Original article:

Knowledge attitude and practices for antenatal care and delivery of the mothers of Kalindi Vihar and Mudi Jahangirpur District Agra Uttar Pradesh

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Abstract:

The present study aimed to access the influence of socioeconomic factors on antenatal care and delivery practices of the mothers of Kalindi Vihar and MudiJahangirpur District AGRA…….. A community based study was carried out among 216 families of the 1 blocks of AGRA district. Various socio economic factors were considered for the antenatal care and delivery practices. We also tried to find out the relationship between antenatal check up with perinatal mortality. The study shows that the Muslim mothers, Scheduled tribe mothers, non -educated and mothers with higher age group are less interested about ANC. Family income 2000/- month showing 62.42% ANC coverage. We found that only 7.11% mother used Govt. hospital and 2.65% used private clinic. The mother with medical problems and obstetric problems has high ANC coverage. So, socioeconomic factors significantly influence the antenatal coverage and delivery practices. Hence initiative may be taken at Government and non government levels to raise knowledge, attitude and practices for the improvement of antenatal care and delivery practices of the mother at these zones.

INTRODUCTION

The National Population Policy (NPP) proposes a reduction in the infant mortality rate to 30 per 1000, and of maternal mortality rate to 100 per 100000 by the year 2010.[1] The goal is to reduce infant mortality by nearly 60 (from about 72 per 1000 in 1996 to 30 per 1000 in 2010) in a span of about 14 years considering that it took almost 20 years for the infant mortality rate to decline from about 125 per 1000 in 1978 to 72 per 1000 in 1996. On the positive side, the basic institutional mechanism for achieving lower infant mortality levels is already in place. The ICDS (Integrated Child Development Services), instituted in the mid- 1970's, has proven effective in reducing infant mortality in the areas where it has operated. The program offers supplementary nutrition and basic health care to children less than 3 years of age, pregnant women, and mothers of young children. In the mid-1990's, the ICDS program to all Community Development Blocks and Urban Slums, and funding to ICDS was increased substantially. Although the program serves 22 million women and children, a large percentage of women and children eligible to receive ICDS services do not receive them.[2] Expanding the coverage to include more beneficiaries is clearly necessary if rapid reductions in infant and child mortality are to be effected over the next decade. The ICDS program has the potential for greatly expanding the distribution of folic acid and iron supplements to pregnant women who suffer

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from nutritional anaemia. According to NFHS, only about 50% of women received folic acid/iron supplements during pregnancy for India as a whole, and the percentage receiving these supplements was lower still in Rajasthan, Uttar Pradesh, Bihar and Nagaland i.e. less than 30%. [3] A study shows that in West Bengal, 67.5 % mother have 3 or more ANC visit, 97% got TT-1, 91.4% got TT-2 or booster, 87.3% got Iron and Folic Acid (IFA) and 61.6% received 3 ANC, IFA and TT-2. [4] Another study in rural North zone showed that 78.6% visited health centre for antenatal care but 35% received 3 antenatal cares. [5] Reductions in maternal mortality will also require a rapid expansion of antenatal and obstetric services for pregnant women, particularly in rural areas where only a minority of births are supervised by trained health personnel. Non-utilization or under-utilization of maternal health-care services, especially among the rural poorand urban slum population are high due to either lack of awareness or access to health-care services. Understanding of the knowledge and practices of the community regarding maternity care during pregnancy, delivery is required for program implementation. Common people of Agra district are daily labroursand farmers. Most of them are illiterate and poor. Therefore, the present study was carried out to evaluate the socio-demographic correlates and barriers of maternal health-care utilization among married women aged 18-42 years living in Kalindi Vihar 100 feet road Agra and MudiJahangirpur tehsilEtmadpur district Agra.

MATERIAL AND METHODS

The study was conducted in the RHTC & UHTC area of MudiJahangirpur Tehsil Etmadpurand Kalindi Vihar 100 feet road district Agra in the period of May 2015 to October 2015. 216 families were selected by random selection method. The mothers were interviewed using a pre-structured interview schedule including details of ANC, socio-demographic profile, delivery practices and infant mortality to assess the antenatal care and delivery practices of the mothers. We also tried to find out the reasons for perinatal mortality.

OBSERVATION

Table-1 Showing the age, religion, caste,education, occupation and income wisedistribution of mothers and their ante natal care.Table shows that mothers of 18-25 years of agehave taken more ante natal care. Mother belongsto Hindu religion, general caste, highlyeducated, farmers and higher income group alsotaken more antenatal care than the other group.Higher age group, Muslims, Scheduled tribes,illiterate and poor economic group mothers have taken less ante natal care. All the variableshave significant relationship with the antenatalcare.

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Column1	Column2	total	NO(%)	not NO(%)	P value and Chi Square
	18-25	143	131(91.60)	12(8.40)	
Age	26-33	161	132(81.98)	29(19.02)	Chi=17.477
	>33	96	68(70.83)	28(29.17)	P=0.000
Religion	Hindu	261	225(86.20)	36(13.80)	Chi= 4.840
	Muslim	139	107(76.90)	32(23.02)	P=0.028
Caste	Gen	190	165(86.84)	25(13.15)	
	SC	120	98(81.66)	22(18.34)	Chi=4.697
	ST	90	69(76.66)	21(23.34)	P=0.095
Education level	Illiterate	152	125(82.23)	27(17.76)	
of mother	Primary	177	140(79.09)	37(20.90)	Chi= 5.629
	above	72	66(91.66)	6(8.34)	P=.06
Education level	Illiterate	163	130(79.75)	33(20.25)	
of father	Primary	146	125(85.61)	21(14.39)	Chi=1.833
	above	91	76(83.51)	15(16.49)	P=0.400
Occupation	Farmer	120	95(79.16)	25(20.84)	Chi=1.418
	Garden	280	237(84.64)	43(15.36)	P=0.234
Family Income	1200/month	262	211(80.53)	51(19.47)	Chi=2.785
	2000/month	138	121(87.68)	17(12.32)	P=0.095

Table-2 Shows the status of antenatal care of themothers. We found that 67.95% mothers usedgarden hospital and 22.29% mothers used localPHC. Only 2.65% mothers used private clinics.

Place where ANC taken	No	(%)
Garden hospital	270	67.5
Local PHC	77	19.25
Govt. Hospital	27	6.75
Private clinic	6	1.5

Tetanus toxoid schedule	No	%
TT-1	81	23.14285714
TT-2/ Booster	203	58
None	66	18.85714286

Table-3 Represent that the mothers come to thehealth centers or hospitals for ANC mostlybecause they found some problems during earlypregnancy. Delivery place, delivery type,Doctor, Postnatal visit etc plays some role inhaving ANC. All the variables have significantrelationship with the ante natal care coverage ofthe mothers.

Variables		**Ante natal care**		**P value and Chi square**
	Total	Yes(%)	No(%)	
Medical problems				
Yes	230	186(80.86)	44(19.14)	Chi=.008 P=0.929
No	170	136(80)	34(20)	
Obstetric problems				
Yes	115	102(88.69)	13(11.31)	Chi=6.535 P=0.011
No	285	219(76.84)	66(23.16)	
Delivery place				
Home	258	184(71.31)	74(28.69)	Chi= 35.014 P=0.000
Garden/Local Hospital	142	137(96.48)	5(3.6)	
Delivery type				
Vaginal	338	274(81.06)	64(18.94)	Chi= 29.610 P=0.000
Caesarean	62	47(75.80)	15(74.20)	
Done by		0	0	
Doctor/Nurse	181	139(76.79)	42(23.21)	Chi=2.475 P=0.116
Dhai	219	183(83.56)	36(16.44)	

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Breast feeding within 24 hour				
Yes	161	142(88.19)	19(11.81)	Chi=9.919 P=0.002
No	239	179(74.89)	60(25.11)	
Postnatal visit				
Yes	98	92(83.87)	6(6.13)	Chi= 14.092 P=0.000
No	302	229(75.82)	73(24.18)	

Table-4 Shows the perinatal death rate inrelation to antenatal care taken by the mothers.It clearly shows that the perinatal death rate isvery much related to the antenatal care. Ourstudy shows that the mothers who have takenless than two antenatal cares are havingperinatal death rate of 82.40, but the motherswith two and more antenatal care are havingless perinatal death rate (67.07).

No 0f ANC	NO Of Live Birth	No of perinatal death	perinatal death rate
>2	1968	132	67.07/1000
<2	1784	147	82.40/1000

Table – 5 Represents the delivery places of thepoor economic people, Muslims, scheduled castes and tribes. The mothers of Joint familyand illiterate mothers do not like to go tohospital for delivery. We found that the socio economic charactersplay some role in delivery practices of themothers of our study area. Economy, religionfamily and education of the mother significantlyrelated to the delivery practices of the mothers.We also found that caste does not play any rolewith the delivery practices of the mothers.

Character	Hospital delivery No (%)	Home delivery No (%)	Total	p-value
Economy				
Very low	101 (35.96)	179(64.04)	280	Chi=1.581 P=0.209
Lower	52 (43.48)	68(56.52)	120	
Religion				
Hindu	125(42.2)	165(56.8)	290	Chi=5.993 P =0.014
Muslim	32(29.62)	78(70.38)	110	
Caste				
Gen	82(41.36)	118(58.64)	200	Chi =9.104 P =0.011
SC	44(40.04)	86(59.96)	130	

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ST	12(30.13)	48(69.27)	60	
Family				
Joint	72(32.81)	148(67.19)	220	
Nuclear	83(45.85)	97(54.15)	180	
Education of Mother				
Illiterate	45(37.48)	75(62.52)	120	
Primary	66(41.43)	94(58.57)	160	Chi=1.833
above	40(33.66)	80(66.34)	120	P =0.400

DISCUSSION

Antenatal care is most important health care forthe maintenances of sound health of pregnant mother and intrauterine fetus. Poor antenatalcare may results severe health problems of boththe mother and prenatal baby [6]. In the surveyzone, the overall antenatal care level is poor, may be due to economical factor [7]geographicalbarriers as primary health center are located farway from their villages. The level iscomparatively less in Muslim than Hindu [8] which may be due to low educational level [9,10], social customs [11]and wrong ideas as proposedby others. The previous facts have beensupported here by the results of this reportwhere home delivery of the pregnant mother iscomparatively less in educated family than theilliterate or low educated family. Similarly theantenatal care of mother is also high in nuclearfamily. Economical status of the family is alsoone of the factors of antenatal and intra natalcare of the mother which has been reflected here as proposed by others [7].

CONCLUSION

From above discussion it may be cleared thatantenatal care and delivery practices of themother in tea garden areas of North Bengal isvery poor. Social educational and economicalfeatures are responsible for such results. Stepsmay be adopted at Government and nongovernment levels to raise knowledge, attitudeand practices for the improvement of antenatalcare and delivery practices at this zone todevelop as sound health for future generation.

REFERENCES

1. National Family Health Survey-India 1992-93. 1995.Bombay: International Institute of Poulation Studies.
2. Tenth Five Year Plan 1992-97. Volumes I & II. NewDelhi: Government of India, Planning Commission.
3. National Family Health Survey-India 1998-99. 2003.Bombay: International Institute of Population Studies.
4. Singh P, Yadav RJ. Antenatal care of pregnant womanin India, Ind J Community Med. 2000;25:112-7
5. Singh A, Arora AK. The changing profile of pregnantwomen and quality antenatal care in rural North India.Ind J Community Med .2007; 32:135-136

6. Coria-Soto IL, Bobadilla JL, Notzon F. The effectivenessANC in preventing intrauterine growth retardation andlow birth weight due to preterm delivery. International JQuality Health Care. 1996, 8:13-20.

7. N Taguchi. M Kawabata. M Mackawa, T Marua,Aditiawarman LD. Influence of economic backgroundand antenatal care programme on maternal mortality inSurabaya, Indonesia. Tropical Medicine and InternationalHealth, 2003,8: 847-852.

8. Salam A, Siddiqui SA, Socioeconomic inequalities inuse of delivery care services in India. J. Obsetet. GynecolIndia. 2006, 56:123-127.

9. El-gilany AH. Falure to register for antenatal care atlocal primary health care Center. Annals of SoudiMedition, 2000,20:229-232.

10. Woolett A, Dosanjh- Matwala N, Pregnency andantenatal care: attitudes and experiences of Asianwomen. Child Care Health and Development. 2006, 16:63-78.

11. Rezeberga D, Lazdane G, Gilbert G, Donders G. Theimpact of social factors on attendance of antenatal careservices and the subsequent effect on mothers health,measured during the year of economic transition inLatvia. Eur. Clinics. Obslet. Gynocal, 2007, 3:47-51.