Health problems and social consequences in teenage pregnancy in rural Kathmandu Valley

PP Kafle,[1] KN Pakuryal,[2] RR Regmi [2] and S Luintel[2]

[1]Department of Community Medicine, Nepal Medical College Teaching Hospital, Attarkhel, Jorpati Kathmandu, Nepal, [2]Department Sociology and Anthropology, Tribhuvan University, Kathmandu, Nepal

Corresponding author: Dr. Kafle Phanindra Prasad, Department of Community Medicine Nepal Medical College, Jorpati, Kathmandu, Nepal; e-mail; p_99rabin@hotmail.com

ABSTRACT

Early marriage, less awareness of family life education, low socio economic condition and burden of large families in rural area are the contributory factors to high teenage pregnancy and its complications. A rural health centre based cross sectionals study was under taken over six month period among teenage (10-19 years) in the rural Kathmandu Valley. The study sample comprises (15-19 years old) 180 subjects. Data includes demographical variables as anemia, preterm delivery, abortion and hemoglobin. Preterm delivery cases within 37 weeks of gestation. Below 10 gm. of Hb was considered as anemia. The prevalence of anemia was quite high (56.66%) in teenage pregnancy. However severe (<7.9 gm) anemia was observed in 55.67% cases.

Keywords: Teenage pregnancy complications, anemia.

INTRODUCTION

The root of word adolescence indicates a transition by nourishing (alese: prefix) a growing (alescere) in to adult stage (adult, grown up). The World health organization (WHO) has defined adolescence as: progression from appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity; development of adults mental processes and adult identity and transition from total socioeconomic dependence. One-fifth of world population is between ages 10 and 19. Teenage girls today marry later and indulge in sex before marriage. Thus they face more risk of unwanted pregnancy and sexually transmitted diseases (STDS). In developing countries 20% to 60% of teenage girl's pregnancies and birth are unwanted and unplanned. Pregnancy puts teenage girls' health at risk, through childbearing or unsafe abortion. Increasingly, early parenthood means loss of education as well, with lifelong loss of earnings.

Sex education and reproductive health programmes for young adults often face opposition, but research shows that these programme do not lead to more frequent or earlier sex, as opponents fear. To win public support, programme must work with parents and within community norms. At the same time, programme must advocate new social norms that protect the health of young adults.

Family life education is the only widespread programme for teenage girls. The number of teenage girls in developing countries will increase by over the next 15 years.[1] Another way to look at the place of young adults in the world population is through median age of the population which is for the entire world is 25 that is; half of the world's people are under age 25. For developing countries as a whole the median age is 23, whereas for developed countries it is 35.[2]

In most areas women who attain more formal education are more likely to delay childbearing, as well as marriage, than their peers with little or no schooling.[3] In India among ever-married young women 16% of current pregnancies and births in preceding four years were unintended.[4]

Teenage marriages are predominant in developing world. A study of Nepal single out ethnicity as single most important in determination of timing of marriage and first birth much more than education, religion, urban/ rural childhood residence and ecological region. Mean age at marriage 13.5 years in *Brahmin* to 17.5 years among *Tamang*.[5, 6] Its' impact has been felt in some of the advanced countries due to lack of parental control. The legal age of marriage of females is 18 years in Nepal and twenty one percent of adolescent women aged 15-19 are already mothers or are pregnant with their first child.[7,8] Adolescent fertility is major social concern. They are more likely to suffer from severe complications of pregnancy and children.[9]

There are some extrinsic factors such as inadequate prenatal care, illiteracy and poor socio economic condition that affect the out come of pregnancy in teenage girls.[10,11]

The general objective of the study was to find out the socio-cultural attributes of teenage pregnancy. However, the specific objectives are to know the magnitude of

teenage pregnancy of study area, study the social attributes and cultural factors responsible for teenage pregnancies and find out the different socio-demographic characteristic of study population.

RESEARCH MATERIALS AND METHODOLOGY

A list was prepared of those household having teenage pregnancies (pregnant, mother, still birth, miscarriage, abortion and infertility) and pregnancy related cases. All such 180 adolescent girls were selected blanket cover research methods (no one subject was left who meet the criteria during the study) for the study. Interviews were conducted in privacy, i.e., without presence of family members to extract correct information on sexuality, pregnancy and it's socio-cultural and other aspects through pre-tested semi-structured questionnaire and evaluated in SPSS 11.0 software.

RESULTS AND DISCUSSION

The total 180 subjects were from Kapan, Imadol and Jhoukhel of Kathmandu Valley. All subjects were between 15-19 years old pregnant girl. The social worker convinced with social problems and medical complications hence they could subject themselves.

The marital aspect of the teenage pregnancy in 157 (87.2%) cases as in Nepal parents want to continue pregnancy for exploiting the culprit (male counterpart) or for money or compulsive marriage while it has been noticed delay in marriage (Table -1). Substances abuse was observed in teenage but exact percentage could not be determined as 91 (50.6%) were not involve in substances abuse. However cigarette use is commonly found in 60 (33.3%) subjects (Table -2). Several school drop out amongst teenage pregnant subjects is as high as in 33 (28.4%) and social handicapped in getting job is in 21 (18.1%) cases. Polygamy marriages are not uncommon as observed here in 16 (13.3%) subjects. Others subjects 64 (35%) had no social rejection as they were accepted in their society without any ill feeling (Table -3). Anemia in 102 (56.67%) indicates as most prevalent in the study. The complication of preterm delivery 20 (11.11% and abortion 58 (32.22 %) indicate the problems (Table -4). WHO report shows 36-40 % are anemic in the developing countries due to iron deficiency and it is common complication of teenage pregnancy. [12]

Total-1: Marital status amongst teenage pregnancy

Status	n	%
Married	157	87.2
Divorce	2	1.1
Separated	6	3.3
Living together	14	7.8
Widow	1	0.6
Total	180	100

Table-2: Total distribution of subject of substance abuse status

Substance	n	%
No addiction	91	50.6
Cigarette	60	33.3
Alcohol	16	8.9
Both	13	7.2
Total	180	100

Table-3: Various social impacts of early pregnancy

Social impacts of early pregnancy	Respondents	
	n	%
School Dropout	33	28.4
Bearing the health risk	29	25
Handicapped in getting job	21	18.1
Polygamy marriages	16	13.8
Separations	6	5.2
Divorces	2	1.7
Widowed	1	0.9
Infertility	8	6.9
Total	116	100

Status of the pregnancy within 19 years indicates the serious health and social problems though it is found common phenomena in the study area. One time pregnancy 88 (48.9%), two times pregnancy 80 (44.4%), third pregnancy 10 (5.6%) and forth pregnancy or more than four pregnancy 2 (1.1%) is observed (Table -5).

Tamang in migrated population from north and *Chhetri* amongst local population are commonly affected 38 (38.0%) and 31 (57.2%) population. The farmer is ethnic population. Next affects local common population is *Newar* and *Brahmins* 22 (22 %) and 23 (43 %) respectively. In upper caste *Chhitri* are commonly effected comprising 31 (57%) and amongst *Dalit, Damai*10 (45.5%) in this rural area amongst ethnic population in the study (Table -6). Less than 7.9 gm Hemoglobin (Hb) is in 102 (56.67%) (Table -7).

Any teenage pregnancy is often referred to as "at risk pregnancy" and cause of great concern. The risk is very much high for poor socio economic, anemic, illiterates a poor utilization of health services. In the research work 87.2% teenage girls were married willingly or unwilling or different pressures. Divorce (1.!%), separation (3.3%), living together without marriage (7.8%) and widow (0.6) which indicate the ill health of the society. The problems increase if they fall victims of traditional healer (*Dhami*

Table-4: Total distribution of complication in teenage pregnancy

Complication	n	%
Anemia	102	56.67
Preterm delivery	20	11.11
Abortion	58	32.22
Total	180	100

Table -5 Status of the pregnancy amongst the teenage girls

Frequencies of pregnancies	Respondents	
	n	%
One pregnancy	88	48.9
Two pregnancies	80	44.4
Three pregnancies	10	5.6
+ Four pregnancies	2	1.1
Total	180	100

Jhakri) care taker in rural areas. The problem of adolescent motherhood is linked with child survival, maternal mortality and mortality.

The age of marriage is different region to region and in rural area as of Nepal due to traditional beliefs. Like family needs to reduce expenditure and to take care of other sibling while parents are at work in field. Most of rural adolescent are unaware of family planning methods.[13]

This study shows that illiteracy, poverty, lack of sex education (family life education) were more prevalent factors specially in rural area among teenagers. This requires the need for enhancing family life education to delay age at first pregnancy. This can prevent complications in teenage pregnancy. The culture determines the meaning of pregnancy among young women is due to social status, health and gender relations.

Win support by working parents and local leaders. Punish girl having sex to be avoided offer role model. Programme most advocate new social norms in the community.

The increasing trend of prevalence of teenage pregnancy suggests us to take care of adolescent group in rural area and implement a community based activities like information, education and proper communication to vulnerable social high risk group. Even male adolescent requires the family life education in a scientific basis. Also life style changes like substance abuse, alcoholism (Table -1) and control for premarital sex Table -1) can be dealt with proper guidance at right age in school. Family Life Education (F.L.E.) is only wide spread programme for young adults to improve attitude toward health behaviour.

Table-6: The caste/ ethnicity distribution of the respondents

Caste/ethnicity	Respondents	
Caste	n	%
Brahmin	23	43
Chhetri	31	57
Total	54	100
Dalits caste		
Biswokarma (Kami)	6	27.2
Damai	10	45.5
Sarki	6	27.5
Total	22	100
Ethnic group		
Bhujel	4	4
Dhimal	4	4
Gurung	8	8
Kirati	8	8
Magar	14	14
Majhi	6	6
Newar	22	22
Tamang	38	38
Total	100	100

Table-7: Total distribution of subject of hemoglobin status

HB (gm)	n	%
<7.9	102	56.7
7.9-9.9	40	22.2
>10	38	21.1
Total	**180**	**100**

ACKNOWLEDGEMENTS

I am grateful to Dr. S.B. Rizyal, Principal, NMC for encouraging research work. I grateful to Dr. Prof, J.S. Mathur, Prof. S.K. Mehrotra and Prof. Dr. R.K. Gupta Community Medicine, NMC Kathmandu for permission and guidance to carry out this work.

REFERENCES

1. UN. Department for economic and social information and policy analysis population division. The sex and age distribution of the world population. New York (ST/ESA/SER.A/144) 1994.
2. US Bureau of the Census. World population profile, Washing D.C. (report WP/94) 1994.
3. Barker GK, Rich S. Influences on adolescent sexuality in Nigeria and Kenya: finding from recent focus group discussion. Studies in Family Planning 1992: 23:199-210.
4. International Institute for Population Sciences (IIPS). National family health survey 1992-93, Bombay, IIPS, 1995.
5. Thapa S. The ethnic factor in the timing of family formation in Nepal. *Asia Pacific Population J* 1989; 4: 15-9.
6. Kafle PP. Socio- cultural causes of Teenage Pregnancy and health Hazards. Vegetation and society – Their interaction the Himalayas, TU Nepal and University of Bergen, Norway 2002: 287-92.
7. UNICEF. Fighting HIV/AIDS strategies for success 2002 – 2005, 2003.
8. Kafle PP. Socio –demographic attributes of teenage pregnancy in Kathmandu Valley" Social /science in multicultural world Proceedings of the Internat'l Conf. held on 11-13 December 2006, Kathmandu, Sociological /Anthropological Society of Nepal(SASON) and Swiss National Centre of Competence in Research (NCCR) North-South) 2008: 455-62.
9. NDHS. Nepal Demographic and Health Survey. Family health Division, Ministry of Health 2001.
10. Bhaduria S. Teenage Pregnancy: A retrospective study. *J Obstet Gynecol India* 1991; 41: 454-4.
11. Pal A,Gupta KB, Randhawa 1. Adolescent pregnancy: A high risk group. *J India Med Assoc* 1997; 95: 127-8.
12. Baral KP, Onta SR. Prevalence of anemia amongst adolescents in Nepal. *Nepal Med Coll J* 2009; 11: 179-82.
13. Pathak KB, Ram. Adolescent motherhood. Problems consequences. *J Fam Welfare* 1993; 39: 17-23.