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Research Article

Reproductive Health Needs Assessment among Newly Married Women in Urban Slums of Chandigarh, India

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Abstract

Background: Newly married women are particularly vulnerable, as the early years of marriage are marked by strong social pressure to conceive, limited awareness of reproductive health Present study attempts to examine reproductive health needs and associated socio-demographic, cultural, and maternal factors among newly married women in urban slums.
Methods: A community-based cross-sectional study was conducted among 120 newly married women and their husbands in selected urban slums of Chandigarh using a structured interview schedule.
Results: Study included 120 participants of varied socio-economic characteristics. among women, 64.2% of respondents were aware of the appropriate age for marriage, whereas 2.5% believe that being married before turning 18 is legally acceptable. Only 66.6% of women were aware of the legal age for a girl's marriage. Among women, the most common reason of not using contraceptive was lack of knowledge (37.5%), followed by being newly married or having no child currently (11.7%) and spouse disapproval (9.2%). Religious reasons and lack of faith in family planning were reported by 5.0% and 7.5% of women respectively. Among husbands, lack of knowledge was reported by 18.3%, while a higher proportion expressed no faith in family planning (17.5%) and concerns related to loss of pleasure (15.8%). There were 44.2% undesired pregnancies. Reproductive decisions were predominantly joint, including timing of first 68 (70.0%) and second child 67 (66.7%), number of children 67 (67.5%), contraceptive adoption 52 (52.5%), and abortion 64 (64.2%). Women reported relatively higher independent decision-making in contraceptive matters, while spouse-only decisions were minimal across domains.
Conclusion and Suggestions: The study identified gaps in contraception awareness and practice despite predominantly joint reproductive decision-making, reflecting relatively good spousal communication in contraception and birth spacing. Strengthening enforcement against early marriage, improving access to reproductive health services, and providing targeted counselling on family planning and maternal health are urgently needed. Further in-depth and interventional studies are recommended to enhance reproductive health outcomes and promote healthier motherhood among slum women.

1. Introduction

Reproductive health is a central component of women's overall health and quality of life and encompasses the right to decide freely and responsibly on matters related to childbearing. Rapid population growth continues to challenge developmental gains in developing

countries, making maternal and child health a critical priority for achieving a healthy population, as reproductive health outcomes strongly influence overall health and development indicators [1]. Reproductive health is a dynamic and holistic concept encompassing physical, mental, and social well-being in all matters related to the reproductive system and not merely the absence of disease or infirmity [2]. In India, socio-cultural norms, gender inequality, and limited autonomy often restrict women's ability to make informed decisions regarding reproduction, including childbearing, spacing, and contraceptive use [3]. Women residing in slums have lower antenatal care coverage, fewer institutional deliveries, and higher reproductive health disparities compared to non-slum populations [4]. Patriarchal norms, poor awareness of family planning, and restricted autonomy further compromise maternal health, particularly among women living in urban slum settings [5].

Women are biologically and socially burdened with childbearing and domestic responsibilities, which further reduce their ability to prioritize personal health. Due to its multidimensional nature, reproductive health can be examined from medical, social, and cultural perspectives, underscoring the importance of a comprehensive and integrated approach [6]. Reproductive health is influenced by socio-cultural, economic, and political contexts and requires equitable access to quality services and effective delivery systems [6]. Conditions such as anaemia, lack of awareness of services, and domestic violence significantly affect women's reproductive health status and service utilization, particularly among marginalized populations [7].

The first five years of marriage are particularly critical for women, as lack of education, early marriage, early childbearing, and limited autonomy place their physical, emotional, and mental health at risk. Newly married women are particularly vulnerable, as the early years of marriage are marked by strong social pressure to conceive, limited awareness of reproductive health, and a high unmet need for family planning services, especially in urban slum settings [8]. Even with extensive literature on married populations, the specific reproductive health needs of newly married women remain underexplored. Studies among young married women in urban slums demonstrate significantly high unmet need for contraception due to socio-economic and cultural barriers [9]. Present study attempts to examine reproductive health needs and associated socio-demographic, cultural, and maternal factors among newly married women in urban slums.

2. Methodology

2.1. Study Area and Population

The study was conducted in selected urban slum areas of Chandigarh. The study included married women and their husbands within five years of marriage who consented to participate. Unmarried women, women married for more than five years, and those unwilling to participate were excluded.

2.2. Study Design and Sampling Technique:

A community-based cross-sectional study using a two-stage random sampling design was adopted. In the first stage, four slum areas were selected as primary sampling units. In the second stage, eligible newly married women were selected proportionately from each area based on inclusion criteria. All selected participants were interviewed through house-to-house visits.

2.3. Sample Size

The optimum sample size was calculated using power analysis. Assuming 70% prevalence of active reproductive health decision-making based on a pilot study, a confidence level of 90%, and an absolute precision of 10%, the calculated sample size was 116. A total of 120 women were included in the study.

2.4. Data Collection and Data Analysis

Data were collected using a pre-designed and pre-tested structured interview schedule administered in privacy. Information on socio-demographic characteristics, fertility behaviour, contraceptive knowledge and practices, gender preference, spousal communication, attitudes towards abortion, and reproductive health problems was obtained.Informed consent was obtained from all participants. Confidentiality and privacy were strictly maintained throughout the study.

3. Results

Study included 120 married women were included in the study with their spouses. Study included 120 participants in varied age groups classified into 18–21(39.2%), 22–25(42.5%), 26–35(13.3%), and 36–49 (5%). There were 75% women having education levels below graduation that is illiterate/just literate (16.7%), primary (4.2%), middle (18.3%), high school (21.7%), and intermediate (14.2%). Despite living in urban slums, around 22.5% ofthe women were graduates and 2.5% were post- graduates. Majority 85.8% of women were housewives.

Table 1: Socio-demographic profile of study participants

Socio-demographic characteristic	Number	Percentage
Age		
18-21	47	39.2
22-25	51	42.5
26-35	16	13.3
36-49	6	5.0
Educational Status		
Illiterate/justliterate	20	16.7
Primary	5	4.2
Middle	22	18.3
high school	26	21.7
Intermediate	17	14.2
Graduate	27	22.5
post graduate	3	2.5
Occupation		
Housewife	103	85.8
Service	5	4.2
Business	3	2.5
Laborer	8	6.7
Skilled worker	1	0.8

Table 2 illustrates that 5% of women get married before the age of 18, of which 1.7% at the age of 16, and 3.3% at the age of 17. Most of the women got married at the age of 23 years, which is 11.7%. Only a few of them got married at the age of 30 or above. Out of 120 married women, 24 (20.0%), had their first coitus at the age of 22 and 11.7% at the age of 23. About 3.3% had their first coitus before the age of 18.It shows that the maximum number of husbands got married at the age of 25 (20%), followed by the age of 23 (14.2%), whereas 10% of the total got married before the age of 21, out of which 3.% got married before the age of 18.It also illustrates that a maximum of the husbands had their first coitus at the age of 25(19.2%) and 8.3% had it before attaining the age of 21.Study reported significant associations between family type and variables such as age at marriage, age at first coitus, preferred age of marriage, and birth intervals, while no significant association was observed with awareness of legal marriage age.

Table 2: Reproductive characteristics of study participants

Reproductive characteristic	N (%)
Wife Age at Marriage	
<18 years	6 (5.0%)
18–20 years	29 (24.2%)
21–25 years	69 (57.5%)
26–30 years	14 (11.7%)
>31 years	2 (1.7%)
Wife Age at First Coitus	
<18 years	4 (3.3%)
18–20 years	28 (23.3%)
21–25 years	73 (60.8%)
26–30 years	15 (12.5%)
>31 years	0 (0%)
Husband Age at Marriage	
<18 years	4 (3.3%)
18–20 years	8 (6.7%)
21–25 years	64 (53.3%)
26–30 years	37 (30.8%)
>31 years	7 (5.8%)
Husband Age at First Coitus	
<18 years	4 (3.3%)
18–20 years	6 (5.0%)
21–25 years	65 (54.2%)
26–30 years	39 (32.5%)
>31 years	6 (5.0%)

Table 3: Reproductive behavior of couples

Reproductive behavior	Number
Awareness of legal age at marriage	
14	1(0.8)
15	2(1.7)
18	77(64.2)
21	35(29.2)
22	5(4.2)
Awareness of legal age at marriage by spouse	
15	2(1.7)
18	63(52.5)
21	54(45.0)
22	1
Awareness of women regarding contraceptives	
Female sterilization	21(17.5%)
Male sterilization	19 (15.8)
IUCD	41(34.2%)
Oral Pill	25(20.8%)
Injections	26(21.7%)
Condom	60(50.8%)
Foamjelly/cream/diaphragm	0(0%)
Safeperiod /withdrawal/ abstinence	21(17.5%)
Don't Know	37(30.8%)
Noresponse	3(2.5%)
Awareness of spouses regardingcontraceptives	
Female sterilization	21(17.5%)
Male sterilization	23(19.2%)
IUCD	16(13.3%)
Oral Pill	16(13.3)
Injections	21(17.5%)
Condom	93(77.5%)
Foamjelly/cream/diaphragm	2(1.7%)
Safeperiod /withdrawal/ abstinence	58(48.3%)
Don't Know	12(10%)
Noresponse	0(0%)
Current contraceptive use	**87(82.5)**
Never used contraception	**33(27.5)**
Reasons of not using contraceptive	
Not applicable	33 (27.5)
Newly married / No child currently	14 (11.7)
Lack of knowledge	45 (37.5)
Against religion	6 (5.0)
No faith in family planning	9 (7.5)
Spouse does not like	11 (9.2)
Loss of pleasure	0
Worried of side effects	0
Breastfeeding	1 (0.8)
Others	1 (0.8)
Gender Preference	
Son preference of respondent	91(75.8)
Son preference ofspouse	81(67.5)
Daughter preference of respondent	94(78.3)
Son preference of spouse	91(75.8)
Desire of more children after two live children	
Yes	51(42.5)
No response	9(7.5)
Not applicable	60(50.0)
Last pregnancy was desired	**64(53.3)**
Induced abortions	
No	**108(90.0)**
Yes	**12(10.0)**
Number of induced abortions	
0	99(82.5)
1	11(9.2)
2	1(0.8)
Not conceived yet	9(7.5)

Table 3 illustrates that among women, 64.2% of respondents were aware of the appropriate age for marriage, whereas 2.5% believe that being married before turning 18 is legally acceptable. Only 66.6% of women were aware of the legal age for a girl's marriage and only 45% of men are aware of the correct legal age of marriage. Current contraceptive use was reported by 87 (82.5%) women. Among women, the most common reason of not using contraceptive cited was lack of knowledge (37.5%), followed by being newly married or having no child currently (11.7%) and spouse disapproval (9.2%). Religious reasons and lack of faith in family planning were reported by 5.0% and 7.5% of women respectively. Among husbands, lack of knowledge was reported by 18.3%, while a higher proportion expressed no faith in family planning (17.5%) and concerns related to loss of pleasure (15.8%). Religious opposition was reported by 5.0% of husbands. Very few participants in either group cited breastfeeding (0.8%) or other reasons (0.8%) as barriers.

Table 4: Reproductive decisions reported by respondents

Reproductive decisions	Number	Percentage
Time to have 1st child		
Self	10.0	20.8
Spouse	15.0	5.0
Both	68.3	70.0
No response	5.0	4.2
When to have second child		
Self	10.8	21.7
Spouse	18.3	7.5
Both	66.7	66.7
No response	4.2	4.2
Regarding number of children		
Self	5.0	22.5
Spouse	23.3	5.8
Both	67.5	67.5
No response	4.2	4.2
Decision to adopt contraceptive		
Self	10.0	32.5
Spouse	26.7	1.7
Both	50.0	52.5
No response	13.3	13.3
Choice of contraceptive		
Self	6.7	30.0
Spouse	25.0	1.7
Both	50.8	50.8
No response	17.5	17.5
When to use contraceptive		
Self	6.7	27.5
Spouse	22.5	1.7
Both	53.3	53.3
No response	17.5	17.5
Duration of contraceptive use		
Self	5.8	25.8
Spouse	21.7	1.7
Both	55.0	55.0
No response	17.5	17.5
Abortion of unwanted pregnancy		
Self	3.3	13.3
Spouse	14.2	4.2
Both	64.2	64.2
No response	18.3	18.3

There were equal 17.5% of men and women were aware of female sterilization, compared to 16% of women and 19.2% of husbands who were aware of male sterilization. Only 13.3% ofmen are aware of the IUCD, compared to 34.2% of women. While 20.8% of women are already aware of the use of injections as a form of contraception, only 13.3% of males are. 77.5% of males and 50.8% of women are familiar with condoms. None of the women are aware of the diaphragm, foam jelly, or cream. Just 1.7% of men are aware of it. Only 17.5% of women are aware of the safe period/withdrawal/abstinence approach, compared to 48.3% of husbands. Women who don't use any kind of contraception make up 30.8% of the population, while 2.5% choose not to answer the question. With regard to the intention to delay pregnancy, 42.5% of participants reported that they wanted to wait, while 7.5% did not respond. For 50.0% of respondents, the question was not applicable.When asked whether they desired to have more children at the time of the previous pregnancy, 44.2% reported that they did not want additional children, whereas 42.5% expressed a desire for more children. The remaining 13.3% indicated that the question was not applicable. Approximately 5% of women desire to become pregnant after 6 months, and 0.8 are hoping to do so after 8 months. After one year, 7.5% of spouses indicated they would like to have another child, followed by 12.5% after two years, 8.3% after three years, and 3.35 after four years. Also, 90% of the study participants had never undergone an induced abortion, 12% had not yet become pregnant.

The findings from Table 4 demonstrate that reproductive decision-making was predominantly joint across most domains. Regarding the timing of the first child, 68 (70.0%) respondents reported joint decision-making, while 20 (20.8%) indicated self-decision and 5 (5.0%) reported spouse-led decision; 4 (4.2%) gave no response. Similarly, for timing of the second child, 67 (66.7%) reported joint decisions, 22 (21.7%) self-decisions, and 8 (7.5%) spouse-decisions, with 4 (4.2%) non-responses. Concerning the number of children, 67 (67.5%) respondents reported mutual decision-making, 23 (22.5%) self-decision, and 6 (5.8%) spouse-decision; 4 (4.2%) did not respond. For adoption of contraception, 52 (52.5%) reported joint decision-making, 33 (32.5%) self-decision, and 2 (1.7%) spouse-decision, while 13 (13.3%) gave no response. Regarding choice of contraceptive method, 51 (50.8%) reported joint decisions, 30 (30.0%) self-decisions, and 2 (1.7%) spouse-decisions; 18 (17.5%) were non-respondents. With respect to timing of contraceptive use, 53 (53.3%) reported joint decisions, 28 (27.5%) self-decisions, and 2 (1.7%) spouse-decisions, while 18 (17.5%) did not respond. For duration of contraceptive use, 55 (55.0%) reported joint decisions, 26 (25.8%) self-decisions, and 2 (1.7%) spouse-decisions; 18 (17.5%) were non-respondents. In cases of abortion of an unwanted pregnancy, 64 (64.2%) respondents reported joint decision-making, 13 (13.3%) self-decision, and 4 (4.2%) spouse-decision, while 18 (18.3%) did not respond. Overall, joint spousal decision-making predominated across fertility and contraceptive domains, with relatively greater independent decision-making by women observed in contraceptive-related matters compared to fertility-related decisions.

Out of the 120 participants in the study, 69 of them have already experienced breastfeeding mothers. After giving delivery, the majorityof women (44.9%) started nursing. 39.1% of the deliveries began after the second hour. Only 4.4% of the 69 women had not provided colostrum for the newborns, out of which 95.7% had done so. While 1.4%, 5.8%, and 4.3% of women started supplemental feeding their infants at 4, 5, or 8 months, 72.5% of women did so after 6 months. Unmarried women made up 15.9% of the population.

Table 5: Breastfeeding behavior of surveyed women

Breastfeeding behavior(N=69)	**Number**	**Percentage**
Initiation of breastfeeding		
Within one hour	31	44.9
Between 2-8 hours	34	49.3
Prelacteal feed given	4	5.8
Giving colostrums		
Yes	66	95.5
No	3	4.4
Reasons of not giving colostrums		
Illness of child	61	88.4
Pre-matured baby	3	4.4
Others/not specified	5	7.2
Age of starting complementary feeding (months		
Not started / Not applicable	11	15.9
4 months	1	1.4
5 months	4	5.8
6 months	50	72.5
8 months	3	4.3

4. Discussion

The present study assessed reproductive health needs and maternity experiences among 120 married women within five years of marriage and their spouses residing in urban slums of Chandigarh. Study highlights persistent reproductive health challenges among newly married women residing in urban slums, including strong son preference, early initiation of childbearing, and suboptimal contraceptive use. At the time of study, all participants were married; 69 were lactating and 17 were pregnant. Most women belonged to the 22–25 year age group (42.5%), followed by 18–21 years (39.2%).Although 75% of women had education below graduation and illiteracy was lower (16.7%). Despite relatively better education, 85.8% of women were housewives, with only 14.2% engaged in income-generating activities. Most of spouses were aged 26–35 years (73.3%), and the majority had education up to high school or intermediate level. Joint families were predominant (66.7%), and large family size was common, which may negatively influence women's reproductive health due.

Awareness regarding the legal age of marriage was suboptimal among both men and women, with early marriage still prevalent. Although awareness of contraceptives existed, utilization was low may be due to lack of knowledge, misconceptions, spousal opposition, and fear of reduced pleasure. Low contraceptive use contributes to unintended pregnancies, increasing socio-economic strain on already vulnerable families. Despite decades of global investment in family planning programs, unintended pregnancy remains a major public health challenge. A substantial proportion of unintended pregnancies culminate in induced abortion, particularly in settings where access to effective contraception is limited or inconsistent. Evidence from multiple countries suggests that gaps in contraceptive knowledge, misconceptions regarding methods, and discontinuation of use are key contributors to this burden [10–12].

Spontaneous abortions were reported by 10% of participants. Attitudes toward abortion were largely conservative, with most women willing to accept unplanned pregnancies. These findings differ from a study conducted in different setting in Romania, where abortion was viewed both as a woman's right and a moral issue [13]. Knowledge of contraception was relatively high among both women (70%) and men (89.2%), yet contraceptive use remained low (31.7%). Early childbirth and teenage pregnancies were still common, posing risks to maternal and child health and increasing socio-economic burden. In majority of cases reproductive decisions were reportedly being taken jointly by the couples. Despite moderate awareness of family planning methods, utilisation remained low, suggesting the influence of socio-cultural norms and family pressures. Joint family structures were found to significantly influence reproductive decision-making.

Encouragingly, strong opposition to abortion and positive attitudes toward breastfeeding were observed. Breastfeeding practices were encouraging, with 84% initiating breastfeeding within 1–2 hours of delivery, although this was lower compared to studies reporting initiation within 30 minutes and higher exclusive breastfeeding rates [14].

This study has several strengths, addressing multiple dimensions, including reproductive health needs, maternity experiences, family planning, and spousal factors among slum women, a relatively under-researched population. Inclusion of spousal factors enabled better comparison and understanding of shared decision-making. However, accuracy of responses might have been influences due to reporting bias, recall bias and because of sensitivity of questions. Cross-sectional design also limits causal inference and long-term assessment.

5. Conclusion

The study highlights gaps contraception awareness and practice. Joint reproductive decisions reflected good spousal communication particularly regarding contraception and birth spacing. Strengthening legal enforcement against early marriage, improving access to reproductive health services, and:organizing targeted counselling on family planning, maternal health, are urgently needed. Further in-depth and interventional studies are recommended to ensure improved reproductive health outcomes and a healthier motherhood experience among slum women.

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Informed Consent: Informed consent was obtained from all participants. Confidentiality and privacy were strictly maintained throughout the study.

Data Availability Statement: Data available on reasonable request.

Clinical Trial Registration: Not Applicable.

Disclaimer (Artificial Intelligence): The author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.), and text-to-image generators have been used during writing or editing of manuscripts.

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