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Knowledge Attitude and Practice Regarding Maternal Health Care Services

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ABSTRACT

Through this paper the author aims to provide a high-level overview of the root cause of the issue of sedentary life. With the onset of the modern age came the onset of a new category of diseases, the diseases caused due to a sedentary lifestyle. With a fall of 30% since 1960 in jobs requiring physical activity, 80% of jobs today are sedentary or require only light activity. According to WHO, 60-85% of the population does not engage in enough activity keeping this thought in mind the author through this paper aims to shows that the rate of diseases like obesity, cardiovascular diseases and diabetes type-2 has increased substantially since the 1950s, which may be attributed to the increased availability, affordability and range of different machines for different purposes which has made life easier and at the same time brought human energy expenditure to a relative stand still.

Keywords: Sedentary; Diabetes; Obesity; Cardiovascular diseases; Headaches

INTRODUCTION

Maternal health is a giant project in the majority developing countries. With the loss of mother's life 673/100,000 and 19,000 maternal deaths per year, it makes biggest contribution to the death of all mothers around the world [1].

To check the knowledge, attitude, and practice regarding the antenatal, natal and post natal health care among these women during period of pregnancy. Knowledge about Pregnancy complications, educational background and belief in women, prenatal health care, transportation and postnatal health care providers and individual, institutional, social and cultural qualitative data was created to establish a meaningful relationship between those looking for triangular behaviours [2].

Maternal healthcare offerings have been with the most superb interventions to restriction maternal morbidity and mortality. Because of this truth, developing nations has recognized a particular thinking to it in the preceding two decades. Maternal health is with the six most essential hassle areas in the reproductive health coverage of the country. A discovers out about suggests the increment of lady who are getting maternal fitness care preferences from time to time. Though, the maternal health care looking for matters to do of lady is then again low down. One clarification for horrible health penalties between ladies is the non-use of up to date health care provider with the aid of way of way of way of a large extent of women in the country.

Misconceptions or lack of interest or information, and the demand for harmful social and cultural norms have significant barriers to the management and access to reproductive health services, especially for socially educated groups. The National Medicines Service (NDS) is only to meet the required operating standards, however, especially for reproductive health and maternal, newborn, neonatal and adolescent health services (RMNCAC) average increase in pregnancy. This vision is a key element in development country plans and policies to achieve the Sustainable Development Goals (SDG), in particular by using 2030 and Dreams 3 and 5. In addition, the United Nations Women's Initiative, in line with the United Nations Women's Initiative, ensures that every child can significantly reduce maternal and infant mortality from preventable causes, as outlined in the regulatory framework [3].

The use of a maternal health facility had little place information. Recent efforts to cope with persistent inequalities in the condition of mother, infant and child used the "life cycle" perspective to improve health and prevent disease. Accidental pregnancy is associated with a range of community health problems, including delays in antenatal care, negative maternal health and preterm labour. In response, prenatal health interventions aim to promote physical fitness for women and children early in pregnancy and beyond, and to focus on identifying evidence-based interventions and increasing community compliance concerns [4].

It highlights prenatal care as an important part of maternity health care because proper care will lead to successful pregnancy outcomes

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and healthy babies. Better development for maternal health is one of the progressive goals of thousand years. A development goal (MDG) 5 was put in place to 'Improve maternal health' it was supported by. Knowledge was assessed about ANC visits, tetanus immunization, investigations, and nutritional factors, danger signs of pregnancy, contraception, and personal habits. Each parameter was awarded. The aim of this study was to find out the level of knowledge, attitude and practice (KAP) on maternal health care of rural married women of KAP. Study tells us what people know about certain things, how they feel and also how they behaved. A sound knowledge, correct attitude and proper practice of antenatal, intra natal and postnatal care and early detection of danger signs and seeking medical help from appropriate centres could lower the mortality and morbidity [5].

LITERATURE REVIEW

Pakistan is the sixth most crowded united states of the united states of one hundred eighty Million human beings with population mass of 548.51sqmi. According to World Bank report, lady is 48.6% of the populace amongst an estimated existence hope of 65.45 years. 2 Around 800 women for the duration of the world die all day in being pregnant and its related complications. In growing countries, it is in addition cautious as subsequent most quintessential purpose of loss of life after HIV sickness with ladies of reproductive age. The explanations of maternal deaths consist of sever haemorrhage, infections, risky abortions and hypertensive disorders [3].

Globally, over 90% of births and infants die in developing countries, depending on the highest number of deaths due to population distribution. No contact or inability of maternal health priorities will increase the risk of pregnancy and childbirth problems, which may impact the high cost of maternity and death, reducing the chances of the unborn child. In Asia, the health care system does not meet the needs of women in healthcare. The maternal mortality rate in Asia remained inappropriately high, with more than 510 maternal deaths per 100,000 live births. For decades, there has been increasing practice in providing and accessing health-care offers to mothers in developing countries, especially in those emerging from years of long civil war, such as Liberia. Activity is a common effort to reduce maternal and neonatal mortality rates that are continuously recorded at high prevalence [5].

Every 12 months, approximately 1,200 girls in the United States face fatal pregnancy and birth problems and 60 fatal problems - the cost of birth care in the United States surpasses 60 billion in 2012. Dollars There is an abnormal obstetric practice. Hospitals in the United States lack a preferential route to manage obstetric emergencies and pregnancy and childbirth problems are postponed regularly. There is incompatible obstetric practice. Hospitals during the USA lack a favoured bypass towards to managing obstetric emergencies and the issues of being pregnant and childbirth are regularly recognized too delayed. Nationally motivated approach to manage obstetric emergencies and surroundings friendly teaching and on imposing this method is an extreme and persevering with need [6].

MMR necessities are set up alarmingly immoderate in Pakistani population. Earlier a large range (250-500) of MMR used to be advised in a vary of unbiased reports. This marked big distinction in MMR requirements can also additionally be diagnosed to the factors which consists of versions in analyze about design, methodology opted, files set and neighbourhood of hospitals (rural or town area). Based on brand new well-known values to affirm the development tiers set forth by means of capability of way of way of WHO, scenario of MMR in Pakistani populace falls in the range of very excessive mortality (>=500) to excessive mortality (200-500). A share decline of ~47% in MMR has been cited in America smart enchantment photo on UN file for Pakistan. This decline style is additionally in contract with the global give up end result from 400 deaths in 1990 to 210 deaths in 2010 with all outstanding countries. Despite the located decline in MMR with the useful resource of possible of 3.1%, the estimated rate of 5.5% is the set purpose for our population [7].

Mothers are additionally most necessary to make great the health and charge of existence of children. According to the World Health Organization (WHO), moms are the gorgeous companies of care such as diet, oral fitness and psychosomatic health. The role of female in fitness is also significant: data from a survey carried out by way of the utilization of Kantar Health in 2015 show off that quintessential health preferences are outfitted through using way of women. According to the survey, 94% of lady makes picks of their personal healthcare and 59% make healthcare preferences for others. So making certain the mother's fitness is a way to make wonderful the health and well-being of the complete family [8].

One of the key techniques for reducing maternal mortality ratio is make pleasant get entry to and use of maternal and baby health facility. Some of the key interventions which have been delivered through authorities to beautify get appropriate of entry to maternal fitness care facility with the implementation of free maternal fitness care services, linking a maternal scientific team and infant welfare sanatorium in each district, education of guys and girl in tightly closed motherhood skills, abortion care and lactation managing. These rule interventions have to some stage decreased maternal mortality, but the countrywide MMR intention of 187 in each 100,000 childbirths with the useful resource of 2015 stays unachieved indoors these frameworks of interventions furnished with the aid of way of the government as the existing country huge MMR is 319.

PROBLEM STATEMENT

During the survey of community, a lot of problems related to antenatal, natal and postnatal care revealed. This topic is selected to evaluate the knowledge, attitude and practice regarding maternal health care.

OBJECTIVES

1. To find out the knowledge, and attitude of women regarding antenatal services.

2. To investigate the knowledge and attitude of women towards Natal services.

3. To find out the knowledge and attitude of women regarding postnatal services.

OPERATIONAL DEFINITIONS

Antenatal care: Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women.

Intra-Natal care: Intra natal care means care taken during delivery.

Post-natal: Postnatal care (PNC) is the care given to the mother and her new-born baby immediately after the birth and for the first six weeks of life.

HYPOTHESIS

A hypothesis is a statement showing expected relation between 2 variables. A hypothesis is needed in the following study designs:

i. All interventional studies;

ii. Cohort;

iii. Case Control;

iv. Comparative Cross Sectional

MATERIAL AND METHODS

Study Design: It was a cross sectional descriptive study.

Settings: This study was conducted at Ali Raza Abad, Lahore from September 2019 to January 2020.

Duration of Study: Four months, September 2019 to January 2020.

Sample Size: There were about 200 females who were taking antenatal, Natal and post natal services. Sample size was estimated 90 females, assuming 95% confidence level and 5% margin of error.

Sampling Technique: A simple random sampling technique was used to collect data.

Sample Selection:

a) Inclusion Criteria:

1. In this study only those females were included that were taking the antenatal, natal and postnatal services.

2. Females who were willing to participate in this study.

3. Mentally and physically healthy females included.

b) Exclusion Criteria:

1. Unmarried females were not included.

2. Mentally and physically disabled married females excluded.

3. Females not willing for giving information were excluded.

Equipment:

A questionnaire was used to collect data from the participants. The questionnaire was translated into Urdu language, and back into English. The questionnaire included four sections, namely socio-demographic characteristics of the study subjects, knowledge, attitude and practice regarding antenatal aspects, natal aspects, and postnatal aspects.

ETHICAL CONSIDERATIONS

- Written informed consent was taken from all the participants.
- All information and data collection was kept confidential.
- Participants were remained anonymous throughout the study.
- The subjects were informed that there are no disadvantages or risks on the procedure of the study.
- They were also informed that they are free to withdraw at any time during the process of the study.
- Data was kept under key and lock. In laptop it will be kept under password.

DATA COLLECTION PROCEDURE

A questionnaire was used to collect data from the participants. The questionnaire was translated into Urdu language, and back into English. The questionnaire included four sections, namely socio demographic characteristics of the study subjects, knowledge, attitude and practice regarding antenatal aspects, natal aspects, and postnatal aspects.

Independent variables:

1. Antenatal

2. Natal

3. Postnatal

Dependent variables:

1. Knowledge

2. Attitude

3. Practice

DATA ANALYSIS PROCEDURE

The questionnaire consists of two parts of analysis. First part contains Demographic data analysis which includes four questions. Second part includes data of Knowledge, Attitude and Practice regarding maternal health services. The collected data is analysed and computed using frequency, table, charts and graphs trough SSPS version 21 (Figure 1).

DISCUSSION

Unlike most previous studies, this study covered the three dimensions of pregnancy-related care antenatal, natal and postnatal services. In this study, all participants were female (n=105) 39.0% female were 15-25 years old, 48.6% were 26-35 years old, 12.4% were 36-45 years old (Table 1). 30.5% respondents have 10000-20000 monthly income, 49.5% have 21000-30000 and 20.0% have 31000-40000 monthly income (Table 2). 16.2% were illiterate, 30.5% were primary passed, 8.6% were middle passed and 44.8% have matric education (Table 3). 100% participants were Muslims (Table 4).

In this study 62 (59%) participants were respondents for government hospital and 43 (41%) for private clinics. 73 (69.5%) were not satisfied with government services due to long time waited hours for health care services. 18 (17.1%) less than 30mints, 44 (41.9%) 30 min to 1 hour, 43 (41.0%) more than 1 hours. 55 (52.4%) participants were used public transport, 17 (16.2%) were used bicycle and 33 (31.4%) on walking distance from primary health care center (Table 5).

In this study, during delivery (natal care) 69 (65.7%) female respond yes for receive medical care at government center and 36 (34.3%) were respond no. 70 (66.7%) 1-3 visits during pregnancy and 35 (33.3%) more than 3 visits. 55 (52.4%) females were respond for physical examination and 50 (47.6%) gynaecological examination on visit. 82 (78.1%) no any complication were detected during pregnancy and 23 (21.9%)response yes. 48 (43.8%) doctors attend the patient during deliveries 35 (33.5%) nurses and 24 (22.9%) midwifes attend the patients. 59 (56.2%) Participants were completely satisfied and 46 (43.8%) were partially satisfied during delivery (Table 6).

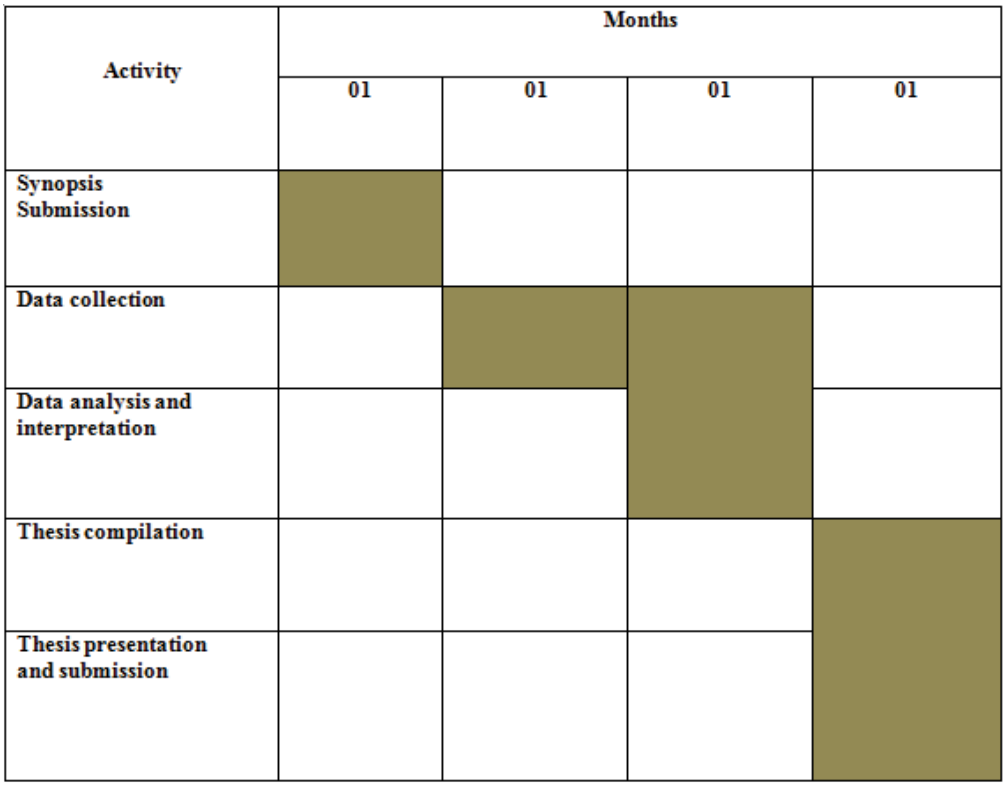

Figure 1: GANTT CHART.

Table 1: Age.

s/no	Age	Frequency	Percentage
1	15-25 years	41	39.0
2	26-35 years	51	48.6
3	36-45 years	13	12.4

Table 2: Income.

s/no	Income	Frequency	Percentage
1	10000-20000	32	30.5
2	21000-30000	52	49.5
3	31000-40000	21	20.0

Table 3: Education.

s/no	Education	Frequency	Percentage
1	Illiterate	17	16.2
2	Primary	32	30.5
3	Middle	9	8.6
4	Matric	17	44.8

Table 4: Religion.

s/no	Religion	Frequency	Percentage
1	Muslim	105	100.0
2	Non-Muslim	0	0

In this study, 100 (95.2) female respond yes and 5 (4.8). 1-2 visits 48 (43.8%) more than 2 visits 59 (56.2) after delivery. 36 (34.3%) female visit after delivery for physical examination, 34 (32.4%) female were came for counselling breastfeeding, 35 (33.3%) female for nutrition supplement. 9 (8.9%)female were visit after delivery and 96 (91.4%) were not visit after delivery. 48 (45.7%) paid patient on demand and 57 (54.3%) no bribes. 59 (56.2%)were completely satisfied with postnatal care and 46 (43.8%) partially not satisfied. in this study suggestion of patient female doctors more than two in OPD for improving maternal health services at government primary health clinics (Table 7).

Unlike most previous studies, this study covered the three dimensions of pregnancy-related care antenatal, natal and postnatal services. This study shows that majority of the pregnant

Table 5: Antinatal.

s/no	Antenatal	Frequency	Percentage
1	Which type of health facility did you visit for maternal health services during your most recent pregnancy?	62 (Government)	59%
		43 (Private)	41%
2	If you did not use a government hospital, what was the primary reason?	73 (Not satisfied)	69.50%
		32 (Long duration)	30.50%
3	How long does it take you to travel to the government primary health clinic?	18 (Less than 30 mints)	17.10%
		44 (30 min-1hour)	41.90%
		43 (1hour-1hour 30 min)	41
4	Which mode of transport do you use to go to the government primary health clinic?	55 (Public transport)	52.40%
		17 (Bicycle)	16.20%
		33 (Walk)	31.40%
5	What was the average amount of time that you waited to see medical staff when you visited the clinic?	47 (Less than30m)	44.80%
		58 (30m-1hour)	55.20%

Table 6: During delivery (Natal).

S/no	Postnatal	Frequency	Percentage
1	Did you receive medical care after delivery?	100 (Yes)	95.20%
		5 (No)	4.80%
2	How many times did you visit the clinic after delivery?		43.80%
			56.20%
3	What health services did you receive when you visited the clinic after your delivery?	36 (Physical Examination)	34.30%
		34 (Counseling breastfeeding)	32.40%
		35 (Nutrition supplement)	33.30%
4	What health services did you receive when you visited the clinic after your delivery?	9 (Yes)	8.60%
		96 (No)	91.40%
5	Did you receive a referral to a secondary hospital?	13 (Yes)	12.40%
		92 (No)	87.60%
6	In total, how much did your household spend for maternal services during your last pregnancy?	80 (Less than 1000)	76.20%
		25 (2000-4000)	23.80%
7	Did you pay any bribes for maternal health services?	36 (Yes)	34.30%
		69 (No)	65.70%
8	For what purpose was the bribes paid?	48 (Paid on demand)	45.70%
		57 (No demand)	54.30%
9	Was it demanded or did you pay it on your own?	48 (Paid on demand)	39.00%
		57 (No demand)	61.00%
10	Overall, how satisfied were you with the maternal health services you received?	48 (Paid on demand)	56.20%
		57 (No demand)	43.80%
11	What are your suggestions for improving maternal health services at government primary health clinics?	Female doctors more than two in OPD at RHC	100%

females used government hospitals for antenatal care. A study conducted by Umar Haruna shows that utilization of antenatal care is increasing [9]. The current study shows that accessibility of maternal health services have many challenges in terms of quality of maternal health care, availability of maternal health care etc. These challenges are obstacles in the immediate use of maternal health services like antenatal, natal and postnatal care.

This study revealed that majority of the pregnant women intends to use antenatal, natal and postnatal care. 66.7% pregnant females did 1-3 visits to health clinic and 33.3% did more than 3 visits. 52.4% pregnant females received physical examination facility and 47.6% received gynaecological examination services. These finding are supported by a study conducted by Andreea A [10,11].

The current study shows that 69% pregnant females receive antenatal care, 95.2% pregnant females receive postnatal care. The findings shows that 96.2% participants respond that they were attend by skilled birth attendant. 56.2% participants were completely satisfied and 43.8% were partially satisfied with maternal health care. 85.7% experience no complication during delivery. A study conducted by Babalola S revealed that 60.3% pregnant mothers utilized antenatal services, 43.5% pregnant females had delivery through skilled birth attendant and 41.2% utilized postnatal services. Antenatal findings supported the

Table 7: Postnatal.

S/no	Postnatal	Frequency	Percentage
1	Did you receive medical care after delivery?	100 (Yes)	95.20%
		5 (No)	4.80%
2	How many times did you visit the clinic after delivery?		43.80%
			56.20%
3	What health services did you receive when you visited the clinic after your delivery?	36 (Physical Examination)	34.30%
		34 (Counseling breastfeeding)	32.40%
		35 (Nutrition supplement)	33.30%
4	What health services did you receive when you visited the clinic after your delivery?	9 (Yes)	8.60%
		96 (No)	91.40%
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11	What are your suggestions for improving maternal health services at government primary health clinics?	Female doctors more than two in OPD at RHC	100%

current study, while natal and postnatal findings are contrary to present study [12].

CONCLUSION

This study shows that the level of utilization of maternal health care services is satisfactory. There is a need to educate the married females to regarding utilization of maternal health services to enhance the maternal health and minimize the risk factors in antenatal, natal and postnatal period.

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