UNMARRIED TEENAGE PREGNANCY: A MULTIFACTORIAL AND MULTIDIMENTIONAL MEDICO-SOCIAL PROBLEM***

(A Prospective Study of 80 Cases)

By

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SUMMARY

A randomised and prospective study was conducted on 80 cases of unmarried teenage pregnancy from rural and urban areas. The various socio-demographic factors leading to unmarried teenage pregnancy have been analysed. Maximum teenage pregnancies were among girls, from poor socio-economic back ground (62.5%). While none had sex education, 98.5% were either ignorant or indifferent towards contraception. Medico-social problems have been discussed. Possible remedial measures have been suggested.

Introduction

There is every reason to believe that premarital sexual relation among unmarried teenagers is wide-spread. Annually one million adolescents become pregnant in U.S.A. (Klein, 1980). More than 60,000 of these go to term. Approximately 30,000 of these adolescents are under the age of 15 years.

According to Katchadourian (1980) in U.S.A., 59 per cent of the boys and 45 per cent of the girls between the age of 13-19 years have coitus.

However, the western way of life is relatively much more permissive and unmarried teenage pregnancy is accepted easily within their flexible social norms. Whereas in our Indian society unmarried pregnancy carries a definite social stigma and is associated with various medico-social problems. The cause, effect relationship is far from clear. Indepth studies of the social, psychological and environmental factors involved are few. Friedman (1972) emphasised the role of defective ego functioning as an important factor leading to this malady.

Eighty cases of unwed teenage pregnancy have been studied and their data regarding various social and medical problems is presented in this study. An attempt is made to identify the dynamic factors involved in this sudden upsurge in the teenage unwed pregnancies. Social and medical aftermaths have been outlined. Possible remedial measures have been suggested.

Material and Methods

The present study was carried out on 80 unmarried teenage pregnancy cases

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from service hospitals, and private clinics, over a period of 5 years. The randomised samples were obtained from different localities, comprising both urban and rural areas. The data was collected through direct and indirect sources and charted in a specially prepared proforma. Since many patients were reluctant to divulge detailed information, only those cases where the proforma was complete are included in this study.

Emphasis was laid on detailed history as regards to age group, social status, educational and family background, occupation, knowledge of sex education and contraception, as well as associated medico-social problems if any. Follow-up was done as regards, social and medical sequalae following the pregnancy for a period varying from 1 to 3 years.

Observation with Results

Certain interesting and important observations have been made by studying sociodemographic factors in the 80 subjects of unmarried teenage pregnancy. The observations seem to have some prospective values and could provide insight into the problem of unmarried teenage pregnancy and consequent medico-social consequences.

Sociodemographic factors

A high incidence of teenage pregnancy was found in mid-teenagers (70%), urban girls (75%), Hindus (58.75%), school dropouts (68.75%), unskilled labour (70%), lower class (62.5%) and liberal family (70.5%) as shown in Tables I to VII.

TABLE I
Age-group Distribution

Age-group	Age (Years)	No. of cases	Percentage
Early Teens	13-15	5	6.25
Mid Teens	16-17	56	70
Late Teens	18-19	19	23.75

TABLE II
Geographical Distribution

Urban/Rural	No. of cases	Percentage
Rural	20	25
Urban	60	75

TABLE III
Religion

Religion	No. of cases	Percentage
Hindu	47	58.75
Muslim	3	3.75
Christian	30	37.5

TABLE IV
Educational Status

Educational status	No. of cases	Percentage
(a) Illiterate	15	18.75
(b) Literate		
Dropout from school	55	68.75
College studies	10	12.5

TABLE V
Occupation

Occupation	No. of cases	Percentage
Students	10	12.5
Unskilled Labourers (Domestic servants & casual labourers)	48	60
Semiskilled Labourers	8	10
Skilled (Including clerical workers)	4	5
Unemployed	10	12.5

TABLE VI
Socio-economic Status

Socio-economic	No. of cases	Percentage
Upper	5	6.25
Middle	25	31.25
Lower	50	62.5

TABLE VII
Family Back Ground

Family back ground	No. of cases	Percentage
Unsupervised	50	62.5
Liberal	12	15
Conservative	18	22.5

Sex Education and Knowledge of Contraceptives

Table VIII, revealed that none of the patients had adequate sex education.

In U.S.A., 15.20% of private Paediatricians provide contraceptive counselling (Freeman and Rickels, 1979). They quote that adolescents can effectively use all of the contraceptive options available to adults, including combined pill, IUCDs, Diaphragm, condom and spermicidal foam. No single method is appropriate for all adolescents. The physician must individualize the most appropriate method for each patient.

TABLE VIII
Sex Education

Sex education	No. of cases	Percentage
Adequate	0	0
Inadequate/Absent	80	100

Most of the patients in the present study were indifferent (62.5%) or ignorant about the use of contraceptives, as shown in Table IV. Only, 6 patients reported to have used condom for contraception irregularly.

TABLE IX
Knowledge of Contraceptives

	No. of cases	Percentage
(a) Ignorant (no idea, whatso-ever)	24	30
(b) Aware (but indifferent)	50	62.5
(c) Used contraception (improper)	6	7.5

Place and Trimester of Abortions/Delivery

Table X, indicates that, of the 80 cases studied 60% were first trimester abortions as compared 35% second trimester abortions. This incidence of 35% of second trimester abortions is significantly high. Another important observation made was that 56.25% subjects had abortion at private clinics and 7.5% went to quacks. Only 27.5% went to govt. hospitals which have better facilities. It is impossible to determine the exact number of cases that are treated by quacks as these are never brought to light. Only those cases which were treated by quacks initially and subsequently transferred to Govt. Hospital for treatment are included in this study. Four patients were delivered at term (two in private clinics and two in government hospital).

TABLE X
Place and Trimester of Abortion/Delivery

Places	*First Trimester* No. of cases and percentage	*Second Trimester* No. of cases and percentage	*Third Trimester* No. of cases and percentage
Private clinics	35 (43.75)	12 (15)	2 (2.5)
Govt. Hospital	11 (13.75)	12 (15)	2 (2.5)
Quacks*	2 (2.5)	4 (5)	— —

* Initially treated by, quacks and subsequently treated at Govt. Hospital for eiher a com plication or failure.

Medical problems

The immediate problems included haemorrhage (6.5%) and sepsis (3.75%) as seen in Table XI. The delayed medical problems included PID (10%) and Infertility (5%). Suicide, septic abortion, and infanticide were seen in 1.25% each. 6.25% of the cases in this study had STDs.

TABLE XI
Morbidity & Mortality
(Medico-social)

		No. of cases	Percentage
1. Pre-operative morbidity			
(a) STD	(i) Gonorrhea	2	2.5
	(ii) Syphilis	3	3.75
(b) UTI		8	10
2. Post-operative complication			
(a) Immediate	(i) Sepsis	5	6.25
	(ii) Haemorrhage	3	3.75
(b) Delayed	(i) PID	8	10
	(ii) Infertility	4	5
3. Maternal death	(i) Suicide	1	1.25
	(ii) Septic abortion	1	1.25
4. Infanticide		1	1.25

TABLE XII
Social Problems

	No. of cases	Percentage
Hasty marriage	5	6.25
Intercast marriage*	4	5
Marriage at religious place only	3	3.75
Delivery out of wedlock	3	3.75
Dissolution of marriage	3	3.75

* Although, this is not serious problem in the broad perspective, in the above cited cases it caused considerable disharmony.

Hasty marriage (6.5%) and intercast marriage (5%), constitute the major social problems, of unmarried teenage pregnancy. Other social problems like marriage at religious places only, delivery out of wedlock and dissolution of marriage were seen in 3.75% of the cases in this study.

Discussion

This study has brought out certain socio-demographic factors and other variables and has also demonstrated various medico-social problems associated with unmarried teenage pregnancy.

Inspite of the social stigma attached to illegitimate pregnancies, unmarried mother-hood is a continuing problem (Hussain *et al*, 1976).

The high incidence of unmarried teenage pregnancy is found among the unskilled labourers especially those who had migrated to city in search of employment and were living under conditions where they were free from family supervision and control, as also from the fear of being identified (Sathe, 1987). None of the subjects were willing to continue the pregnancy. An illegitimate pregnancy also affects the girl's future prospects of marriage. When abortion is not possible due to various reasons, secrecy is preserved and the child is abandoned or infanticide may be resorted to (Sathe, 1987). We had one case of infanticide.

Inspite of the liberalisation and legalisation of abortion, a very large proportion of the abortions continue to be performed by quacks and dais and comparatively less cases go to government hospitals, where, the relative incidence of abortion in the 15-19 years group is low as per our study.

Contraceptives are rarely used by the unmarried teenagers due to ignorance of human reproduction, contraception and intercourse.

Conclusion

As adolescents develop their sexual identities they are at risk for acquiring unwanted pregnancies and sexually transmitted diseases. Sex education is the urgent need of the hour and should be imparted by the parents and through health clinics at the high school level. It will develop mature and healthy sexual attitudes and sexual responsibilities. It will also reduce the incidence of unmarried teenage pregnancy and associated medico-social problems. It is felt that counselling regarding contraception will play a definite role in helping the high risk teenager.

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