

Adolescent Motherhood: Problems and Consequences

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Introduction

In some developing countries like India, adolescent motherhood is closely associated with early marriage leading to early initiation of sexual activity. In Indian society, early motherhood as well as large family size are still considered ideal to ensure that an optimum number of children, especially sons, will survive to adulthood to provide old age security for the parents. Thus both ignorance of family planning methods and the desire to compensate for child loss has prompted couples to have a large number of children. However, reproductive behaviour is controlled by many sex taboos and social and cultural norms. A number of indirect checks on the sexual lives of couples have kept down their completed family size to much below the biologically possible number. Thus, early marriage does not necessarily help women to achieve a large family size.

A number of studies [1-3] have hinted at the possibility of poor reproductive health and a higher incidence of secondary sterility due to early initiation of childbearing. Early marriages are associated with a number of health problems for the girl: early sexual activity leads to early, pregnancy at a time when she is not biologically mature to rear the foetus. As such, a pregnant woman in her teens runs a high risk of abortion. The reproductive behaviour of an adolescent woman is also affected by the attitude and behaviour of her parents, kin and the society at large, towards childbearing.

In developing countries, women, and especially adolescents, do not enjoy the reproductive rights as envisaged in the UN declaration [4] which includes the selection of marriage partners, and equal right to divorce in case they are not satisfied with their married life. Most adolescent girls, being illiterate, are not aware of family planning methods, and even if they are, they do not have easy access to family planning services or fail to utilise them due to inhibitions or pressure to attain motherhood to satisfy their mothers-in-law or husbands. Naturally, the idea of seeking an abortion in the early stages of childbearing is neither approved by the family members nor is it socially sanctioned. Since the bulk of the deliveries in India, especially in rural areas, take place at home, the risk to the mother's life is high. This risk is compounded by early pregnancy, malnutrition and inadequate antenatal care.

In order to provide better health and family planning services to adolescents, it is necessary to understand the spatial distribution of adolescent marriages and motherhood and their consequences. Therefore, an attempt has been made in this paper to examine the magnitude of the problem in terms of marriage and motherhood among adolescent girls and the consequences in terms of child survival and maternal mortality. It may be noted, however, that it is difficult to get information on the incidence of foetal loss and morbidity related to adolescent motherhood, which are also important consequences of early marriage and motherhood.

Magnitude of the Problem

It is generally agreed that 1966 marks the start of the fertility transition in India [5]. Prior to 1966, the crude birth rate (CBR) fluctuated around 45 per thousand populations and the total fertility rate (TFR) around 7.0 per woman. By 1988, the CBR had declined by 30 percent and the TFR by 43 percent. However, adolescent fertility has not exhibited a similar decline, especially in recent years. In view of the changing pattern of marriages (that is, age at marriage and proportion married at young ages), a slow decline in adolescent fertility should draw greater attention from planners, programme managers and researchers. In the following paragraphs, we discuss separately, the extent of adolescent marriages and motherhood.

Adolescent Marriages

During the last three decades, India has, seen a transition in the age at marriage from the childhood (i.e. a very early age) to the adolescent years. The mean age at marriage has increased from less than 15 years prior to 1961 to around 18 years in 1981, and is very likely to reach 19 years in 1991. In 1961, there were 4.4 million married women aged 10-14. This number declined to 2.6 million in 1981. During this same period, the number of married women in the age group 15-19, increased from 12 to 13 million. This mean that there are over 13 million married women under the age of 18, the legal age at marriage. Undoubtedly, then there has been a decline in the number of child marriages, but adolescents are still marrying at almost the same rate. The Marriage Act of 1978 thus seems to have had no impact on marriage behaviour. Therefore, in order to bring about a rise in age at marriage, we need to bring about a congenial social change wherein the parents are able to accommodate modern ideas by engaging their teenage daughters in school or in some economic activity [6].

There is a large variation in child and adolescent marriages across the states. At one extreme, we have states like Rajasthan, Uttar Pradesh, Bihar and Madhya Pradesh and at the other, we have states like Kerala and Punjab ([Table 1](#)).

Table 1 : Proportion of married adolescent females, India and major states

States	10 - 14 years			15 - 19 years		
	1961	1971	1981	1961	1971	1981
Andhra Pradesh	.203	.121	.066	.781	.668	.562
Bihar	.332	.211	.104	.830	.761	.639
Gujarat	.073	.035	.220	.568	.395	.267
Haryana	--	.125	.070	--	.610	.476
Karnataka	.113	.066	.038	.669	.496	.362
Kerala	.013	.005	.002	.258	.181	.141
Madhya Pradesh	.365	.251	.131	.863	.776	.621
Maharashtra	.179	.068	.031	.722	.531	.382
Orissa	.103	.036	.008	.681	.567	.308
Punjab	.087	.011	.009	.531	.223	.134
Rajasthan	.326	.249	.183	.843	.755	.643
Tamil Nadu	.024	.005	.003	.432	.267	.228
Uttar Pradesh	.307	.220	.113	.822	.729	.606
West Bengal	.176	.052	.023	.730	.514	.375
India	.212	.115	.065	.696	.554	.434

Source: Estimated from Social and Cultural Tables: Census of India 1961, Part II-C(i); Census of India 1971, Part II-c(ii); and Census of India 1981, Part IV-A, Registrar General and Census Commissioner, New Delhi.

[Table 1](#) shows that as many as 75 percent of the total married women in the 10-14 age group come from the four large northern states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. These four states also contribute as much as 51 percent of the total married women in the next age group of 15-19 years. Further, these states are also the ones in which female literacy is very low; in 1991, only 20 percent of girls' aged 10-14 were attending school.

It may be noted that the school attendance girls especially in the 10-14 age group, and early marriages are negatively and highly correlated. In 1981, only 25 percent of the girls' aged 10-14 in the four large northern states were attending

school as compared to 84 percent in Kerala. Thus, the problem of child and adolescent marriages is concentrated in these four Hindi-speaking states and can be ameliorated only through the spread of education in general, and female education in particular. This calls for a gearing up of the educational system in order to increase the skills of girls so as to enable them to engage themselves in household and cottage industries.

Adolescent motherhood

According to SRS reports, early marriages have resulted in rather high levels of fertility in the adolescent age group. Though we assume that no birth takes place between the ages of 10 and 14, the 15-19 age group contains a large number of women of third and fourth parities. Obviously, these women would have had some childbirth experiences when they were in 10-14 years old. In 1971, over 10 percent of 15-19 year-old women were observed to have attained motherhood. This figure declined to 8.8 percent by 1988. However, at the all India level, out of 100 married women aged 15-19, about 21 and 26 had attained motherhood in 1971 and 1988 respectively.

In absolute terms then, there were 2.2 million adolescent mothers in 1961, increasing to 2.7 million in 1971 and to 3.3 million by 1988. This means that the number of the adolescent mothers has increased by 50 percent during the last 27 years and is likely to increase further due to the population momentum [5]. Surprisingly, the share of births occurring to adolescents among all births has also increased from 11 percent in 1971 to 13 percent in 1981 (Table 2). This again indicates a slower decline in adolescent fertility as compared to fertility among women of higher ages.

Table 2 : Proportion of total births occurring to adolescents, India and major states, 1971-88

State	1971	1981	1988
Andhra Pradesh	.165	.168	.237
Assam	.133	--	.130
Bihar	--	.113	.161
Gujarat	.234	.081	.072
Haryana	.066	.108	.114
Karnataka	.140	.116	.162
Kerala	.093	.109	.091
Madhya Pradesh	.107	.145	.172
Maharashtra	.094	.122	.228

Orissa	.134	.104	.152
Punjab	.043	.024	.042
Rajasthan	--	.102	.144
Tamil Nadu	.099	.129	.133
Uttar Pradesh	.079	.096	.114
West Bengal	.079	.194	.187
India	.111	.121	.132

Source: 1) Estimated from Social and Cultural Tables: Census of India 1971, Part II-c(ii) and Census of India 1981, Part IV-A, Registrar General and Census Commissioner, New Delhi.

2) Registrar General of India, Sample Registration System 1970-75, 1981, 1988 Ministry of Home Affairs, Government of India, New Delhi.

3) Registrar General of India, 1988, Report of the Expert Committee on Population Projections, Census of India 1981. Occasional Paper No. 4 of 1988, Ministry of Health & Family Welfare, New Delhi.

The highest rates of adolescent motherhood in 1981 (i.e. above the national level) have been observed in Madhya Pradesh, Andhra Pradesh, Bihar, West Bengal, Rajasthan and Maharashtra in that order. Punjab, Kerala, and Gujarat are states with the lowest levels of adolescent fertility. It can be seen from [Table 2](#) that the highest contribution of births occurring to adolescents to total births is from Andhra Pradesh followed by Maharashtra. Further, school attendance of 15-19 year-old girls shows a weak relationship with their fertility suggesting that there are other social and cultural reasons such as early marriage and sexual union which account for fertility in these ages. Most of the north Indian states still practice *Gauna*, that is girls who marry early make frequent visits between the natal and nuptial places. This custom is not prevalent in other states.

It may also be noted that with modernisation certain social and cultural norms restricting sexual behaviour get relaxed and hence might have led to an increase in marital fertility. It is necessary therefore, to evolve a strategy to increase the use of family planning methods among married adolescents. According to a 1988 All India Survey of family planning practices, only 8.6 percent of women in the 15-19 age group were using contraception. Further, the majority of these women (about 75 percent) were using traditional methods which may not be very effective in protecting them from conception.

Consequences of Adolescent Motherhood

The problems of adolescent mothers in India are very different from those of their counterparts in developed countries. Unlike the western countries, births in India, take place within marriage; mostly in a joint family, and are always welcome events. The attitudes of couples towards birth are likely to change with modernisation and increasing opportunities for salaried employment, and so on. Nevertheless, under the economic conditions prevailing in rural India and the poor utilisation of health services, the problem of adolescent motherhood is linked with child survival and maternal mortality. We know that even today, more than 60 percent of the deliveries in rural India are attended by untrained persons. This affects both infant and maternal mortality rates [8].

Adolescent Motherhood, Infant Mortality and Maternal Mortality

In India, data on infant mortality by age of the mother is generally not available. We know, however, that the infant mortality rate (IMR) is still very high (above 80). A number of studies have shown comparatively higher infant mortality rates for children born to adolescent mothers. At higher levels of infant mortality, children of adolescent mothers experience a 24 percent higher mortality risk as compared to children of mothers in the 20-24 age group [9]. According to 1984 SRS data, excess mortality is higher by 16 percent when compared to the 25-29 age group when the IMR is lowest. It appears then that over 300,000 children of adolescent mothers (15-19 age) die in infancy, and further, that their survival beyond infancy is comparatively lower.

There is also a large variation in the comparative risk of infant mortality across states. Even in Kerala, the infant mortality rate is around 31 for children born to adolescent mothers as compared to 18 when the mother is in the 25-29 age group. In fact, the infant mortality rate of children born to mothers in the 15-19 age group varies from 31 in Kerala to 143 in Madhya Pradesh (Table 3).

Table 3 : Index of IMR and MMR for childbearing women, India and major states

State	Observed IMR*	Relative IMR (15-19) 1984+	% Excess over index age (25-29)	MMR (15-49 age group)			
				1985	1986	1987	1988
Andhra Pradesh	89	138	38.3	49.16	36.46	37.23	10.40
Assam	95	114	14.4	102.85	93.66	87.43	117.36

Bihar	88	97	-2.8	54.68	48.99	48.07	42.15
Gujarat	107	102	2.0	19.46	19.38	16.23	14.51
Haryana	116	120	20.5	10.64	10.09	11.69	26.89
Karnataka	86	151	51.0	44.27	43.45	43.08	17.14
Kerala	31	168	68.2	26.83	7.20	7.33	--
Madhya Pradesh	143	155	55.6	30.35	45.81	45.17	44.29
Maharashtra	83	126	26.3	17.64	21.79	21.59	19.52
Orissa	108	81	18.4	33.12	24.55	25.74	26.99
Punjab	71	102	2.7	33.72	5.44	5.23	13.86
Rajasthan	153	133	33.1	84.63	50.98	55.15	47.57
Tamil Nadu	89	121	21.3	35.67	19.54	19.79	32.07
Uttar Pradesh	138	97	2.3	79.95	44.50	14.69	44.31
West Bengal	105	136	36.9	--	--	--	--
India	108	115	15.9	43.04	35.44	34.16	27.93

Source: * Registrar General of India: 1989. " Mortality differentials in India," Ministry of Health Affairs, New Delhi, 1984.

+ Pathak, K.B. and Ram, F.: "Impact of fertility transition in India on child survival and Maternal mortality". Mimeography Report, International Institute for Population Sciences, Bombay, 1993.

Child loss among adolescent mothers has far-reaching effects on their future reproductive behaviour. By postponing first births beyond the age of 20, not only can a large number of children can be saved from dying but child survival beyond the age of one can be enhanced. This would also allow adolescent girls to mature physically as mentally so as to bear healthy children at a later age.

Childbirth to a woman, who is still at the growing stage, affects her health. The maternal mortality rate (MMR) in the 15-19 age group is one of the highest in India. In 1985, the maternal mortality rate for rural India was 43 per 10,000 live births, which declined to 28 in 1988. The maternal mortality rate for the 15-19 age group could not be estimated for the different states and therefore we have discussed it for the reproductive life as a whole, i.e. for the 15-49 age group.

It m be noted from [Table 3](#) that Bihar has the highest maternal mortality rate, followed by Rajasthan, Uttar Pradesh and Gujarat. The infant mortality and maternal mortality rates are highly related to the type of care received by the woman at the time of delivery. Correlation's among different variables for 1988 by taking the state as the unit of analysis are shown in [Table 4](#).

Table 4 : Correlation matrix showing correlation coefficients among different variables

	IMR	Neo-natal mortality	Post-neonatal mortality	MMR
Delivery attended by untrained personnel	0.77	0.83	0.53	0.66
Doctors/100,000 population	-0.55	-0.25*	-0.71	-0.43*
Nurses/100,000 population	-0.71	-0.71	-0.56	-0.49

* These values are significant at a 5 percent level of significance.

It is felt that the infant mortality rate (especially its neo-natal component) and the maternal mortality rate can be reduced to a great extent by educating women to utilise the services of trained dais and nurses at the time of delivery. In this content, the improvement of health services and their utilisation become very important. The proportion of deliveries attended by untrained persons is negatively related to the availability of nurses and doctors. The less developed states have problems of recruiting trained nurses and doctors to man several of their Primary Health Centres.

Conclusion

In the present paper, an attempt has been made to highlight the magnitude of adolescent marriages and motherhood in India and to discuss the consequences in terms of child survival and maternal mortality. The analysis indicates that about 13 million women marry below the age of 18. It also shows that 75 percent of those in the 10-14 age group and 51 percent of those aged 15-19 come from the four large north Indian states. The phenomenon of early marriage is highly related to their schooling especially when they are in the 10-14 age group. This suggests that the education of girls' upto the 10th standard should be made compulsory to bring about a substantial change in the pattern of adolescent marriages. This would directly reduce the extent of adolescent motherhood, which is still very high in India and varies widely across the states. Adolescent motherhood adversely affects child survival and maternal life. Because of the high incidence of foetal wastage, women have to experience a comparatively greater number of pregnancies to give birth to a child that will survive. It has been observed that adolescent mothers suffer a higher child loss than mothers

aged 20-24 or 25-29 years. Maternal mortality among mothers' aged 15-19 is also very high as compared to that among mothers in the 20-24 age group. Due to frequent pregnancy, the health of the mother is badly affected she becomes anaemic and gives birth to an underweight child who faces a higher risk of death at each age.

Child and maternal mortality are directly related to the place of delivery and the person attending the delivery (trained or untrained). In order to avoid these deaths, we need to take steps to educate adolescent married girls about the health hazards of successive child bearing to both mother and child. There is also a need to provide them with suitable culturally sensitive opportunities for education and economic activities to delay marriage (beyond the age of 18 years). If married adolescent girls can be better educated about family planning methods and can be motivated to adopt the small family norm by postponing the birth of the first child and properly spacing birth, both infant and maternal mortality rates can be significantly reduced.

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