CHAPTER I

INTRODUCTION

While the age of marriage is generally on the rise, adolescent marriage is still widely practiced. Adolescence, defined as the period between childhood and adulthood doesn’t last long for girls who enter into an early wedlock since they go directly from child to wife and mother, becoming statistically invisible as ‘children’. Early marriage not only truncates the childhood of girls but also places them at risk of an array of adverse sexual and reproductive health outcomes. Despite national laws and international agreements forbidding early marriage, social norms and religious values in many countries dictate the practice. In South Asia, the first sexual experience for adolescent girls usually occurs largely within marriage with over 45 per cent of girls in Bangladesh, India and Nepal been married before their 18th birthday (UNICEF, 2015). In India, there has been a slow trend toward delaying marriage (Moore AM et al., 2009).

Customs surrounding marriage, including the desirable age and the way in which a spouse is selected, depend on a society’s view of the family – its role, structure, pattern of life, and the individual and collective responsibilities of its members (Donahue, 2010). Culture, tradition and values based on patriarchal norms also play an important role in early marriage. Other reasons include poverty, lack of education and knowledge, shortcomings in the law, and the lack of will and action on part of the administration (Ingberg, 2010). According to the Proposal to Amend the Prohibition of Child Marriage Act, 2006 and other allied laws, Government of India, 2008, early marriage is one way to
ensure that a wife is ‘protected’, or placed firmly under male control; that she is submissive to her husband and works hard for her in-laws’ household; that the children she bears are ‘legitimate’; and that bonds of affection between couples do not undermine the family unit. Parents may genuinely feel that their daughter will be better off and safer with a regular male guardian. The general demand for younger brides also creates an incentive for these families to marry the girl child as early as possible to avoid high dowry payments for older girls. Young girl may be offered to a family in order to improve the financial and social standing of the girl’s family (Hezer, 2003).

The girl in a patriarchal set up is believed to be somebody’s property and a burden. Many parents experienced anxiety about getting their daughters married. In some cases, parents believed that they would fulfill their religious duties by marrying their daughters early. Others worried that if girls delayed marriage, it would become “hard to find a suitable bridegroom”. In addition, much pressure for early marriage came from concern over a girl’s ‘character’. The longer girls remained unmarried, the more chances there were of ruining their character and of reducing their chances of marriage. Many parents fear that she might run away with a man or have a love marriage, which will bring dishonor (Thapa et al., 2000). There is also a belief that child marriage is a protection for the girls against unwanted masculine attention or promiscuity. In a society which puts a high premium on the patriarchal values of virginity and chastity of girls, girls are married off as soon as possible (UNICEF, 2001). Besides the culture and tradition based on patriarchal norms leading to early marriage, some of the adolescent girls also gets married out of ‘love’.
The low age at marriage is an issue of utmost concern due to its implication on the sexual and reproductive health of the adolescents. The adolescent girls enter into married life in a phase of life which is marked by transition from childhood to adolescence. From being a child, they become sexually active adolescence who has to exhibit their reproductive ability. Experiencing the transition into adolescence and marriage at the same time makes them vulnerable and in need of considerable support. However, married adolescent girls have attracted global attention only recently (Erulkar, 2015 although they comprise the majority of sexually active adolescent girls in most developing countries (UNICEF, 2015). Married adolescents are largely invisible, overlooked by both research and programs. They are presumed to have the same service needs and access as adult women; yet emerging evidence suggest that this may not be the case (Erulkar and Bello, 2007). The increased public health attention to adolescents in developing countries, in response to their numbers, their reproductive health problems, and, most recently, to the increasing rates of HIV infection among this group has been focused almost exclusively on the unmarried, with little or no attention paid to married adolescent (Mensch et al., 1998). The lack of attention on married adolescent girls from research and programs is partly due to the changed social status that marriage confers, regardless of age.

The issue becomes even more multifaceted when the married adolescent girls follow a religion that influence their way of life to a great extent. Sexual and reproductive health research addressing Muslim patients is characterized by a significant empirical deficit. Very little is known about devout Muslims' attitudes, negotiations, and contestations of sexual and reproductive health matters (Arousell and Carlbom, 2015). The unmet needs among women in the Muslim world for reproductive health services,
and for reproductive and other societal rights, are enormous (Boonstra, 2001). Looking into the reproductive health needs of these young and vulnerable adolescent girls is therefore of paramount importance.

1.1 INTERNATIONAL CONSENSUS ON REPRODUCTIVE HEALTH

The term “reproductive health” was first used in an international policy agreement at the United Nations International Conference on Population and Development, held in Cairo in 1994. According to the conference’s Programme of Action, Reproductive Health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”. It further states that the notion of good reproductive health covers all aspects of the reproduction process – including a satisfying and safe experience of sexual relations, the capability to reproduce, and the freedom to decide if and when to bear a child.

With regard to the sexual and reproductive health and rights of young people, this UN document states that, “Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, these services must safeguard the rights of adolescents to privacy,
confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents”.

All governments participating in the Cairo conference endorsed its Programme of Action. Muslim countries generally endorsed it with the reservation that they would interpret and adopt the recommendations in accordance with Islam—a position that enabled the delegations to take the recommendations back home for implementation. Since the International Conference on Population and Development (ICPD) in 1994, The United Nations Population Fund (UNFPA) focus on culture has intensified and broadened, especially its linkage to issues of gender and reproductive health. Culture, along with gender and human rights, has increasingly become an important analytical and programming tool. These three elements are closely interlinked and constitute an end as well as a powerful means to address the respective issues of gender inequality and inequity, human and reproductive rights, and cultural values and practices that are inimical to attainment of sustainable human development (UNFPA, 2005).

According to a statement issued by Thoraya Ahmed Obaid, UNFPA Executive Director to the Executive Board Meeting of February 4, 2002, “Cultural and religious beliefs are the very essence of our individual and collective identities. UNFPA must respond to increasing cultural challenges by helping countries, communities and individuals to link universal principles with their cultural values and by designing culturally-sensitive programmes in systematic and well conceptualized ways that fit into different religious and cultural identities and understandings”
UNFPA views culture as a window of opportunity for the implementation of ICPD through partnerships with local power structures and institutions, to address issues of gender, human rights and reproductive health that are rooted in religion, traditions, customs and social practices (UNFPA, 2005).

1.2 THE STAGE OF ADOLESCENCE AND ITS CULTURAL MEANINGS

The World Health Organization (2015) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. Adolescent girls are generally subsumed under the rubric of either children (ages 0 to 18 years), youth (ages 15 to 24 years), or mentioned in tandem with or absorbed within the heading of women – all of which are broad categories themselves. Different policies and programmes define the adolescents’ age group differently. For example, adolescents in the draft Youth Policy have been defined as the age group between 13-19 years; under the Integrated Child Development Services (ICDS) program, adolescent girls are considered to be between 11-18 years; the Constitution of India and labour laws of the country consider people up to the age of 14 as children; whereas the Reproductive and Child Health Programme mentions adolescents as being between 10-19 years of age. Internationally, the age group of 10-19 years is considered to be the age of adolescence. In India, age limits of adolescents have been fixed differently under different programmes keeping in view the objectives of that policy or program. Adolescent girls are also recognized as a cohort with its own subsets. Approximate age categories include pre-adolescence (9 to 12 years), early adolescence (12 to 14 years), middle adolescence (14 to 16 years), and late adolescence (16 to 18 years) (UNFPA and
Population Council 2006). For the present study, the age group 10-19 is taken as the stage of adolescence.

Other relevant subsets for analysis for adolescents are rural or urban residence, marital status, education, socio-economic status, and marginalization (such as disability, migration status, living in a vulnerable area, or belonging to an ethnic or religious minority) (Bruce, 2003).

In developed countries, “adolescence” is the term used to describe the transition between childhood and adulthood. Coincided in the beginning of the twentieth century, the term commonly connotes a stressful and critical period during which young people struggle to come to terms with their sexuality; a widening world beyond their family; new ideas; and their changing social settings, this developed-country definition became more applicable. Erickson (1975) a well-known psychologist, viewed adolescence as a natural period of uprootedness in human life. Drawing a parallel between an adolescent and trapeze artist, he conceptualizes the young person as being in vigorous motion between two landings one representing childhood and the other adulthood, ‘who must let go his safe hold on childhood and reach out for a firm grasp on adulthood’. He also theorized adolescence as a stage of life during which inner identity is to be achieved and called it a period of identity crisis. The crisis term has been used by Erickson in a developmental sense to connote a ‘threat of catastrophe, but a turning point, a crucial period of increased potential (Erickson, 1968).

It is pertinent to raise the question— has the period of ‘adolescence’ been recognized universally having the same meaning? In reality, there are markedly different notions of adolescence in different parts of the world. According to WHO, the biological
Determinants of adolescence are fairly universal; however, the duration and defining characteristics of adolescent stage may vary across time, cultures and socio-economic status. Adolescence is also a cultural construction, not simply a biological phenomenon or an age range. Cultural anthropologists like Margaret Mead and Ruth Benedict gave the cultural context of adolescent development. Their insight on the diverse understanding of adolescent development is contradictory to the commonly understood period of storms and stress as described by G. Stanley Hall in 1904. Margaret Mead maintains that the major task facing adolescents today is the search for a meaningful identity. This task is immeasurably more difficult in a modern democratic society than in a primitive society. In her book *Coming of Age in Samoa* she concludes that unlike stressed American girls, the sexually active Samoan girls are well balanced and have carefree nature, devoid of the storms and stress of the adolescent period. She asserts that it was due to the cultural stability of their society free of conflicting values, expectations, and shameful taboos. Largely relieved of the baby-tending responsibilities that had burdened them as little girls; Samoan adolescents reveled in their freedom and deferred marriage during their “best period” in their lives. Thus, according to Mead (1928), “*The stress is in our civilization, not in the physical changes through which our children pass*”, thereby emphasizing on the importance of culture in adolescent growth and development.

Cultures vary in how they define adult status and in the content of the adult roles and responsibilities adolescents are learning to fulfill. There are cultures where adult status is granted to both boys and girls through initiation rites at puberty, amounting to an abrupt transition from childhood to adolescence and adulthood. For girls, menarche is the
pubertal event in many cultures that initiates a monthly ritual related to menstruation that lasts throughout a woman’s reproductive life.

In the book *The Golden Bough: a study of magic and religion*, Sir James George Frazer mentioned about initiation rites of girls in various society like Kolosh Indians of Alaska, Nootka Indians of Vancouver Island, Ot Danoms of Borneo girls and the Yaraikanna tribe of Cape York Peninsula. In these societies, after seeing signs of puberty or before puberty, girls are kept confined at a secluded hut or cage for few days or several years. The girls will be considered as adult woman after coming out of their confinement. This usually happens few days or a couple of years after attaining menarche. In such societies, adult identity is given to the pubertal individuals by their unique cultural or religious ceremonies. However, adolescence may be an extended period of transition in other cultures as in the Western society of today. In Samoa, the traditional rite of passage into adolescence involved an elaborate process of tattooing sometime between ages 14 and 16. In spite of the pain, few young men or young women declined to take part in it, because being tattooed was considered essential to sexual attractiveness and to being accepted as a legitimate candidate for full adult status (Mead, 1928). Among the Muslim of Mataram, Indonesia, once a woman’s family is aware that she has reached menarche, they typically hold a ceremony to acknowledge her departure from childhood and entrance into womanhood. Young women are given two bowls of colored porridge from which to eat. In one bowl, the porridge is red in color, symbolizing the woman’s menstrual blood and fertility; the other bowl contains white porridge, signifying her sexual purity prior to marriage. A woman’s fertility and chastity are symbolically aligned in this ceremony, indicating the significance of these characteristics in defining ideal
femininity While such ceremonies can be considered a rite of passage they do not signify that women have achieved full adulthood. This status is reached only upon marriage and the birth of a first child (Bennett, 2005).

Signs of puberty like menstruation, growth of pubic hair as well as reaching the age of fifteen years are considered by many Islamic scholars as an entry into adulthood. There is a verse in the Holy Quran which says:

“Try, test, well the orphans, before reaching maturity with regard (the duties of) religion and (before) they can (legally) manage their own affairs, until they reach the age of marrying, that is, until they have become eligible for it through puberty or (legal) age which according to al-Shafi’i, is the completion of fifteen years” (Tafsar al-Jalalayn)

Due to such wide variability in the adolescent stage in different cultural settings, it would be fitting to describe adolescence as “a phase of life that begins in biology and ends in society” (Sharma, 1996). Though the physical and biological changes are universal due to maturation, the psychosocial and behavioral manifestations are determined by the meaning given to these changes within a cultural system.

1.3 THE INTERFACE BETWEEN REPRODUCTIVE HEALTH AND CULTURE

Procreation or reproduction is not just a biological phenomenon. It is often entangled with cultural belief and practice which prevents it from being a “simple biological phenomenon”. Anthropological studies of different cultures have shown how men’s awe and fear of women’s reproductive powers have found expression in cultural practices consisting of rites, rituals and taboos around fertility and reproduction to control
the sexuality and fertility of women in their societies (Mead, 1950). Cultural factor shapes the process of reproduction which is explicitly described by Ford (1964) as follows:

“The human race does not reproduce itself automatically by biological means alone. To be sure, the sex-drive brings male and female together, conception occurs, pregnancy runs its course and contractions of the uterus results in expulsion of the child. But the picture is actually far more complicated. Conception does not always follow coitus. Miscarriage frequently occurs and willful abortion is possible. Labor is painful and often dangerous. Female infanticides do occur. These and many other difficulties arise to thwart an automatic biological production of offspring. Human reproduction is effected by biological process assisted by learned behavior. The customs which are thus adjustment to the imperfection of human biological process of reproduction arise from the desire to bear children. This wish for offspring is not an innate component of human nature; it is not a basic drive. On the contrary it is an acquired motive which is continuously being reinforced by social reward and punishments. Promise of security, approval and prestige support the desire for children; threats of insecurity, punishment, and ridicule block incipient wishes to escape the pains and cares of childbirth and parenthood”.

The ways a society copes with the major events of birth, illness and death are central to the beliefs and practices of that society. Culture influences a woman’s reproductive beliefs, behavior and decisions. For instance, South Indian women eat less during pregnancy not just to ease the birth process but to give more “baby space” to their
body. They believe that pregnant women must be fed less so that the child is not smothered by too much food and can grow (Nitcher, 1981).

Cultural factors also influence women’s perception of reproductive health problems. It is crucial to diagnosis, treatment, and care (Kleinman, 1981). Ooman (1996) in her works among the rural Rajasthan women recognize the importance of studying the cultural meanings of words such as “weakness” when used to describe gynecological problems. Her findings explicate that women’s report of dhola pani do not map with the bio-medically defined disease categories. She found that women in rural Rajasthan associate poverty as the cause of illness and therefore an underlying synergism of poverty and pathology. Ooman concludes that reproductive tract infections represents “disease” a pathological state while dhola pani represents “illness” a condition of impoverishment (Ooman, 1996). Some evidence suggests that women may perceive white discharge as part of sexual maturation and consider it normal (Bang Bang, 1992). Therefore, different societies encounter, define and experience reproductive health problems biologically as well as culturally. What is recognized as reproductive illness in a particular cultural setting may not be so in others.

Culturally constructed hierarchical norms can strongly affect reproductive health. Son preference (Asghar et al., 2014) and women’s economic dependence on men contribute to high rates of fertility in many settings. Inability to negotiate sex on equal terms or to use contraception leaves the majority of women and girls at risk of unwanted pregnancy, illness and death from pregnancy-related causes and STDs (UNFPA, 2005).

The differentiation of key concepts like disease and illness is another important dimension in the cultural context of health. Evidence suggests that in every culture, there
is built around the major life experience of health and illness a substantial and integral body of beliefs, knowledge and practices (Scotch, 1963). Ackernecht (1947) wrote, “Disease and its treatment are only in the abstract purely biological processes”. Facts such as whether a person gets sick at all, what kind of disease he acquires and what kind of treatment he receives depend largely upon social factors”. Disease in the western paradigm is just the malfunctioning or maladaptation of biologic and psycho physiologic processes. Illness is culturally constructed (Kleinman et al., 1978). Because illness experience is an intimate part of social systems of meaning and rules for behavior; it is strongly influenced by culture. Illness is shaped by cultural factors governing perceptions, labeling explanation, and valuation of the discomforting experience, process embedded in a complex family, social and cultural nexus. Young (1981), in his study of the community of Pichataro in Mexico, attempted to understand illness which people mentioned in terms of perception of their bodies. On the basis of his findings, he showed how men and women made “medical choices” to treat their illnesses and how these choices varied according to the beliefs about causes of illness. Therefore, behavior, decisions or attitude about health are intertwined with many other aspects of culture. When these attitudes and behaviors are examined against a cultural backdrop, they are considerably easier to understand.

In anthropology today, culture is not seen as homogenous or static. Culture is not a single variable but rather comprises multiple variables, affecting all aspects of experience. It is considered inseparable from economic, political, religious, psychological, and biological conditions (UNFPA, 2005). Cultural processes frequently differ within the same ethnic or social group because of differences in age cohort, gender,
political association, class, religion, ethnicity, and even personality (Kleinman and Benson, 2006). Age, like sex, is basic to the human condition universally, though with different implications in different cultures. Primarily conceived as a chronological measure for reckoning the physical development of human beings, the concept of age has its social significance through the concurrently changing status of a person. That is the reason why the stage of adolescence though chronically and biologically determined, also have a cultural construct. While the physical changes of pubescence signal the beginning of this phase, cultural criteria such as achievement of adult status and marriage frequently mark the termination of adolescence. Early marriage brings an array of reproductive health needs and problems to married adolescents that are markedly different from unmarried adolescents. Other than age, religion also has important implications in the cultural process (Kleinman and Benson, 2006). In most cultures, the central healing practices take place in a religious context, and there are always religious practitioners who have a responsibility for healing members of the group (Winkelman and Baker, 2008). In common for all major religions is that they offer a distinct belief system, which aims to guide devout followers in sexual and reproductive health matters (Chrishtopher, 2006). Within all major religious traditions, scholars have in one way or another reflected upon the meaning of sexuality, providing frameworks for good and bad sexuality, characteristics of male and female sexuality, and family planning strategies. Thus, religion cannot be easily separated from sexuality and reproductive health (Geels and Roos, 2010).

Owing to the importance of cultural factors in affecting reproductive health, international agencies have always called for inclusive reproductive health programme
approach that is sensitive to culture and tradition. Medical anthropology focuses on the
discovery of local reproductive norms and practices, including how individual living
within communities define and experience their reproductive health problems. As a
matter of fact, women’s reproductive health is a complex domain involving effects that
are direct and indirect, biological and social. Besides the biomedical explanation, the
meaning and lived experience of reproductive health within a particular local, cultural
context is important in order to get a holistic understanding of their reproductive health
problem. That is the reason why medical anthropology often takes over where standard
epidemiological and demographic research leaves off “by attempting to understand why
women behave the way they do in the realm of reproductive health” (Nations, 1986).

1.5 PROBLEM IDENTIFICATION

The situation and needs of married adolescent girls are different from that of
unmarried adolescent girls and married adult women, posing distinct programme
challenges (Clark, Bruce and Dude, 2006; Santhya and Jejeebhoy, 2003). Married
adolescent girls are often defined by social custom solely as wives and mothers instead of
being viewed as children or teenagers. They are equated with adult women although there
may be a significant difference in the level of physical and mental maturity between an
adult married woman and a married adolescent girl. Married adolescent girls are more
vulnerable and face greater reproductive health risk compared to unmarried adolescents
and married adult women (Maitra and Schensul, 2000; Barua and Kurz, 2001; Sharma et
al., 2003; Prasad et al, 2005; Clark et al., 2006, Reynolds et al., 2006; Ram et al., 2008).
National and international indicators on maternal health, education, food security, poverty eradication, HIV/AIDS, and gender equality are all negatively linked with high child marriage rates (ICRW, 2011). Emerging evidence suggests that in settings where marriage marks sexual initiation for girls, but not necessarily for boys, early marriage may place young females at special risk of acquiring HIV and other sexually transmitted infections (Clark, Bruce and Dude, 2006). Young women are particularly susceptible to STIs because they have fewer antibodies to fight pathogens and greater cervical ectopy. Adolescent women infected with *Chlamydia trachomatis* are more likely than their adult counterparts to develop cancer of the cervix or PID and, consequently, infertility (WHO, 2015). Marriage puts adolescents at heightened risk of unwanted pregnancies and sexually transmitted infections (Maitra and Schensul, 2000; Clark et al., 2006). A recent review of evidence on the prevalence of HIV infection among married young women in India reports that in a number of hospital-based retrospective studies conducted among HIV-positive women, a substantial proportion of those infected were young women whose only HIV risk factor was sexual relations with their spouses (Santhya and Jejeebhoy, 2007).

Moreover, due to the social pressure to initiate childbearing soon after marriage, they are far more likely to experience regular sexual relations, less likely to use condoms and less likely to refuse sex than unmarried sexually active adolescents or adult women. This place married adolescents at higher risk than unmarried sexually active adolescents of acquiring sexually transmitted infections and, among those under 16, at higher risk than married adult women of experiencing obstetric complications associated with early childbearing (Santhya and Jejeebhoy, 2003). Worldwide, adolescent girls younger than
18 years are more likely to die in childbirth than women in their twenties. The main causes of mortality in young mothers are toxemia, abortion, and obstructed labor caused by immaturity of the birth canal (MOHFW 1998). Prolonged and obstructed labor can result in obstetric fistulas, which disproportionately affect very young and first-time mothers due to their incomplete development (Raj et al., 2010). Moreover, the extra nutritional demands of pregnancy come at the heels of the adolescent growth spurt—a period that requires additional nutritional input itself. Any shortfall in nutrition can result in the further depletion of the already malnourished adolescent. As a consequence, pregnancy at an early age, before the adolescent is physically fully developed, can result in severe damage to the reproductive tract, elevated risks of maternal mortality, pregnancy complications, perinatal and neonatal mortality, and low birth weight. Adolescent mothers have higher incidence of low birth weight and premature births after controlling for parity, height, weight, educational level, financial assets, and utilization of prenatal care, all of which were lower among adolescent mothers (Miller, 1998). In addition to its associated health consequences, early childbearing has an adverse effect on a young mother’s socioeconomic status. It cuts short her education, limits her ability to earn income for the family, and can lead to marital difficulties (MOHFW 1998).

To make matters worse, Indian adolescents aged 18 or younger are significantly less likely than older women to receive any skilled prenatal or delivery care (Reynolds et al., 2006). Dhak (2003) in his study reported that 55.7% of the adolescent mothers had utilized antenatal services as compared to 75% mothers in the age group of 20-24 years. Nanda (2002) in her study reported that, more than one-third of all teenage mothers did not receive antenatal care.
Regardless of whether more-vulnerable girls are married early, or whether early marriage itself creates some of the vulnerability, or both, the fact is that married girls tend to be less mobile, have more limited social networks, may have less say in decision making, at greater risk of spousal abuse, have less exposure to the media, and have less education than unmarried girls and/or slightly older married females. The social disadvantage married girls experience is striking and is an issue of deep concern in its own right. From a programmatic perspective, while it is far from irrelevant whether early marriage is the cause of these girls’ vulnerability or whether more-vulnerable girls tend to marry in adolescence, the fact is that the married girl—has special needs and circumstances, whatever the underlying determinants (WHO, 2003).

The issue becomes multifaceted when biological vulnerability is accompanied by cultural vulnerability. According to UNFPA (2005), cultural vulnerability constitutes a particular challenge to achieving the eight MDGs all of which are inextricably linked to reproductive health. Regarding cultural vulnerability, reference is made to: i) ethnic and religious minorities, two of the key groups that are often outside of the mainstream socio-cultural setting in a country and ii) groups which practice or are exposed to risky reproductive and sexual beliefs and practices. These two sets of groups are often subject to discrimination of some form or another. Often living outside the mainstream population, such groups tend to constitute the poorest in society and more often than not, they also have least access to reproductive health services and information. There is no doubt that cultural factors combined with non-availability and inadequacy of services, are issues at the heart of socio-economic stagnation of these groups. Undoubtedly, this
situation requires building alliances with under-served people so as to ensure that their needs are prioritized (UNFPA, 2005).

The Muslim married adolescent girls belong to religious minority group, amidst the mainstream socio-cultural setting of Manipur and are reproductively vulnerable due to their early marriage. It is important to explore their reproductive health needs and to discover whether they are truly vulnerable or in a disadvantaged position and in what manner. While looking at cultural context, it is also important to explore the individual perception and response to traditional beliefs and practices on reproductive health as there may be individual variations. An increasing amount of publications has focussed on the general complexity surrounding sexuality, reproductive health, and health outcomes among devout Muslims (Ussher et al., 2012; Meldrum, 2013). This is because individuals' religiousness with regard to sexuality and reproductive health is relative to a specific time and place (Moreau et al., 2013; Ryan, 2013). Thus, it is important to explore how the married adolescent girls deal with their reproductive health and illness in their cultural and socio-economic settings. This calls for the need to holistically explore the married Muslim adolescent girls’ lived experiences and realities on reproductive health in their socio-cultural context.

1.6 OBJECTIVES

I. To highlight the socio-economic background, marriage and childbearing pattern of the married adolescent girls.
II. To explore the reproductive health experience of married adolescent girls against the backdrop of their socio-cultural context.

III. To understand the interface between tradition and modernity in reproductive health amongst the married adolescent girls.

1.7 METHODOLOGY

1.7.1 FIELD SETTINGS

Three Muslim localities in Manipur are chosen as field sites for this research

1. Urban locality: Minuthong, Hatta Golapati is the most important and prominent Muslim urban areas in Manipur. It is located in Imphal East district under Imphal Municipal Council. One locality from Minuthong Hatta Golapati is selected as an urban field site.

2. Sub-urban locality: Tarahei, located in Hiyangthang, Imphal West District, is selected as sub-urban field site. This site is selected as it is one of the few Muslim villages located in the rural-urban transition zone of Manipur.

3. Rural locality: Kwakta, located in Bishnupur district is chosen as a rural field site. I was well acquainted with a couple of villagers from Kwakta. The presence of prior acquaintance in the village made my introduction into the field relatively easier. Owing to the magnitude of Kwakta village, only one locality of Kwakta is chosen as a field site.

The field work was carried out from January 2011 to June 2013, alternating between the three localities.
1.7.2 RAPPORT ESTABLISHMENT

Rapport establishment with the people of the three localities is one of the most important aspects of my field work. I was well acquainted with some of the key informants from Kwakta and Golapati even before I began my field work. It consisted of both married men and women as well as unmarried adolescent girls. They introduced me to their relatives and friends in the three localities. Even though they made my rapport establishment relatively easier, I also tried to immerse myself and mingle with the residents in the best possible way. Since I am from a different cultural background, I sensitively tried to use their cultural norms of social interaction, for instance, using their kinship terminologies while addressing people. I also learnt about “the acceptable and unacceptable” in their society so that I would “adopt or avoid” them in my interactions with them. I showed my receptiveness and enthusiasm to learn about their culture. I also participated in the mundane activities of their everyday life, like, visiting a neighbor’s house for tea along with my key informant, fishing in the local stream or joining a group of women in their usual afternoon chit-chat in the local tea stall. It made me closer to them and increased our comfort level. I tried to be a good listener while being non-judgmental, encouraging, appreciative and making people feel ‘safe’ in my presence or with me which also helped me in establishing a good rapport with them.

1.7.3 METHODS OF DATA COLLECTION

1.7.3.1 SAMPLING

Purposive sampling is used in this study as I wanted to focus in-depth on particular characteristic of a population that are of interest, which will best enable me to
answer my research questions. Researchers working on the notion of purposive sampling assert that while probability methods are suitable for large-scale studies concerned with representatives, non-probability or purposive approaches are more suitable for in-depth qualitative research in which the focus is often to understand complex social phenomena (Marshall, 1996; Small, 2009). The area of research, even though on reproductive health, is on a specific group consisting of married Muslim adolescent girls. Key informants like maiba (traditional healer), maibi (traditional birth attendant cum healer), Moulvi (religious leader cum traditional healer) who have expertise in this field are also limited in number. Due to the characteristic and number of the population in study, purposive sampling is best suited. For the present study, adolescent girls refer to those in age group 10-19 going by the WHO and international consensus of adolescent age group. Since the total number of married adolescent girls in the three areas is 68 (22 in Golapati, 6 in Tarahei and 40 in Kwakta), questionnaire and structured interview is administered to all of them. For in-depth interview, particular cases are selected according to the requirement of data.

1.7.3.2 HOUSEHOLD CENSUS

Household census of the three localities is carried out to obtain information about the socio-economic status of the households and the demographic characteristics of the village. The collection of the household data includes basic data such as age, sex, age at marriage, lineage, religion, marital status, family pattern, number of individuals in a family, educational status, income, occupation etc. The household census also tries to highlight information about a woman’s family and herself in relation to other household
members. This includes the name of the woman, husband’s name, head of the household, the woman’s position in the family in relation to other women in the family. While collecting household census, I got an opportunity to observe and interact with the members of different households. It provided me with more knowledge about the area, the different households and its people. Many of them directed me to respondents who could enrich my research with related information and data.

But on the flip side, my household census collection coincided with that of the Indian government Census collection for 2011 and they had recently provided information for Census 2011. The redundancy and tediousness of the household questions bored quite many of them and they had a hard time remembering their age, age at marriage and in calculating their income.

1.7.3.3 QUESTIONNAIRE

A mixed questionnaire with both open ended and closed ended questions is employed. The questionnaire is pre-tested among six married adolescent girls, two each from the three field sites. Based on pre-testing, futile and ambiguous questions are modified or excluded in the final questionnaire. The final questionnaire is administered to all the 68 married adolescent girls. For some of the married adolescent girls, collecting information on the questionnaire happened side by side with semi-structured interview. The questionnaire is used to obtain basic information about obstetric and menstrual history, family planning, reproductive health problems and use of reproductive health services. Effort was made to include all the important questions while making the questionnaire as concise as possible. This was done in order to save time as I had to the
double task of asking/explaining the questions to the informants, as well as writing down their response on the questionnaires. Most of them had little or no schooling and were more comfortable giving their responses verbally. Certain biomedical terms that do not have exact translations in the local dialect had to be explained in manners that were understandable to them. In exchange, I became acquainted with the common lingo used by them while talking about women’s body and reproductive health. It helped me a lot while conducting interviews. The questionnaire established uniformity in the questions that were put up to all the married adolescent girls. This latter helped me in getting a comparable and reliable data. It also helped me in selecting particular case or respondents for further inquiry. Questionnaire is also used during the health camp in Tarahei where it was applied to all the women who came to the health camp.

1.7.3.4 INTERVIEW

Both semi-structured and in-depth interview techniques are employed in this research. All interviews are audio taped and field notes are taken during interviews to monitor interview quality.

A set of open-ended interview schedules are used for conducting semi-structured interview. It consists of list of questions and topics that are to be covered during the conversation in particular order. Questions are prepared ahead of time and identical questions are asked to every participants belonging to similar category. There were cases when the respondents got off topic with certain questions either because they misunderstood the question or did not wish to answer the question directly. So I kept the flexibility of reconstructing question in a manner that is understandable to them and in
erecting follow up prompt in order to extract optimal response from them. Semi-structured interview is used in order to get a reliable, comparable qualitative data. It is also fairly quick to conduct compared to in-depth interview.

The interview schedule started with general questions about early marriage in the areas, their beliefs and perception about puberty, women’s body, gender dynamic in their society and traditional beliefs related to reproductive health. Along with these, topics about menstruation, pregnancy, childbirth, family planning, reproductive health problems and health seeking behavior are also included in the interview schedule.

Semi-structured interview of all the 68 married adolescent girls in the three field sites and 24 married women (8 from each field site based on purposive sampling) above the age of 19 years are also conducted. It is done in order to explore their beliefs, practices and experience related with puberty, early marriage and reproductive health. Semi-structured interview went hand in hand with questionnaire for some of the married adolescent girls. It was more convenient for some of the respondent as it saves more of their time and energy. Semi-structured interview of 12 husbands of the married adolescent girls are carried out in order to know the gender dynamics and the role of husbands in reproductive health of the married adolescent girls. 6 local club members, 8 community leaders/social workers (male), 2 ASHA (Accredited Social Health Activists) health worker (female), 3 social worker/ women leaders (female), 4 anganwadi teachers (female), also participated in the structured interview. The participants are chosen based on their experience and local knowledge about their village and its socio-cultural dynamics, local culture, health, woman issues including women’s illness.
4 Moulvi (two each from Kwakta and Golapati), 2 maibi (one each from Golapati and Kwakta), 1 maiba from Golapati, 1 doctor in the primary health centre Tarahei, 2 doctors in the public hospital Hatta are also interviewed. They are chosen for their knowledge and expertise in religion and health, most importantly, for their knowledge about reproductive health in the community.

In-depth interview of 36 married adolescent girls, 3 Moulvi, 2 maibi, 1 maiba, 1 female doctor in Golapati, 3 community leaders and 12 married men and women in the age group 25-70 years is conducted. In-depth interview helped me to probe for deeper understanding, to clarify and to steer direction of the interview based on their answers and emerging new themes. Issues which appeared during structured interview were also probed deeper to get more comprehensive insight during in-depth interview. By using in-depth interview, I was able to holistically explore their beliefs, practices and on various issues of reproductive health problems.

These in-depth interviews are informal in style and followed a free flowing format in which I avoided interrupting their narratives. I also gave them the opportunity to ask me questions. The interviews frequently involve breaks where I was usually invited for tea and snacks. I usually offer kwa or paan (beetle nut and leaves) to those informants who are fond of it during the breaks and we usually chit chat on mundane affairs of our life. Multiple and repetitive in-depth interviews are conducted with some of the informants as I had to conduct further interviews based on the emerging new themes or data collected during the previous in-depth interview. The opportunity to contact respondents and to interview them more than once contributed to the refinement and clarification of concepts.
In-depth interviews served as a teaching learning process for the married adolescent girls as well as for me. Most of the married adolescent girls were filled with queries about reproductive health; especially menstruation, contraception, reproductive health problems, pregnancy and childbirth. They often put up their queries, confusion and personal problems with the hope that I would give them reliable information and clear their doubts. I did my best to answer their queries and listen to their personal problems. We exchanged information on various issues of reproductive health, sometimes narrating my personal experience as well. In turn, we built a sense of trust with each other which also enabled me to go back to them for further interviews. Repetitive in-depth interview with some of the girls increased our comfort level, intimacy, trust and friendship, which enhanced the depth and quality of the data.

My interactions with the older married women and the Moulvi, maiba and maibi were different than that with the adolescent girls. They usually gave their interviews like educating me or giving me advice; as an older man/woman would do to a young unmarried girl. The Moulvi, maiba and maibi were keen to educate me about their cultural beliefs, customs and other traditional beliefs related with reproductive health thereby enlightening me on various issues other than reproductive health. The interactions with the maibi were even most interesting. They usually try to diagnose my health and well-being based on their local understanding.

1.7.3.5 CASE STUDIES

Out of the 36 married adolescent girls who participated in the in-depth interview, I conducted case study of 20 of them. These case studies are collected via multiple in-
depth interviews, participant observation, life histories and reproductive histories. Peculiar cases are selected for case studies in order to have a comprehensive understanding of the reproductive health issue in question. For example, those who suffer from peculiar illness, experience, symptoms and disorders related with their reproductive parts.

1.7.3.6 MEMO-WRITING

After each interview, I wrote memos reflecting on what I learned from the interview. It contained my impressions about the respondent’s experiences, and my reactions. They are also used to systematically question some of my preconceived ideas in relation to what had been said in the interview. In these memos, I also raised questions to be answered in continuing interviews.

1.7.3.7 OBSERVATION

Non-participant observation is used to observe important aspects of their village, settlement, household activities, activities at health centre, sanitation, health and hygiene, clothing, behavior etc. I had the opportunity to observe women’s participation in many of their special occasions like wedding, celebration of childbirth, religious ceremony and festivals like Eid. I also witnessed the postnatal care of a married adolescent girl who had home birth by maibi, and another two who had hospital delivery, by immersing myself amongst their female kin groups. In the health camp conducted at Tarahei, I observed the women seeking treatment from medical professionals for various health problems. Non-
participant observations helped me in observing how the women relate with their families, community, peers and health care providers.

1.7.3.8 FOCUS GROUP DISCUSSION (FGD)

15 FGDs are conducted involving a total of 98 participants. The number of participants in each of the FGDs ranges from 6-8. The minimum number of participant is kept at 6 as a lesser number would limit the generation of a rich diversity of views. The maximum number of participants is also limited to 8 as a larger number would lead to difficulty in facilitating the FGD. The participants in all the FGDs are homogeneous in terms of gender and marital status as most of the information can best be obtained in a homogeneous group owing to its sensitiveness and particularity. 3 FGDs (one from each field site) are held with unmarried adolescent girls from the three localities. Questions pertaining to their experience of being an unmarried adolescent in their society, puberty, early marriage, their reproductive health issues, modernity, traditional beliefs, their desire and dreams were raised in the focus group discussion. 1 focus group discussion is also held with female anganwadi teachers and health workers in Kwakta to discuss about the adolescent girls and their reproductive health issues. 6 focus group discussions with married adolescent girls and 5 focus group discussions with married women of age group of 24-65 are also held in the three localities. Questions about early marriage, puberty, traditional beliefs, modernity and reproductive health issues are raised in the discussion.

Focus group is beneficial because, like a chain reaction, once a woman starts talking about some issue of reproductive health, others would follow suit with eagerness and zeal. They seem to remember more while listening to other women’s narratives. New
themes and aspects which would have been missed out in private interview emerged in the FGD. These discussions also indicated what subjects are popular or sensitive in a group context, thereby providing cues as to what topics would be best pursued through more private, one-on-one interaction. It also provided a critical insight into cultural modes of communication and social interaction among women especially when they are with peers.

1.7.3.9 HEALTH CAMP

Since there are only 6 married adolescent girls in Tarahei, a health camp is conducted in Tarahei in order to obtain more information about women’s reproductive health in the area. Obtaining reproductive health information from older married women helped in comprehensive understanding of the married adolescent girls’ reproductive health. Questionnaire is administered to all the women who came to the health camp. Medicines are also distributed to them.

1.7.3.10 SECONDARY SOURCES

It includes books, journals, popular magazines, official documents and policy papers of the government departments particularly Family Welfare Department, Manipur Government.

1.7.3.11 ETHICAL CONSIDERATION

Pseudonyms have been used to protect my informants and key identifying characteristics have been altered or removed from their narratives. Consent has been
taken in all the interviews and questionnaires. FGDs are conducted by asking the participants whether information they shared could be recorded and used as data. Moreover, the potential uses of the information collected are also explained to participants when seeking their informed consent. The photographs are also taken with their due consent and with the possible use of it.

1.7.4 DATA ANALYSIS

Due to the complexity and range of issues that intricate with the reproductive health of married adolescent girls, grounded theory is considered to be the most salient form of analysis. An inductive methodology, grounded theory facilitates the discovery of meanings, social processes, and social interactions as they emerge from the data for the purpose of theory generation. Because it emerges directly from data analysis, the resulting theory is empirically grounded in the experiences, perceptions and contexts of study participants. Grounded theory involves the progressive identification and integration of categories of meaning from data. It is both the process of category identification and integration (as method) and its product (as theory).

The beauty of grounded theory is that it helped me discover new meanings and themes which are obscured while transcribing interview data plainly or while looking generally at the raw data. New meanings and themes surprisingly became obvious through the meticulous coding process. Through coding, one defines what is happening in the data and begin to grapple with what it means. Coding is central to grounded theory and occurs in stages. In initial coding, ideas are generated as much as possible inductively from early data. In focused coding, a selected set of central codes is pursued throughout
the entire dataset. This requires decisions about which initial codes are most prevalent or important, and which contribute most to the analysis. In theoretical coding, the final categories in the theory are refined and categories are related to one another. The purpose behind ‘theoretical sampling’ (Strauss and Corbin, 1998) – a process of searching for concepts relating to ‘incidents, events or happenings’ which appear frequently and which influence outcomes – over a period of time whilst building codes, is to start with creating many codes and then refining these ultimately to contribute towards theory building. Coding is done until theoretical saturation or informational redundancy is reached.

Initially, entire transcripts are read several times to obtain a clearer understanding of issues discussed within each interview or FGDs. The text is then coded line by line to generate categories. This process consisted of identifying discrete ideas and concepts related to reproductive health; breaking transcripts down into smaller conceptual text units (e.g., sentences and paragraphs), and labeling or coding text units according to their meaning. Combining categories that pertained to the same phenomena and/or developing sub-categories is used to develop the final list of categories. The category system is then reviewed and compared to the data many times to determine relationships between constructs. Data obtained from questionnaire are also incorporated to make the data more comprehensive and reliable. Data from household census and questionnaire are analyzed using Microsoft Excel.