An exploratory qualitative study on marriage and pregnancy of adolescent females in the Hikkaduwa Medical Officer of Health (MOH) area

KTAA Kasturiratne MBBS, MSc, MD

Department of Public Health,
Faculty of Medicine,
University of Kelaniya,

Correspondence:

Kasturiratne KTAA,
Department of Public Health,
Faculty of Medicine,
University of Kelaniya,
P.O. Box 6,
Thalagolla Road,
Ragama, Sri Lanka.

Tel: +94-11-295-3411
Fax: +94-11-295-8337

Abstract

Introduction: Marriage in adolescence before 18 years is prohibited in Sri Lanka. However, marriages of adolescent females are not rare in some areas in Sri Lanka.

Objective: To describe the factors associated with marriage of and pregnancy among adolescent females (14-17 years) in a village in the Hikkaduwa Medical Officer of Health (MOH) area.

Methods: This exploratory qualitative study was conducted in Angankanda in the Kalupe PHM division in the Hikkaduwa MOH area in November 2007. Data were collected through focus group discussions and key informant interviews and analysed using qualitative content analysis.

Results: Fourteen females who had been married during adolescence (14-17 years) and five key informants participated in the study. Marriages of adolescent females have taken place following emotional relationships. Married adolescents have a low level of education and reduced awareness about health issues. Death or separation of a parent, poverty and lack of security within the family unit are important predisposing factors to adolescent marriages. Elopement is common following which parents or relatives from both parties collaborate to register the marriage to avoid litigation on the male partner. Most male partners are above 18 years of age at the time of the marriage. The age of the adolescent provided at registration of the marriage was false. Public health field staff of the area were aware of the problem and have taken preliminary steps to focus on this group. The services provided by the Public Health Midwife for married females are sought and acknowledged but not strictly adhered to, due to negative pressures or lack of motivation from the family. Delaying of the first pregnancy is not a common practice. Exposure to other modes providing awareness on health issues is limited.

Conclusion: Despite legislature, marriages of adolescent females are a common occurrence in this community. Targetted interventions to prevent these marriages and to upgrade the overall health of adolescent females are necessary in areas where this problem is prevalent.

Introduction

There is an important cultural significance attached to marriage in Sri Lanka, as in all other South Asian countries, where most childbirths occur within marriage. While demographic patterns show that the age at marriage for both males and females have been increasing through the last 200 years, marriages of adolescent females are not rare in some areas in Sri Lanka.

Marriage in adolescence has many negative health, social and psychological implications on the individual. The adverse impact of under-age marriage is more pronounced on the female due to the risk of pregnancy and childbirth before reaching adulthood. Marriage in adolescence before 18 years of age is prohibited in Sri Lanka but the legal framework is not effective due to the lack of a system for monitoring its implementation.

Adolescent pregnancy is a public health problem in both developed and developing countries though the epidemiology is different. The public health significance of adolescent pregnancy is well documented. The adverse physical, social and psychological effects of early childbearing on maternal and fetal health are immense (Shawky and Milaat 2001) while the broader social impact cannot be underestimated

Sri Lanka has achieved good health indicators that are on par with the developed countries of Asia with the high literacy of females being identified as an important factor for this achievement. Nevertheless, there are regions within Sri Lanka where adolescent pregnancy is still a public health problem. These problems are related to lack of awareness and poor socio-economic conditions which may further enhance the negative consequences of adolescent marriage and pregnancy. This study was conducted in an area where adolescent marriage is a common problem and a demand for intensified reproductive health services from the preventive health sector exist.

The objective of this study was to describe the factors leading to marriage and pregnancy of adolescent females (14-17 years) in a village in the Hikkaduwa Medical Officer of Health (MOH) area using qualitative methods.

Methods

Study design: This study was an exploratory qualitative study.

Study setting

The study was conducted in the Angankanda village located in the Kalupe Public Health Midwife (PHM) division in the Hikkaduwa MOH area situated in the coastal belt of the Galle District. Hailed as a prime tourist location in the country for many decades, the coast of Hikkaduwa is well known for its attractive beach and the coral reef. There is a fishing harbour and a multitude of tourist resorts. The population was severely affected by the 2004 tsunami during which the town and adjoining villages were severely damaged and many lives were lost. The devastating effects of this natural disaster permanently changed the lives of the survivors.

The majority of the people in the area are engaged in informal occupations in fisheries and cinnamon industry, manual labour and occupations related to tourism. The education and income levels are generally low. The main public health problems in the area are alcoholism and drug abuse, trauma related to violence and malnutrition.

Study population

The participants of the study comprised of two groups who were purposively sampled. Fourteen females who have been married or borne children before 18 years of age and currently less than 50 years of age participated in two focus group discussions and five in- depth interviews. Five individuals who were able to provide information on different aspects related to adolescent marriage and pregnancy participated in five in-depth interviews.

Data collection

The principal investigator had worked in this village prior to the study and had identified two female community leaders in the village. These community leaders were consulted prior to the study and given an outline of the study. They were able to name all the eligible females in the village. Efforts were taken to invite all identified females for participation. The community leaders visited each of the households where these females lived and invited them for a preliminary meeting with the investigator after briefly explaining the purpose of the meeting.

The meeting was held in the afternoon of the same day. At the meeting the investigator explained the nature and the purpose of the study and the issues of confidentiality involved. All consenting females were involved in two focus group discussions which were held on consecutive days.

Subjects who participated in the first FGD were females less than 26 years of age. The second FGD was conducted with females over 25 years of age. In-depth interviews were held with five selected participants who had the potential to provide more detailed information. In depth interviews were held with the Public Health Midwife of the area, a mother, a father and a husband of an adolescent mother and a female over 50 years of age who had married in adolescence.

The data collection was conducted by the principal investigator (female) and a female research assistant. Each session was recorded and additional notes were taken down by the research assistant.

Data analysis

The data were analysed using qualitative content analysis (Schindler and Coley 2007). Audio taped interviews were transcribed into text documents and a coding system was developed for open coding. Coded concepts were categorized into themes. These themes are presented as the main headings in the results.

Ethical considerations: Ethical approval for the study was obtained from the Ethics Committee of the Faculty of Medicine, University of Kelaniya.

The discussions and interviews were conducted only by female researchers. A good rapport was established between the researchers and the subjects. The study participants were anonymous and identification details were not obtained. The information disclosed were kept confidential. The data obtained were only to be used for the purpose of research.

Results

The females who had married in adolescence reported a discontented life before marriage. The adolescent marriages took place following elopement resulting from emotional relationships between adolescent females and their male partners without parental consent. The age of the female provided at the registration of the marriage was falsely inflated and the officials registering the marriage accepted the age stated. These marriages survived due to some family support available from the extended family.

Life before marriage

Life of the adolescent females before marriage was unhappy and uncertain. Loss of one or both parents either through death or separation was a common feature among many of these adolescents. This loss had led to a feeling of insecurity in the home environment and the community. The guardians were grandparents or older siblings who were unable to provide a completely secure environment. Many adolescents were involved in routine household work or babysitting for their siblings while their guardians or parents were at work. Premature emotional relationships with the opposite sex originated in this background. The male partners of these relationships were members of the same community or relatives of families residing in the same neighbourhood.

The educational level and general knowledge about health and wellbeing was poor among the adolescent females. There were significant limitations on educational opportunities such as difficulties in transport, financial constraints leading to early school drop-out and lack of motivation to continue education from the families.

Attitudes on adolescent marriage

Prospects of security for the female are associated with marriage. The females who married in adolescence do not strongly oppose adolescent marriages. The physical and psychological demands exerted by marriage, pregnancy and childbirth are not considered negative factors. Difficulties in meeting these demands for an adolescent are not appreciated. Despite early opposition, parents and relatives view the prospect of marriage as a safe alternative following elopement and encourage and support the registration of the marriage. This option is regarded as a step to avoid single parenthood.

Attitudes on adolescent pregnancy

The adverse effects of adolescent pregnancy are not fully appreciated by this group. Early pregnancy is regarded as an advantage for the fetal well being and survival, supported by the notion that a young mother is stronger physically. Once within marriage they see no reason to delay pregnancy. The psychological demands on a young mother are not appreciated. The duties of parenthood of the female are regarded as her prime responsibility. The duties of parenthood of the male partner are not given much prominence.

Family support

Survival of the adolescent marriages depends a lot on family support. Due to being young and inexperienced, many mothers lack the skills of child rearing. A considerable proportion of maternal duties are fulfilled by older females in the extended family such as the mother, mother-in-law or older sisters. The support extended by one's own family or in-laws to maintain the balance within the marriage was important.

The existing legal system

If a couple elopes following a mutual consensual emotional relationship, parents or relatives from both parties collaborate to register the marriage to avoid litigation on the male partner and the negative social impact on the female. This has occurred even in situations where there had been strong opposition for the relationship from the families initially. Most males are above 18 years of age at the time of marriage. The age of the adolescent provided at registration of marriage is falsely inflated. The stated age of the female had not been questioned if the male partner had been proven to be over 18 years of age.

Opportunities to promote health

Exposure of these females to different modes of communication providing awareness on health issues is limited. A few of them are illiterate. Many have only received schooling upto Grade 5 and do not have a sufficient level of reading and comprehension skills to peruse sources of information such as women's weekly newspapers. The females who have a satisfactory level of reading and comprehension ability have limited access to such sources due to financial and other constraints.

Television is the most popularly accessed media in this community, but the use of television is limited to entertainment programmes. Educational programmes telecast on television channels are not popular among the target group.

Services of Public Health Field staff

The public health field staff are aware that adolescent marriages are common in this area and have taken preliminary steps to focus on this group. They have used educational and counselling methods to control this problem using their clinic and home based services. The services provided by the Public Health Midwife for married females are sought and acknowledged by adolescents, but the advice given are not strictly adhered to, due to negative pressures or lack of motivation from the family. Delaying the first pregnancy is not a common practice despite repeated educational interventions.

Discussion

This exploratory qualitative study was conducted to describe the problem of adolescent marriages which is still common in some communities in Sri Lanka, despite the general increase in the age at marriage. The communities where adolescent marriages are common have many unique characteristics but the low socio-economic conditions prevailing in these communities seem to be the main predisposing factor.

Low educational and socio-economic levels have been identified as important predictors of adolescent marriages in studies conducted in other countries (Rahman and Kabir 2005; Gokee et al. 2007). Poverty may be the main reason for the choice of an early marriage by a female who has faced economic hardships in early life. Ignorance or lack of concern about the risks involved is a supportive factor.

Lack of concern by the parents about the risks involved and the non-acceptance of family planning methods in this community may be due to weaknesses in the public health system. Lack of supportive environments for good health behaviours is a major obstacle faced by these adolescent females.

The existing legislation on age at marriage has not been able to control this practice effectively due to problems in implementation and monitoring. The registration authorities who are often members of the same community do not strictly adhere to guidelines as the circumstances leading to these marriages are complex. The consequences of non-registration of adolescent marriages after elopement of a couple can have devastating effects on the females involved and their families. The community leaders therefore try to solve the problem to the best of their ability safeguarding the females from stigma and other social problems.

Targetted interventions to prevent these marriages and to upgrade the overall health of adolescent females are necessary. The interventions should focus on education and health promotion. Due to poor education and the low level of awareness, traditional modes of education may fail in this situation. Innovative methods of awareness building have to be adopted by public health authorities to educate these communities. The participatory approach may help to achieve better outcomes. General improvements in living conditions by improving opportunities for education of females, improving access to information using multi media and other resources and upgrading the existing infrastructure in these villages are recommended.

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