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RISK FACTORS AND LATE PRESENTATIONS FOR ABORTIONS: A COMPREHENSIVE STUDY ON TEENAGE PREGNANCY TERMINATION AND ITS SUBSEQUENT IMPACT ON MATERNAL HEALTH

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ABSTRACT

Pregnant women who have abortions during their teens are more likely to experience anemia, stillbirths, preterm deliveries, and low birth weight babies in subsequent pregnancies. Our aim is to identify risk factors for late presentations for abortions among women presenting for abortions at our facility. During mandatory pre-abortion counseling, a questionnaire was prepared to collect data. Chi-square test was used to compare profiles of women aged 20 and under with those aged 20 and over; otherwise, Fisher's exact test was used. We investigated the risk factors associated with second trimester pregnancy termination using logistic regression. During the course of the study, 1055 women had induced abortions, whereas 999 had just one abortion. Women who had a single abortion on average were 28.3 years old (standard deviation 6). 91(8.5%) of the women with a single abortion were teenagers. There was a higher likelihood of pregnant teenage girls not using contraception (52.2% vs. 26.3%) and of coming to abortions late (38.8% vs. 17.2%) when compared to pregnant women over 20. Among other factors contributing to late abortion presentations are singleness, nulliparity, and lack of contraception use in the past. It is more likely for teenagers to present late for abortions with no previous contraceptive use. There may be a major contributing factor to such a trend in teenage abortions due to a lack of adequate sexual education and awareness of contraception measures. The problem has been addressed through recommendations.

Key words: Abortion, Teenagers, Contraception.

INTRODUCTION

As a result of this act, attitudes toward abortion were liberalized [1], despite being intended to protect women against illegal abortions. It is strictly forbidden to terminate a pregnancy without the approval of the Ministry of Health. Pregnant women should not undergo abortions if they are at least 24 weeks pregnant unless the abortion is urgently needed to save their lives or prevent grave injury to them [2]. In 1975, 35% of pregnancies were terminated, which represented a dramatic increase in abortions [3]. Abortion rates declined in 1993, with 24.6% of pregnancies terminated as a result of mandatory abortion counseling in 1986 [3].

Anesthesia-related complications and uterine hemorrhage are some of the complications that may occur during an abortion [4]. During the second trimester of pregnancy, complications are more likely to occur after 14 weeks of gestation [5]. Adverse outcomes are more likely to occur in teenage pregnancies in particular. The risk of complications during pregnancy among teenagers is higher than that among other groups [6, 7], such as anemia [6, 7], stillbirths, preterm delivery, and low birth weights [8]. Consequently, teenage abortion and late abortion are the subject of intense research.

Study objectives included identifying risks associated with second trimester abortions and describing

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the profiles of teenage abortions and comparing them to the general population. As necessary, further interventions would be based on this information.

METHODS AND MATERIALS

Sociodemographic and obstetric information about these women was collected through an interview with abortion counselors, including states, activity level, marital status, parity, abortion history, gestation period, contraceptive use, reasons for termination. Afterwards, each woman completed an abortion counseling form. Using Microsoft Excel, data was entered. Teenage pregnancies are defined as pregnancies occurring in females aged below 20 years of age, hence characteristics of women in the teenage age group (<20 years) were compared to those ≥20 years to find out if there are any significant differences in their profiles. [9] Teenage boys are usually grouped in an age range similar to that of teenage girls. Women with only a single abortion during a particular period were compared to gravid women in our study whose number of abortions was equal to the number of pregnant women (including women who had both single and multiple abortions during the study period). This percentage was derived by comparing women with only a single abortion to women who had both single and multiple abortions during the same period. The risk of mid-trimester abortion is also associated with certain factors when the abortion takes place below the 24th week of pregnancy. We conducted this study only on a group of women who had experienced only one abortion during the study period, so as to avoid erroneous multiple analyses of the profile of a single woman with multiple abortions. Then, the data were compared between women and girls aged under 20 years of age.

Table 1: Abortion rates

STATES	Gravid women (deliveries plus abortions) N = 7,100	Women with 1 abortion (% of gravid women) n = 999
TAMIL NADU	2766	332 (14.0%)
KERALA	2483	364 (15.5%)
KARNATAKA	1461	257 (18.5%)
Others	195	47 (13.0%)

Table 2:

	Total (n =999)	Below 20 years (n = 46)	Above 20 years (n = 908)	P-value
STATES				<0.001
TAMIL NADU	332 (35.0%)	31 (35.0%)	301 (34.0%)	1
KERALA	364 (37.3%)	50 (55.3%)	314(35.5%)	<0.001
KARNATAKA	257 (26.6%)	8 (9.7%)	249 (28.3%)	<0.001
Others	47 (5.6%)	3 (3.6%)	45 (5.8%)	0.764
Activity status				<0.001
Employed	550 (56.0%)	32 (35.5%)	519 (58.0%)	<0.001
Unemployed	366 (37.5%)	21 (24.0%)	345 (38.8%)	<0.001
First trimester	819 (82.8%)	55 (61.3%)	764 (85.0%)	<0.001
Second trimester	181 (19.0%)	36 (38.8%)	145 (17.2%)	<0.001
Contraceptive usage				<0.001
Practised up to time of pregnancy	561 (57.1%)	41 (45.4%)	521 (58.2%)	0.003
Discontinued after pregnancy	163(17.2%)	4 (5.3%)	159 (18.4%)	<0.001
				<0.001
Single, widowed or divorced	321(33.0%)	83 (91.6%)	239 (27.2%)	<0.001
Enough children	247 (25.6%)	0 (0%)	247 (28.0%)	<0.001
Too close to last pregnancy	119 (12.8%)	3 (3.6%)	117 (13.9%)	<0.001
Not ready to start a family or for another child	62 (7.1%)	2 (3.1%)	60 (7.5%)	0.198
Contraceptive failure	15 (2.4%)	0 (0%)	15 (2.5%)	1
Fetal anomalies or medical	57 (6.6%)	1 (0.4%)	57 (7.1%)	0.017

reasons				
Othersa	41 (5.0%)	1 (0.4%)	40 (5.3%)	0.119

RESULTS

There were 7100 gestational women who delivered or had abortions, as well as 1055 women who had induced abortions. Of the women included in this study, 999 (95.6%) had only one abortion record during the study period, while 56 (6.2%) had multiple abortions. Among 56 women, 38 (69.4%) had one repeat abortion, 13 (23.4%) had two repeat abortions, and 5 (8%) had three or more repeat abortions. Following this study, only 999 women with only one abortion record over the entire five-year period will be analyzed.

A comparison of proportions of women with a single abortion out of all gravid women (delivery plus abortion) was conducted to determine whether abortion rates varied by ethnicity. A single abortion was performed on 15.0% of the 2766 gravid Tamil Nadu women (Table 1).

An average of 28.3 years old (standard deviation 6) was the age of presentation. There were 67.3% of married women in the study. Another 34.5% of the study population was composed of unmarried women. Among the study population, 33.8% were nulliparous. Pregnancy terminations were most common in the first trimester (82.8%), while those in the second trimester (20.0%) were prevalent.

One third of respondents were single, widowed or divorced (33.0%), followed by having too many children (25.6%), financial problems (12.8%), being too close to the last pregnancy (12.8%), and last but not least not being ready for another child or for a family (7.1%). Additionally to socioeconomic factors, medical or fetal anomalies account for 6.6% of terminations, and advanced maternal age accounts for 3.0% and 2.4% of terminations. Pregnant women who practiced contraception up until the time of pregnancy usually stopped using it when they found out that they were pregnant, while non-pregnant women stopped using it before learning that they were pregnant.

In Table 2, subanalysis of women aged 20 and under is presented. There were 46 (9.4%) women under the age of 20 who presented for an abortion at our hospital in this study. A third of women with complaints during the second trimester of their pregnancy had been terminated, as opposed to 18.1% of women across the population ($p < 0.001$). Women with abortion experience made up 15.7% of women over the age of 20 as opposed to 33.4% of women over the age of 20 (p0.001). A study of women ages 20 and over who used contraceptives before they got pregnant found that 53.1% did not use contraceptives before conception, as opposed to 27.2% in the study. Among the key risk factors for late abortion in second trimester, age, marital status, activity status, prior contraceptive use, prior abortions, and parity were identified (Table 3). The educational level of women did not show any statistical significance ($p = 0.879$), so it is not considered a significant risk factor for second trimester abortion.

DISCUSSION

Over the past decade, abortion cases have increased significantly, which is a cause for urgent concern. Singh et al. [10] noted 1370 cases (range 218-352) in a previous study focusing on a similar group of subjects. From 2005 to 2009, however, about 1.6 times as many cases (range 413 to 482) were recorded, about 2230. In the period 2005-2009, 15.7% of abortions and deliveries occurred. As a consequence, abortions continue to climb in our institution, requiring more effective programs to curb the trend. As a limitation of our study, we have found that women who have had a single abortion record between 2005 and 2009 may not necessarily have only had one abortion, because abortions can be performed at other hospitals at the time of the abortion. As a result, our study's results are not invalidated because our sample size is large, and the proportion of these patients is unlikely to be significant.

Inadequate sexual education and awareness of contraceptive measures may have increased the number of teenage pregnancy terminations. Growing Years and Breaking down Barriers are two of the programs implemented over the last five years. Despite that, the number of teenage abortions continues to rise. This is because each programme only provides students with 4-8 hours of exposure per year, along with an opt-out option for parents, which may explain why students only receive minimal exposure. Students could be taught both abstinence and contraception accessibility in these programs if their duration is extended and their duration is taught in conjunction with abstinence. These four key groups of programs include delaying sex, increasing condom use, reducing teen pregnancy, and increasing condom availability. One-on-one protocols are offered in these programs, service learning is offered, and an intensive youth development programme is offered [11-13]. A high-risk group for teenage abortions, school nurses could be educated on abstinence if contraception is not aligned with their religious beliefs. There is also an urgent need for schools to do more to prevent dropouts since statistically significant studies have shown that women with a high level of education were more likely to drop out.

CONCLUSION

Low educational levels are therefore postulated to increase abortion rates. In this situation, irresponsible behavior could be caused by a lack of understanding of

both the moral and health implications of abortion. It is also possible to establish postabortion groups in a school-based health clinic in order to reduce the risks of repeat pregnancies among teenagers. Besides providing family planning services and education about family life, other interventions that delay first pregnancy include improving family welfare measures.

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