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STUDY OF SOCIO – DEMOGRAPHIC PROFILE OF MTP SEEKERS

Medical Science

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ABSTRACT

Objective: To study the socio-demographic and obstetric profile of women seeking medical termination of pregnancy(MTP) at two tertiary centres in Bhubaneswar.

Methodology: Cross sectional study of 257 women seeking MTP in two tertiary care hospitals in Bhubaneswar. Socio-demographic and obstetric data was collected from these women on a pre structured questionnaire.

Results: Maximum number of women seeking MTP belonged to the age group of 20-30 years (64.2%). More than half of them were from low socio-economic status with a low level of literacy. In our study a significant 7.3% of MTP seekers were unmarried. Limiting the family size was the most common cause for seeking MTP (43.5%) followed by the need for spacing between two children (23.3%).

Conclusion: Educating women regarding their reproductive health will go a long way in preventing unwanted pregnancies. Counselling women in the post partum period will definitely reduce the unmet need for spacing and limiting the family.

KEYWORDS

Unplanned pregnancy, MTP, Socio-demographic profile, Unmet need.

Introduction

Abortions, be it spontaneous or induced, are the most common adverse outcome of pregnancy, yet its prevalence and underlying causes are subject to continuing investigation and understanding. The reported prevalence of spontaneous abortions is 10 to 15% of clinically recognised pregnancies.[5] Worldwide, about 46 million pregnancies end in induced abortion annually, of which 60% are conducted under safe conditions.[14] Further WHO reports that globally approximately 42 million pregnancies are voluntarily terminated each year, 22 million within legal system and 20 million by unskilled providers or in unhygienic conditions, or both.[22] Global fertility rate is 2.5 ranging from 1.7 for industrialised countries and 2.9 for developing countries to 4.1 for least developed countries. Fertility rates depend on numerous factors. The higher fertility rate in India is attributed to universality of marriage, low level of literacy, poor level of living, limited use of contraceptives and traditional ways of life. [15] According to NFHS 2015-16 (National Family Health Survey) 20% of pregnancies are unwanted. In this scenario Family Planning plays a key role in deciding the desired family size and effective limitation of fertility once that size has been reached. But the NFHS 4 survey indicated that the unmet need for family planning services in India is 12.9% with 5.7% for spacing. [13]

Objectives

Taking all the above points into consideration, the present study was undertaken with the following objectives-

- To study the socio demographic profile of women seeking MTP at two tertiary care centres in Bhubaneswar, Odisha.
- To identify the reasons why women seek MTP.

Materials and methods

A cross sectional study was carried out on women seeking MTP at the outpatient departments of two tertiary health care centres in Bhubaneswar.

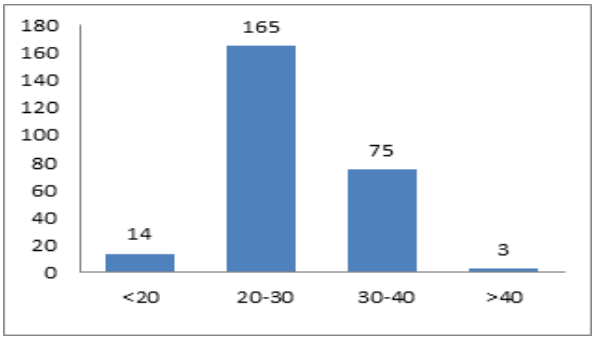
Inclusion criteria was women in the age group of 15-45 who were pregnant and seeking MTP. Data was collected using a pre-structured questionnaire which included questions regarding the socio-demographic and obstetric profile of these women. The reason for seeking MTP was also noted in all these women. Only those women willing to participate in the study were included in the study group.
This data was collected over a period of two years from January 2014 to December 2016. The responses of the participants to the questions were analysed and the data was expressed in proportions and percentages.

Results

A total no. of 257 women between January 2014 and December 2016 came to the out patient department of Obstetrics and Gynaecology at the two tertiary health centres of Bhubaneswar, seeking MTP and were willing to participate in the study. Majority of these women were between 20-30 years of age (64.2%). A total of 75 women were aged between 30-40 years (29.2%) and only 3 of them were above 40 years (1.2%). 14 women (5.4%) were less than 20 years of age and are included in the adolescent age group (Table I).

Table I : Distribution of women seeking MTP according to age

Age	Number	Percentage
< 20yrs	14	5.4
20-30yrs	165	64.2
30-40yrs	75	29.2
>40yrs	03	1.2



Bar diagram of distribution of women according to age

Socio-demographic data of these women shows that more than half of the women (65.6%) had low literacy level, having been educated only up to primary level (47.8%) or were illiterate (17.8%). 36 women (14%) had studied up to secondary level, 31 (12%) up to higher secondary level and only 8.1% or 21 women were educated up to graduate level or above. 216 women (84%) were housewives while only 16% (41 women) were working. As the level of education increased there were fewer number of MTP. According to Modified Prasad's classification, most of the women (84.4%) belonged to lower social class (IV and V), 10.11% belonged to social class - III, 3.1% were in class II and the least number of women (2.3%) were from a higher class I. In our study group, most women were married (92.6%) but still a 7.3% were unmarried and had come for a MTP. (Table II).

Table II : Socio-demographic profile of MTP seekers

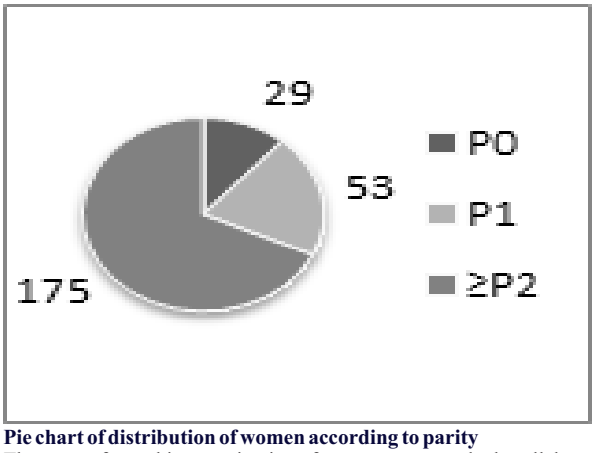
Socio-demographic characteristics		Number	Percentage
Religion	Hindu	247	96.1
	Muslim	6	2.3
	Christian	4	1.5
Types of family	Nuclear	178	69.2
	Joint	79	30.7
Literacy	Illiterate	46	17.8
	Primary	123	47.8
	Secondary	36	14.0
	Higher Secondary	31	12.0
	Graduate and above	21	8.1
Occupation	House wife	216	84.0
	Working	41	16.0
Socioeconomic status*	I	6	2.3
	II	8	3.1
	III	26	10.1
	IV	131	50.9
	V	86	33.4
Marital status	Married	238	92.6
	Unmarried	19	7.3

*Based on modified Prasad's classifications

The obstetric profile of these women showed that a majority, 175(68.1%) were having two or more living children, 53(20.6%) had one living child while 29 (11.3%) had no children or were primigravida. (Table III)

Table III: Distribution of women according to parity

Parity	Number	Percentage
P0	29	11.3
P1	53	20.6
P2 and above	175	68.1



Pie chart of distribution of women according to parity

The reason for seeking termination of pregnancy was asked to all these women. A completed family was cited as the most common reason by 112(43.5%) followed by an unplanned pregnancy where the last child was too young 60(23.3%). 38(14.7%) women were having some socio-economic constraints, 34(13.2%) had contraceptive failure, 9(3.5%%) had some abnormality in the foetus for which they wanted a termination of pregnancy. 4(1.5%) women had some medical disorder for which they had been advised to terminate the pregnancy. (Table IV)

Table IV: Reasons for seeking MTP

Reasons	Frequency	Percentage
Family completed	112	43.5
Previous child too young	60	23.3
Contraceptive failure	34	13.2
Socioeconomic	38	14.7
Eugenic	9	3.5
Medical	4	1.5

Discussion

The medical termination of pregnancy act was passed by the Indian parliament to safeguard the life of women from illegal abortions, which is considered an important strategy under the Reproductive and Child health programme II. In the present study 69.6% MTP seekers were below 30 years. Similar study in Jamnagar showed 68.4% women requesting termination of pregnancy were in age group of 20-29 years. [7] Another study in Chennai showed 72.3% as the MTP seekers less than 30 years. [20] This shows that younger women seek termination of pregnancy more frequently than older women. This may be attributed to lack of maturation and decision making among these younger women for accepting contraceptive measures either to postpone pregnancy or after the family is completed.

To find out whether levels of literacy and their socio-economic status had any correlation to the incidence of MTP we included the educational status of the study group in the questionnaire. Women who were illiterate or educated only up to primary level constituted the maximum number (65.6%). This is almost similar to the Jamnagar study where 71.05% of women belonged to lower educational status. [7] Working women seemed to be more aware of contraceptive methods and their needs as they constituted only 16% of the study group. Maximum number (84.4%) of women who had come for MTP belonged to the lower socio-economic status (IV and V of Modified B.G. Prasad socio economic classification). Lower educational and lower social status of the women are the reasons for their repeated and unwanted conceptions making them vulnerable to all the possible risks of morbidity and mortality due to abortions. Both the Chennai and Jamnagar studies show similar findings.[7,20] 238(92.6%)women of our study were married, but another 19(7.3%) were not married. This finding is similar to other studies where the vast majority of women seeking abortion in India are married, though about 2-30% are unmarried [4].

Reasons for induced abortions are many and include postponement of child bearing, socioeconomic factors and lack of support from partners [9]. There were 42(16.3%) women who were pregnant for the first time and had come for an abortion. This included the 19 unmarried women but the rest 23 felt that it was too soon after marriage for them to have a child. Several studies indicate that most abortions are sought to limit family size or to space next pregnancy [4,11]. A lot of women consider termination of pregnancy as a method of contraception. This is supported by the fact that the most common reason for seeking abortion in our study was completed family (43.5%) which is similar to a study in Madhya Pradesh (41%) [11]. Women who did not want children soon after the first child and came for an abortion constituted 23.3%.

Khokhar and Gulati in their study at urban slums of Delhi noted that the most common reasons for abortion stated by the women undergoing MTP were unplanned pregnancy (last child very small) (62.5%), inadequate income (52.08%), family complete (31.25%), contraceptive failure (10.41%), health problems (2.08%) [10]. Dhillon et al in their study found that the most common reason given for terminating the pregnancy was “did not want any more children” (42%). Other reasons included “child too young” (23.4%), “exposure to illness” (13.4%), “pregnancy due to contraceptive failure” (7.8%) [2]. Several other studies indicate that most abortions are sought to limit family size or space the next pregnancy [16,3]. Studies conducted in northern India have shown that unplanned pregnancy was the most common reason for undergoing MTP, while completed family was the most common reason cited for MTP in the studies from New Delhi [1,19,18].

In developing countries about half of sexually active women of reproductive age, or 818 million women, want to avoid pregnancy of which 17%, or 140 million, are not using any method of family planning, while 9%, or 75 million, are using less effective traditional methods together, 215 million women are said to have an unmet need for modern contraception [8]. Unmet needs are global, which look at issues as they relate to the family planning needs of its reproductive population in a quantifiable mode, “unmet need for prevention of pregnancy or birth or consequences, in currently married women who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth, but are not using any form of family planning” [21]. Millions of women and men either do not have access to appropriate contraceptive methods or do not have adequate information and support to use them effectively and no contraceptive method is 100% effective. Many studies have examined the reasons why some women do not use contraception even though they do not want to become pregnant, referred to as unmet need for

family planning [21,17].

The World Health Organisation defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both. [24] Morbidity is a much more common consequence of unsafe abortion than mortality. Complications include haemorrhage, sepsis, peritonitis and trauma to cervix, vagina and uterus in surgical abortion. [6] The WHO estimates that about 20-30% of unsafe abortions result in reproductive tract infections that about 20-49% of these result in upper genital tract infections and infertility. An estimated 2% of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections. [23] Unsafe abortions also increases the long-term risk of ectopic pregnancy, premature delivery and spontaneous abortions in subsequent pregnancies. [6]

Studies show that integration of family planning services with Post Abortion Care (PAC) can (1) increase the uptake of contraceptive method prior to hospital discharge, (2) increase a woman's intentions to use a contraceptive method after hospital discharge, (3) decrease unmet need for family planning among PAC patients, (4) reduce subsequent repeat abortions and unplanned pregnancies. [12]

Conclusion

Though the problem is daunting it is not without solutions. Preventing unintended pregnancy should be a priority of all health personnel associated with family planning services. The major reasons for women seeking MTP was a completed family or becoming pregnant soon after the birth of the first child. This is the area of unmet need of our women which should be concentrated upon by our health workers. Educating women regarding their reproductive health should be incorporated into the school curriculum where they can learn to overcome cultural and social misconceptions that restrict them from receiving proper health care. And lastly health care personnel should counsel women that termination of pregnancy is not a way to control unwanted birth and it is not without risk to the life of the woman.

References

1. Bahadur A., Mittal S., Sharma J.B., Sehgal R., Socio-demographic profile of women undergoing abortion in a tertiary centre. Arch Gynaecol Obstet 2008; 278 (4):329-32.
2. Dhillon B.S., Chandhiok N., Kambo I., Saxena N.C., induced abortion and concurrent adoption of contraception in the rural areas of India (an ICMR task force study). Indian Journal of Medical Sciences. 2004, Vols. 186-235.
3. Elul B., Barge S., Verma S., et al. 2003, Unintended Pregnancy and Abortion: A Community-based Study in Rajasthan-Summary Report. New Delhi: Population Council.
4. Ganatra BR. Abortion Research in India: What we know and what we need to know. In: Ramasubban R, Jejeebhoy S, ed. Women's Reproductive Health in India. 1sted, Jaipur, India: Ranat Publication; 2000: 186-235.
5. Garcia-Enguidanos A., Calle M.E., Valero I., Luna S., Dominguez- Rojas V., Risk factors in miscarriage: a review. Euro J ObstetGynecolReprodBioly2002; 102:111-9.
6. Grimes D.A., Benson J., Singh S., Romero M., Ganatra B., Okonofua F.E. et al, Unsafe abortion: the preventable pandemic. Lancet. 2006; 368 (955 0): 1908-19.
7. Gupta S., Dave V., Sochaliya, Yadav S, A study on socio-demographic and obstetric profile of MTP seekers at Guru Govind Singh Hospital, Jamnagar. Health Line 2012; 3(1): 50-4.
8. Jacqueline E.D., Sedge G., Ball H., Contraceptive technologies: responding to women's needs. In: Jacqueline E.D., Sedgh G., Ball H., eds. 1st ed. New York: Guttmacher Institute; 2011: 3-51.
9. Khan M.E., Barge S., Kumar N., Almroth S., Abortion in India: Current situation and current challenges. In: Pachauri S., Subramaniam S., eds. Implementing a Reproductive Health Agenda in India: The Beginning. 1st ed. New Delhi: Population Council Regional Office; 1998: 507-529.
10. Khokhar A., Gulati N., Profile of Induced Abortions in Women from an urban slum of Delhi. Indian Journal of Community Medicine. 2000, vols. 25 (4): 10-12.
11. Malhotra A., Nyblade L., Parasuraman S., Mac Quarrie K., Kashyap N., Realising reproductive choices and rights: abortion and contraception in India. In: Malhotra A., Nyblade L., Parasuraman S., Mac Quarrie K., Kashyap N, eds. ICRW. Washington DC: International Centre for Research on Women (ICRW); 2003: 5-35.
12. McDougall J., Fetters T., Clark K.A., Rathavy T., Determinants of contraceptive acceptance among Cambodian abortion patients. Studies Family Plan. 2009; 40 (2): 123-32.
13. MOHFW; NFHS - 3; Government of India 2005-2006; page 5.
14. Park K., Parks Textbook of Preventive and Social Medicine. 22nd ed. Jabalpur: BanarasidasBhanot; 2013.
15. Park K., Textbook of Preventive and Social Medicine; 23rd edition; Jabalpur: M/s BanarasidasBhanot Publishers ; 2015 : pg 481 .
16. Ramasubban R., Jejeebhoy S.J., eds., Women's Reproductive Health in India. Jaipur: Rawat Publications. Vols. 186-235.
17. Sedgh G., Hussain R., Bankole A., Singh S., Women with an unmet need for contraception in developing countries and their reasons for not using a method. In: Sedge G., Hussain R., Bankole A., Singh S., eds. Occasional Report No. 37. New York: Guttmacher Institute; 2007b: 5-40
18. Sehgal R., Mittal S., Aruna J., Medical termination of pregnancy and concurrent contraceptive adoption in a tertiary referral hospital in Delhi. Indian J Public Health 2009; 53(4): 246-9.
19. Shivakumar B.C., Vishvanath D., Srivastava P.C., A profile of abortion cases in a tertiary care hospital. J Indian Acad Forensic Med 2011; 33(1): 33-8.
20. Uma Maheswari R., Jayanthi T.P., Abortion seeking behaviour: a study from tertiary care hospital Chennai. International Journal of Community Medicine and Public Health. 2017 Jul; 4(7): 2303-2307.
21. Westoff C.F., New Estimates of unmet needs and the demand for family planning. In: Westoff C.F., eds. DHS Comparative Reports No. 14. Calverton, Maryland, USA: Macro International Inc; 2006: 1-68.
22. World Health Organisation. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003. In: WHO, eds. WHO Book. 5th ed. Geneva, Switzerland: World Health Organisation; 2007: 1-43.
23. World Health Organisation. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000. In: WHO, eds. WHO Book. 4th ed. Geneva, Switzerland: World Health Organisation; 2004: 1-36.
24. World Health Organisation. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. In: WHO, eds. WHO Book. 6th ed. Geneva, Switzerland: World Health Organisation; 2011: 1-56.