

Health Services and Rural Pregnant Mothers

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One thousand consecutive births were recorded in a rural community of a north Indian State. And retrospective study on every third mother was carried out to record utilization of health services during pregnancy. More than 40% of mothers who suffered from weakness, oedema and bleeding P/V, did not avail medical help. And those who got treatment favoured private practitioners than government medical facilities.

ANTE-NATAL care has a profound effect on the outcome of pregnancy, in relation to perinatal mortality rates, incidence of low birth weight babies and tetanus neonatorum. And care during pregnancy is one of the few areas of medical practice for which clearly formulated minimum standards are available concerning time for initiation of medical care, frequency of patients visits and contents of professional care.¹ However, disparity exists between need and utilization of professional services.²

One of the causes of this disparity may be that there is inadequate health infrastructure to provide care to the rural pregnant mothers. Within miles the equipments like syphygnomono-meter, weighing balance and examination table are not available, and the mere contact with health personnel does not serve the purpose for high risk mothers who need timely referral. Over and above it, poor nourished women are the ones who get and seek little care during pregnancy.

As Gardinar points out: "Poor people live from day to day, from crisis to crisis, and they seek medical care only when the disability or discomfort becomes severe enough to constitute a crisis. Pregnancy in the majority of the instances is not believed to achieve a crisis status until the third trimester and for many not even until labour begins."³

Apart from keeping pregnancy away from the medical attention, the rural pregnant mothers have great faith in traditional birth attendants who are illiterate, from poor families and are volunteer workers and have no effective referral links with health institutions. Studies on the utilization of health services by pregnant mothers from rural set up are scarce. Whereas such studies can be of immense help to introspect the existing pattern of delivery of health services.

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The present study was undertaken in a backward rural community development block of a northern state to evaluate the pattern of utilization of health care during pregnancy. In the block, mostly the land is unirrigated and there is no industry. Part of the block is hilly area with seasonal rivulets which make around 25% of these villages cut off during monsoon, though most of the villages are connected by metalled roads. Every village has electricity. Facilities like educational institutions for primary and secondary education have shown an increase during the study period.

The Block-Level Set-Up

The health institutions in the block include a primary health centre, 3 rural dispensaries, 23 subcentres, 3 maternal and child health centres and 6 Government Ayurvedic dispensaries to provide health services in the area. In each village, community health guide and Anganwari worker were also available to extend first aid and nutrition services. On an average one traditional birth attendant was available for 500 population. The referral services in the area were provided by a Tehsil hospital, district hospital and a Postgraduate Medical Institution. For providing antenatal services, multipurpose workers and female supervisors hold antenatal clinics at all subcentres, maternal and child health centres and at primary health centre once a week.

Female multipurpose workers are also entrusted with the job of making home visits to mothers for registering pregnant mothers and educating them to attend antenatal clinics.

For the study, villages were selected randomly to represent about 10% of the population of the block. The selection of the villages was by stratified random method with stratification based on the presence or absence of health facility in the villages. The sample for study comprised a village with Primary Health Centre, a village with subcentre and two villages with no subcentre. The general characteristics of the villages in respect to population during study period, distance from health facilities, availability of health persons in the villages and some of the basic equipments to provide antenatal care are given in Table 1. About 63% of this population belonged to lower socio-economic status, and about 60% of them were living in joint families. Head of 72% of these families were illiterate.

Among the chosen population, the first 1000 consecutive deliveries were recorded during the period of September, 1978 to January, 1982. Home

visit was paid to every third of these mothers within a week of delivery, and detailed information was sought on a pretested semistructured proforma. The proforma comprised information on social status of the mothers, their obstetric and prenatal history and utilization of health services during pregnancy. The respondents were mothers, their family members, traditional birth attendants and multipurpose workers/supervisors.

Thus the study is retrospective, based on recall method and interview schedule. However, the interviews were conducted in congenial atmosphere of homes after building good rapport with families. In most of the cases, two or more home visits were paid to get information.

Observations

Age of 76.4% mothers was below 35 years 75.5% were illiterate and 96.6% were housewives. Twenty four percent of mothers were Primipara, 25.2% of mothers were second para, 31.8% were of third and fourth para and 19% were above fourth para. According to history 62% of mothers did not have any health complaints, whereas 33.9% of mothers suffered from complaints like malaria/fever, 18.9% from diarrhoea/constipation and 13.2% from excessive vomiting (Table 2). Amongst significant problems reported, 7.1% mothers had swelling over face and feet, 10.8% mothers had bleeding per vagina during pregnancy, the severity of which ranged from spotting to heavy bleeding and 3.4% suffered from communicable diseases.

Table 3 shows the treatment pattern according to various health complaints. About 50 to 70% of mothers did not seek any treatment for complaints of diarrhoea/constipation, excessive vomiting, weakness/aches and pains, oedema, heaviness in lower abdomen and vaginal infection. This leads to thinking that complaints were either of less severity or mothers were ignorant of their complications. 'No treatment' for oedema (54.6%) bleeding P.V. (40%) and weakness (62.9%) can lead to severe complications for both mothers and their foetus. Those who got treatment favoured private practitioners for complaints like diarrhoea, constipation, weakness, aches and pains, bleeding P.V. and vaginal infection. For skin infections and communicable diseases, the treatment of government health personnel were favoured. For other health complaints both agencies (government and private) had almost equal number of clients. Table 4 depicts pattern of seeking treatment for health complaints in relation to the availability of government health services. However, the number of cases were few to make any useful comparison of treatment seeking pattern. And it is difficult to say whether the utilisation pattern is appropriate or not. Preference to avail services of private practitioners is clearly depicted.

On the whole 63.2% of pregnant mothers attended MCH clinics, and 11.5% consulted private medical practitioners for promotion of health. Vitamins and mineral tablets were consumed by 46.7% of pregnant mothers, though only 28.3% of mothers

had these tablets for more than one month. And 39.2% of pregnant mothers did not have tetanus toxoid immunization even though home confinement is the rule in the study villages. Response of attending maternal and child health clinics and getting immunization against tetanus was found less often by mothers who lived in villages where there was no statutory health facilities, but had to travel 1 to 5 km for attending clinic or were dependent on health workers to visit their homes (Table 5).

Findings of the study do not give an encouraging account of utilization of health services by pregnant mothers. There is paucity of studies from rural areas to confirm the findings. Work needs to be undertaken to find out prospective health problems of pregnant mothers and their utilization of health

Table 1

General Characteristics of the Study Villages

Characteristics	Village with PHC	Villages with subcentres	Village with no health post
Population	4296	3756	2007
Distance in km. from			
Sub-centre/MCH	—	—	1
P.H.C.	0	12	11 to 22
Tehsil Hospital	17	30	29 to 40
District Hospital	50	40	41 to 50
Resident Workers			
T.B.A.	8	5	5
R.M.P.	8	16	—
Anganwarhi workers	2	3	1
C.H.G.	2	2	3
M.P.W. (F)	2	1	—
Health Supervisor (F)	2	—	—
Doctors	4	—	—
Equipments			
For urine test	+	+	—
For H.B. estimation	+	—	—
Sphygmomeno meter	+	—	—
Weighing balance	+	+	—
Examination table	+	+	—

+ present
— not present

services during normal health and for sickness. It has been pointed out even by professionals that mothers having good health during pregnancy need no professional care. But rural pregnant mothers who are malnourished, anaemic and bear 30-60 perinatal mortality rate definitely need the best of care that the health profession can provide to them.

This care becomes more acute when deliveries take place at homes in villages, where first aid during emergencies is non-existent and transportation becomes impossible to save mother and babies. Ways and means of enlisting community support to reach all pregnant mothers must be found. Self learning and evaluating record of health for mothers, TBAs and health workers need to be developed and equipment to provide minimum care during pregnancy must be made available at centres near residential areas which are accessible to the pregnant mothers. Findings that registered practitioners are popular to provide care for health complaints than the government health workers, need to be seriously considered while planning to provide drugs to the health workers.

Corporating registered practitioners in health manpower for providing antenatal care can be tested as alternate strategy of delivery of health services for rural communities. For having health for all by 2000 A.D. it is time to look after every foetus and every pregnant mother.

Table 2

Health Problems Reported by Pregnant Mothers

Health problems	N-333	Percentages
No problems	205	(61.6)
Problems experienced	128	(38.4)
<i>Types of health problems</i>		
Fever	113	(33.9)
Diarrhoea/constipation	60	(18.9)
Excessive vomiting (early pregnancy)	44	(13.2)
Weakness/Aches and pains	36	(10.8)
Swelling over feet and hands	24	(7.1)
Pain or heaviness lower abdomen	19	(17.1)
Bleeding per vagina	12	(10.8)
Others	54	(16.2)

* Typhoid, Tuberculosis, Jaundice, Skin infections and prolapse uterus.

Note: Mothers experienced multiple problems/several episodes were included as one.

Table 3

Medical Care Sought for Health Problems by Pregnant Mothers

Health problems	Total 333	Care not sought		Contacted Govt. health personnel		Contacted private practitioners	
		N	Y	N	Y	N	Y
Fever	113	28	(22.7)	50	(40.6)	35	(36.7)
Diarrhoea/Constipation	60	36	(60.0)	8	(13.4)	16	(26.6)
Excessive vomiting	44	25	(56.9)	9	(20.4)	10	(22.7)
Weakness/Aches and pains	36	23	(63.9)	5	(13.9)	8	(22.2)
Swelling over feet and hands	24	14	(58.4)	6	(25.0)	4	(16.6)
Pain/heaviness lower abdomen	19	13	(62.5)	2	(10.5)	4	(21.0)
Bleeding per vagina	12	6	(50.0)	2	(10.7)	4	(32.3)
Others	54	34	(63.0)	12	(22.2)	8	(14.8)

NB : — Birth attendant's help was sought for pain in legs, pain in abdomen and for suspected abortion by 3 mothers.
 — Syanas help was sought for pain abdomen, epileptic fits and evil spirit by other 3 mothers.
 — One mother got radiotherapy for keloids on legs till 30 weeks of pregnancy.

Table 4

Percentage of Mothers (having health problems) who Sought Care in Relation to Available Health Facilities in their Villages.

Health problems	PHC		Villages with health facilities				No health post	
			Sub-Centre					
	N	%	N	%	N	%	N	%
1. Fever	29	(87.8)	30	(62.5)	25	(81.3)		
2. Diarrhoea/constipation	6	(31.6)	15	(60.0)	3	(18.8)		
3. Excessive vomiting	9	(39.1)	8	(66.7)	2	(22.2)		
4. Weakness/Aches and pains	4	(30.8)	6	(33.3)	3	(60.0)		
5. Swelling over feet	3	(42.9)	7	(100.0)	—			
6. Pain or heaviness lower Abdomen	1	(12.5)	3	(75.0)	2	(28.6)		
7. Bleeding per vagina	2	(66.7)	3	(60.0)	1	(25.0)		
8. Others	12	(80.0)	7	(31.8)	1	(5.9)		

NB : Percentage is calculated from the number of mothers suffering from respective problems in the village.

Table 5

Care Received by Pregnant Mothers

Care	Total		PHC	Available Health Services in the Villages			
				Sub-Centre		No Health Post	
Attended MCH clinics	207	(62.16)	80	(69.56)	94	(78.33)	33 (33.67)
Consulted private practitioners	40	(12.01)	5	(4.34)	23	(19.16)	7 (7.14)
Supplemented vitamin and minerals/tablets	152	(45.64)	64	(55.65)	51	(42.50)	37 (37.75)
Received tetanus toxoid	225	(67.39)	89	(71.89)	86	(71.06)	50 (51.02)
	333		115		120		98