Fertility Decision-making and Access to Information and Services by Young Married Couples in Andhra Pradesh and Telangana

One in three girls married in childhood worldwide lives in India (UNICEF 2014), and child marriage is linked to adolescent fertility, lowered female autonomy, reduced access to education and earning opportunities, and the intergenerational transmission of poverty. Yet relatively little is known about life after marriage for adolescents and married young couples in India. A recent study, 'Marital and fertility decision-making: the lived experiences of adolescents and young married couples in Andhra Pradesh and Telangana, India', explores these experiences in two southern Indian states. The research was a qualitative sub-study under the Young Lives longitudinal study of childhood poverty that has traced the life trajectories of 3,000 children and their households in India over a 15-year period.

This policy brief offers a set of recommendations based on the key findings emerging from the research.

Key findings

- Cultural taboos surrounding the discussion of sexual and reproductive health by unmarried adolescents limits their access to accurate information, leading adolescents to rely on informal sources of information.
- Sexual and reproductive health services targeting adolescent married girls and young brides result in adolescent boys and young men being left out. Since the frontline workers are mainly women, boys and young men are generally kept out.
- Adolescents enter married life with little information on contraception, fertility and birth spacing, and their access to information and services remains limited up until their first pregnancy. Families as well as health workers become more open to discussing contraception and birth spacing after the first pregnancy.
- The research points to changing fertility preferences, with couples expressing a desire for smaller families, and weaker preferences for boys than anticipated.
- Family members are a very important influence on young couples' fertility decision-making. Girls' and young women's opinions often come second to the opinions of their husbands and in-laws, upon whom they are very dependent. Married adolescent girls feel family pressure to prove their fertility and hence become pregnant soon after marriage.
- Couples – and particularly young women – who find it difficult to conceive face intense pressure and receive little support from services.
- Sterilisation is widely practiced as the preferred method of family planning among young married couples. The burden of sterilisation is almost entirely on women. At the same time, abortion for spacing is stigmatised.
- Perceptions that other contraceptive methods may impact on future fertility contribute to low use of contraception before a couple's first child is born.

Introduction

The study provides evidence on decision-making around child marriage, adolescent pregnancy, fertility and contraception, and the barriers to accessing information and services for married young people. The findings are situated within the large number of state programmes designed to reach adolescent girls and boys in India. Most of these programmes are delivered by the Department of Health and Department of Education. Health programmes are delivered through auxiliary nurse midwives (ANMs), accredited social health activists (ASHAs), and Anganwadi workers, and education programmes through teachers in schools. There are a large number of central and state programmes, mostly delivered by the Ministry of Health and Family Welfare, Ministry of Women and Child Development, and Ministry of Human Resource Development, such as the Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme), the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls, and the Adolescence Education Programme. Health programmes comprise counselling and health services. In education programmes, trained teachers are expected to provide sex education to girls and boys. Frameworks therefore exist for community-based government programmes and frontline functionaries to be active in providing information to adolescents before and after marriage. Within this scenario, the study looked at the lived experiences of adolescent married girls and married couples.

This policy brief pulls out findings and policy recommendations related to sexual and reproductive health (SRH) information and services available to adolescents and married young couples, around two main questions:

- What were the sources of information on sexual and reproductive health (SRH) for unmarried adolescents? What were the barriers faced by adolescents in accessing this information?
- How did the available services and sources of information on SRH influence decisions on contraception and childbirth in the early years of marital life? Who made the decisions?

What were the sources of, and barriers to, SRH information for adolescents?

Adolescents accessed information on SRH in schools. However, the reports of teachers and adolescents varied in regard to information that was taught and the extent to which adolescents retained what they were taught. Teachers explained that students should receive information about the biological facts of reproduction, sexually transmitted diseases, contraception, child marriage, infanticide and menstruation. However, the girls interviewed could only remember discussions on menstrual hygiene and HIV/AIDS. The girls also mentioned their interactions with frontline health workers like ASHAs, ANMs and Anganwadi

workers, whose information was restricted to the topics of menstrual hygiene, HIV/AIDs and the harmful impacts of child marriage and early pregnancies.

A small number of health workers believed that there were differences in service provision and information for unmarried young people according to location. They thought that young people in urban areas would be better informed about SRH. However, this was at odds with the descriptions girls themselves gave of their exposure to services and information – descriptions which varied little between urban and rural settings.

Key issues

Accessing information by adolescents on sexual and reproductive health was culturally discouraged. Unmarried girls seeking information on sexual and reproductive health risked inviting accusations of misconduct. The advice and information offered to girls before marriage came mainly from families and was focused on the expected behaviours and duties of being a new wife and daughter-in-law in the marital household, rather than on advice relating to their sexual debut with husbands or to sexual health or family planning.

Health workers hesitate to discuss sexual and reproductive health with adolescent girls. Health workers thought that family members would talk to young people about sex or pregnancy just before marriage, and that it would only be appropriate for them to speak with girls about contraception and fertility after they were married. Health workers also thought that girls would feel able to approach them directly, but from discussions with the girls themselves, this seemed unlikely.

> “Like we go tell the ladies, when we go the gents will not be there, they would have gone out, we go tell them not to get pregnant very soon, use condoms to avoid early pregnancy, we will tell them to tell … their husbands, but we will not tell the gents ... wherever there are male assistants in the sub-centres there the gents go and take what they need, they will not ask me.”

Community-based health worker (female)

Adolescent boys have limited access to information. Adolescent boys seemed to gain information about SRH from watching movies and TV, from using their mobile phones and the internet, and from discussing such matters with their friends. Neither Anganwadi workers, ASHAs, nor ANMs felt responsible for providing information or services to boys at all, and they agreed that boys were extremely unlikely to approach any of them for information relating to SRH. They assumed that boys were more likely to ask male health assistants, but this was not found to be the case.

A low quality of information and low retention. Lessons on SRH in schools are normally delivered by science teachers, sometimes in mixed classes, but more frequently separately for girls and boys, with girls taught by female teachers and boys by male teachers. In practice, the quality of teaching, as well as young people’s retention of the information covered in lessons, were found to be low.

Confusion about who is responsible for providing information and what information to provide. One Anganwadi worker explained that ANMs were responsible for providing information in schools, but the ANM from that location explained that instead she provided materials on SRH for teachers to deliver to their classes. Anganwadi workers, ANMs and ASHAs spoke of raising awareness among unmarried girls on the importance of nutrition and on risks associated with child marriage, early childbearing and pre-marital relationships.

The quality of provision of SRH information and services to adolescents does not reflect the reality that marriage and motherhood occur in adolescence. Poor engagement with unmarried adolescent girls and boys regarding SRH results in many girls, boys, young women and young men, entering married life with limited support and knowledge with which to make well-informed fertility decisions.

How did the SRH information and services influence decisions in the early years of marital life?

There is a close link between child marriage and adolescent childbearing. For the newlywed couples in this study, the question was not whether they would have children, rather when. In the early phase of marital life, young married couples reported that they did not discuss contraceptive options together, and there appeared to be at least three reasons for this: the topic was too embarrassing; they lacked awareness of their options; and/or they did not intend to actively prevent pregnancy.

They reported getting information on family planning and fertility from family, media (television, popular movies, internet, and newspapers), books, and health programmes.

Once married, couples seldom received advice from doctors on issues such as delaying their first pregnancy. Many adolescent married girls and young women were aware that Anganwadi teachers and ANMs were sources of family planning and reproductive health information in their communities; however, even when the information and services were available, adolescent girls and young women did not actively seek them out. Living in a small community meant that there was a risk of neighbourhood gossip as to the purpose of girls’ and couples’ health visits.

Anganwadi workers, ASHAs and ANMs shared that they initiated discussions on contraception and fertility with young married women only after the first birth. Anganwadi workers, for instance, had a limited role in raising awareness about contraceptive options prior to the conception of the couple’s first child, and their relevance increased only once girls became pregnant and thereafter.

Key issues

A lack of complete information from families due to cultural taboos. Fear of shame meant many adolescent girls and young married women learnt what little they did know informally and indirectly. Some of them knew about condoms, but condoms were not considered a way to prevent pregnancy in the context of marital relations. Rather, they associated condoms with the prevention of HIV infection and other sexually transmitted diseases.

Confusion on what is meant by contraception. Many of the young women conflated 'contraception' with emergency contraception used to terminate (not prevent) unwanted pregnancy. Mention of 'injections' and 'tablets' was usually in reference to emergency contraception. A few women mentioned knowing about injectable birth control (but did not use it), and some women mentioned traditional methods.

Little or no awareness of contraceptives. Young married couples had sparse information about contraceptive options and the surrounding socio-cultural environment disabled rather than enabled their capacity to seek out increased knowledge. In a focus group discussion, young mothers said that they were not advised about other methods besides sterilisation by doctors and nurses.

Social stigma of infertility leading to early pregnancy. Couples who failed to bear children in a timely manner feared being the targets of social judgement. Women were typically held accountable for fertility problems, no matter what the actual source of the issue. The possibility of not bearing children was therefore a serious concern for them, because of the social stigma attached to women labelled as 'barren'.

Men are not receiving counselling from health workers. Similar to unmarried young men, husbands did not appear to have much contact with health workers. Anganwadi workers, ASHAs and ANMs did not provide services, nor speak to, married men about SRH. Instead they relied upon wives relaying information to their husbands about contraception.

Information on contraception does not start flowing before the first childbirth. Prior to confirming their first pregnancy, the space for fertility decision-making was relatively constrained; communication between couples was limited and interaction with services was weak. However, subsequent to pregnancy and childbirth, there was an increase in the intentionality in couples' actions to shape fertility outcomes. Family members (such as married sisters-in-law) and health workers, who had previously withheld family planning information, became more forthcoming in their advice.

> As a very young woman, Sunitha found herself with little ability to influence the timing of her first pregnancy. She became pregnant five or six months after getting married. After the birth of Sunitha's first child, her mother and mother-in-law advised a period of abstinence for the couple on the basis that she should not have sex while breast feeding, for the sake of the child. Sunitha now hopes to maintain a gap of another year before having her second child, but the advised period of abstinence has ended and the couple are not using contraception.

Knowledge does not lead to behavioural changes. More information and improved communication did not necessarily lead to behaviour change. Despite widespread consensus on the benefits of spacing children, most couples did not use contraception.

Sterilisation is more a woman's responsibility. Social norms dictated that women rather than men got sterilised, and this was not something that was openly questioned. It was thought that vasectomies diminished men's capacity for hard work and heavy manual labour which their household incomes depended upon.

Stigmatisation of abortion for birth spacing. Abortions for medical reasons were generally accepted as necessary; they did not carry stigma or shame and could be justified when the survival of the foetus or of the woman was at serious risk. However, abortion for birth spacing or to terminate a healthy pregnancy was generally stigmatised.

Recommendations

Support girls and young women across the life course. The importance of supporting girls across the life course and through particular periods of transition is crucial. Targeting child marriage in isolation does not address other areas of girls and young women's lives where they lack agency, and efforts to improve married girls' roles in fertility decision-making need to begin well before those decisions need to be made, enhancing girls' status and the spaces in which they can exercise their agency, prior to and leading up to marriage.

Identify the most vulnerable girls and young women. Interventions should be attuned and responsive to the context-specific, multiple critical moments across the early life course that potentially increase girls' vulnerability, such as menarche, school holiday periods, parental death, and the point at which alliances are negotiated; as well as to those following marriage, such as the couples' first sexual encounter, through to their first pregnancy.

Reach out beyond the 'child bride'. When it came to reaching out to young newlyweds with information that might help them postpone their first pregnancy (should they wish to), there appeared to be society-wide collusion to prevent young married couples from delaying their first pregnancy. Counselling services should target the older family members who influence these decisions, along with the husband and wife. Changing the norms that relate to gender, age and social position requires a strategy that addresses girls, their families, other gatekeepers, and communities at large. Hence, programmes must engage with a wide variety of stakeholders.

Engage with men and boys before and after marriage. Men and boys were found to be accessing information informally, and only accessed programmes formally in schools. They transitioned to marital life poorly informed of contraceptive options and were ill-prepared. Husbands wielded greater fertility decision-making power compared to their wives, including on matters directly relating to women's bodies, such as female contraception, childbirth, abortion and female sterilisation. Boys and young men should be included as targets for counselling services, if needed, through frontline male health workers. Community-based health programmes should provide them with knowledge on SRH, contraception and family planning.

Undertake capacity enhancement, mentoring and improved access to quality messaging. The mixed quality of message delivery has led to low levels of retention. This calls for continuous training and mentoring of frontline functionaries such as teachers, Anganwadi workers, and ANMs, in terms of what messages to give and how to provide these. Frontline functionaries should be mentored by senior colleagues, and consult with young people directly, on how to effectively cover topics that are culturally gender- and age-sensitive.

Policymakers should also consider the potential for providing sexual and reproductive health information and relationship advice through additional channels, particularly newspapers. Digital technologies may provide useful routes in the future, as more adolescent girls and boys gain access to mobile phones and the internet.

Provide access to contraceptives. A wide range of different contraceptive methods should be made available to adolescents and young couples, as well as capacity building for health workers, private providers and shopkeepers. These should give accurate, non-judgemental advice to young people about the pros and cons of different methods, and provide information and signposting for couples who find it difficult to conceive.

Build on promising social change. Social pressures exerted on newlywed couples to prove their fertility early on in their marriage remain a current reality. The weight of such pressures means young couples often succumb to familial and social expectations to bear children soon after marrying. No matter their educational attainment, nearly all married couples in the early phases of marital life found it very difficult to challenge their elders; neither did they discuss sex, fertility preferences and contraception as a couple, due to embarrassment. Messaging needs to factor in these social norms and address them to change mindsets.

The good news is that there are many signs of social change. The younger generation expressed a desire for smaller families and they did not wholeheartedly buy into the cultural preference for sons over daughters. According to the older generation, girls and young women were more educated and informed when it came to sex and family planning, and when they married, their marital relations were more gender-equitable than before. However, interviews with young wives and husbands painted a different picture, one of slower and uneven social change. Even when young married women and men wanted to delay marriage or pregnancy, or to take more of the fertility decision-making into their own hands, they often lacked the power to prioritise their preferences. There is a gap between what they want and what they are able to do.

Cultural norms governing communication between genders and generations need to shift in ways that improve dialogue across more and less powerful social groups. The programmes delivered through schools and health functionaries need to include progressive messaging and follow ups to bolster social change, and these need to be backed up by adequate and sustained funding and material resourcing.

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