

PRACTICES RELATED TO DELIVERY AND ANTENATAL CARE AMONG FEMALES IN RURAL BLOCK OF HARYANA,

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ABSTRACT

Objectives: Objective of this study was to find out practices related to delivery and antenatal care among a group of females in a rural block of Haryana

Methodology: We conducted a study in the block Lakhanmajra which is a rural field practice area attached to Department of Community Medicine PGIMS, Rohtak. A total of 210 study subjects were selected out of a cluster sampling and they were interviewed by a pre-tested, semi structured schedule.

Results: It was found that only 72% of females received antenatal care. Tetanus toxoid (TT) coverage was 95.7% and 4.3% females did not receive even a single dose of TT. More than half of the subjects (55%) were not consuming adequate number of Iron Folic Acid (IFA) tablets. Almost 24.7% deliveries were conducted at home and nearly 50% of deliveries were in government facility. Still 4.7% deliveries were attended by untrained persons.

Conclusion: Utilization of antenatal care (ANC) services and promotion of institutional deliveries should be increased by enhancing awareness among females, ensuring availability of health staff, improvement in quality of services in government setups and training of all untrained birth attendant.

Key words: Antenatal care, rural area, delivery practices

and an enjoyable anticipation (1). Pregnancy requires specialized care and it is generally agreed to be a preventive activity. Notwithstanding it's obvious benefits, pregnancy will remain a risky business as we enter the next millennium. No doubt, many of the historically significant adverse outcomes of pregnancy have been eliminated by modern medical care. Nevertheless, maternal death complicates childbirth in approximately nine of 100,000 deliveries. The three leading causes of maternal death are pregnancy-induced hypertension, hemorrhage, and pulmonary embolism. Factors affecting women's health-seeking behavior, especially as related to pregnancy and childbirth, is that traditionally in rural India pregnancy is considered a natural state for a woman rather than a condition requiring medical attention and care. Even if antenatal visits are there, they are done less frequently, that too late in the pregnancy and their content is unclear. Moreover, it appears that antenatal services are likely to be sought by women who experience difficulty or signals of a complicated delivery than other women (2). Poor utilization of services is also related to cultural and socio-economic constraints as well as perceptions regarding accessibility of facilities and quality of care. The primary aim of antenatal care is to achieve, at the end of pregnancy, a healthy mother and a healthy baby (3).

In India, both child mortality (especially neonatal mortality) and maternal mortality are high. Six out of every 100 children born in India die before reaching 1 year of age and approximately three out of every 1,000 mothers who become pregnant die of causes related to pregnancy and childbirth (4). India

INTRODUCTION

Pregnancy and childbirth are special events in women's lives. This can be a time of great pleasure

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accounts for more than one-fifth of all maternal deaths worldwide. Despite many benefits associated with ante-natal care and institutional delivery, India's maternal and child health programmes have not aggressively promoted these, except in high-risk cases (5). Though there is uniformity in programme design throughout the country, yet there is considerable regional diversity in the cultural beliefs, availability and quality of health services, in turn affecting utilization of these services. Effective antenatal care (ANC) can improve the health of the mother and give her a chance to deliver a healthy baby. Regular monitoring during pregnancy can help detect complications at an early stage before they become life-threatening emergencies.^[6] Lack of finances, transportation problems, unwilling husbands and family members whose permission is often required to go to a health centre, are some of the major social barriers for accessing care (6).

Objective of this study was to find out practices related to delivery and antenatal care among a group of females in a rural block of Haryana.

MATERIAL AND METHODS

The study was conducted in block Lakhanmajra, the rural field practice area attached to Department of Community Medicine PGIMS, Rohtak. The block is at a distance of 35 km from PGIMS, Rohtak and has 24 villages with a total population of 1,04,548 as on 31st March 2012. It was a cross-sectional type of epidemiological study conducted from November 2012 to February 2013. Thirty cluster sampling technique was used for the study to maintain uniformity. Seven females were selected from each of the selected cluster making a total sample size of 210. Females having child aged less than one year were included in the study. If there were two eligible subjects in any household, both the subjects were enrolled in the study. It was an interview based study and a pre-designed, pretested, semi-structured schedule regarding ante-natal care received and delivery practices adopted was used for the study. Antenatal care was defined as when the female had received ≥ 100 tablets of Iron Folic Acid (IFA), taken two doses or booster of tetanus toxoid (TT) vaccination and had undergone at least three antenatal visits at any health institution. Analysis was done using percentages and proportions.

A list of sub-centers in the study area was obtained from the concerned community health centre. A few days prior to the first visit, the health

worker was contacted and was asked to prepare a list of all women who had child less than 1 year from the respective antenatal check-up, birth and immunization registers (register no. 3) at that point of time. On the day of visit to a particular sub-center, the list was taken to select 7 females randomly from the clusters prepared. Similarly seven females were selected for each cluster making a total of 210 females for 30 clusters. They were visited and were interviewed with a pre-designed, pretested, semi-structured schedule regarding ante-natal care received and the delivery practices adopted.

Consent was taken before initiating the interview. A pre-tested semi-structured interview schedule was used for interviewing the study subjects. The interview schedule included information on socio-demographic profile, antenatal care received, place of delivery, any complications, place of referral, advice given by health worker, relevant medical and obstetric history. Collected data were entered in the microsoft excel spreadsheet and coded appropriately. Analysis was done by simple percentages and proportions wherever necessary. Institute's ethical committee approval was taken for the study.

RESULTS

In the study conducted, almost 57% of the study subjects had an ANC card with them, whereas the rest 43% did not (**Table 1**). Considering the coverage

Table 1: Type of records available with study Subjects (n=210)

Type of records	Number	Percentages
ANC card*	120	57.1
No records	90	42.8

*Cards issued by government health facility i.e. subcentres, PHC, CHC etc.

Table 2: Coverage of TT (n=210)

TT	Number	Percentage
TT ₁	201	95.7%
TT ₂ /Booster	186	88.6%

of tetanus, it was found that 95.7% had taken the first dose of tetanus injection and 88.6% had taken the second dose / booster (Table 2). Similarly for IFA consumptions, there were 45% of them who had taken > 100 IFA tablets (Table 3). We analysed the

Table 3: Consumption pattern of iron and folic acid (IFA) tablets (n=151)

Consumption of Iron Folic Acid Tablets	Number	Percentages
<100 Tablets	83	55%
≥100 Tablets	68	45%

source of utilization of ANC services and found that 84.2% of subjects went to the subcentre for their TT dose, whereas, 8% and 3.3% availed the hospital and private institutes respectively. For IFA tablets, 54% availed it from the subcentre, 12.8% from the hospital, 4.7% from private institutes and 28% did not take any IFA tablets at all (Table 4). A total of

Table 4: Place of utilization of the ante natal care services (n=210)

Services	Source			No service
	Subcentre	Hospital	Private	
Tetanus toxoid injection	177 (84.2%)	17 (8%)	7 (3.3%)	9 (4.3%)
Iron folic acid tablets	114 (54%)	27 (12.8%)	10 (4.7%)	59 (28%)

49.5% of all deliveries were held in government institutions and 25.7% were in private institutes. There were still 24.7% of subjects who had home deliveries (Table 5) and 36.16% of study subjects

Table 5: Place of Deliveries (n=210)

	Place of Deliveries		
	Home	Govt. Health facilities	Private Sector
Number	52	104	54
Percentages	24.7%	49.5%	25.7%

were attended either by TBA and untrained staff, 49.5% were attended by government health care staff and rest 14.3% by others (Table 6).

Table 6: Personnel attending deliveries (n=210)

	Deliveries attended by			
	Untrained persons	Trained TBA	Govt. Health Staff	Others*
Number	10	66	104	30
Percentages	4.76%	31.4%	49.5%	14.3%

DISCUSSION

What women think of pregnancy and how they perceive the risks during pregnancy are some important determinants of seeking antenatal care. Women in our settings generally do not perceive childbearing as a problematic issue. This negatively affects the utilization of maternal health services. A complete ante-natal care provided allows for early detection of complications, prompt management and thereby reduction in maternal mortality.

In our study, only 72% women had received antenatal care services. In a study conducted in an urban slum of Delhi, only 67.1% of pregnant women were registered for antenatal care (7). If we try to see the TT coverage among our study subjects, we find that almost 96% females had received TT 1st dose and yet there were about 4% females who did not receive even a single dose of TT. While in a study conducted in 90 districts of various states of India, 77.9% of pregnant women had received TT2 / booster and 13.6% had not taken even a single dose of TT. It was also observed that 68% of pregnant women consumed IFA tablets and among them only 70.27% took them regularly (8). In our study more than half of the subjects (55%) were not consuming adequate number of IFA tablets.

It was very appreciating to see that pregnant women were aware of TT and IFA supplementation and mainly availed these services from government health functionaries. This suggested that the service providers were carrying out very few of the recommended procedures efficiently but were leaving other important tasks like ante natal examination, health and nutrition advice. Similar findings have been reported in a study on antenatal

care, care seeking and morbidity in rural Karnataka (9).

In our study, we found that about 4-5% of subjects received ante-natal care from private health facility and for delivery about 26% went to the private setups. A total of 49.5% of all deliveries were held in government institutions and 25.7% were in private institutes. There were still 24.7% of subjects who had home deliveries and 36.16% of study subjects were attended either by TBA and untrained staff, 49.5% were attended by government health care staff and rest 14.3% by others. Metgud et al revealed that in rural Belgaum 48.39% pregnant women went to private hospitals for antenatal care, 17.74% to district hospital, 16.13% to sub-centre and only 9.68% women went to primary health centre for antenatal care (10). Singh et al revealed that in rural area of Bathinda district of Punjab, 30.8% of pregnant women went to government hospital / primary health centre, 47.2% to private hospitals, 12.0% to sub-centre for getting antenatal care and 10% of them did not receive antenatal care at all (11).

Antenatal visits may raise awareness about the need for care during delivery (12) or give women and their families a familiarity with health facilities that enable them to seek help more efficiently during a crisis (13). However, uptake of these services is far from universal even in settings where they are widely available. Utilization of ANC services and promotion of institutional deliveries should be enhanced by enhancing awareness among females, improving quality of services in government setups, ensuring availability of health staff and training of all the untrained TBAs. Antenatal care plays a critical role in preparing a woman and her family for child birth by establishing confidence between the woman and her health care provider and by individualizing promotional health messages (14).

So the need of the hour is to enhance (female) education through education for all and incorporate primary health information in the curricula of health personnel, make provision for 24 hour delivery facilities with an enabling environment and skilled personnel within reasonable access. Cost of delivery care should be affordable and this will encourage women to go for institutional deliveries especially among the poor and socio-economically marginalised groups. All families with pregnant women or eligible couples should be counselled for complete and good quality antenatal check-ups and

immunisation. All areas should be linked by transport arrangements especially for transporting the mothers for proper management of delivery process during odd hours. Enough employment opportunities should be generated for women supported by the Government (e.g., some kind of employment guarantee programme for women empowerment). Government should increase infrastructure to provide antenatal care universally, spread more and more basic information regarding maternal and child health care through electronic and print mass media to give more emphasis on information education communication (IEC) and social mobilization.

CONCLUSION

Uptake of the services provided is far from universal even in settings where they are widely available. Utilization of ANC services and promotion of institutional deliveries should be increased by enhancing awareness among females, ensuring availability of health staff, improving quality of services in government setups and training of all the untrained TBAs. Antenatal care plays a critical role in preparing a woman and her family for child birth by establishing confidence between the woman and her health care provider.

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