RESEARCH
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ASSESSING THE KNOWLEDGE OF ANTENATL MOTHERS REGARDING HIGH RISK PREGNANCY AT SELECTED HOSPITALS

Ms. Shashikala M. Gadgimath [1]*, Dr. Manish Kumar Sharma [2]
[1] Ph.D Scholar, Shri Venkateshwara University, Gajraula, Uttarpradesh, India.
[2] Ph.D Guide, Professor, School of Nursing, Shri Venkateshwara University, Gajraula, Uttarpradesh, India
*Corresponding Author Email: shashikala.gadgimath@gmail.com

Abstract
Introduction: Early detection of pregnancy-related complications and high-risk pregnancies, as well as effective management of care for these pregnant women through a holistic approach guided by the main objectives of antenatal care (ANC) and efficient, high-quality health care provided through ANC services, can reduce the risk of pregnancy-related complications, benefiting both mother and baby. The purpose of this study was to determine the percentage of pregnant women in high-risk categories who attend ANC clinics.
Objective: To assess the knowledge of pregnant women regarding high risk pregnancy.
Method: Simple random sampling procedure was used to select 60 prenatal moms in total. Multiple choice questions and a checklist were included in the questionnaire used to gather the data. When developing the questions, age, religion, level of education, place of residence, and other socio-demographic factors were considered. For this examination, a quantitative descriptive research design was adopted.
Results: In this study, 10 (16%) reproductive age women had good Knowledge, 16 (27%) had poor Knowledge, and 34 (57%) had average Knowledge. demographic variable educational status of mothers had statistically significant association with the pretest levels of knowledge regarding high risk pregnancy among women. Age, religion, residence area, type of family, family monthly income, Source of information regarding had shown no statistically significant association with the pretest levels of knowledge regarding high risk pregnancy among women. $P<0.05$.
Conclusion: It is important to give mothers enough information about their high risk status so that they can help and encourage other women. This will result in safe pregnancies for both the mother and the baby.
Keywords: High risk, Antenatal, Hospital, Pregnancy.

INTRODUCTION

Pregnancy is the time when one or more babies develop inside a woman. Antenatal care (ANC) is an umbrella term that refers to all medical operations and care provided during pregnancy.In India, 21% of pregnant women received full pregnancy care on average, with rates varying from 2.3% to 65.9% among states. Overall, 51.6% had four or more antenatal visits, 30.8% used active components for at least 100 days, and 91.1% received one or more doses of tetanus toxoid vaccine [1]. However, the overall utilisation of prenatal care was inconsistent; this study sought to investigate these aspects in two primary healthcare (PHC) centres. Receiving ANC at least four times, as recommended by the WHO, increases the likelihood of receiving appropriate and efficient maternal care for the remainder of the prenatal visits[2].

Pregnancy is the time when one or more babies develop inside a woman. ANC is an umbrella term for the medical operations and care provided during pregnancy. In India, 21% of pregnant women received full pregnancy care on average, with rates varying from 2.3% to 65.9% among states. Overall, 51.6% had four or more antenatal visits, 30.8% used active components for at least 100 days, and 91.1% had one or more doses of tetanus toxoid vaccine. [3]. However, the overall use of prenatal care was uneven; this study was designed to analyse these factors in two primary healthcare centres. Receiving ANC for the duration of pregnancy no longer assures the benefit of interventions that might be effective in enhancing maternal health. Receiving ANC a minimum of four times, which is usually recommended by the WHO, will increase the chances of receiving effective and efficient maternal care for the duration of the antenatal visits [4]. The ANC's key aims are as follows: (i) maintaining the mother's health during pregnancy; (ii) identifying high-risk cases and appropriate management; (iii) preventing the development of complications; (iv) lowering maternal and infant mortality and morbidity; (v) relieving the mother's stress and worries about the delivery process; (vi) educating the mother about child-care/nutrition/sanitation/hygiene; (vii) family planning advice; (viii) caring for children under five years old[5].

A high-risk pregnancy is one that is complicated by one or more factors that have a detrimental effect on the pregnancy outcome (maternal, perinatal, or both) Although only 10-30% of moms examined in the antenatal period are considered high risk, they account for more than 70% of all perinatal mortality and morbidity among mothers investigated. Every year, almost 500,000 women die as a result of pregnancy-related complications around the world. For each fatality, roughly 118 women have life-threatening episodes or severe acute morbidity. Early detection and very intensive care for high-risk pregnancies

have the potential to greatly improve perinatal outcomes. All pregnancies should be assessed for risk factors. Age, parity, social status, history of chronic disease (diabetes mellitus, hypertension, heart disease, thyroid disease, etc.), prior pregnancy difficulties, and several previous pregnancies are all factors to consider. Early conception, many pregnancies, and close spacing all contribute to increased perinatal mortality and morbidity, which can have negative health repercussions for both mothers and children [6].

METHODOLOGY

Study area and period
Study was conducted selected hospitals at Kalaburgi and study period one month.

Study design
A cross sectional study was conducted to attain the objectives of the study.

Population
Source and study population: All antenatal women in i.e. 15-49 years residing at selected hospitals and whom can respond the required information without any difficulties.

Inclusion Criteria and Exclusion Criteria

Inclusion Criteria:
- All antenatal women who are attending at selected hospital
- Antenatal women are interested to participate in study

Exclusion Criteria:
- Antenatal women who are absent during data collection period

Sample size: Convenience sampling technique selected 60 Reproductive age women.

Variables
Dependent variable: High risk pregnancy

Independent variables:
Age, Religion, Mother's educational status, husband educational status, occupational status, residence area, family monthly income.

Operational Definition
High risk pregnancy: Defined as a high-risk pregnancy is a pregnancy where the mother or the fetus has an increased risk of adverse outcomes
Reproductive Age women: Antenatal women are defined as either ages 18 to 49 depending on the data source.

Data Quality Control
The data collection questionnaires were pretested on 5% of the sample size one week before the actual data collection date and will be reviewed in areas other than the study area. Following the pretest, the tools will be edited and changed to meet the study's objectives. The consistency of the data was monitored during the collection process by closely monitoring the data collectors and the collection method, as well as reviewing the collected data on a regular basis. Any items missing from the questionnaire that the data collectors misunderstood were immediately checked by the supervisors and corrected for the next day of data collection with the principal investigators.

Data processing and analysis
The collected data was washed, coded, and entered into the SPSS program before the actual study began. The data will be entered and analyzed using the statistical kit for social sciences (SPSS) version 20; the findings will be presented in a detailed description using frequencies, proportions, and cross tabs. Association between dependent and independent variables with a P-value less than 0.05 were considered statistically significant.

RESULT

Table:1: Socio-Demographic Characteristics of respondents

Characteristics		Frequency	Percentage (%)
Age	18-30 Years	31	51.7
	31-49Years	29	48.3
Religion	Hindu	37	61.7
	Muslim	16	26.7
	Christian	7	11.7
	Others	0	0
Husband Education	No formal education	18	30.0
	Primary	17	28.3
	secondary	9	15.0
	Higher secondary	5	8.3
	Bachelor	6	10.0
	master and above	5	8.3
Mother Education	No formal education	13	21.7
	Primary	16	26.7
	secondary	15	25.0
	Higher secondary	6	10.0
	Bachelor	6	10.0
	master and above	4	6.7
Residence	Urban	30	50
	Rural	30	50
Family Monthly Income	5000-10000	24	40.0
	10000-20000	18	30.0
	> 20000	18	30.0
Source of information	Health person	25	42.0
	Friends	15	24.0
	Neighbor	10	17.0
	Mass media	10	17.0

As shown in the **Table (1),** A total of 60 Antenatal women part in the study, resulting in a 96% response rate. According to the study, 29 respondents (48.3%) and 31 (51.7%) of the respondents were between the ages of 18 and 49 respectively. Regarding the husband' educational backgrounds, 18 (30%) had no formal education, 17 (28.3%) had elementary education, 9 (15%) had secondary education, 5 (8.3%) had upper secondary education, a master's degree or higher, and 6 (10%) had a bachelor's degree or higher. 16 (26.7%) of the mothers had only had a primary education, 15 (25%) had completed a secondary education, 13 (21.7%) were illiterate, and 6 (10%) had completed both a higher secondary and a bachelor's degree. 4 (6.7%) had a master's or above. Most of the mothers 30(50%) were urban and rural residence. Regarding source of information regarding high risk information 25(42%) were health person,15(24%) were friends,10(17%) were neighbor and mass media.

Table:2: Knowledge level of respondents

Characteristics	Knowledge score	
	F	Percentage
Poor Knowledge	16	27%
Average Knowledge	34	57%
Good Knowledge	10	16%

According to Table 2, 10 (16%) reproductive age women had good Knowledge, 16 (27%) had poor Knowledge, and 34 (57%) had average Knowledge.

Section: IV - Association between pretest levels of knowledge regarding antenatl mothers regarding high risk pregnancy among mothers and demographic profile or characteristics

n=60

variables		Knowledge level			Total	Chi square df	P value
		Poor	Average	Good			
Age (In Year)	18-30	9	18	6	33	1.578 2	0.199 NS
	31-49	7	16	4	27		
Religion	Hindu	8	16	4	28	0.584 2	0.178 NS
	Muslim	6	14	3	23		
	Christian	2	4	3	9		
Residence area	Urban	10	20	5	35	0.163 6	0.272 NS
	Rural	6	14	5	25		
Husband education	No formal education	2	2	1	5	0.216 2	0.158 NS
	Primary	4	4	2	10		
	secondary	2	6	2	10		
	Higher secondary	4	18	4	22		
	Bachelor and above	4	4	1	9		
Family Monthly income	< 5000	9	4	2	15	3.373 2	0.818 NS
	6000-10,000	8	8	4	20		
	>11, 000	12	9	4	25		
Educational status mother	No formal education	1	12	3	16	1.714 3	0.003***S**
	Primary	5	8	2	15		
	secondary	4	8	2	14		
	Higher secondary	5	2	2	9		
	Bachelor and above	1	4	1	6		
Source of information	Health person	9	10	4	23	1.280 3	0.355 NS
	Friends	2	10	2	14		
	Neighbor	3	12	2	16	0.155 3	0.979 NS
	Mass media	2	2	2	6		

*p<0.05 indicates significant association, NS- Not- significant.

The table 6 showed that demographic variable educational status of mothers had statistically significant association with the pretest levels of knowledge regarding high risk pregnancy among women. Age, religion, residence area, type of family, family monthly income, Source of information regarding had shown no statistically significant association with the pretest levels of knowledge regarding high risk pregnancy among women. P<0.05.

DISCUSSION

The above findings were validated by a study on the prevalence of high-risk pregnancy variables among 150 pregnant women selected using a convenience sampling technique while attending a prenatal OPD at a specific hospital in Punjab. A standardized questionnaire was utilized to analyse sociodemographic variables and prevalence factors. It was shown that 30% of the women were in high danger.

Another study examined the prevalence of high-risk pregnancies among prenatal women. The study included 100 pregnant moms chosen using a convenience sampling technique at Chettinad Hospital and Research Institute in Kanchipuram district, India. The study found that 25% of mothers were at high risk[7].

A subsequent study used community-based research to identify the frequency and correlates of high-risk pregnancy in rural Haryana. The purpose of this study was to assess the prevalence and correlates of high-risk pregnancy in a rural block of Haryana. From July 2011 to June 2012, a cross-sectional study was conducted in all 20 sub-centres of the Community Health Centre (Block Lakhanmajra), the rural field practice area of the Department of Community Medicine at PGIMS in Rohtak. Assuming a 10% prevalence of high-risk pregnancy, the sample included 900 eligible participants. All registered pregnant women in the subcentre at the time were included. Interviews with study individuals were conducted using a pre-tested semi-structured interview schedule[8].

Kumar and Gnanadeep were able to determine that the prevalence of high-risk pregnancy in rural Dharwad was high. Although just 10-30% of mothers visited in the antenatal trimester were considered high risk, they accounted for 70-80% of the population's perinatal death and morbidity rates. The study's goal was to assess the prevalence of high-risk pregnancies and their relationship with socio-demographic characteristics in rural field practice regions affiliated with the Department of Community Medicine, DM College of Medical Sciences and Hospital, Dharwad. The study involved pregnant women who visited health clinics in the area. Data were gathered from August 1 to October 31, 2013. A pre-designed, pre-tested proforma was utilised to collect data on socio-demographic variables and obstetric history. Height, weight, and blood pressure were measured; general physical and systemic tests were performed. The haemoglobin was estimated using Sahli's approach. According to the findings, 37% of all pregnancies are high-risk[9].

CONCLUSION

Pregnancy outcomes are heavily influenced by a woman's socio-demographic, obstetric, and medical factors. The WHO recommends a minimum of four ANC visits to mitigate the risks of a high-risk pregnancy by providing access to interventions vital to their health and well-being as well as that of their infants; this should ideally be done by skilled health personnel, which refers to workers/attendants who are accredited health professionals-such as midwives, doctors, or nurses-who have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies. Raising awareness has helped boost ANC attendance and use by empowering pregnant women and educating them.

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Competing Interests:

- The authors declare no competing interests.

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References

1. *Kumar G, Choudhary T S, Srivastava A, et al. Utilisation, equity, and determinants of comprehensive antenatal care in India: findings from the National Family Health Survey. Childbirth 2019;19:327.*
2. *WHO UNICEF. UNFPA. Managing complications in pregnancy and childbirth: a guide for midwives and doctors. 2nd ed. Geneva: World Health Organization; 2017.*
3. *Saidu R, August E, Alio A, Salihu H, Saka M, Jimoh A. An assessment of essential maternal health services in Kwara state. Nigeria Afr J Reprod Health. 2013;17(1):41–8.*
4. *Wichaidit W, Alam M, Halder A, Unicomb L, Hamer D, Ram P. Availability and quality of emergency obstetric and newborn Care in Bangladesh. Am J Trop Med Hyg. 2016;95(2):298–306*
5. *Iyer V, Sidney K, Mehta R, Mavalankar D. Availability and provision of emergency obstetric care under a public–private partnership in three districts of Gujarat, India: lessons for universal health coverage. BMJ Glob Heal. 2016;1:e000019.*
6. *Mony M, Krishnamurthy J, Thomas A, Sankar K, Ramesh B, Moses S. Availability and distribution of emergency obstetric care services in Karanataka state South India: access and equity considerations. PLoS One. 2013:e0064126.*
7. *Echoka E, Kombe Y, Dubourg D, Makokha A, Evjen-Olsen B, Mwangi M, et al. Existence and functionality of emergency obstetric care services at district level in Kenya: theoretical coverage versus reality. BMC Health Serv Res. 2013;13:133.*
8. *WHO. The world health report 2005: make every mother and child count. Geneva; 2005.*
9. *Rani M, Bonu S, Harvey S. Differentials in the quality of antenatal care in India. Int J Qual Heal Care. 2008;20(1):62–71.*
10. *Dhar R, Nagpal J, Bhargava V, Sachdeva A, Bhartia A. Quality of care, maternal attitude and common physician practices across the socio-economic spectrum: a community survey. Arch Gynecol Obstet. 2010;282(3):245–54.*