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## RESEARCH ARTICLE

### STUDY OF PREGNANCY COMPLICATIONS IN CORRELATION WITH EDUCATIONAL STATUS IN A TEACHING HOSPITAL

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#### ABSTRACT

Maternal complications and poor perinatal outcome are highly associated with nonutilisation of antenatal care services and poor socioeconomic conditions of the patient. It is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies. Study designed to assess the educational status and sociodemographic data and its risk of pregnancy outcome in rural care teaching hospital. A total of 120 study participants were enrolled in this study. Poor knowledge about prelacteal feed, and nutrition consumption was noted in the population. The mean age was 28.3±10.6 years. A majority of the women were within the age group 20-29 years. Almost half of the pregnant women had no formal education. The majority of the women had 2-5 children, but 2.5 % had more than 5 children. The majority of the women had their last delivery after 24 months. Hence, Antenatal care and its education may improve the quality, accessibility, and utilization of maternal health care services provided by the government agencies in both rural and urban areas.

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#### INTRODUCTION

It is a well-known fact that literacy among women in many developing countries is low, and there are sociocultural beliefs and practices with adverse effects on pregnancy and birth occurring even among educated women (1). Antenatal care (ANC) is a careful, systematic assessment and follow-up of pregnant women that includes education, counseling, screening, and treatment to assure the best possible health of the mother and her fetus (2). The principles of ANC for women with uncomplicated pregnancies are to provide advice, education, reassurance, and support; to address and treat the minor problems of pregnancy; and to provide effective screening during the pregnancy (3). There were many studies done which found that educated women have better pregnancy outcomes compared with uneducated women and that education during the antenatal period can reduce pregnancy and delivery complications (4). A single antenatal visit does not give information about the completeness and components of the care provided. Additional indicators were the number of visits (it is recommended by WHO that at least four are made during the pregnancy) and the timing (ideally, ANC should be initiated within the first 12 weeks of pregnancy). Women in rural India experience more episodes of illness than males. These women have less access to health care facilities before the illness is well advanced. This situation is directly linked to poverty; a vast majority of poor women caught in this vicious circle are young mothers in the reproductive age, who are deprived of their basic right to be healthy (5).

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The aim of this study was to assess the educational and demographic parameters to assess the risk status of the pregnant women presenting for antenatal care in a rural health facility. The information obtained from this study will be used to help develop guidelines for community-based interventions to improve the content and utilization of antenatal care services and to reinforce existing policy documents on maternal health care.

#### METHODOLOGY

This descriptive study was conducted for 2 years duration at Department of Obstetrics and Gynaecology, GMC Srinagar, India. The study population comprised 120 women aged 18-40 years. The questionnaire included questions on socio demographic data (age, education, employment and family income/month), medical history (previous pregnancy complications), clinical data (complication during this pregnancy, treatment and blood pressure), and food and drink intake.

#### RESULTS

The demographic characteristics of age and education of the 120 pregnant women selected and interviewed for the study are shown in Table 1 and Table 2. The age range of the women was 18-42 years. The mean age was 28.3±10.6 years. A majority of the women (49.17%) were within the age group 20-29 years. Almost half of the pregnant women (43.3%) had no formal education. The maternal history characteristics of the women interviewed are shown in Table 2. The majority of the women had their last delivery after 24 months.

The majority of the women had 2-5 children, but 2.5% had more than 5 children. An additional examination of the current antenatal care practices and prior delivery history of the women with high risk pregnancies is shown in Table 3.

**Table 1. Demographic characteristics**

Demographic characteristics	Frequency	% total
Total population	120	
Age group		
<19	25	20.84
20-29	59	49.17
30-39	29	24.17
>40	7	5.89
Education		
No formal education	52	43.33
Primary school	30	25
Secondary school	25	20.83
Higher studies	13	10.84

**Table 2. Maternal characteristics**

Characteristics	Frequency	% Total
Time of last delivery		
<24 months	58	48.33
>24 months	62	51.67
Number of children		
0-1	58	48.33
2-5	59	49.16
>5	3	2.5
History of previous obstetric complications and perinatal deaths		
Yes	22	18.33
No	98	81.66

## DISCUSSION

WHO defines maternal death as 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 (6). Pregnancy related complications are among the leading causes of death and disability for women aged 15-49 in developing countries. The desired outcome of pregnancy is always a healthy mother and a healthy baby. The results of this study showed that a substantial proportion of the women visiting the Department of Obstetrics and Gynaecology, GMC Srinagar, India for antenatal care could be classified as having a high risk pregnancy. 28% of pregnant women showing high risk pregnancies sought antenatal care late, in the second and third trimesters of pregnancy. This is in keeping with the findings of most previous studies from rural area pregnant women in other parts of the country as well. While it was not within the scope of this study to explore the reasons for this practice, previous studies suggest that ignorance of and misconceptions about the purpose of antenatal care, and financial constraints, are the dominant underlying factors in late initiation of antenatal care (7). Late initiation of antenatal care is clearly detrimental to the achievement of the objectives of modern antenatal care and negates the recommendations of the World Health Organization on the optimal timing of the commencement of antenatal care in developing countries (8). It prevents early detection and modification of many pre-existing or pregnancy-related conditions like chronic hypertension, diabetes mellitus, cervical incompetence, and infections.

It prevents early commencement of health education. Because there is no reliable way to predict which woman will develop pregnancy-related complications, it is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies. Maternal complications and poor perinatal outcome are highly associated with nonutilization of antenatal and delivery care services and poor socioeconomic conditions of the patient. Poorer outcomes are seen in unbooked than booked patients (9). In low-and middle-income countries, less than half of all pregnant women have a

minimum of four antenatal care visits (10). Educational status has significant impact on the utilisation of the ANC services. This can be reflected from the fact that comparatively there were more full term deliveries among urban (91.8%) subjects who were more educated than that of among the rural subjects (87.8%). Adekanle and Isawumi reported that those who had primary school education or none, 152(85.4%), were more likely to register late compared to those who had secondary school education and above, 215(79.3%) (11). among teenage mothers (15-19) death due to abortion is the highest, followed by bleeding of pregnancy, anaemia, and toxemia. Also prevalence of death due to bleeding gradually decreases with age. Most of the maternal deaths are concentrated in age 20-24 (12). Our findings and that of previous workers is that there is a deep seated belief in the safety of traditional birth attendants by rural women and that current antenatal clinic-based health education programmes may have been largely ineffective in modifying the attitudes of rural women towards antenatal care by traditional birth attendants. This suggests a need for community-based studies to clearly identify the basis for belief in intrapartum care by traditional birth attendants and hence plan appropriate interventions to effect a change. Almost half of the study population was mainly comprised of women with little education and low socioeconomic status. These are factors recognized to influence access to information on crucial health issues including contraception. These factors underlie the need to develop and implement effective community-driven family planning educational programmes to effect longer birth intervals and smaller family sizes.

## Conclusion

Utilization of maternal and child health care (MCH) services was poor in both urban and rural areas. Early antenatal registration and regular attendance at antenatal clinics will allow for early detection and correction of pregnancy complications. Awareness of women regarding her health assumes special significance in the Indian context because the maternal health problems are mainly due to ignorance, poverty, and lack of knowledge regarding the issue.

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