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Research Article

Clinico-Demographic Profile and Maternal and Neonatal Outcomes of Rape-Related Pregnancy in Western Visayas Philippines

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Abstract

Context: Pregnancy as a consequence of rape is a continuing and significant public health issue[1]. In this study, we explore the association between the clinico-demographic profiles and maternal and neonatal outcomes of rape-related pregnancy in Western Visayas Philippines.

Method: We conducted an analytic cross-sectional study in two Department of Social Welfare and Development (DSWD) maintained women's shelters in Western Visayas Philippines from February 2017 to June 2017. The validated questionnaire was divided into five parts: socio demographic profile of the pregnant residents; maternal and neonatal outcome of the pregnancy identified; perpetrator of the mother; custody of the newborn; and psychiatric consult. Only chart review was done by the DSWD Social Worker in charge of the Record Section to complete the research tool. Upon completion, the social worker turned over the data to the researcher. The researcher encoded and analyzed the data using SPSS trial version 21.

Results: Records of 41 women who were admitted to the shelter were included. Most of them (90.2%) were teenagers' ages 10 to 19 years old. They did not graduate high school (80.6%), no occupation (87.9%) and no income (82.9%). None of the 41 women were subjected to psychiatry check-up during the prenatal period. Maternal outcome includes: undergone Cesarean section (14.6%); maternal complications (9.7%) and psychiatric diagnosis post-delivery (14.6%). Neonatal outcome includes: mortality rate of 2.4% and neonatal sepsis (43.9%). The rape incidents were incestuous (51.2%) and most of the newborns were transferred to other centers for placement (41.5%).

Conclusions: The result of this study indicates that there is a need for a multi- disciplinary clinical and social management and planning for survivors of violence against women and children.

Keywords

Rape-Related Pregnancy, Clinico-Demographic Profile, Maternal Outcomes, Neonatal Outcomes, Western Visayas, Sexual Violence.

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Background

Pregnancy as a consequence of rape is a continuing and significant public health issue [1]. Studies show that in the US [2] 5% of the non-partner rape cases result in pregnancy; whereas, in Mexico this is as high as 26% and 15–18% among victims seeking help for psychological and medical assistance at rape crisis centers in Thailand and the Republic of Korea [3]. It is documented that sexual violence has an adverse impact on women's physical, psychological, behavioral and reproductive health [4-14], including complications of pregnancy [15,16]. Though literature is inconclusive because there were studies that did not show significant differences between sexually abused adult and birth outcome [17-20], some studies have shown associations between adverse outcomes and sexual violence. These significant associations include the 9-fold increase in the odds ratio of caesarean section among women raped as adults [21] and the greater than 3-fold increase in the odds ratio of premature delivery among women with a history of sexual violence such as rape [22].

In the Philippines, only rape incidence is recorder in the Philippine National Police (PNP) report and rape-related pregnancy is not included. Published data only accounts for the overall rape percentage as compared to other cases of Violence Against Women (VAW) recorded by the PNP. In 2014, the total number of women in the Philippines is almost 50 million and in the same year a total of 7,409 rape cases [5] were reported in the whole country which account for Filipino woman or girl raped every 72 minutes [6]. Western Visayas Philippines, posted the highest reported VAW cases among the different regions from January to December 2013 with 4,833 reported cases, accounting for 20.3% of the total reported VAW cases nationwide [5]. Hence, the study was conducted in this locality because the prevalence is high. Therefore, it is important to gain insight into the socio-demographic characteristics of the rape survivors who became pregnant to understand what these women need in terms of medical and social services.

To date, there has been no local and national data available in the registries regarding the association between the demographic profile and outcome of rape-related pregnancies. Therefore, this study aimed to explore the association between the clinico- demographic profile of women and maternal and neonatal outcomes of rape-related pregnancies in two temporary women shelters maintained by the Department of Social Welfare and Development in Western Visayas Philippines. Such association would be beneficial particularly to pregnant VAW survivors sheltered for safe keeping to receive immediate multi-disciplinary medical and social services such as Psychiatric, Obstetrics, Pediatrics, Internal Medicine and Social Work.

Methods

We conducted a cross sectional study including all 41 women from the two women's shelters maintained by the DSWD in Western Visayas Philippines namely: Cabatuan Home for Girls and Haven Home for Women in New Lucena, Iloilo. It was conducted from February 2017 to June 2017. Inclusion criteria of study participants of any age include the following: pregnant due to sexual violence or rape; under the care of DSWD at any time of Age of Gestation and women who gave birth from January 1, 2002 to December 31, 2015. Pregnant residents whose data are incomplete were still included, as this would describe the whole picture of the clinico-demographic profiles and outcomes (maternal and neonatal) of the participants.

Ethical Issues

The research proposal was approved by the four ethics committees namely: Technical Review Ethics Committee of the West Visayas State University Medical Center (WVSU-MC) Department of Psychiatry; WVSU-MC Research Department of the medical hospital; the Unified Biomedical Research Ethics Review Committee (UBRERC) of West Visayas State University and the Western Visayas Regional Office Ethics Bureau of the Department of Social Welfare and Development. Informed consent was not required by the four ethics committee during the conduct of the study because the researcher does not have direct contact with the participants and their records. Also, more than half of the participants are already discharged from the shelter during the conduct of the study; hence, the DSWD Regional Director as the legal owner of the data needed authorized the release of information.

Data Collection Method

The individual records are kept in the respective women shelters owned by the DSWD. The DSWD Social Worker-in-charge of the Record Section was the one who filled out the data collection tool (Appendix A). The data collection tool was developed by the researcher and validated by three experts (Psychiatrist, Pediatrician, Obstetrician and Gynecologist). No names or even aliases were included in the data collection tool to uphold utmost confidentiality. Upon completion, the social worker turned over the data to the researcher. The researcher encoded and ran the data using SPSS trial version 21 and the results were submitted to a statistician to ensure the correctness of the data.

The validated questionnaire was divided into five parts: socio demographic profile of the pregnant residents; maternal and neonatal outcome of the pregnancy identified; perpetrator of the mother; custody of the newborn; and psychiatric consult. The demographic profile of the participants include: age, civil status, educational status, economic status, occupation, residence during the occurrence of the rape, parity, age of gestation upon admission in the shelter, pre-natal comorbidities (medical and psychiatric) and prenatal check-up. The maternal outcomes includes: mode of delivery and the post-partum complications. Neonatal outcomes are live births and neonatal complications. The relationship of perpetrator to the survivor: incest or non-incest. The custody of the newborn as to either: living with the mother; transferred to other shelter; adopted or others. Lastly, a psychiatric consult history both prenatal and post-partum was also included.

Data Processing and Analysis

Frequency and percentages were used to determine proportion of the respondents when classified according to the clinico-demographic profile; maternal and neonatal outcome; perpetrator of the respondents and custody of the newborn. Chi-Square test at 0.05 alpha was used to determine the associations between the maternal and neonatal outcomes; socio-demographic profiles of the respondents; perpetrator of the respondents and the custody of the newborn.

Results

Clinico-Demographic Profile

A total of Forty-one records from the two women shelters maintained by the DSWD Western Visayas Philippines were included. Table 1 shows the socio-clinico- demographic profile of pregnant residents. In this table, most of the women (90.2%) were at their teenage years with an average age of 16 years old. All of them were single. In terms of educational attainment, most of them did not finish high school (80.6%), has no income (82.9%), no occupation (82.9%), more than half lived with either or both parents (66.15%) at the time of rape incident, almost half (48.9%) came from a broken family and all (100%) were primigravida. Most of them (85.3%) subjected themselves to the shelter after the first trimester of pregnancy with the mean age of gestation (AOG) of 23 weeks. About 40% of them were reported to have urinary tract infection (UTI) and/ or other comorbidities. All of them underwent prenatal check-up but none were referred to a psychiatrist for evaluation. Reason indicated for not referring to a Psychiatrist was because of no atypical behavior was noted. All residents delivered their newborn at the hospital.

Table 1: Socio-Clinico-Demographic Profile (n=41).

Categories	n	%
Age		
10 to 15 years old	24	58.5
16 to 19 years old	13	31.7
20 years old and above	4	9.8
Civil Status		
Single	41	100
Educational Attainment		
Elementary level	17	41.5
Elementary graduate	4	9.8
High school level	12	29.3
High school graduate	5	12.2
College level	3	7.3
Economic Status (Annual Income)		
5,001 to 10,000	7	17.1
No Income	34	82.9
Occupation		
None	34	82.9
Student	2	4.9
Helper	5	12.2
Residence During the Rape Incident		
Living with both parents	14	34.1
Living with mother	9	22
Living with father	4	9.8
Living with maternal grandparents	4	9.8
Living with employer/custodian	4	9.8
Living with sister	2	4.9
Living with partner	1	2.4
Living with stepfather	1	2.4
Living with boyfriend	1	2.4
Living with co worker	1	2.4
Parity		
Primigravida	41	100
AOG Upon Admission in the Shelter		
First Trimester	6	14.6
Second Trimester	21	51.2
Third Trimester	14	34.1
Prenatal Comorbidities		
UTI	11	26.8
None	25	61
Others (asthma, contraction, varicella, goiter, abdominal pain)	5	12.2
Prenatal Check up		
Medical Check up	41	100
Psychiatric Check up	0	0

Maternal outcomes are presented in Table 2. Most of the women delivered their child through a Normal Spontaneous Vaginal Delivery (85.4%) but a significant percentage of 14.6% delivered via Caesarian Section. Fortunately, despite the background of pregnancy, most of the women had no maternal post-partum complications. However, medical complication such as eclampsia and arrest of dilatation occurred in 7.3% of the women. A significant number (14.6%) had psychiatric complications such as depression (4.9%), psychosis (7.3%) and posttraumatic stress disorder (2.4%). It should be noted that these patients were not referred to psychiatry during prenatal check-up.

Table 2: Maternal Outcome (n=41).

	n	%
Mode of Delivery		
Normal Spontaneous Vaginal Delivery	35	85.4
Caesarean Section	6	14.6
Maternal complication after birth		
None	37	90.2
Eclampsia	3	7.3
Arrest of dilatation	1	2.4
Maternal Psychiatric Complication after birth		
None	35	85.4
Depression	2	4.9
Psychosis	3	7.3
Post Traumatic Stress Disorder	1	2.4

The Neonatal outcomes are presented in Table 3. As seen, one newborn was recorded to have died and 18 (43.9%) of newborns were admitted in the hospital because of sepsis.

Table 3: Neonatal Outcomes (n=41).

Neonatal Outcomes	n	%
Live Births		
Alive	40	97.6
Dead	1	2.4
Neonatal Complications		
Admitted (All Sepsis)	18	43.9
Not admitted	23	56.1

Table 4 shows that 21 (51.2%) of the rape were incest cases. For incest cases, 22% of the women were raped by their own father, followed by stepfather (14.6%). For non-incest rape, boyfriends (17.1%) were identified by women as the perpetrator; some were raped by their employer or neighbor (7.3%). Two women were not able to identify the perpetrator of the rape.

Table 4: Perpetrator (n=41).

Perpetrator	n	%
Incest	**21**	**51.2**
Father	9	22
Stepfather	6	14.6
Cousin	2	4.9
Brother	2	4.9
Uncle (maternal)	1	2.4
Maternal Grandfather	1	2.4
Non Incest	**18**	**43.8**
Boyfriend	7	17.1
Employer/custodian	3	7.3
Neighbor	3	7.3
Brother in law	2	4.9
Husband of Cousin	1	2.4
Friend of father	1	2.4
Worker of custodian	1	2.4
Unidentified	**2**	**4.9**

In Table 5, shows the placement of the newborn after the delivery. Many (41.5%) of the newborns were transferred to other centers. Thirty-nine percent of the newborns were left to be with their mother. One newborn was adopted and another one was taken care by the foster guardian while 5 of them were given to the grandmothers of the victim women for care.

Table 5: Placement of the newborn (n=41).

Placement of the New-born	n	%
Living with the mother	16	39
Transferred to other centers	17	41.5
Adopted	1	2.4
Foster	1	2.4
Newborn Died	1	2.4
Given to Grandmother	5	12.2

Association between Maternal Mode of Delivery and Neonatal Complications

Table 6 shows the association between maternal outcome and neonatal outcomes. Neonatal outcomes are significantly associated with the mode of delivery (x=5.382, p<.020) and maternal post partum medical complication (x=15.802, p<.000). All 3 women who suffered eclampsia (7.3%) and (11.4%) women with no complications during birth had neonatal complications.

Table 6: Association between Maternal Outcome and Neonatal Outcomes.

Neonatal Complication								
Variables/ Categories	**Yes**		**No**		**Total**			**Chi-Square Result**
	N	**%**	**N**	**%**	**N**	**%**	**x**	**p value**
Mode of Delivery								
Normal Spontaneous Vaginal Delivery	4	11.4	31	88.6	35	85.4		
Caesarean Section	3	50	3	50	6	14.6	5.382*	0.02
Total	7	17.1	34	82.9	41	100		
Maternal Complication								
None	4	10.8	33	89.2	37	90.2		
Eclampsia	3	100	0	0	3	7.3	15.802 *	0
Arrest of Dilation	0	0	1	100	1	2.4		
Total	7	17.1	34	82.9	41	100		

*Significant at .05 and .01 alpha

Association between Post-partum Psychiatric Referral and Maternal Mode of Delivery

Table 7 shows that there is a significant association between referral to psychiatrist and mode of delivery (x=7.037, p<.008). Only a small portion (8.6%) of those who undergone normal delivery were referred to the psychiatrist as compared to those who undergone Caesarean Section (50%).

Table 7: Association Between Post partum Psychiatric Referral and Maternal Outcome.

Referred to Psychiatrist at Post Natal								
Variables/ Categories	**Yes**		**No**		**Total**			**Chi-Square Result**
	n	**%**	**n**	**%**	**n**	**%**	**x**	**p value**
Mode of Delivery								
Normal Spontaneous Vaginal Delivery	3	8.6	32	91.4	35	85.4		
Caesarean Section	3	50	3	50	6	14.6	7.037*	0.008
Total	6	14.6	35	85.4	41	100		

*Significant at .05 and .01 alpha

Discussion

This study was conducted to determine the clinico-demographic profile and outcomes of rape-related pregnancy in two temporary women shelters maintained by the Department of Social Welfare and Development in Western Visayas Philippines for 14 years from 2002 when it was first established until 2015.

Results of the study revealed that more than half of the cases were women between 10 and 19 years old with a mean age of 16.

All of them were single and mostly with low educational level, low economic status with no occupation and no income. These findings provide further evidence that young age; single civil status and low socioeconomic statuses [23,24] are risk factors for abuse [25,26]. The result of this study as to the range of age is similar to a report done by the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention that 42.2% of female rape victims were first raped before age 18; 29.9% of female rape victims were first raped between the ages of 11-17 and 12.3% female rape victims were first raped when they were age 10 or younger [27].

All of the women in this study are primigravida and primipara. This could be the contributing factors for maternal and neonatal outcomes in this study. This is because primiparous and primigravida are risk factors for prolonged first and second stage of labor, increased chances of fetal distress during labor, operative vaginal delivery, emergency caesarean section, primary postpartum hemorrhage, perinatal morbidity and need for intensive monitoring as compared to the multigravidas [28]. Primigravida teenage mothers who not only have to contend with the stigma of being a single mother, but also has to cope with the trauma of being a rape survivor. Studies have shown that these adolescents tend to be revictimized again by rape when they become adults [29]. Most of the women survivors only underwent shelter care after the first trimester of their pregnancy, and 40% of them were reported to have UTI and/ or other comorbidities. This result is consistent to the several studies done on the association between sexual violence and maternal comorbidities [6,30].

On the other hand, the late enrollment of women survivors in shelter and prenatal exam has adverse effects on the outcome of pregnancy. Prenatal care is known to be an effective intervention in improving the mental and physical health of the mother, the child, and the family. It is not surprising therefore that non-utilization / delayed provision of prenatal care is associated with maternal and fetal mortality, pre-term labor, pre-term births, or low-weight births. A study found that women with inadequate pre-natal care were 1.36 times more likely to have preterm labor, and their babies 1.08 times to have lower birth weight compared to those with adequate and intensive care [31].

In addition, while the 41 women were given prenatal check up monthly with a primary physician or rural health midwives, none of them were referred to a psychiatrist during the said check-ups despite the rape and its increased risk for psychiatric comorbidities. The reason for not referring women to psychiatrist is because the social workers, midwives and primary physicians did not find any behavioral change among patients. This is very alarming because several studies showed those clinical examinations that were normal and non-specific are common in sexually abused pre-pubertal girls. There are also studies which showed that while overt symptoms maybe absent, there are 'hidden traumas' that need to be addressed [32]. It may also be the case that primary healthcare health providers wanted to do psychiatric referral. However, they have inadequate capacity and skills to detect psychiatric disturbances with women survivors [33,34].

It was also found in this study that more than half (51.2%) of rape incidence was incestuous in nature, with fathers (22%) and stepfathers (14.6%) as perpetrators. This might also have been the reason why more than half (66.15%) of rape victims in this study were those living with either or both of the parents. The result of this study is higher than the reported number of incest cases (32.9%) in 2009 and (37.5%) in 2010 by the DSWD Philippines [35]. It is also know that victims of intimate partner violence or forced sexual intercourse by any perpetrator appear to be at greater risk of unwanted pregnancy than women with no history of abuse, across the span of their reproductive lives [36].

One of the significant findings of the present study is that 14.6% had maternal post partum psychiatric complications. This finding is complimentary to those of other studies which found that sexual abuse is associated with diagnosis of psychiatric disorders across the lifespan [29,37]. Moreover, it is established that rape is a risk factor for mental health disorders, such as posttraumatic stress disorder (PTSD), major depressive episodes (MDE), and substance use disorders [38-41]. Women with rape histories involving both substance facilitation and forcible tactics reported the highest current prevalence of PTSD (36%) and MDE (36%) as compared to the general population with a lifetime prevalence of (7.8%) for PTSD and (10%) for MDE [42]. Under-reporting is common in the topics of violence against women [6]. Thus, under-reporting makes it difficult to assess the actual prevalence. It has been documented that sexual abuse can affect pregnancy and birth [42]. It has also been documented that women who were sexually abused in childhood may predispose them to 'reenact' the abuse they suffered [43].

It is widely known that rape has deleterious effects on children in later years. Child sexual abuse was significantly related to later engagement in unprotected sexual intercourse, sex with multiple partners, and sex trading (i.e. sex for money, drugs, or shelter) [44,45]. It was also significantly related to depression, self-esteem impairment, and other psychological problems (i.e. suicidal ideation or behavior, anxiety, personality, psychotic, somatoform, and dissociative disorders, borderline personality disorder) including intelligence and learning impairment as well as social maladjustment [46].

Neonatal complications were significantly associated with mode of delivery and maternal complication during birth. Most of those who were of caesarean section and with maternal complication would have neonatal complications. Placement of the newborn was significantly associated with the age, economic status and educational attainment of rape survivors, Younger, less educated and no income survivors tend to have their newborns transferred to other centers. This may have something to do with the perception that women survivors with these demographic characteristics may not have the physical, emotional and financial capacity to care for

their newborn, hence social workers and other providers may have deemed it best for the child to be transferred to other more able care providers.

An alarming result of the study is that none of the 41 women who underwent prenatal check-up were referred to a psychiatrist for assessment or counseling. This referral system is also not in DSWD protocol, because social workers only referred the women to an OBGYNE or a Pediatrician. Recently, the World Health Organization released clinical guidelines for "Responding to Children and Adolescents who have been Sexually Abused" [47]. With this alarming result, it is highly suggested that screening for psychiatric disorder in rape-related pregnancy should be done in clinical practice. The implications for creating a multi-disciplinary medical and social referral system is highly beneficial for the survivors.

Limitations of the Study

This study was based on the data given by the social worker in-charge of the records of women residing in the two DSWD women's shelters in Western Visayas Philippines. The study was not able to determine the percentage of rapes resulting in pregnancies since data were from two centers only. Maternal and neonatal complications were only determined from a chart review of case reports done by the social worker in charge so that this was dependent on the expertise of the health professional and the completeness and preciseness of documentation. This did not seek out and interview the individual person. Thus, the researcher cannot assess the emotional and psychological aspect of pregnancy as a result of rape. Neither did the researcher take note of the APGAR score, birth weight and reason for Caesarean Section and legal outcome.

Conclusion

The result of this study suggests that there is a need for a multi-disciplinary clinical and social management and planning for survivors of VAW. The findings regarding none of the women were referred or seen for psychiatric evaluation during the prenatal period support the need to prioritize mental health in primary health care especially in vulnerable population. Further studies are required to define recommendations for psychiatric and psychological referral for vulnerable population such as rape survivors.

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APPENDIX A
Data Collection Tool

Control No.:_____ Date: _____ Name of Shelter::_____ Encoded by: _____

Part I: Clinico- Demographic Profile:

Age: _____

Civil Status:

_____ Single _____ Married _____ Widow

Educational attainment:

_____Elementary level _____College level

_____Elementary graduate _____College graduate

_____High school level _____Master's degree

_____High school graduate _____Doctorate degree

Annual Personal Income:

_____ less than 5,000 ____ 5,001 to 10,000

_____ 10,001 to 15,000 _____ More than 15,000 specify_____

Occupation: _____

Residence during the rape incident:

_____Living alone _____Living with husband

_____Living with partner _____Living with mother

_____Living with father _____Living with both parents

_____Living with relatives _____Others (Pls specify) Parity: _____

Age of Gestation upon admission in the shelter: _____ (weeks)

Prenatal check up: _____ Yes _____ No Where? _____

Medical Prenatal co-morbidities:

_____ Hypertension _____Diabetes _____ UTI _____None _____Others

Psychiatric Prenatal Co-morbidities:

_____ Post Traumatic Stress Disorder ____ Depression ____ Psychosis

_____None _____ Others (Specify pls._____)

Part 2: Maternal and Neonatal Outcome

Mode of delivery:

_____ Normal Spontaneous Vaginal Delivery _____ Cesarean Section

_____Others

Maternal complication after birth: _____

Where did the mother give birth?

_____ Hospital Why? _____

_____ Birthing Clinic Why? _____

Did the mother stay at the hospital more than 2 days after birth? _____ Why? _____

Were there any complications after birth? _ Yes _____ No Is the newborn _____ Alive _____ Dead

Did the newborn admitted in the hospital?_____ Yes _____ No

Part 3: Perpetrator of Pregnant women

_____Father

_____Uncle (maternal)

_____Maternal Grandfather

_____Husband

_____Others (Specify)

_____Brother

_____Uncle (paternal)

_____Paternal Grandfather

_____Boyfriend

Part 4: Custody of Newborn

Custody of the newborn:

_____ Living with the mother

_____ Transferred to other centers

_____ Adopted

_____ Others (Pls Specify)

PART 5: Psychiatric Consult

Was the patient referred to a Psychiatrist?

Prenatal: _____ Yes _____No Why? _____

Post-natal:_____ Yes _____No Why? _____