CHAPTER VII

RESULTS OF CONCEPTIONS (Outcome of pregnancies)

Chapter VI has discussed the knowledge, attitude and practice of family planning among the sample women. This chapter deals with the outcome of their pregnancies.

In G. N. Ramu’s study, the outcome of 481 pregnancies among 249 wives was as follows: 432 living children, 16 premature deaths and 33 infant/child deaths. In essence, about 10 percent of the conceptions resulted in either miscarriage, premature or infant deaths.¹

In the present study the outcome of 554 pregnancies among 225 wives was as follows: 419 living children (421 live born), 123 premature deaths, 10 still births and 2 infant/child deaths. Thus a much larger proportion as compared to G.N. Ramu’s study resulted in either miscarriages still births or infant deaths in this study (32.0%).

However, the proportion of infant and child deaths to total pregnancies is very low as compared to one in the G.N.Ramu’s study. Thus while it is 6.86% in that study it is only 0.36% in this study. This may be due to the fact that all the sample women
of this study were educated above secondary school certificate, the mean years of education were 15.9 years and the mean income of their husband was Rs.3539 per month. As is noted by G.N.Ramu, the income of husband and wife's education are inversely related to reported infant/child mortality. Thus the level of infant/child mortality is matching the high level of husband's income and wife's education in the sample.

What is significantly related to the purpose of the present study is, however, not infant and child death, as even though they do affect fertility performance, they are not themselves a part of it. Still births are, however, a part of fertility performance but they are not studied further, as from earlier studies there is no link found between them and women's employment. Their number and percentages to total live births, as seen from G. N. Ramu's study is also negligible (Number is ten and percentage to live births is 2.3%). The present study therefore, concentrates on the analysis of abortions, induced and spontaneous.

7.1 Abortions: extent of induced and spontaneous abortion

It is generally observed that induced abortion is one event which women do not like to confess while spontaneous loss of early pregnancy is
another which they often would not care to remember. The present researcher had the same expectations but thanks to the detailed fertility history table included in the schedule on the line suggested by Dr. Bouge she received very frank answers on the first and almost exhaustive answers on the second. The frankness may also be due to the fact that "The Medical Termination of Pregnancy Act" is in operation from April 1972 and many women no more feel that induced abortion is something that they should conceal.

These two factors may be responsible for the larger proportion of induced abortion that are recorded in this study compared to the earlier studies. G. N. Ramu in his book 'Family structure and fertility' mentions that only about 8 percent in his sample admitted ever having an induced abortion while in this study 25.8% have admitted ever having in induced abortion (The total of 70 induced abortions in this study were related to 58 respondents). But if the attitude about 'abortion in this study and in G. N. Ramu's is compared approximately 1 in 4 (60 out of 225 in the present study) disapproved induced abortion. This is very much less than the 82.53% disapproval of induced abortions in 'Fertility and Family planning in Greater Bombay', by Rele and Kanitkar in 1966.
In Rajani Pathare's study the number of women who have sometime or other thought of abortions constituted 19.08 percent of the sample. This was higher than those who had actually done it (7.48%). She expressed the opinion that "It is possible that if abortion is legalised this gap would be smaller".6

The present research indicates the possibility of her opinion being right as, out of the total 123 unwanted conceptions only 17 have resulted in live births. The others have either resulted in spontaneous abortions or induced abortions.

Thus the present research can indicate that the legislation of abortion seems to have reduced the 'gap' between the 'thought' and 'act' of abortion. However, legislation of abortion seems to have done something more than that as while in Dr. Rajan's Pathare's study there were 19.08% who thought of abortion, in the present study there were 25.8% who have undergone abortion. But one does not know whether a part of this difference is a result of the situation that more women are now able to accept having acted on the thought of induced abortion than were formerly able to accept having thought of it.

The Shantilal Shah Committee
appointed by the Government in the mid 1960s noted that, 'some genesis can be made on the magnitude of the problem; it is assumed that for every 73 live births, 25 abortions take place of which 15 are induced'.

In the present study, for the 421 live births there were 123 abortions of which seventy were induced and 53 spontaneous. The percentages are 29.2%, 16.6% and 12.6% respectively for total induced and spontaneous abortion to live births. (This is comparatively smaller than the guess of the Shantilal Shah Committee which is 34.2% for total abortions to total live birth, 20.5% for induced abortion to live births and 13.7% for spontaneous abortion to live births).

However, the percentage for induced abortion to live birth is much larger than the actual figures given for 1983-84. According to the actual figures given for 1982-83 only 2.2% of the pregnancies are reported to have been terminated on medical and health ground including contraceptive failure. It can be commented that the figures for 1982-83 seem to be gross underestimates. No mass scale recording can reveal statistics regarding sensitive issues like abortion.
The comparatively larger proportion of induced abortion to live births in this study may be due to actual increase in induced abortion during the course of time. A part of it may be due to the more open reporting by respondents. But a possibility remains that the incidence of induced abortion is higher in case of employed wives.

7.2 Causes of spontaneous abortion

There is association between women's employment status and the occurrence of spontaneous abortion experienced by them. Paul Schultz mentions that overwork, heavywork, double work load, hurry, too much travelling, crowding, irregular eating etc. increase the possibility of spontaneous abortion. All these factors must have been working on the respondents of the present sample.

The factor of travelling time is specially important as was found from the responses to question No.8 in part A of the schedule. In the case of 108 (48%) of the respondents, the travelling time from the place of residence to the place of work was high between marriage and first child and in case of 113 (50.2%) respondents, it was high during the time between the first and the last child. (It is considered to be "high" when it was more than one hour).
When the travelling time is high, it increases the effective working time increasing the strain of work and leading to more of irregular eating. These factors might have led to the increase in spontaneous abortions.

Along with these factors mentioned by Paul Schultz, this researcher has added one factor which she feels to be important from her observation. It is 'timings' of service. The same work, if it is to be performed at night is specially strenuous for women during pregnancy. It is also strenuous if it is to be performed in the morning shifts of school from 7.25 a.m. to 1.25 p.m. Taking into consideration the travel time most of the employed women working in morning shifts have to complete the morning cooking before they leave the house making their double work strenuous. This aspect is very important and to the best of the knowledge of the present researcher it has not been covered in the earlier research, related to working women's spontaneous abortions and through them to her fertility.

The response to question No. 8, column VII of part 'A' of the schedule show that the work timing was inconvenient to 25 respondents between marriage and the first child and to 37 respondents during the time between the first and the last
child. It must have added to their double work, hurry as well as to their irregular eating.

The researcher would also like to make a note of her impression that the work timings were actually inconvenient to a larger number of respondents. Many respondents said that the work time was convenient with the remark that, 'once you are employed, you should not complain about the timings.' It clearly indicated that the work time was inconvenient to them but they felt it improper to complain about it. Their responses were recorded as 'convenient timings' as that was what they directly said but if the implied meaning of their remarks is analysed they should have been added to the respondents finding their work timings inconvenient. It shows that a special study concentrating on this aspect would be able to contribute a better insight in the relation between women's employment and their experience of spontaneous abortion.

7.3 Induced abortion for spacing

A. Occupation of respondents and their use of induced abortion for spacing

Five (6.7%) respondents from both teaching and medical occupation have resorted to
abortion for spacing purpose. The corresponding number of respondents from the occupational category of office workers is ten (13.4%). Thus a larger number of office workers have resorted to abortion for spacing as compared to the respondents from teaching and medical occupation. This may have resulted from either or all of the following situations.

(1) More respondents from office workers having experienced spacing failures.

(2) Office workers being more worried about spacing as compared to respondents from teaching and medical occupations.

(3) Respondents from teaching and medical occupations being more reluctant to resort to abortion in case of spacing failures.

More research will be needed to judge the weightages of all these factors in bringing about the result.

B. Respondents occupational level and their use of induced abortion for spacing

The number of respondents undergoing induced abortion for spacing is the lowest for high occupational level, four (5.33%), higher for middle occupational level, 5 (6.7%) and very high for the lowest occupational level, 11 (14.7%). Thus the low occupational level has a much higher incidence of
induced abortions for spacing as compared to the middle and high occupational level. It may be due to two reasons. As seen earlier in the chapter on knowledge attitude and practice of family planning, use of less effective family planning methods in the initial stage of family planning is more prevalent in the low occupational level and so is the high proportion of pregnancies at undesired time. Secondly six respondents from high occupational level, and not a single one from low occupational level preferred closer spacing to free themselves for their career pursuits. Thus it was quite possible that the respondents from the higher occupational level were not really serious about spacing even when they used some family planning methods for spacing. That is why respondents from high occupational level must not have resorted to abortion even after spacing failures.

7.4 Induced abortion for limiting family size

A. Occupation and induced abortions for maintaining the desired family size

While only five (6.7%) respondents from the medical occupation have resorted to induced abortion for limiting family size, nine (12%) from teaching and 24 (32%) from office worker's category have done so. This may not be taken as an indication of
the less intense desire of respondents from medical and teaching occupation to maintain the desired family size as these occupations have a smaller proportion of respondents experiencing failure after desired family size.

However, even if the respondents resorting to induced abortions for maintaining the desired family size are considered as a proportion of the number of respondents conceiving after reaching the desired family size, it is 35.7% for teaching, 42.85% for medical occupation and 85.7% for office workers. It shows that while the office workers are less serious in their efforts in not conceiving after desired family size as compared to respondents form teaching and medical occupations [21 (28.0%) from teaching, 14 (18.7%) from medical and 28 (37.3%) from office workers have conceived after reaching the desired family size] they are the most serious groups in dealing with undesired conceptions after the desired family size and in avoiding unwanted children. Respondents from both teaching and medical occupation lag for behind. The reason may be found in their attitude regarding induced abortion.

In response to the question regarding whether induced abortion can be resorted to
avoid unwanted children (Q.1, Sub Q.9, in part B of the schedule) more than 45% form both teaching and medical occupation answered in the negative while less than 25% of office workers did so. While respondents from teaching occupation supported their negative attitude towards induced abortions in terms of ethical considerations the respondents from the medical occupation did so in terms of physiological considerations. The reluctance to accept induced abortion must have led both the groups to be more cautious in avoiding undersired conceptions. As avoiding undersired conceptions is the real method of family planning and not the use of induced abortion after experiencing an undersired conceptions, the spread of the knowledge of the adverse effects of abortion is very much desirable.

B. Occupational level and induced abortions for maintaining the desired family size

The number of respondents resorting to induced abortions for maintaining the desired family size is 17 (22.7%), 8 (10.6%) and 13 (17.3%) respectively for high, middle and low occupational level. If the number of these respondents is considered as a percentage of those conceiving after reaching the desired family size, it is 65.3%, 40% and 76.5% for high, middle and low occupational levels respectively.
Thus it is the highest for low occupational level followed by the high occupational level. The percentage is the lowest for middle occupational level. The middle occupational level seems to be moderate in resorting to measure like induced abortions.

If the attitudinal differences between these occupations regarding induced abortions are considered; 65.7% from the high occupational level, 57.3% from middle and 58.7% from low occupational level have attitudes accepting induced abortions. Along with these attitudinal differences the lower financial capacity of the respondents from the low occupational level to accept a more than desired family size may be a cause of their acceptance of induced abortion to maintain the desired family size and in the case of the high occupational level the demands on their time by the occupation may also have been a partial cause of their acceptance of induced abortions.

The action against the first unwanted conception after reaching the desired family size, can perhaps be more useful in finding out the effect of both occupation and occupational level in the decision regarding induced abortion. The following is the account of it.
7.5 Action taken on the first conception after reaching the desired family size

A. Occupation and action taken on the first conception after reaching the desired family size

While only two respondents each (2.6%) from teaching and medical occupation had resorted to abortion when they experienced the first accidental conception after reaching the desired family size, 13 (17.3%) from office workers did so. This shows that persons from medical and teaching were either less sure about their desired family size and did not mind crossing it or they were unfavourable to induced abortion to such an extent that they could accept a larger than desired family size than accept induced abortion.

Taken as a percentage of those who experienced the accidental conception after reaching the desired family size, the percentage of respondents resorting to induced abortion came to 8% for teaching, 11% for medical and 36.1% for office workers. Thus at the time of the first conception after reaching the desired family size the respondents from the medical occupation were seen to be the most reluctant to accept induced abortion followed more or less closely by respondents from teaching occupation. The office
workers had strikingly different performance—more than thrice the percentage accepting induced abortion as compared to respondents from the other two categories.

This is quite an important aspect to be noted. There are no striking differences in the achieved family size by the respondents occupation. It is 1.8 for respondents from the teaching occupation and 1.9 for respondents from both medical occupation and office work. But there are differences in the way through which they achieved the desired family size. As is seen in the earlier chapter, respondents from Medical occupation have relied on the use of the most effective contraceptive methods followed by teachers while office workers have resorted to abortion.

Taking into consideration the fact that induced abortion is having adverse effect on the health of the women both physiologically and psychologically it can be said that the respondents from medical occupation were achieving their desired fertility level with less of physical and mental agony. The highest pregnancy wastage of the respondents from office workers category is an aspect which should be seriously considered. Future research to find out the causes will be certainly rewarding.
B. Occupational level and action taken on the first experience of conception after reaching the desired family size

Eleven (14.6%) from high occupational level, 4 (5.3%) from middle occupational level and 2 (2.6%) from low occupational level had resorted to abortion after the first accidental conception after reaching the desired family size. The percentage was 78.5%, 44.4% and 40% respectively for the high, middle and low occupational level if it was taken as a percentage of those experiencing the accident. It shows that respondents from high occupational level resorted in a much larger proportion to induced abortion to avoid the effect of first undesired conception after the desired family size than the respondents from the lower occupational level. This may be the result of the higher demands of higher occupational level.

Earlier it was noted that the occupational levels are not rigid and respondents have moved from lower to upper levels. In that case those who have the potential to move to higher occupational levels were also seen to have the strong desire not to exceed the desired family size as is indicated by the very high percentage of respondents from the high occupational level resorting to induced abortions on
the first accidental conception after reaching the desired family size. However, these very same respondents had experienced a larger proportion of accidental conceptions after reaching the desired family size. A likely reason may be the neglect of family planning due to the high pressure of work at high level or the pressure of efforts to reach the high level. A further study of this aspect is desirable.

Conclusion

The chapter discusses the results of conception. It shows how spontaneous and induced abortions are differentially affected by employed women's occupation as well as by their occupational level. As the fertility performance of any group of women will ultimately depend not on the number of pregnancies that they experience but on the number of live births that are the outcome of those pregnancies and as the number of live births is the result of number of pregnancies minus abortions and still births, the effect of employed women's differential experience of induced and spontaneous abortions is bound to affect their fertility differentially. However, the same low level of fertility is comparatively less desirable if it is achieved with more of pregnancy wastage. The analysis of the results of conceptions throws light on the situation regarding pregnancy wastage and is
therefore very important in fertility analysis. The chapter studies the differential experience of induced abortions of employed women working in different occupations and at different occupational levels and thus explains the possibility of differential fertility of women employed in these occupations and at these occupational levels.

References


4. Ibid, pp 142.

