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BARRIERS FOR PREGNANCY SUPPORT: EXPERIENCES OF SLUM-DWELLING PREGNANT TEENAGERS IN COLOMBO CITY

J.A.P.S. Perera[1‡] K.T.Silva[2]

[1]*Department of Social Studies, Open University of Sri Lanka*

2Department of Sociology, University of Peradeniya

INTRODUCTION

Teenage Pregnancy (TP) has become an escalating problem in socio-economically disadvantaged population subgroups such as internally displaced people (IDP) (Tambiah 2004), urban slum-dwellers and estate and rural-disadvantaged communities in Sri Lanka (Dissanayake 2008) causing devastating medical, psychosocial and socio-economic challenges (Palihawadana et al. 2009). World-wide research on teen populations have highlighted the fact that TP occurs in the context of poor social support (Siddhartha et al. 2008; Ginger 2005; Connelly 1998; Barrera 1981) but provision of adequate support during pregnancy can improve perinatal outcomes for the mothers and offspring (Clemmens 2001; De Jonge 2001). A few Sri Lankan studies conducted most notably by health care professionals have emphasised that TP can be well concealed mostly through family support and wider social support networks (Palihawadana 2009; Dissanayake 2008; Linganathan 2006; Herath 2007: Goonawardena *et al* 2005). However, these studies explore the biomedical aspects related to pregnancy conditions and the relative neglect of social aspects of TP. Hence, there is a gap in the knowledge in relation to the nature of existing pregnancy support mechanisms and the barriers that the pregnant teenagers (PTs) encounter in accessing and utilizing such pregnancy support mechanisms in Sri Lanka.

OBJECTIVE

This paper discusses the experiences of pregnant teenagers (PTs) regarding the factors which deny there access to pregnancy support mechanisms and their utilization.

RATIONALE

This study is important from a service point of view as there is a possibility to identify gaps in support provision from the standpoint of young pregnant women. Consequently, the research findings may contribute to a pool of knowledge which can be used for advocacy regarding the loopholes in existing pregnancy support mechanisms.

METHODOLOGY

Having obtained the ethical approval from the Ethics Review Committee of the Faculty of Medicine, University of Kelaniya, this descriptive-cross sectional study was conducted during 2008 July to 2010 July in the urban slums located in the Colombo Municipal Council (CMC) area (CMC) from which high prevalence rates of TPs have been reported over several years (FHB 2009). The study sample included 109 (N=109) PTs representing 96 public health midwife (PHM) areas which are clustered under 13 antenatal clinics (ANC) in CMC area. Both qualitative and quantitative data were collected from PTs through questionnaire administration, in-depth interviews and case studies. In order to analyze the quantitative data, the software package called SPSS (SPSS -16.0 for Windows, 2007) was used and the qualitative data was analyzed through 'Framework' analysis technique.

Correspondences should be addressed to J.A.P.S. Perera, Department of Social Studies, The Open University of Sri Lanka (email: jaspurnima@yahoo.com), Phone: 011- 2881402.

RESULTS AND DISCUSSION

Characteristics of the respondents studied revealed that out of 109 PTs (N=109), 9.2% (n=10) were under 16 years while 19.3% (n = 21) were below 18 years. Distribution of PTs by ethnicity showed that the majority of them were Muslims (41.3%, n=45) followed by Sinhalese (37.6%, n=41) and Tamils (21.1%, n=23). Of the 109 PTs, 88.1%, (n=96) were married while 11.9% (n=13) of PTs were out of wedlock. Although the early marriages are not much prevalent in Sri Lanka at present, the current study results revealed that under-age marriages are prevalent among the slum population studied (45%, n=49). Further, one in every four PTs (25.7%, n=28) is from female headed households. The majority of the PTs (55%, n=60) were from deteriorated slums (43.1%, n=47) or shanties (11.9%, n=13). Of the total pregnancies (n=109), only 21.1% (n=23) were expected pregnancies while 78.9% (n=86) were unexpected pregnancies and of them 13.8% (n=15) were unwanted pregnancies.

The study revealed that the support seeking behaviour of PTs is influenced by individual level, family level, community level and policy level barriers. As a result, every PT does not receive social support in a similar manner. A salient feature observed throughout the present study was that many PTs have limited knowledge in the reproductive process including pregnancy symptoms and it caused a delay in entry in to pregnancy care. Some teenagers were unable to differentiate vaginal bleeding early in pregnancy from normal menstruation. Many PTs did not know that they were pregnant until somebody else identified their pregnancy signs. Hence, out of all PTs (n=109), only 10.1% (n=11) recognized that they had got pregnant by pregnancy signs. The rest of pregnancies (89.9%, n=98) were identified by some others who are related to the teenagers. Importantly, many PTs were unable to identify pregnancy signs on their own and also did not want to believe that they were pregnant and consequently they had delayed seeking antenatal care. Further, poor awareness of the availability of existing support services, when and how to seek support from such services were identified as barriers. Some PTs (37.6%, n=41) reported that they were unaware of the availability of antenatal clinic service in the area. Another group of PTs (48.6%, n=53) reported that they were unaware of when to seek antenatal care. Only 13.7% (n=15) teenagers were aware of when, how and from whom care should be sought. Lack of motivation of PTs to seek support was another constraining factor. Further analysis showed that PTs tend to be less motivated for seeking support either due to lack of willingness to continue pregnancy and/or having previous pregnancy experiences. In the perception of teenagers whose pregnancies are unplanned and who do not wish to continue with their pregnancy, antenatal care is not of primary importance and is often delayed. Moreover, even if the PTs live in close proximity to an ANC facility, they were not able to visit the facility without the permission of the husband/ partner or the guardian and this indicated the limited autonomy of PTs. Hence, lack of autonomy for being females of teen age, gender inequality in society and limited mobility exacerbated by pregnancy status were identified as barriers.

It was found that the family perception on pregnancy during teenage has been a barrier to receive support in some cases. The unmarried PTs are rejected by their parents as they have caused shame to the family. The following illustration exemplified the manner in which the family perception on pregnancy during teenage deprived the PTs from receiving social support.

> *"My family members consider my pregnancy as a shame for them...They cursed me...My mother brought a bottle of kerosene oil and frightened me that she would drink it if I further remained in their home. So, I left them...and they don't help me at all"* (Rasika, 18y).

The findings reflected that, of the total number of PTs (n=109), 17.4% (n=19) of PTs had migrated from somewhere. As migrants they were socially isolated to a certain extent due to

separation from family and other social support networks and they have not had enough time to establish new social networks and they used support services less frequently than non-migrant PTs. They experienced certain limitations in accessing the sources of social support due to poor participation in social groups, organizations and social networks that are important for making informed decisions and locating a support provider.

In the current study financial dependency was identified both as a potential factor that creates needs for social support and as a factor that constrains access to social support. A vast majority of PTs (97.2%, n=106) were involved in housekeeping roles traditionally assigned to females. This may be due to lack of education which restricted employment prospects among PTs making them financially dependent on their partners or family members. Hence, financial dependency negatively influenced the PT's autonomy to decide when, where and who they should seek care from. Further, some PTs who experienced social stigma due to unmarried status, elopement or pregnancy out of wedlock developed unfriendly attitudes towards support providers and such attitudes constrained them from seeking support from divers support networks.

The Tamil speaking PTs in particular highlighted that the communication barrier discouraged them from seeking pregnancy support. The inability of some pregnancy support providers such as public health midwives (PHMM) to communicate on sensitive subjects such as family planning in a second language (notably in Tamil) was mentioned as a constraint. It was also revealed that support providers are less sensitive when dealing with underage pregnancies and/or pregnancies out of wedlock. Apart from the provider aversion in providing support services to unmarried teenagers, the sense of fear that their confidentiality would not be honoured has also been influential. Hence, this necessarily highlights the need for including friendly and non-judgmental staff and a counseling part in the pregnancy care services for teenagers.

Moreover, the PTs were constrained by certain legal barriers to access to and use of appropriate pregnancy care. Since underage sex is considered as statutory rape whether it happens with or without consent, the social fear, created by unmarried status and bearing pregnancy underage contrary to law often prevented such PTs from seeking timely care. This fact is affirmed by the rather late pregnancy registration of unmarried PTs. The unmarried PTs registered their pregnancy significantly later than the married PTs (Mann-Whitney Test, Mann-Whitney U = 388.5, p-value = .026). Also, the partners of under-age PTs were arrested and remanded for offences supposedly committed by them notwithstanding the fact that they were living together as husband and wife. However, the married females irrespective of the legal interpretation of marriageable age are anyhow included in support networks. Hence, those who are constrained more and require special attention are those who are pregnant underage, outside marriage and the ones who are constrained more by such inhibitions.

CONCLUSIONS

The individual level, family level, socio-cultural, legal and policy level barriers constraint the PTs from accessing and utilizing pregnancy support mechanisms. Poor awareness of PTs on available support services, lack of autonomy as females of teen-age and limited mobility were identified barriers. Bearing pregnancy out of marriage constrained them seeking support from divers support networks. Since underage sex is considered a statutory rape, social fear created by unmarried status and bearing pregnancy underage contrary to law has prevented PTs from seeking care. Poor coordination between statuary law and reproductive health policy, inadequate attention given for specific reproductive and sexual health needs of teenagers in the National Maternal and Child Health policy in Sri Lanka were recognized as barriers that the PTs encounter when accessing and utilizing pregnancy support mechanisms.

RECOMMENDATIONS

Public Health Midwievs should be recruited from all ethnic groups including Tamils and Muslims in order to make sure that cultural sensitivities of PTs are taken in to account in the delivery process of pregnancy support services. The service providers who do not speak Tamil need language training in spoken Tamil. There is a need to review and revise the existing legal framework in relation to the marriage (i.e. existing laws on the minimal age of marriage) in order to prevent it from being an instrument of social exclusion. Considering the unmarried, less-educated and under-aged women, special pregnancy care service provision component should be included in the maternal and child health policy of the country in general. Improving access to antenatal care services for both married and unmarried teenagers and mobilizing the teenagers about their right to have access to healthcare services is also important.

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