



CODEN [USA]: IAJPBB

ISSN: 2349-7750

INDO AMERICAN JOURNAL OF PHARMACEUTICAL SCIENCES

Available online at: <http://www.iajps.com>

Research Article

SOCIODEMOGRAPHIC FACTORS RESPONSIBLE FOR POOR ANTENATAL CARE

Dr. Shugufta Shaheen¹, Dr. Salma Khushk², Dr. Sara Ejaz³

¹MBBS, MCPS, FCPS, Consultant gynecologist, Lady Dufferin Hospital, Karachi

²MBBS, FCPS, Department of Medicine, Services Hospital Karachi

³MBBS, FCP, Professor of OBS and Gynae department, King Edward medical University

Abstract:

Objective: To determine the factors responsible for poor antenatal care in our population. **Material & Methods:** This descriptive cross sectional study was conducted in the Gynae department of Lady Dufferin Hospital, Karachi from 2015 to 2016. All the pregnant women having gestational age more than 12 weeks were included in the study. All the women were underwent complete gynecological examination and ultrasound FWB. Predesigned proforma was filled from patients regarding biodata, their reasons of not receiving antenatal care and factors responsible for it. Results were analyzed on SPSS version 17. **Results;** Total 70 patients were included, out of them 18 patients had received good antenatal care while 52 had not received it properly. Majority of the patients i.e. 45(64.28%) were with age group of 30-40 years and 33(46%) were multipara while 28(41.2%) were grand multipara. 27(37%) women were with poor socioeconomic class while 22(32.4%) patients belong to upper class and 21 (30.9%) were with middle class. Majority of the patients had received only primary education while 18(24%) were illiterate and only 9(13.2%) were graduated. Regarding husbands education, 20(29.4%) were graduate while 19(27.9%) had received secondary education and 17(23%) patients were illiterate. When patients were interviewed poor antenatal care than most important reason found was poverty which was seen in 27(38.57%) of patients. 11(15.71%) patients had not received antenatal care because facility was far away from their home, while 19(14.28%) patients said that nobody advised them and 7(10%) patients had no transport facilities. Antenatal care was received by specialists / consultant in 30(42.85%) patients, by general practitioner in 23(32.85%) patients, by midwives in 12(17.14%) and by dais in 5(7.14%) patients. Poor socioeconomic status and low education level were found significantly associated with poor antenatal care. $P=0.003$ and $P=0.045$ respectively. Mostly uneducated women were not conscious regarding antenatal care, and unfortunately some rural uneducated women were under rich cholesterol diet even they were obese and hypertensive. **Conclusion:** We concluded that unavailability of antenatal clinics nearby; low education level and poor socioeconomic status were the most common reason behind poor antenatal care.

Key Words: Antenatal care, sociodemographic factors, women

Corresponding author:

Dr. Shugufta Shaheen,
Consultant gynecologist
Lady Dufferin Hospital, Karachi

QR code



Please cite this article in press as Shugufta Shaheen et al., *Sociodemographic Factors Responsible For Poor Antenatal Care*, Indo Am. J. P. Sci, 2017; 4(12).

INTRODUCTION:

About half a million women and girls die every year due to developed complication during pregnancy, during birth or six weeks following birth. Most of the 99% death in women occurred in the developing nations [1]. The general motivation behind antenatal consideration is to advance the outcome of pregnancy for the mother, her child and her family. History taking, examinations and the utilization of investigations are tailored to every individual pregnancy to survey chance and to screen for possible physical, mental and the social issues [2]. Pakistan is challenging the difficulties to lessen the higher prevalence of maternal, and under five year's children mortality [3]. Internationally the mortality ratio of mothers has been decreased by 47% over the past twenty years, from 400 mother deaths per 100,000 live births in 1990 to two hundred and ten in 2010. Newly maternal mortality ration in the developing nations is fourteen times greater in contrast to the developed nations [4] and coverage of the antenatal care "at least a visit to a doctor, nurse or midwife during the pregnancy" have improved from 63% to 81% between the years of 1990 to 2011. Many of the struggling nations, like some in the southern Asia, western Asia and Northern Africa have developed in last 10 years, and the areas like eastern Asia, south eastern Asia, Latin America and Caribbean have touched antenatal care coverage about 90% or more [5]. Via good and proper antenatal care one may reduce, perceive and manage the factors which adversely affected fetomaternal health and to deliver the advices, reassurances, support and education to woman and their families. The underlying risk appraisal of pregnancy is crucial if more concentrated levels of consideration are to be properly focused to the females at high risk of complications. Risk evaluation ought to be seen as a continuous exercise all through the pregnancy so the sort of consideration offered to a female can change if her level of risk changes.

When pregnancy is supposed to be low risk, a least care-standard is yet to be assumed. Females with risk factor recognized at booking can possibly have additional appointments at hospital. This enhances consultation and lets every health care personal to approach to same evidence.² Many studies carried out in underdeveloped nations on socio-cultural and demographic factors affecting use of services for maternal healthcare, have exhibited that factors such as number of living descendants, maternal age, occupation, residential area, education, ethnicity and religion are considerably correlated with antenatal care practice [6,7]. Antenatal-care is as well regarded as a significant point of communication amid health workforces and females as well as an opportunity for

health schooling facility together with technique of detecting pregnancy associated complications and developing birth plans to make sure deliveries at health services[8]. Reproductive wellbeing is a program of main concern for every country of Southeast Asian Region. The deaths are because mainly of five key factors: hemorrhage; after that infection (sepsis), eclampsia, obstructed labor and abortion complications [9]. Further issues compounding maternal death are shortage of acquaintance and awareness regarding reproductive wellbeing within the family, health providers and community. To avoid undesirable outcomes of pregnancy, antenatal care is a highly significant approach to timely detect pregnancy-related issues [10]. Antenatal care (ANC) is an essential component to reduce maternal mortality, as well as to provide pregnant females with a variety of health support and preventive wellbeing facilities [11]. A most vital function of ANC is to provide health statistics and facilities that can considerably develop the health of females and their newborns. ANC is as well a prospect to let females know regarding the risk signs and symptoms for which urgent support should be looked for from a healthcare worker [12]. A review of studies from several nations exhibits that the utilization rate of antenatal care is yet low because of several factors that are required to be investigated for instance socio-demographic attributes, awareness of social provision and ANC facilities.¹³ It is drastically needed to distinguish and cure the factors associated with poor presentation of health system as well as to be trained regarding community behaviors associated with low use of antenatal care that can assist superior planning and putting into practice the strategies in future. This study intended to find out the factors responsible for poor antenatal care in our population.

MATERIALS AND METHODS:

This descriptive cross sectional study was held in the gynaecology and obstetrics department of Lady Dufferin Hospital, Karachi from 2015 to 2016. All the pregnant women having gestational age more than 12 weeks were enrolled into study. All the females were underwent complete gynecological examination and ultrasound FWB. Predesigned proforma was filled from patients regarding demographic information as; education level, husband education level, importance of antenatal care, socioeconomic status, availability of antenatal health facilities and causes of poor antenatal care. All the data was recorded in the proforma regarding their reasons of not receiving antenatal care and factors responsible for it. Results were analyzed on SPSS version 17. Chi square test was used and P value < 0.05 was kept significant.

RESULTS:

In this study total 70 patients were included out of these 18 patients had received antenatal care properly while 52 had not received it properly. Antenatal care was received by specialists / consultant in 30(42.85%) patients, by general practitioner in 23(32.85%) patients, by midwives 12(17.14%) and under antenatal of Dais were 5(7.14%) patients.

Most of the cases i.e. 45(64.28%) were with age group of 30-40 years and 33(46%) were multipara while 28(41.2%) were grand multipara. 27(37%) patients were from poor socioeconomic class while 22 (32.4%) patients belong to upper class and 21 (30.9%) from middle class. Majority of the patients in this study had received only primary level education while 18(24%) were illiterate and only 9(13.2%) were graduated. Regarding husbands education, 20(29.4%) were

graduate while 19(27.9%) had received secondary education and 17(23%) patients were illiterate.

TABLE:1.

When patients were interviewed that why they had not received antenatal care than most important reason found was poverty which was found in 27(38.57%) of patients. 11(15.71%) patients had not received antenatal care because facility was far away from their home, while 19(14.28%) patients said that nobody advised them and 7(10%) patients had no transport.**TABLE:2.**

Table 3 shows factors affecting the use of antenatal care. Results shows that patient education and sec affect the use of antenatal care and result are significant. P=0.003 and P=0.045 respectively.

TABLE:3.**TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF WOMEN n= N=70**

VARIABLES	FREQUENCY	PERCENTAGE
Age Groups		
<30	10	14.28
30-40	45	64.28
>40	15	21.42
Parity		
Nullipara	9	13.2
Multipara	33	46.0
Grand multipara	28	41.2
SEC		
Poor	27	37.0
Middle	21	30.9
Upper	22	32.4
Education level		
Illiterate	18	24.0
Primary	30	44.1
Secondary	13	19.1
Graduate	9	13.2
Husband education		
Illiterate	17	23.0
Primary	14	20.6
Secondary	19	27.9
Graduate	20	29.4

TABLE 2: REASONS FOR POOR ANTENATAL CARE

Reasons for poor antenatal care	N =70	Percentage (%)
No antenatal care is important	06	8.57
Nobody advised for antenatal care	10	14.28
Husband did not gave permission	09	12.85
Facility of hospital is far away	11	15.71
Transport not available	07	10.0
Poverty	27	38.57
Ignorance	07	10.0

TABLE3: EFFECTS OF EDUCATION, PARITY AND SOCIOECONOMIC STATUS ON ANTENATAL CARE (n= 70)

VARIABLES	Antenatal care USED (n=18)	Antenatal care NOT USED (n=52)	Chi Square	P- value
Patient education				
Illiterate	1(05.6%)	17(30.3%)	13.760	0.003
Primary	5(27.8%)	25(50.0%)		
Secondary	7(38.9%)	6(12.0%)		
Graduate	5(27.8%)	4(8.0%)		
Husband education				
Illiterate	4(22.2%)	13(22.3%)	0.924	0.820
Primary	5(27.8%)	9(18%)		
Secondary	4(22.2%)	15(30%)		
Graduate	5(27.8%)	15(30%)		
Parity				
Nulliparous	3(33.3%)	6(12%)	1.487	0.475
Multiparous	8(34%)	25(50%)		
Grand multiparous	9(50%)	19(38%)		
SEC				
Poor	5(27.8%)	22(40.2%)	6.213	0.045
Middle	3(16.7%)	18(36%)		
Upper	10(55.6%)	12(24%)		

DISCUSSION:

In our population, healthcare facilities are generally poor, however they are predominantly inadequate for maternal wellbeing resulting in adverse consequences for both newborns and females. Antenatal care is termed as a safe maternity initiative: though its comparative role in maternal healthcare has been under dispute, its significance is undeniable. Although maternal death has declined over the years and growing number of females do seek ANC facilities throughout pregnancy, several females yet do not follow the suggestion of \geq four visits. In this study, majority of the patients i.e. 45 (64.28%) were from age group of 30-40 years and 33 (46%) were multipara while 28 (41.2%) were grand multipara. 27(37%) patients were from poor class while 22 (32.4%) patients belong to upper class and 21 (30.9%) from middle class. Majority of the patients in this study had received primary education while 18(24%) were illiterate and only 9 (13.2%) were graduated. Regarding husbands education, 20 (29.4%) were graduate while 19 (27.9%) had received secondary education and 17 (23%) patients were illiterate.

Results of the study conducted in Ethiopia reveal that pregnant females with age ranging from 15 to 19 years were further likely to look for ANC facilities contrasted to the females aged from 35 to 39 years [14], which is consistent with our findings. One more study from Tanzania explored factors correlated with ANC appointments and established that younger females had considerably higher likelihoods of making 4 ANC appointments contrasted to older age females [15]. Though, studies exploring the correlation of females' age with ANC use are incoherent [16]. A review of findings recounted that females' education is positively correlated with antenatal care use [17, 18]. There are several accounts for education to be a key factor of demand. Education is expected to develop female independence: females thus acquire greater capabilities and confidence to take decisions about their own and their children's wellbeing. It is expected that more educated females look for higher quality facilities and possess higher ability to utilize healthcare contributions to produce better wellbeing. Education is significant as stated in further studies, only in presence of formal schooling years [19]. In this study, total 122 patients were included. Out of these, 70 patients had received antenatal care properly while 52 had not received it. A community based cross-sectional study from Ethiopia exhibits that 42% participants of study made below 4 visits to clinics of ANC throughout pregnancy [20]. Alike

findings were encountered from a study from Uganda [21] Antenatal care is a significant factor of perinatal and maternal mortality and ANC visits is a vital element of maternal healthcare on which wellbeing of newborns and mothers is dependent. Females' lack of independence is a crucial restriction in obtaining desired care. Cultural limits on mobility are a substantial obstacle to females' approach to maternal health facilities. Majority of females had no permission to move around freely, and most are prohibited to go alone in public. In our study, when patients were interviewed that why they had not received antenatal care than most important reason found was poverty which was seen in 27(38.57%) of patients . 11(15.71%) patients had not received antenatal care because facility was far away from their home, while 19(14.28%) patientsaid that nobody advised them and 7(10%) patients had no transport.

Another study conducted by Akashi Andrew Rurangirwa et al reported that around 54% of pregnant females did not seek for the suggested 4 ANC visits throughout pregnancy. The risk of poor use of ANC provisions was greater among females aged \geq 31 years (AOR, 1.78; 95% CI: 1.14, 2.78), in single females (AOR, 2.99; 95% CI: 1.83, 4.75) and females with poor social provision (AOR, 1.71; 95% CI: 1.09, 2.67) [22]. Another study conducted by Abdul ghaffar et al [23] reported that females from high wealth index and with education had further likelihoods to get ANC. Antenatal care was received by specialists / consultant in 30(42.85%) patients, by general practitioner in 23(32.85%) patients , by midwives in 12(17.14%) and by dais in 5(7.14%) patients in our study.

In comparison to these results, study conducted by N. Nisar et al [24] reported that among 152 females who obtained antenatal-care, 33% received it from an inexpert care provider (specially a dai), 20.4% from midwives, 20.4% from a nurse , 19.1% from a doctor and 7% from Lady Health Visitors. Studies have exhibited that traditional birth attendants and doctors are the lead ANC providers of antenatal care. [25]. In Pakistan primary healthcare facilities are delivered via other health workforces comprising community health personnel for instance community midwives, lady health visitors and lady health workers. The contribution of these further health workers did not exhibit any significant correlation with the number of ANC appointments. It is evident that the quality of facilities delivered by nurses and doctors can elevate number of visits in the course of ANC [26].

In this study, when patients were interviewed about factors influencing the use of antenatal care, results showed that patient education and sex affect the use

of antenatal care and result were significant. $P=0.003$ and $P=0.045$ respectively. Household wealth and Education are significantly correlated with ANC use [27]. It is obvious that woman literacy can raise the 'want' side factors to attain healthcare however undoubtedly cannot balance deficiencies in providing services. These scarcities can be relieved via higher levels of government expenses and contribution in health care that will encourage higher usage rates of maternal health facilities [28]. This study exhibited that richer pregnant females achieved further ANC than pregnant females in lower wealth. Various studies established that populace from lower income levels have poor usage and sense preventive, curative and promotive characteristics of healthcare facilities. They are negatively correlated with good health status and positive health outcomes [29,30].

CONCLUSION:

We concluded that unavailability of antenatal clinics nearly, low education level and poor socioeconomic status were the most common reason behind poor antenatal care. Ignorance and unconsciousness had also a big role in poor antenatal care. Strategies should be developed regarding antenatal care including awareness regarding its importance.

REFERENCES:

1. Agus Y, Horiuchi S. Factors influencing the use of antenatal care in rural West Sumatra, Indonesia. *BMC pregnancy and childbirth* 2012 Dec;12(1):9.
2. Baker PN, editor. *Obstetric by Ten Teachers*. 18th ed. Cambridge: Arnold. 2006; 72-83.
3. Bhutta ZA, Hafeez A, Rizvi A, Ali N, Khan A, Ahmad F, et al. Reproductive, maternal, newborn, and child health in Pakistan: challenges and opportunities. *Lancet*. 2013;381(9884):2207-2218.
4. WHO, UNICEF, UNFPA, Bank TW, Division UNP. *Trends in Maternal Mortality: 1990 to 2013*. World Health Organization 2014.
5. UN. *The Millennium Development Goals Report 2013*. New York: United nations; 2013.
- 6 Celik Y, Hotchkiss DR. The socioeconomic determinants of maternal health care utilization in Turkey. *Soc Sci Med* 2000;50:1797-1806.
7. Bhatia JC. Levels and causes of maternal mortality in Southern India. *Stud Fam Plnng* 1993; 24: 310-8.
8. Abou-Zahr C, Wardlaw T. Antenatal care in developing countries: promises, achievements and missed opportunities: an analysis of trends, levels and differentials, 1990–2001. Geneva: World Health Organization. 2003.
9. Berhan Y, Berhan A. Causes of maternal mortality in Ethiopia: a significant decline in abortion related death. *Ethiopian journal of health sciences*. 2014;24:15-28
10. Sadiq AA, Poggensee G, Nguku P, Sabitu K, Abubakar A, Puone T. Factors associated with adverse pregnancy outcomes and perceptions of risk factors among reproductive age women in soba LGA, Kaduna state 2013. *The Pan African medical journal*. 2016;25.
11. Miltenburg AS, van der Eem L, Nyanza EC, van Pelt S, Ndaki P, Basinda N, Sundby J. Antenatal care and opportunities for quality improvement of service provision in resource limited settings: A mixed methods study. *PloS one*. 2017;13;12(12):e0188279.
12. WHO & UNICEF: *Antenatal Care in Developing Countries: Promises, Achievement and Opportunities: An Analysis of Trends, Levels, and Differentials. 1990-2001*. 2003, Geneva: WHO & UNICEF
13. Simkhada B, Teijlingen E, Porter M, Simkhada P: Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. *J Adv Nurs*. 2007, 61: 244-260
14. Bayu H, Adefris M, Amano A, Abuhay M. Pregnant women's preference and factors associated with institutional delivery service utilization in Debra Markos Town, North West Ethiopia: a community based follow up study. *BMC Pregnancy Childbirth*. 2015;15:15.
14. Shivam G, Yea G. Factors Associated with Four or More Antenatal Care Visits and Its Decline among Pregnant Women in Tanzania between 1999 and 2010. 2014.
15. Swenson IE, Thang NM, Nhan VQ, Tieu PX. Factors related to the utilization of prenatal care in Vietnam. *J Trop Med Hyg*. 1993;96(2):76–85
16. Kwast BE, Liff JM. Factors associated with maternal mortality in Addis Ababa, Ethiopia. *Int JEpidemiol* 1988;17:115-21.
17. United Nation International Children Emergency Fund, Pakistan. *Women's health in Pakistan, fact sheets prepared for Pakistan National Forum on Women's Health 3-5 November, 1997*, pp. 1617.
18. McDonald TP, Cobum AF. Predictors of prenatal care utilization. *Soc Sci Med* 1988;27:167-72.
19. Abosse Z, Woldie M, Ololo S. Factors influencing antenatal care service utilization in hadiya zone. *Ethiop J Health Sci*. 2010;20(2):75–82.
20. Kawungezi PC, AkiiBua D, Aleni C, Chitayi M, Niwaha A, Kazibwe A, Sunya E, Mumbere EW, Mutesi C, Tukei C, et al. Attendance and Utilization of Antenatal Care (ANC) Services: Multi-Center Study in Upcountry Areas of Uganda. *Open J Prev Med*. 2015;5(3):132–42.
22. Rurangirwa AA, Mogren I, Nyirazinyoye L, Ntaganira J, Krantz G. Determinants of poor utilization of antenatal care services among recently delivered women in Rwanda; a population based study. *BMC pregnancy and childbirth*. 2017 Dec;17(1):142.
23. Ghaffar A, Pongponich S, Ghaffar N, Mehmood T. Factors associated with utilization of antenatal care services in Balochistan province of Pakistan: An analysis of the Multiple Indicator Cluster Survey (MICS) 2010. *Pak J Med Sci* 2015;31(6):1447-1452.
24. N. Nisar, F. White. Factors affecting utilization of Antenatal Care among reproductive age group Women (15-49 years) in an urban squatter settlement of Karachi. *JPMA*, Vol 53, No.2, Jan. 2008.

25. Pallikadavath S, Foss M, Stones RW. Antenatal care: provision and inequality in rural north India. *Soc Sci Med.* 2004;59(6):11471158.
26. Ghaffar A, Pongpanich S, Ghaffar N, Chapman RS, Mureed S. Expediting support for the pregnant mothers to obtain antenatal care at public health facilities in rural areas of Balochistan province, Pakistan. *Pak J Med Sci.* 2015;31(3). doi: 10.12669/ pjms.313.7082
27. Goland E, Hoa DT, Malqvist M. Inequity in maternal health care utilization in Vietnam. *Int J Equity Health.* 2012;11(1):24.
28. Kruk ME, Galea S, Prescott M, Freedman LP. Health care financing and utilization of maternal health services in developing countries. *Health Policy Planning.* 2007;22(5):303310.
29. Rahman M, Haque S, Mostofa M, Tarivonda L, Shuaib M. Wealth inequality and utilization of reproductive health services in the Republic of Vanuatu: insights from the multiple indicator cluster survey, 2007. *Int J Equity Health.* 2011;10(1):58.
30. Magadi MA, Madise NJ, Rodrigues RN. Frequency and timing of antenatal care in Kenya: explaining the variations between women of different communities. *Soc Sci Med.* 2000;51(4):551561