that is why the problems of the respondents can be more deeply understood through case studies.

8.1.5: Educational Status: The educational status of adolescent women is described in the following figure. The educational status of adolescent women is better than the women who are adults and admitted for pregnancy. But one important point should be noticed. The married adolescents are less educated than the unmarried adolescent women. The adolescent girls are married early and sometimes forced by their family members to become pregnant. In the sample taken, 5 of them are dropouts. The unmarried adolescents can continue with their education, out of the 12 unmarried adolescents 2 of them have attended twelfth class, 6 of them are studying in tenth class and 4 of them in twelfth class. 1 of them is a drop out. 3 married women are still studying, 2 in tenth class and 1 in twelfth class. Although it is a very small data but it has been observed that out of the 5 drop outs, 4 of them are Muslim (1 unmarried and 3 married). 2 Muslim women have attended fifth class out of 6, 2 Muslim women have attended seventh class out of 5, 7 have attended eighth class out of 13 women, 9 have attended tenth class (2 of them unmarried), out of 14 and 1 (unmarried) Muslim woman have attended twelfth class out of 3 women. The occupation of all the married adolescents are described in the following figure.
8.1.6: Occupation: The occupational status of the respondents is described in the following figure 15. It shows that maximum number of women are either homemakers (15) or students (14). Out of 14, 11 are unmarried adolescents. The married women who stays at home are married early and have very early pregnancy. They are burdened with household responsibilities and some of them are not allowed to work outside due to religious taboos (mainly Muslim community). Microcredit is the major occupation among the married women (8). Other occupations include agriculture (4), attendant (3), beauty parlour (1), embroidery (4), cosmetic ship (1), grocery shop (2), tuition (3) and vendor (4). Most of the married adolescents do not have high educational levels as shown in figure 14. So they do not get any high collar jobs. The women who are qualified do private tuitions in the locality. The women who work outside are more aware of their health status and they have better perception compared to the women who stays at home. The decision making ability is more but in some cases it is found that inspite of being economically independent they do not have the decision making ability regarding their health status. The occupational details are not subdivided into religious status. Only the important points are stated here. Out of 14 students 11 of them are Hindus. From the
data collected it may be observed that the Muslim women are married early and very small percentage of them pursue higher education. Out of the 15 women who mostly engage in household activities it has been found that 6 of them are Hindus and 9 of them are Muslims. 3 women have been found tuitions, out of them 1 is Muslim. Within this short amount of data it is not always possible to give statistical conclusions depending on their religious status. The qualitative methodology will fill this gap by analysing with the help of case studies.

![Occupation]

**Figure 24. Source: Computed from Survey Data**

**8.2 : Mental Health Status:** The mental health status of the respondents show that most of them face acute depression in their adolescent age. Majority of the unmarried adolescents suffer from depression and 3 of them suffer from mental torture. The awareness regarding mental health is very poor among the adolescent group. 9 of them don’t know whether they have a mental health problem or not. Out of them 7 are married and 2 are unmarried. 16 of them said that they had no problem regarding their mental health. Of them 12 are married and 4 are unmarried. The mental health problems are severe in the case of some of
the unmarried adolescents for both the religions, which has been further elaborated in the case studies.

8.3: Findings Regarding their Health Status: Out of 12 adolescent unmarried women, 4 have been found with gynaecological problems like heavy menstrual bleeding and other menstrual problems, 1 with ovarian cyst and menstrual problem, 2 with illegal abortion and unwanted pregnancy, 3 with sexually transmitted diseases and, 1 with HIV and 1 with Hepatitis B and minor genital infections. Issues like irregular menstruation, ovarian cyst, urinary tract infections, abnormal vaginal discharge, painful intercourse and unprotected sex are never discussed in the households. There is lack of awareness regarding the above issues although 7 of the respondents have been found to be sexually active. They even cannot disclose it to others in shame, fear and embarrassment. Avoidance of conditions like irregular

![Mental Health Status](image-url)
menstruation, abnormal vaginal discharge etc lead to ovarian cysts and other gynaecological complications. Lack of knowledge and incapability in decision making result in unintended pregnancy, forceful abortions and sexually transmitted diseases They lack awareness regarding sexual health and sexual rights which results in unintended pregnancies and sexually transmitted disease including HIV/AIDs. Abortion has been done at advanced stage when it is very risky for the health of adolescent woman. Forceful abortion without the help of trained health professions can have various negative consequences on the health of women. These issues influence the mental health of adolescents who suffer from trauma, mental torture, anxiety and depression.

Out of 47 married adolescents number of women married under 18 years is 22, number of women having anemia is 26 which is more than 50% of the respondent. The number of women whose first child is below 18 years is 7 which mean that spacing is a major issue. There are 3 cases of spontaneous abortion and 5 cases of birth defects. 1 case of forced sterilization has been found where the woman does not have any right of self decision making. The number of haemorrhage cases is 4, babies with low birth weight is 8 and 2 babies die after birth. Perinatal Asphyxia or respiratory failure . (see details in case studies) has been found in one infant which is a result of hypertension and severe anemia from the mother’s side. Misconceptions, lack of awareness, and decision making, lack of proper understanding and perception are substantial factors. Self care practice is very low which led to ignorance and negligence of many symptoms. The perception regarding sexual and reproductive health is worth mentioning. Motherhood is always glorified in the families and society ignoring the primary health of women. Women do not have proper perception regarding family planning and their husbands never try any methods. Women still feel that it is better to go to a female gynaecologist for check up. They feel shy, embarrassed and fear of going to male doctors. Their family members also try to take them to female doctors .
Son preference is still there in some cases. We found that number of women using contraceptives is 7, women having a preference for male doctors is 12, number of women having son preference is 9. Mental health which has been neglected throughout in health policies has been predominant in many cases. 24 women have been found to have mental illness including depression, insomnia, anxiety, mental torture, hypertension and mood swings. Almost none of them consider it to be an illness. They do not have any idea and perception regarding mental health. All that they know is that if a person is eccentric she/he needs medical treatment. Thus we found that proper awareness is required to develop their perception and understanding about sexual health and mental health.

8.4: Analysis: The MDG targets do not mention about these issues which affect a lot of women. The level of knowledge, attitudes and practices regarding sexual health is grossly understudied. There are always shame and taboo attached to the matters of sexual health of women. It is more so in case of the adolescents because they are in a more vulnerable position. On the one hand they are less informed and experienced in matters of sexual health and they are women. As a result, their choices are very limited. So the reproductive and sexual needs of adolescent girls should have greater emphasis compared to sexual health of married women. Lack of knowledge and decision making result in unintended pregnancy, forceful abortions and sexually transmitted diseases. From a feminist perspective it can be seen that although they own their bodies, their bodies are controlled by someone else. They are single but they cannot take decisions regarding a sexual health. In our society it is still believed by many people that a woman’s body is owned by her husband after marriage. But it is quite unfortunate that even before marriage a woman cannot exert her sexual and reproductive rights. In the changing global context the sexual health and reproductive health of adolescents should be highlighted as they have special needs which are different from the needs of the adults.
The problem of the unmarried adolescent girls is far greater than the married adolescents. Most of them are sexually active and end up in high risky sexual activities without knowing the consequences. The unmarried adolescents own their bodies but still her sexual health needs are not taken care of by themselves. They are sexually active but they are not aware about their sexual health and consequences of unsafe sex. They cannot take their own decisions. They do not have clear perception about their sexual rights. The problems of irregular menstruation, gynecological diseases and unprotected sex are ignored by them. From the feminist perspective it can be said that although they own their minds and bodies still their sexual health is neglected. In the patriarchal society the motherhood is often glorified ignoring the primary health rights of women. But unmarried adolescents can also become pregnant and may need abortion. They experience a lot of mental trauma in these given circumstances. But their mental health issues are never brought into focus. They cannot exert their sexual and reproductive rights inspite of owning their own bodies.

In case of married adolescents sexual health is always associated with reproduction and fertility. However many of them face severe obstetric complications which can be avoided if proper antenatal care was provided to the women. The ignorance of primary health care also results in complications during pregnancy which can result in high birth defects of the babies and even mortality. Women are found to be anaemic and they are overburdened by household chores which has deep impact on their health status. Their male partners are ignorant of using contraceptives. Female sterilization is quite common and women also face severe complications due to wrong usage of contraceptives. Spontaneous abortion due to negligence of primary healthcare is also common. Issues like haemorrhage, high blood sugar and nerve diseases affect the health of the foetus which are grossly ignored. The mental health of the women is completely ignored. `They do not have any decision making regarding their reproduction, healthcare and sexual rights. Low spacing between babies is a common
phenomenon. Some women also suffer from different taboos and superstitions. They do not want to visit male doctors.

However the married adolescents can exert their choices more in comparison to the unmarried adolescents. The sexual health is often related to reproduction. The married adolescents find it easier to disclose their problems with their families mainly their husbands. They can also discuss freely with them as well as with the medical practitioners. But the unmarried adolescents cannot disclose anything in fear and shame. They have a perception that the issue of sexual health cannot be disclosed before marriage. Does it mean only married women and women who are mothers have sexual and reproductive health problems? This is a serious issue of concern where the marriage is making a difference in the whole perception of sexual health of adolescents. It is quite common that a woman is given special care and importance during pregnancy. Does that mean women’s health will be neglected if she is not pregnant? Some people fail to understand that if the problems are addressed at initial stages then many complications can be avoided and treated properly during pregnancy. Thus a holistic approach is needed to ensure attainment of women’s health rights.

8.5: Detailed Analysis

A. Correlation of “Primary Rights Neglected” to input variables

A1. Description of the Input Variables:


- Output Variable: Primary health Rights
Split sequence:

1. Decision Making Problem (SS ~ 6.7)
2. Education (SS 1.2)
3. Profession (SS 1.1)

A2. Analysis of the Figures:

Fig. 26 Split History

![Split History Graph](image)

Source: Computed from Survey Data

Fig. 27 Partition for Primary Rights Neglected

![Partition Graph](image)

<table>
<thead>
<tr>
<th>Decision Making Problem</th>
<th>Education (Class IX, Captivate, C)</th>
<th>Profession (Agriculture, Beauty, Embroidery, Grocery Shop, Home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Rows</td>
<td>Education (Class IX, Class VIII)</td>
<td>Profession (Agriculture, Beauty, Embroidery, Grocery Shop, Home)</td>
</tr>
<tr>
<td></td>
<td>Decision Making Problem = 1</td>
<td>Decision Making Problem = 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Rights Neglected</th>
<th>RSquare</th>
<th>RMSE</th>
<th>N of Splits</th>
<th>AICc</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.675</td>
<td>0.27508686</td>
<td>59</td>
<td>3</td>
<td>25.45086</td>
</tr>
</tbody>
</table>
A3. Explanation: From the above split history, column contribution, partition analysis and split details it can be very well understood that decision making is the most important factor which is influencing primary health rights of women. Top 3 input variables correlated to “Primary Rights Neglected" are Decision Making Problem (SS 6.7), Education (SS 1.2) and...
Profession (SS 1.1). It implies that women who can make their own decisions have a better health status compared to the women who cannot make their own decisions.

**A4. Discussion:** Gender power relations are prevalent in society. This is reflected in the decision making ability of women. Men in many parts of the world make decisions on behalf of women (Sen et al, 2007). In this particular study the decision making factor is a major determinant of the women’s health status. Out of 47 married women only 22 can take their own decisions and out of 12 unmarried women 4 of them can take their own decisions. The women who can make decisions in other household matters also take independent decisions regarding health care. These effects in improved health status in most of the cases because women can understand their own problems compared to other family members. In the patriarchal society women cannot make their own decisions regarding health. It is taken by their husbands or other senior members of the family. It is quite obvious that women who are decision makers have better physical health compared to those who cannot make their own decisions. Women who are decision makers can take decisions regarding their sexual and reproductive health as well as their primary health rights. They have choices regarding healthcare services. As a result they maintain a good health status. The primary rights of women are ensured if the women have free choice regarding healthcare and can make their own decisions.

**A5: Explanation:** Education is also an important factor. Educations give empowerment. Educated women can make their own choice, can make their own decisions and their health status is better compared to less educated/uneducated women. Wang & Pillai (2001) posited that women cannot make independent reproductive decisions as long as they lag behind men in terms of their social and economic power. Study shows that for increasing women’s health status we should address the social, economic and political vulnerabilities that jeopardise the health of select subpopulations and groups (Mosely & Cowley, 1991). As we know the above vulnerabilities can be ruled out if one has education.
A6. Discussion: In this study all the adolescent unmarried women are educated, only one is a drop out. 5 of the married women are not literate and 3 of them are dropouts, the rest are educated. It is found that educated women are aware of their rights. They have better awareness and perception regarding diseases and healthcare. They can have their choices regarding healthcare. So their health status is better compared to the less educated women. It is worth mentioning that education is less influential compared to decision making. The unmarried adolescents are educated but they still cannot make independent decisions. 22 of the married women can make independent decisions. Among the women who cannot make independent decisions, most of them are educated. It means that all the women who are educated cannot make their own decisions in the patriarchal society. Education can bring awareness but there is a power relationship in the society. Women who are empowered can make their own decisions and this empowerment depends on various social, cultural, economic and political factors.

A7. Explanation: Profession is also important because it gives women economic empowerment which in turn gives women free choice to make their own decisions. Women who are engaged in some kind of professions can spend their own money and can take independent decisions regarding their healthcare. Hence, they have a better health status compared to the women who are socially and economically vulnerable (Sen, 2007).

A8. Discussion: In this particular study all the unmarried adolescent women are students. Out of the 47 married women, 32 of them are engaged in some kind of occupations. The rest of them stay at home. It has been found that women who are economically independent can see medical help according to their own needs, they do not have financial constraints and generally enjoy a better position in households compared to the women who stay mostly at home. They can buy some healthy nutritious food or can make them at home.
according to their needs. This results in a better health status and their primary health rights are ensured. Education and economic independence give the power to choose and make their own decisions. They give women social and economic power which enables them to make reproductive and other health related decisions (Wang & Pillai, 2001).

B. Correlation of “Health Awareness and Perception” to input variables

B1. Description of Input Variables:


Top 3 input variables correlated to “Health Awareness and Perception”:

- Profession (SS ~ 3.6)
- Religion (SS ~ 0.5)
- Decision Making Problem (SS ~ 0.3)

Overall R square of 3 Splits is low at 0.313.

Split sequence:

1. Profession (SS ~ 3.6)
2. Religion
3. Decision Making Problem
B2. Analysis using Figures:

Fig. 30: Partition for Health Awareness and Perception

Source: Computed from Survey Data

Fig. 31. Split History:
Source Computed from Survey Data

Fig. 32. Column Contributions:

<table>
<thead>
<tr>
<th>Term</th>
<th>Number of Splits</th>
<th>SS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
<td>1</td>
<td>3.0137416</td>
</tr>
<tr>
<td>Religion</td>
<td>1</td>
<td>0.5237088</td>
</tr>
<tr>
<td>Decision Making Problem</td>
<td>1</td>
<td>0.3214286</td>
</tr>
<tr>
<td>Anemia</td>
<td>0</td>
<td>0.0000000</td>
</tr>
<tr>
<td>Education</td>
<td>0</td>
<td>0.0000000</td>
</tr>
<tr>
<td>Nutritional Deficiency</td>
<td>0</td>
<td>0.0000000</td>
</tr>
</tbody>
</table>

Source : Computed from Survey Data

Fig. 33. Split Details
B3. Explanation: From the above split history, column contributions, partition analysis and split details it can well be understood that profession (SS~3.6) is the most important input variable which is influencing awareness and perception of women. The second and third most important variables are religion(SS~ 0.5) and decision making status(SS ~0.3) of respondents.

B4. Discussion: Study shows that social and economic power enable the women to make decisions regarding their health (Wang & Pillai, 2001). Women who are engaged in any kind of profession have more exposure to the outer world compared to the women who mostly stay at home. They have more access to information, more peer groups and are more aware compared to the women who are not engaged with any kind of profession. The adolescents unmarried women are students and 32 of them are engaged in some kind of professions. The students have a peer group and more exposure compared to the women staying at home. This give them awareness. The married women who work outside naturally has more access to information which brings awareness.

B5. Explanation: The second and third most important variables are religion(SS~ 0.5) and decision making status(SS ~0.3) of respondents. But the values are very negligible in this particular category. So it is not very significant for determining a relationship between two variables. However, decision making can play a very important role in relation to awareness. 34 women cannot take their own decisions Women can make their own decisions are more independent and empowered(as discussed in the Chapter 8 Section A4, A5 and A6. ). They can have their own perceptions and can be more aware due to their independent nature.
**B6. Discussion**: The extent of control over women and their reproductive choices is determined by social structural factors. (Ramirez & McEneaney, 1997). It is an interesting to find that religion plays an important part in determining the health awareness and perception of women although the value is very negligible. There are 33 Muslim adolescent women and 22 Hindu adolescent women. Out of the 12 unmarried adolescents only 4 are Muslims. In this small sample population it has been found the Hindu unmarried adolescent women are slightly more aware than the unmarried Muslim adolescents. The reasons cannot be generalised after studying this small group of women. It may happen that women from a particular religious group is less careerist compared to another group. One group may be less mobile and stay at home(both willingly and unwillingly) compared to another group. Religious taboos also result in discrimination and differential behaviours among these two groups of women.