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Maternity health care practices of rural women

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Abstract

The study evaluated maternity health care practices of women during their gestational time. The sample size comprised of 103 and a pre developed questionnaire was used to gather information on dietary, physical care practices and health care services adopted by the women at the village level. The data were analyzed using frequency and percentages. The findings revealed that the utilization of health care services as very low among the study respondents. The study adds literature on the factors affecting the utilization of services by the women and helpful in informing the stakeholders in the health sector about issues important to the assessment of health programmes.

Keywords: Dietary care practices, physical care practices, maternal health care services

Introduction

Maternal health care remains a major challenge to the global public health system, especially in developing countries [13]. Maternal and child health is most crucial components of the human health. In health systems the maternal health encompasses the family planning, preconception, pre-natal, child birth (delivery) and postnatal care. Hence, the aim of maternal health concerns with reducing the maternal morbidity and mortality. Similarly, the child health in general covers health of a child as a fetus during pregnancy, child birth environment, breastfeeding and post-natal child health involving the childhood diseases and nutrition till a minimum of five years age of the child. In the health care dimension of the child health it encompasses anti-natal checkups and pre-natal care, skilled attendance at child birth, immunization and nutrition. Acknowledging the importance of the issue, the United Nations focused on improving maternal health in the Millennium Development Goals to reduce Maternal Mortality Ratio (MMR) by 75% percent during 1990-2015 [20]. Primary Health Care and Family Welfare Programmes are implemented in all over India to support maternal and child health by implementing performance indicators at MCH, PHC and CHC. The ANC Registration, child immunization, JSY scheme and family planning programmes are the core performance indicators being implemented in Telangana State by the government in order to promote health care mothers and children.

In spite of the maternal and child health care programmes, the cases of home deliveries ignoring iron and folic acid supplements and other services are quite commonly observed in rural women. This is supported by the news given in Hindu paper during the year 2012-13 that in Rangareddy district of Telangana state, home deliveries were prevalent though the percentage of home deliveries has shown a clear downward trend over the past five years. In addition, in India, the proportion of institutional deliveries among women was found to low (13%) in low socioeconomic status families compared to highest wealth quintile (84%) [21].

Most of the maternal and child care problems can be prevented [11, 18, 21] if women regularly attend the antenatal care, deliver in an institution and utilize postnatal care services. It has also been shown that antenatal (ANC) is the gateway for other healthy behaviors adopted during and after pregnancy [9]. In this backdrop, the present study was aimed to collect information on maternal care practices followed and utilization maternal health services by rural women of Maheswaram Mandal of Telangana state.

Materials and Methods

The present study was a community-based cross-sectional study and carried out in five villages of Maheswaram Mandal of Telangana State. Around 103 women who already had children and living in the village for the last 15 years were selected randomly for the study purpose. A questionnaire was framed to collect the information on maternity care practices and utilization of government services available in the village level. Frequency and percentages

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were used to analyze the data for the research questions.

Results

Socio demographic profile of farm women

The majority of the study respondents were in the age group of 20-30 years, followed by 31 to 40 years. 84% of the women reported that they were living in the joint families. The social group wise distribution shows that most of the respondents were from backward classes (40%). 77% of respondents had their own agricultural farm and 57% of farm

women’s families source of income were from farming. The agricultural land holding was <3 acres by 42% respondents, followed by 3-5 acres by 28% and >5 acres by 7% of respondents. Agricultural laborer (17%) followed by another lively hood occupation (14%) daily laborer (6%) and business (6%) was found to be the major occupation of the respondents’ families. About 41% of farm women opined they had an income of more than Rs.5000/- per month as shown in Table 1 and Fig. 1, 2 & 3.

Table 1: General characteristics of respondents (N = 103)

Character	Description	Frequency	Percentage
Age (years)	20-30 years	65	63
	31-40 years	38	37
Family type	Nuclear family	87	84
	Joint family	16	16
Caste	Scheduled Caste	24	16
	Scheduled Tribe	24	23
	Other Backward Class	41	40
	Other classes	14	14
Land availability	Yes	79	77
	No	24	23
Land (acres)	<3 acres	43	42
	3-5 acres	29	28
	>5 acres	7	7
Occupation	Farming	59	57
	Agriculture laborer	17	17
	Daily laborer	6	6
	Animal Caregiver	1	1
	Own business	6	6
	Others	14	14
Income/Monthly	Rs.500-1000/-	5	5
	Rs.1000-3000/-	9	9
	Rs.3000-5000/-	47	46
	>Rs.5000/-	42	41

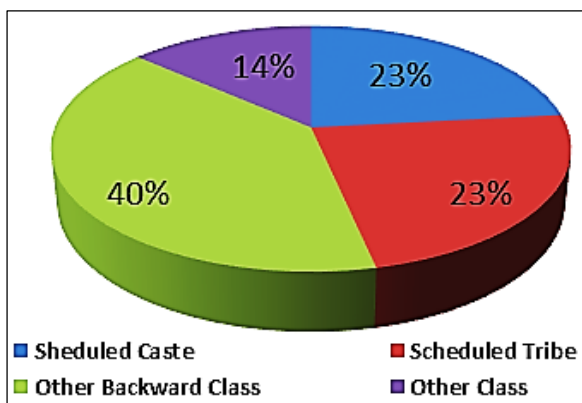


Fig 1: Caste of the respondents

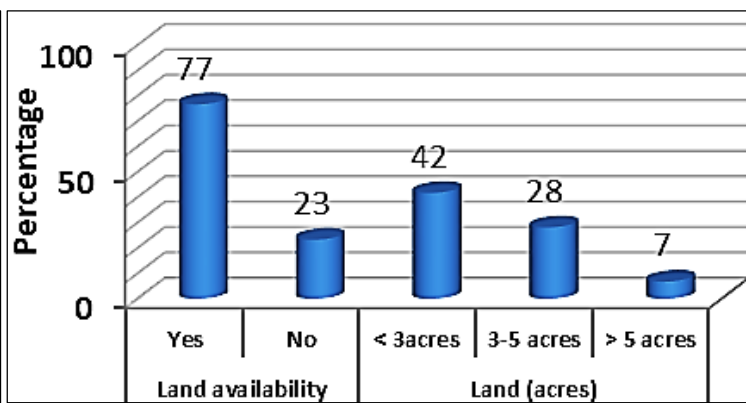


Fig 2: Possession of agricultural land of respondents' families

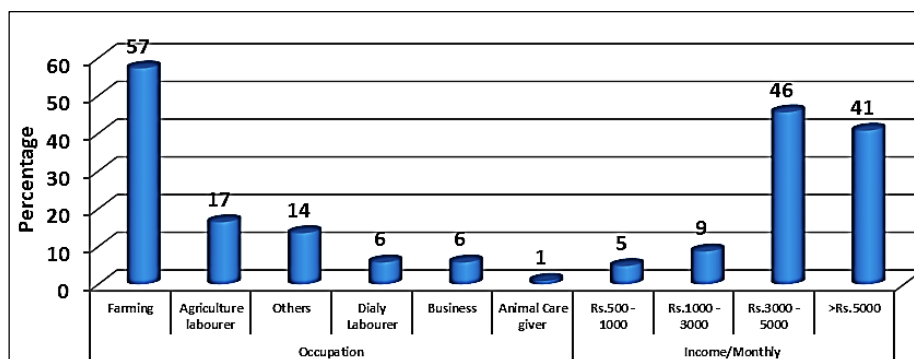


Fig 3: Occupation and income of the respondents' families

Table 2: Participants by dietary, physical and health care practices (n=103)

Practice	Description	Frequency	Percentage
Dietary care practices	Regular food	43	41
	Take additional food	46	44
	Increase frequency of taking meals	8	8
	Consume special foods	6	6
Physical care practices	Work daily	47	46
	Reduce work load	54	53
	Avoid restricted works	2	2
Health care practices	No tests	3	3
	Regular checkups	3	3
	Calcium tablets	1	1
	Iron & folic acid tablets	21	20
	TT injections	14	14
	Blood tests	32	31
	Register at ANM	20	19
	All practices	9	9

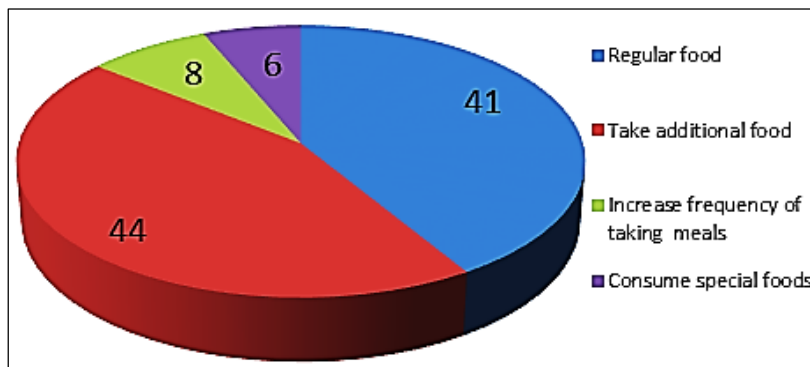


Fig 4: Dietary care practices of respondents during pregnancy

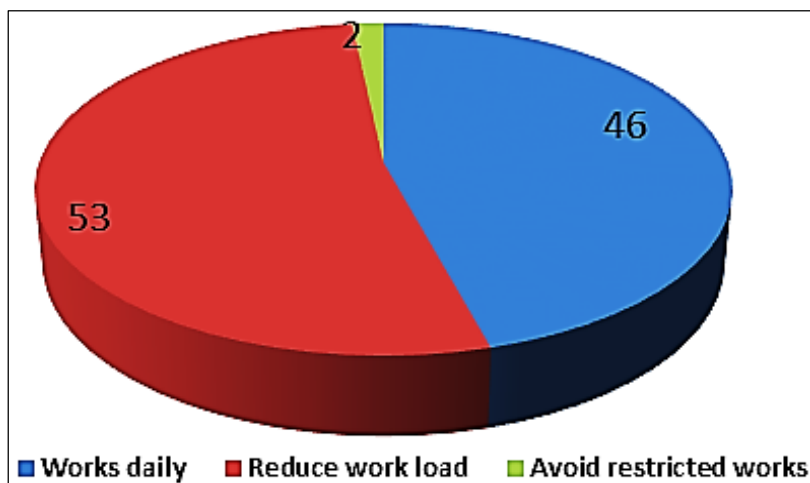


Fig 5: Physical care practices of respondents during pregnancy

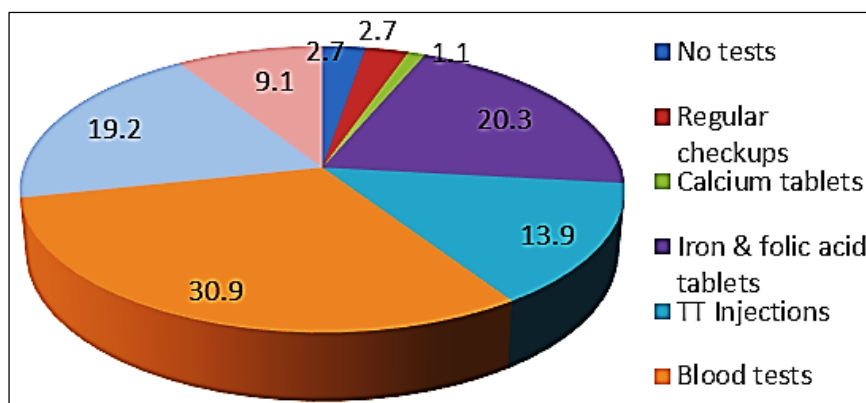


Fig 6: Health care practices of respondents during pregnancy

Table 2 shows the participant’s diet and physical care practices of respondent’s followed during their pregnancy. 44% of the respondents took additional food, whereas 41% of the respondents, followed their regular diet with frequent meals by 8% of the respondents. Only 6% of the respondent’s received special foods during pregnancy period (Fig 4). The regular participation of women in daily works was followed by 53% of respondents and 46% of respondents reduced their

regular work load 6% of women avoided restricted work during pregnancy time (Fig 5). Among the health care practices, blood tests were done by the majority respondents (30.9%). It was seen that the iron and folic acid supplements were taken by 20.3% of respondents, followed by TT injections (19.2%), register at ANM (13.9%). Only 9.1% of the women respondents involved all type tests and supplements during their pregnancy period.

Table 3: Participants by delivery care practices (n=103)

Practice	Description	Frequency	Percentage
Place of delivery	Own house	21	21
	Special house	2	2
	Nurse/Sub center/PHC	80	77
Tool for separating umbilical cord at home delivery	Blade	18	80
	Sickle	3	13
	Knife	2	7
Cleaning agent used for neonate	Warm water	23	100
Postnatal problems faced by mother	Heavy bleeding	22	22
	Obesity	4	4
	Tetanus	4	4
	Weakness	67	65
	Others	4	4

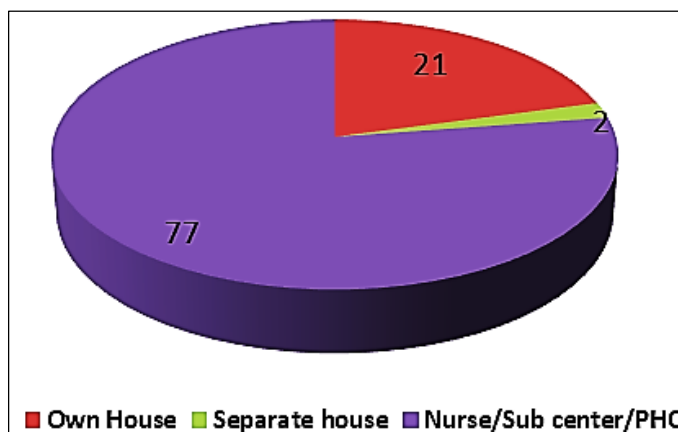


Fig 7: Place of delivery of the respondents

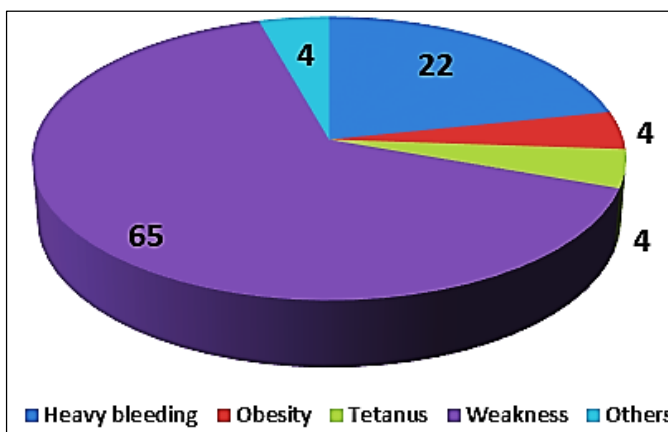


Fig 8: Postnatal problems faced by the respondents

Table 3 describes delivery practices followed by women respondents. In spite of 77% of the deliveries were noted in sub centers or PHC or in the presence of trained nurse, 23% of home deliveries were observed in the study areas. The practices viz. separation of the umbilical cord by using a

blade, cleaning the neonate with warm water were the common practices reported. Weakness (65%) and heavy bleeding (22%) was major post natal problems were complaints by the study participants.

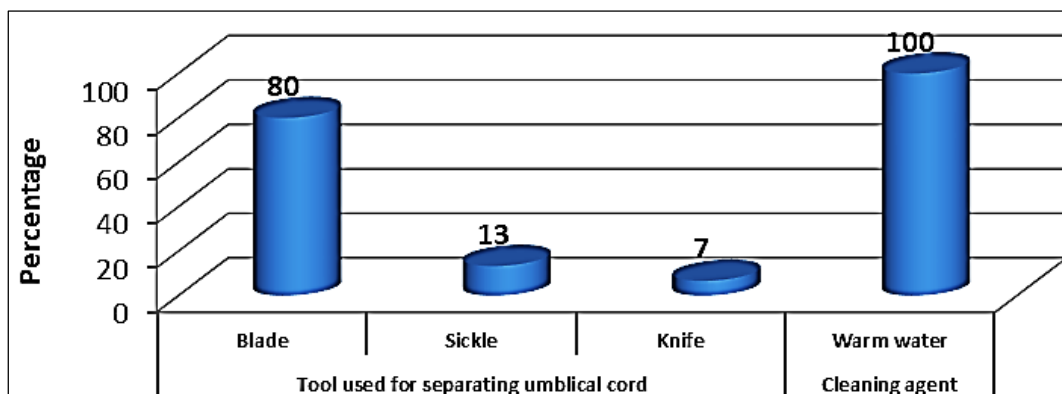


Fig 9: Practices adopted at home delivery

Discussion

Dietary care practices of respondents reported that majority of the respondents (44%) received additional food at the time of

pregnancy. It is necessary to meet the needs of the fetus as well as mother. However, 41% of the respondents followed their regular food habits with no addition of food intake.

Similarly, only 6% percentage of respondents was given less significance, special care foods during their pregnancy. The reasons for less consumption of special foods during pregnancy were mostly might be related to aversion to a specific food, followed by the lack of monetary power to purchase specific food that extremely poor households usually consumed (like rice, dal and locally available vegetable). There were also might be constraints to consume fruits during pregnancy period, especially in the poorest families. Ignorance families also cause less fruit consumption as many the people in rural areas opined that consumption of fruits causes coldness in the mothers.

In reply to physical activity care practices, 46% and 6% the respondents reduced their regular work load and avoided restricted works respectively in their gestation time. It is common practice in rural areas that women are restricted to involve in heavy works, especially in first gravid as the women are new to gestation. This is likely to happen if the women were too weak to work or continue the usual household work.

The findings of the study showed unacceptably lower utilization of maternity care services viz. iron and folic acid supplements by 20% respondents, TT injections by 19% respondents, register at ANM by 14% of respondents. Only about 9% of rural women received full antenatal care services. 3% of respondents not involved in any of the practices mentioned, whereas the similar percentage of women were involved in regular checkups. Only 1% of the respondents received calcium tablets in pregnancy phase.

The reasons for lower rate of utilization of supplements could be perception of the women that that the tablets to be tasteless (or have bad taste) and made the stool black. Adding the factors such as education, economic status, women's education, social group, religion, economic status, birth order and interval, health provider's visit and region of residence have an impact on maternal health care utilization [4, 10, 12 19, 5, 14, 17, 16]. Many studies conducted in other developing countries have found that maternal education is one of the most important determinants of maternal healthcare utilization, after controlling for other factors [19, 5, 8, 16, 7, 1, 2, 3, 6, 15].

Conclusion

This study indicates that the majority of the Maternal and Child Health Services were taken in the regional centers. Though it might be due to lack of education, awareness on the importance of health care services or religious or economic status of the families, the services approach to the target group was not extended in the rural areas. A health worker who is responsible for the services at village level must be more likely to avail to target women and responsible for the promotion of utilization of services. To maximize satisfaction levels of maternal and child Health services adequate human resources (health personnel) should be supplemented at village to maximize utilization of health care services at rural level. This will improve the efficacy of the services and contribute to the utilization and effectiveness of maternal and child Health services thus encouraging healthy maternal and child Health practices. Equally necessary is the need for comprehensive and widespread enlightenment programme aimed at educating mothers on the available services and the benefits of preventive health care for the overall wellbeing of mothers. Alleviating misconceptions and fears, reducing gaps in maternal and child health knowledge through effective communication with mothers about their expectations and

perceptions services delivery may contribute to increase in the satisfaction with services and subsequent utilization.

References

1. Ahmed S, Creanga AA, Gillespie DG, Tsui AO. Economic Status, education and empowerment: implications for maternal health service utilization in developing countries PLoS ONE. 2010; 5(6):e11-190.
2. Amin R, Shah NM, Becker S. Socioeconomic factors differentiating maternal and child health-seeking behavior in rural Bangladesh: A cross-sectional analysis, International journal for equity in health. 2010; 9:9.
3. Bhutta ZA, Chopra M, Axelson H, Berman P, Boerma T, *et al.* Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn, and child survival, The Lancet. 2010; 375(9730):2032-2044.
4. Filippi V, Ronsmans C, Campbell OM, Graham WJ, Mills A *et al.* Maternal health in poor countries: the broader context and a call for action The Lancet. 2006; 368(9546):1535-1541.
5. Gage AJ, Calixte MG. Effects of the physical accessibility of maternal health services on their use in rural Haiti population studies. 2006; 60(3):271-288.
6. Hussein J, Newlands D, D'ambruoso L, Thaver I, Talukder R *et al.* Identifying practices and ideas to improve the implementation of maternal mortality reduction programs: findings from five south Asian countries BJOG. 2010; 117(3):304-313.
7. Jafarey S, Kamal I, Qureshi AF, Fikree F. Safe motherhood in Pakistan, International journal of gynecology and obstetrics. 2008; 102(2):179-185.
8. Kesterton AJ, Cleland J, Sloggett A, Ronsmans C. Institutional delivery in rural India: the relative importance of accessibility and economic status BMC pregnancy childbirth. 2010; 10(1):30.
9. Khan ME, Hazra A, Bhatnagar I. Impact of Janani Suraksha Yojana on selected family health behaviors in rural Uttar Pradesh, J Fam Welf. 2010; 56:22.
10. Navaneetham K, Dharmalingam A. Utilization of maternal health care services in southern India, social science and medicine. 2002; 55(10):1849-1869.
11. Pallikadavath S, Foss MSR. Antenatal care in rural Madhya Pradesh: provision and inequality, In Chaurasia AR SR (Southampton: U of S, editor obstetric care in central India, 2004, 73-88.
12. Pathak PK, Singh A, Subramanian SV. Economic inequalities in maternal health care: prenatal care and skilled birth attendance in India, 1992-2006, PLoS ONE. 2010; 5(10):e13-593.
13. Patton GC, Viner RM, Linh LC, Ameratunga S, Fatusi AO *et al.* Mapping a global agenda for adolescent health, Journal of adolescent health. 2010; 47(5):427-432.
14. Ram F, Singh A. Is antenatal care effective in improving maternal health in rural Uttar Pradesh: evidence from a district level household survey? Journal of biosocial science. 2006; 38(4):433-448.
15. Ronsmans C, Chowdhury ME, Koblinsky M, Ahmed A. Care seeking at time of childbirth, and maternal and perinatal mortality in Matlab, Bangladesh, Bulletin of the World Health Organisation. 2010; 88(4):289-296.
16. Saikia N, Singh A. Does type of household affect maternal health? Evidence from India, Journal of biosocial science. 2009; 41(3):329-353.
17. Singh L, Rai RK, Singh PK. Assessing the utilization of

- maternal and child health care among married adolescent women: evidence from India, *Journal of biosocial science*. 2012; 44(1):1-26.
18. Stephenson R, Tsui AO. Contextual influences on reproductive health service use in Uttar Pradesh, India *Stud fam Plan*. 2002; 33(4):309-20.
 19. Sunil TS, Rajaram S, Zottarelli LK. Do individual and program factors matter in the utilization of maternal care services in rural India? A theoretical approach *social science and medicine*. 2006 62(8):1943-1957.
 20. United Nations Millennium Development Goals. 2009. Available: <http://www.un.org/MillenniumGoals>. Accessed 2010 June 18.
 21. Vora KS, Mavalankar DV, Ramani KV, Upadhyaya M, Sharma B, Iyengar S *et al*. Maternal health situation in India: a case study, *J Health Popul Nutr*. 2009; 27(2):184-201.