# A Study on Maternal health and Antenatal care of pregnant women in Karakambadi, Chittoor district

**Dr. P. Sindhuja, Academic consultant, Department of Home science, S.V. University, Tirupati**

**Abstract**

**Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Most maternal deaths and pregnancy complications can be prevented by quality ante-natal, care during delivery period and post natal care. Antenatal care is the care before birth to promote the well-being of mother and fetus, and is essential to reduce maternal morbidity and mortality, low-weight births and Ante natal care is generally aimed at producing healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well being and that of their infants. The antenatal care period also provides a forum to supply information may positively influence maternal and child outcomes. Thus, it has been suggested that the antenatal care could play a role in reducing maternal mortality rate and that it could ensure that pregnant woman deliver with the assistance of a skilled attendant. Most maternal deaths and pregnancy complications can be prevented by quality antenatal, natal and post-natal care. The present paper mainly focuses on availability of Health Care Facilities and support of Husband and in-laws during Pregnancy and Antenatal care.**

***Key words*: Maternal health, Ante-natal care, Pregnancy.**

## Introduction

Women‘s health status is very important to understand the condition of women in any society. It is not only medical conditions that cause poor health, but gender and patriarchy plays a very important role in women‘s health. There are many issues related to women‘s health like malnutrition and anemia, STI‘s and RTIs, maternal health related problems and even work related health issues like aches and pains that women face in everyday life. All of these can be linked to gender and patriarchy in different ways. Women‘s access to food, decision for treatment, access to proper care, hours spent on work and kind of work done are often not in the control .These have a lot of impact on their health. So it is important to study women‘s health from this angle. Although there are many issues related to women‘s health, maternal health is very important in the context of India. India has very high maternal mortality ratio. Maternal Death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

The promotion of maternal and child health has been included as one of the most important issues of the world. The problem of maternal death and poor health of the children are very acute in the developing as well as under developed countries. The risk is connected with child bearing in case of women and growth developments for infants and children. In India for the poor, the safe delivery of a healthy child and survival of both mother and child cannot be taken for granted. The Government of India took steps to strengthen maternal and child health services as early as the first and second five year plan.

In 1996, the Government has introduced Reproductive and Child Health Programme for both women and men. The child survival with safe mother hoods, being one of the objectives, the child survival and safe mother hood programme failed to achieve its goal to cover the 80% of children and reproductive part of the Indian population as per National Family Health Survey-II, 1998-99 and the utilization of antenatal, natal and post natal care is less than the developed countries (Ganesh Chandra Mallik, 2010).

In India there exist regional and social class disparities in the coverage of reproductive and child health services. The inequality to access and to use even the basic essential reproductive and child health services in the country appears to be primarily responsible for the unacceptable state of reproductive and child health situation (NFHS-III, 2005- 06).Women’s poor reproductive health is affected by a variety of socio economic factors.

Women’s health in general and reproductive health in particular is determined in women’s poor to make a choice inequality of available health care services, life style and women’s position in the society (Uma Mageshwari K and Radha Krishnan M, 2012). Communal belief and cultural practices also influence the health status of mothers and children. The coverage of reproductive and child health services by caste shows that the utilization of the services among Scheduled Tribes (ST) and Scheduled Caste (SC) is comparatively lower than other social groups. Scheduled Tribes occupy the lowest position in case of three ante natal care in the last birth (40.2 percent). It is 44.3 percent for SC and 48.5 percent for back ward classes. Birth attended by professionally trained persons for ST was 26.9 percent and for SC and OBC, it was 42.3 percent and 48.5 percent respectively. Institutional deliveries were 19.6 percent for ST, 35 percent for SC and 39.6 percent for OBC. Mother receiving post- natal care from professionally trained person 22.1 percent for ST, 31 percent for SC and 35.2 percent for OBC and the current use of any family planning method for ST is 42.7 percent, SC-47percent and OBC-48percent during 2005- 06. Primary Health Centres

(PHCs) and Community Health Centres (CHCs) in the tribal areas are very low. Chatham, Shrivastava et al., (2012) stated that among 120 deceased tribal women highest maternal mortality noted in prime gravid (54.16).

It is clear from the fact that the demand for reproductive and child health care services and the accessibility to health services are comparatively lower among Scheduled Tribes than other social groups.

**Objectives of the study**

1. To study the Socio-economic status of pregnant women.
2. To know about maternal health status of pregnant women and availability of health care facilities in their location.
3. To find out awareness on Antenatal and Post natal care among pregnant women.
4. To know the help and support of the husband's and in-laws during prenatal and post-natal care.

**Methodology**

Methodology consists of obtaining information through empirical observation. Methodology makes a study more scientific and realistic it is followed by carrying out systematically under the following sub headings.

**Locale of the study**

The study was conducted in Tirupati mandal of Chittoor district. Cotton mill and Karakambadi Pregnant women were selected for the present study.

**Sampling procedure**

The purposive sampling method was adopted in the selection of the respondents. The total sample comprises of 100 pregnant women.

**Development of Interview schedule**

An interview schedule was prepared carefully to collect the information from the respondents the items in information schedule were worded in the simplest possible way and the schedule designed too was made simple to avoid confusion and misunderstanding.

**Data collection**

The study includes both quantitative and qualitative methods of research. For the purpose of an in-depth understanding of the study the data for the present study was collected by using Interview Schedule.

**Statistical techniques used**

After the data collection the data coded, pooled and analyzed by formulating them into tables, frequencies and percentages were calculated.

**Results and discussion**

Table-1 presents the percentage distribution of the respondents according to age.

**TABLE 1: Percentage distribution of the respondents by Age group**

| S. no | Age | Number of respondents | Percentage |
|---|---|---|---|
| 1 | 20-25 | 43 | 43 |
| 2 | 25-30 | 36 | 36 |
| 3 | 30-35 | 14 | 14 |
| 4 | 35-above | 7 | 7 |
| | Total | 100 | 100 |

The results in Table-1 shows that nearly half (43%) of the respondents belongs to the age group of 20-25 years, more than one third (36%) of the respondents belongs to the age group of 25-30 years, more than one tenth (14%) of the respondents belongs to the age group of 30-35 years, the small percentages (7%) of the respondents belongs to the age group of above 35 years.

**Table 2: Percentage distribution of the respondents by Age at marriage**

| S. no | Age at marriage | Number of respondents | Percentage |
|---|---|---|---|
| 1 | 20-22 YEARS | 84 | 84 |
| 2 | 22-24YEARS | 6 | 6 |
| 3 | Above 24 | 10 | 10 |
| | Total | 100 | 100 |

The clear glance of Table-2 indicates that majority (84%) of the respondents age at marriage was 20-22 years , more than one tenth (10%) of respondents age at marriage was above 24 years, a small percentage (6%) of respondents age at marriage was 22-24 years.

**Table 3: Percentage distribution of the respondents by age at birth of the first child**

| S. No | Age of birth of the first Child | Number of Respondents | Percentage |
|---|---|---|---|
| 1 | 20-25YEARS | 72 | 72 |
| 2 | 25 -28YEARS | 16 | 16 |
| 3 | Above 28 YEARS | 12 | 12 |
| | TOTAL | 100 | 100 |

The perusal of Table- 3 shows that the majority (72%) of the respondents age at birth of first child was 20-25 years, more than one tenth(16%) of respondents age at birth of first child was 25-28 years, more than one tenth (12%) of the respondents age at birth of first child was above 28 years.

Among all socio economic factors education plays a pivotal role, it is important that if mother is educated in a family then she is able to lead a successful role in their family.

**Table4: Percentage distribution of the respondents by Educational status**

| **S.no** | **Educational status** | Number of Respondents | **Percentage** |
|---|---|---|---|
| 1 | Illiterates | 26 | 26 |
| 2 | Primary school | 25 | 25 |
| 3 | Middle school | 22 | 22 |
| 4 | High school | 14 | 14 |
| 5 | Intermediate | 6 | 6 |
| 6 | Degree/P.G | 7 | 7 |
| | Total | 100 | 100 |

The results in Table– 4 shows that more than one fourth (26%) of the respondents were illiterates, one fourth (25%) of the respondents completed primary education, nearly one fourth (22%) of the respondents completed middle school, more than one tenth (14%) of respondents completed high school, small percentage (7%) of the respondents completed intermediate, the least percentage (6%) of the respondents completed Degree/PG.

**Table 5: Percentage distribution of the respondents by occupation of Husband**

| **S. no** | **Occupation of husband** | **Number of respondents** | **Percentage** |
|---|---|---|---|
| 1 | Agricultural labourers | 42 | 42 |
| 2 | Business | 52 | 52 |
| 3 | Employee | 4 | 4 |
| 4 | Others | 2 | 2 |

The table -5 shows majority (52%) of the respondents occupation of their husband was business, nearly half (42%) of them were agricultural labourers, a small percentage (4%) were government employees and the negligible percentage (2%) belong to other categories.

**Table 14: Percentage distribution of the respondents by any perennial health problems**

| S.NO | Perennial health problems | Wife | Percentage | Husband | Percentage |
|---|---|---|---|---|---|
| 1 | Yes | 32 | 32 | 47 | 47 |

| | | | | | |
|---|---|---|---|---|---|
| 2 | No | 68 | 68 | 53 | 53 |
| | Total | 100 | | 100 | 100 |

The table - 6 shows that majority (68%) of the respondents don't have any perennial health problems. More than one third (32%) of respondents have perennial health problems. Among men nearly half (47%) have perennial health problems and 53 per cent of the men do not have any perennial health problems.

**Table 7: Percentage distribution of the respondents by Support of husband and in-laws during pregnancy**

| S.NO | Support of Husband and in-laws during Pregnancy | Number of respondents | Percentage |
|---|---|---|---|
| 1 | Yes | 62 | 62% |
| 2 | No | 39 | 39% |
| | Total | 100 | 100% |

The data in Table- 7 shows that majority (62%) of the respondents reported that they receive support from their husbands and in-laws. More than one third (38%) of the respondents said that they don't receive any support from both their husbands and in-laws.

**Table 8: Percentage distribution of the respondents did they take medicines without consulting the doctor**

| Take medicines without consulting The doctor | Number of respondents | Percentage (%) |
|---|---|---|
| Yes | 65 | 65% |
| No | 35 | 35% |
| Total | 100 | 100% |

The table- 8 shows that majority (65%) of the respondents reported that they take medicines without consulting the doctor for some common illness like fever, body pains, cough and cold etc. More than one third (35%) of the respondents take medicines only after consulting the doctor.

**Table-9 Percentage distribution of the respondents according to Facilities available at the PHC**

| Facilities available at the PHC | Number of the respondents | Percentage |
|---|---|---|
| Good | 63% | 63% |
| Fair | 28% | 28% |
| Poor | 7 | 7% |
| Don't know | 2 | 2% |
| Total | 100 | 100 |

The table-9 shows that one third (63%) of the respondents stated the PHC facilities were 'good'. More than one fourth (28%) of the respondents said 'Fair'. A small per cent (7%) of the respondents stated 'Poor' and a very negligible percent (4%) of the respondents said they don't know about the facilities in PHC.

**Conclusion**

It was concluded that the majority (43%) of respondents belongs to the age group of 20-25 years. Most (84%) of the respondents age at marriage was 22 years. More than one fourth (26%) of the respondents were illiterates, majority (52%) of the respondent's occupation of husband was business, majority (61%) of the respondents reported that they received support from their husbands during pregnancy more than one-third respondents opined that their husband will not get enough time to focus on their health because of their business. It was concluded that majority (65%) of the respondents take medicines without consulting the doctor. More than half (63%) of the respondent's stated facilities available at the PHC as 'good' and 28% of the respondents said 'fair'. Most of the respondents stated that they felt financial burden for their delivery, and one fifth (45%) of the respondents stated 'No'.

**REFERENCES**

1. Arregoces, L., Daly, F. Pitt, C. et al Countdown to 2015: Changes in official development, assistance to reproductive, maternal, new born and child health, and assessment of progress between 2003 and 2012. Lancet Global Health. 2015; 3: 410 - 421.
2. Bhutta, Z.A, Das, J.K. Bahl, R. et al 'Can available interventions end preventable deaths in mothers, new born babies, and still births and at what cost? Lancet. 2013
3. Ekman, B. Pathmanathan, I. Lilje strand, J Integrating health interventions for women, new born babies and children: a framework for action. Lancet 2008