Evaluation of social factors & pregnancy outcome in 100 cases of unmarried primigravidas

Shailesh Kore, Aparna Hegde, Sushma Srikrishna, V. R. Ambiye, P. R. Vaidya.
Department of Obstetrics and Gynaecology, L.T.M.G. Hospital & L.T.M.M. College, Sion, Mumbai – 400 022.

Summary: The paper examines outcome of 100 pregnancies in unmarried girls over a period of 2 years at our Institute. These patients were divided into two groups. In first group 82 pregnancies which were terminated were analysed while second group comprised 18 patients in whom pregnancy was allowed to continue. The higher incidence of antenatal, intrapartum and perinatal complications in these patients was noted. The central role of obstetrician and his/her unique contribution in the management of such patients was assessed.

Introduction:

The incidence of pregnancy out of wedlock has been increasing with urbanisation, industrialization and population explosion and presents an important challenge to the obstetrician. The problems of unwed pregnant girls are not only of medical significance but also has social, behavioral and emotional complications. Though following medical termination of pregnancy act (1971) many of these girls are coming for termination of pregnancy, in some cases pregnancy has to be continued because of late reporting due to social pressure. High incidence of irregular periods in teenagers and ignorance about importance of missed period has further increased the incidence of late reporting.

Materials and Methods:

A prospective study of 100 cases of pregnancies in unmarried girls was conducted over a period of 2 years at L.T.M.G. Hospital, Sion, Bombay – 400 022. The study was done with the help of medical social department of our hospital. Unmarried girls reporting in our hospital with complications of criminal abortion or MTP were not included in this study.

The aim of the paper was to study the incidence of such pregnancies and to analyse the factors responsible and circumstances culminating in such pregnancies and their outcome.

These patients were divided into two groups: Group A comprised of 82 patients who underwent MTP while group B had 18 patients in whom the pregnancy was continued.

Each patient was interviewed in association with social worker regarding their family and social background, menstrual pattern, sexual contact, attitude of the parents and the family. The parents were also interviewed and medicolegal procedures were carried out in some cases.

Observations and Results:

Table I shows 76% of these patients were below 20 years of age, the youngest being of 13 years. This clearly shows an early indulgence in sexual activity in adolescents.

Table I
Age distribution

Age in years	No. of cases
< 15	3
15 – 18	28
19 – 20	35
21 – 25	22
>25	2

Of these 100 girls 42 had some formal school education, majority being school dropouts. 8 of these girls had completed matriculation while 3 girls were doing graduation. Unfortunately none of them had any formal sex education at any stage of their education.

Illiteracy and low level of education explains poor knowledge of biology and consequence of unprotected coitus and less cautiousness while indulging in hetrosexual relations.

Majority of these girls were unoccupied. 19 girls were employed, mainly in small factories or as a house servant with monthly income of 200 to 500 rupees. High incidence in unmarried unoccupied girls can be explained on the basis of less structured leisure time, more association

with peer group, intimacy with neighbours and more time for experimentation with heterosexual relationship and unprotected coitus.

Table II shows that majority of them were from lower middle socio-economic class. Being a general hospital it is logical not to get any such patient from higher class.

Table II
Socio-economic status

Socio-economic class	Monthly family income	No. of cases
Lower IV	Rs. Less than 1500	63
Lower middle III	Rs. 1500 – 3000	28
Middle II	Rs. 3050 – 5000	9
Higher I	Rs. More than 5000	-

About knowledge of contraception, we found that 39% were totally ignorant, 52% were aware but did not use while 9% used barrier method of contraception.

In this study majority of the girls conceived after willed coitus. The reasons for relationship included promise of marriage, receipt of gifts, insistence by boy friends etc. There were four cases of rape but no complaint was lodged due to fear of social discrimination. Only two girls were involved in prostitution. 20 girls did not reveal any information regarding reasons for sexual relationship.

History regarding family and social background showed that 30% of these girls were members of either a single or no parent family. Addiction in the family, mother-father conflict, child abuse were critical features in 40% of cases. There were five unmarried girls who lived alone and reported on their own for MTP. Most of the others were brought by parents or relatives, while 3 girls were referred by social agencies.

The period of gestation at the time of reporting is shown in Table III. It clearly shows high incidence of reporting in IInd and IIIrd trimester.

Table III
Period of gestation at reporting

POG in weeks	No. of cases
≤ 8	11
9 – 12	26
13 – 20	45
21 – 32	12
> 32	6

Detailed history and examination, relevant investigations in these patients revealed certain high risk factors. One patient had severe mitral stenosis and was admitted in the hospital for three months. At term mitral valvotomy followed by caesarean section was done in this patient. One patient was admitted on medical side for organophosphorous poisoning (Table IV).

Table IV
High risk factors

High risk factors	No. of cases
Anaemia	21
PIH	5
Heart disease	1
CPD	2
Psychiatric disorders	2
STD	2

Management: In group A, informed consent from parents and patient was taken before termination. Modes of termination in these patients are listed in Table V.

Table V
Mode of termination (Group A)

Mode of termination	No. of cases
Menstrual regulation	3
Suction evacuation	34
Emcredyl instillation	41
Intraamniotic saline	1
Prostaglandin	3

In group B, majority of the patients were admitted in the hospital for social reasons. Also relevant investigations and treatment of high risk factors were carried out. Antenatally social worker's help was taken regarding counselling, possibility of marriage with the father of tobe born baby, arrangement for adoption, and rehabilitation. The probability of any operative interference was discussed and consent was taken for the same. In this group 14 patients delivered vaginally normally while two patients had forceps delivery. In one patient, caesarean section was done following mitral valvotomy (Table VI). Perinatal outcome: There was one stillbirth. Three patients delivered babies less than 2000 gms, out of which one died within 2 days. There was one case of sudden infant death where mother slept over the baby-probably

Table VI
Mode of delivery (Group B)

Mode of delivery	No. of cases
Normal vaginal	14
Forceps	2
LSCS	1
CMC followed by LSCS	1

Table VII
Maternal complications

Group A		Group B	
Incomplete abortion	5	Prolonged IInd stage	2
Perforation	1	PPH	2
Failure of emcradyl	2	Puerperal sepsis	1
		Postpartum psychosis	1

homicidal.

The maternal complications in these groups are shown in Table VII.

Rehabilitation: Finally rehabilitation of the mother and the baby was considered.

Of 15 babies who lived, 9 were given for adoption. In these cases, inrooming was not permitted. 3 mothers with their babies were sent back to the social agencies from where they were referred. 3 patients took their babies home.

On discharge, contraceptive advice and sex education was given to all these patients.

Discussion:

Thus the incidence of pregnancy in unwed girls is increasing at an alarming rate. Adolescents comprise 10% of the total population and account for a large share of illegitimate births and abortions. A crude measure of sexual activity among these girls is the pregnancy rate which is only the tip of the iceberg. Our study has confirmed the trend of sexuality in adolescent unwed girls in Indian population, where high moral and ethical codes are exercised by society and family. Should this trend be explained as the corrupting influence of entertainment media, liberalisation and influence of western customs on our young population? Isn't it always very easy to blame the foreign hand for all our problem? Wouldn't it be prudent on our part to recognize this problem for what it is and try to improve the sex education of adolescent girls.

Though western studies (Aznar and Bennet, 1961, Mussio, 1962) observed that there is some knowledge about sex and contraception in adolescents, young population in India is ignorant about birth control measures or even a normal reproductive physiology (Purandare et al, 1979, Datta et al, 1979).

Though with liberalisation of MTP act, most of these girls seek termination, the gestational age at the time of reporting is early second trimester in majority of these cases. This observation is also shared by other authors. (Purandare et al 1979, Datta et al 1979).

Social stigma attached to such pregnant girls causes long term effects like disruption of education, separation from parents, psychological and behavioural problems causing decreased earning capacity and indulgence in prostitution. Babies born out of such pregnancies face psychological and social problems later in life and high incidence of juvenile delinquency is seen among them.

Conclusion:

Hence the incidence of unwed primis must be lowered. This can be achieved by proper sex education not only to school/college going girls but also to non school going girls. Also early detection and intervention to lower the psychological trauma and long term effects to the patient and her family are points to be emphasised. The obstetrician can play an important role in preventing a young girl from being a psychological and economic burden to the society.

References:

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