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Reproductive health profile of rural pregnant women in Guntur district of Andhra Pradesh

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Abstract

Present study was conducted in Guntur district of Andhra Pradesh with an objective to study the reproductive health profile of rural pregnant women. A sample size of ninety rural pregnant women from nine villages of Guntur district was selected for the study and data was collected using a structured pre-tested interview schedule. The reproductive health profile of the selected respondents revealed that a great majority (87.77%) of the rural pregnant women were married between the age group of 18-25 years and three-fourth (75.00%) marriages were non-consanguineous. Age at first conception was in the age group of 15-25 years for majority (86.66%) of the pregnant women and a great majority (94.44%) was sedentary workers. More than fifty per cent (54.44%) of the selected rural pregnant women were pregnant for the second time i.e they were placed under gravida2 and 13.11 per cent of the selected pregnant women were primiparous, 2.22 per cent were multiparous and only 1.11 per cent were nulliparous. Among the total ninety respondents, 53.33 per cent of them had single live births and 8.88 per cent of them had two live births. More than ninety per cent had institutional deliveries for their previous delivery, nearly forty per cent (42.22%) of the respondents had single abortion and majority (32.22%) of the rural pregnant women had followed the birth spacing of 1-2 years.

Keywords: Reproductive health, pregnant women and profile

Introduction

“Healthy mothers are children’s first line of defence against death, malnutrition and a cycle of poverty and disease”.(Unadkat *et al.* 2013) [6] Many studies have proven the significance of women’s health. It is now recognized that health status of women plays a major impact on the health status of their children, family, and ultimately the community. Most of the women’s health issues were associated with maternal health. The well-being of maternal health is associated with various factors like nutritional, emotional, social and economic factors. Early marriage, as practiced much among the rural folk force women into the procreative cycle before they are physically and socially mature and set them for repeated pregnancies beyond the risk of their own lives. The age at which a woman marries and enters into conception has a great impact on her health leading to various obstetric complications.

Pregnancy is a physiological condition where utmost care should be taken during the period as it involves the dual life of mother and foetus, but in rural areas of the developing countries like India, it is considered as a normal condition. Hence, more complications during pregnancy are observed in the rural areas leading to high maternal mortality. This is due to lack of adequate knowledge and information availability and accessibility to the rural folk in India.

Although there is a decline in Maternal Mortality Rate (MMR) from 130 per one lakh live births in 2014-16 to 122 per 1 lakh live births in 2015-17 (GoI,2017) [1], the state of Andhra Pradesh have not shown any change in the ratio. This approach will contribute indirectly to reach the Millennium Development Goals by reducing complications of rural pregnant women thereby decreasing maternal mortality rate and infant mortality rate. These kind of problems need to be addressed through various strategies.

In this digital era, people get confuse with plethora of available information which leads to dilemma on what to follow and what not to. Rural pregnant women lack scientific knowledge regarding care during pregnancy & lactation hence they depend on their family members, elders and neighbors for information and are taken into consideration for their health care and sometimes it leads to various pregnancy complications.

With this background, the present study was conducted to study the personal and reproductive health profile of rural pregnant women considering the attributes like age at marriage, type of marriage, age at first conception etc.

Material and Methods

The present study was conducted in Guntur district of Andhra Pradesh during the year 2018-19. Three mandals and three villages from each mandal were selected by simple random sampling from the Guntur district. Ten pregnant women from each village were selected thus, making a total sample of ninety respondents from nine villages for the study.

In order to study the reproductive profile of rural pregnant women, an interview schedule was developed and the women were interviewed individually using the predesigned interview schedule, which elicited personal information about their age, education, occupation, type of family etc. and the reproductive profile of pregnant women covering the

attributes like age at marriage, age at first conception and detailed past & present obstetric history were recorded.

Results and Discussion

Reproductive profile of rural pregnant women was studied under the following sub-heads:

1. Personal profile
2. Reproductive profile

Personal profile

The personal profile included the attributes like age, education, type of family, socio-economic status and family livelihood profile of the rural pregnant women.

Table 1: Distribution of respondents based on the personal profile characteristics

S. No	Profile characteristic	Category	Frequency	Percentage (%)
1	Age	Below 18 years	2	2.22
		18-35 years	86	95.55
		35 and above	2	2.22
		Total	90	100
2	Education	Illiterate	2	2.22
		Functionally literate	1	1.11
		Primary school	2	2.22
		Middle school	12	13.33
		High school	30	33.33
		College	43	47.77
		Total	90	100
3.	Type of family	Nuclear family	31	34.44
		Joint family	59	65.55
		Total	90	100
4.	Socio-economic status	Low (2-6)	17	18.88
		Medium (6-10)	62	68.88
		High (10-14)	11	12.22
		Total	90	100
5.	Family livelihood profile	Agricultural labour/ wage worker	34	37.77
		Agricultural farmer	10	11.11
		Agriculture + Livestock	1	1.11
		Small scale business	28	31.11
		Private sector	13	14.44
		Government service	4	4.44
		Total	90	100

Age

Age was operationalized as the number of years completed by the rural pregnant women at the time of interview.

Table 1. indicated that majority (95.55%) of the respondents were between the age group of 18-35 years and a negligible number (2.22%) were below 18 years and above 35 years (2.22%). It is inferred that very few and equal percentage of women fell under the age of below 18 years and above 35 years which can be considered as high risk pregnancy as they might lead to serious complications of health among the mother and child. It also showed that early marriages of rural women i.e. below the age of 18 years were drastically decreased indicating a positive sign of development. The results might be due to the improved awareness on girl child education and ill effects of early marriages among the rural people. These findings are in line with the results reported by Patel *et al.* (2013).

Education

Education was operationalized as the academic qualification of the rural pregnant women. The results in the table 1, revealed that nearly fifty per cent of the pregnant women have completed their college level education (47.77%), followed by high school (33.33%), middle school (13.33%) and

primary school (2.22%). Meagre percentage of rural pregnant women fell under the category of illiterates (2.22%) and functionally literates (1.11).

The above results showed that awareness about education have been increased among the rural people hence half of the respondents had completed college education and illiteracy had been decreased to a greater extent which needs some more improvement to reach its goal.

Type of family

The type of family was operationally defined as number of pairs of couples and their children living together Table 1 indicated that more than sixty five per cent (65.55%) of the respondents belonged to joint families followed by nuclear families (34.44%).

It is clear from the table that majority of the respondents had joint families followed by nuclear families, as maximum respondent families were involved in agriculture and some of the respondent families were engaged in subsidiary activities like livestock, agricultural laborers, masonry etc, while few were working in private and public sectors etc. Hence, married children were staying in the same home along with their parents in the village without migrating to other places.

Socio-economic status (SES)

The Socio-economic status scale developed by Venkataramaiah (1983, revised 1990) was used for the study with modifications wherever required. The scale consisted of 3 items namely: a) Annual income b) Material possession c) Socio- Political Participation. The Socio-economic status was worked out by adding all the scores given in the above items. The maximum score obtained was 14 and the minimum score obtained was 2. Based on the inclusive class interval method, socio-economic status of the respondents was categorized as low, Medium and high. Results were presented in the form of frequencies and percentages for data analysis and interpretation.

It can be revealed that 68.88 per cent of the pregnant women had medium level of socio-economic status followed by low (18.88%) and high (12.22%) level of socio-economic status.

From the above findings it was observed that most of the respondents were found in medium category of socio-economic status. The above findings might be due to the medium status of its components like family annual income, material possession and socio-political participation of the selected rural pregnant women.

Family livelihood profile

Livelihood profile is operationally defined as the occupation of the husband of the selected pregnant women as major source of family income. The following table provides with the local livelihood occupations and results were expressed in the form of frequencies and percentages.

From table 1. most of the respondents were agriculture laborers/ wage workers (37.77%) followed by small scale business (31.11%), private sector (14.44%), agricultural farmers (11.11%), government service (4.44%) and agriculture + livestock (1.11%).

The results revealed that agriculture was the major livelihood of the family followed by small scale business activities like grocery shops, fancy shops, tailor shops etc. The probable reason might be the dependency of rural families on agriculture and other small scale businesses due to non-availability of jobs in public and private sectors.

Reproductive profile

In order to study the reproductive profile of the rural pregnant women, attributes like age at marriage, type of marriage, age at first conception, gravidity, parity, live births, history of abortions, obstetric complications, place of previous delivery, type of activities of the pregnant women and birth spacing were studied.

Age at marriage

Age at marriage can be operationally defined as the age of the rural pregnant women when she got married. Based on the age at marriage, pregnant women were categorized into five groups by using inclusive class interval method.

Table 2: Distribution of respondents based on age at marriage

S. No	Category	Frequency	Percentage (%)
1.	Below 18 years	5	5.55
2.	18 - 25 years	79	87.77
3.	25 - 35 years	6	6.66
4.	35 - 45 years	0	0
5.	Above 45 years	0	0
Total		90	100

Results revealed that few (5.55%) of the pregnant women were married below the age of 18 years and a great majority (87.77%) of the rural pregnant women were married between the age group of 18-25 years and a few (6.66%) were married in the age group of 25-35 years.

Hence, it can be concluded that there was decline in child marriages i.e below the age of 18 years. The cause might be the impact of increased awareness among rural folk on the problems of early pregnancy. Continuous efforts of Govt. on awareness creation and basic education of the pregnant women.

Type of marriage

Type of marriage is operationally defined as a kind of marriage performed within the blood relation called consanguineous marriage and outside the blood relation known as non-consanguineous marriage. The results revealed that 83.33 per cent of pregnant women had consanguineous marriages whereas 16.66 per cent of rural pregnant women had consanguineous marriage.

The decrease of consanguineous marriages among rural community might be due to constant efforts of the Government on creating awareness about ill effects of consanguineous marriage on health of both mother and child.

Age at first conception

Age at first conception is operationally defined as the age of women at birth of her first child. Based on the age at first conception, pregnant women were categorized into five groups by using inclusive class interval method.

Table 3: Distribution of respondents based on age at first conception

S. No	Category	Frequency	Percentage (%)
1.	Below 15 years	1	1.11
2.	15 - 25 years	78	86.66
3.	25 - 35 years	9	9.99
4.	35 - 45 years	2	2.22
5.	Above 45 years	0	0
Total		90	100

From the above results it is apparent that age at first conception among the rural women was between the age group of 15 to 35 years which is an indication of declination of child marriages. Age at first conception above the age of 35 years was very negligible and the reason might be that most of the women are going for family planning as a measure of birth control leading to reduction of late pregnancy.

Gravidity

Gravidity is defined as the number of times that a woman has been pregnant. Based on the number of gravida of the pregnant women the data was presented in the form of frequencies and percentages.

Table 4: Distribution of respondents based on the gravidity of respondents

Gravidity	Frequency	Percentage
Gravida1	34	37.77
Gravida2	47	54.44
Gravida3	7	7.77
Gravida4 and above	2	2.22
Total	90	100

Results depicted that more than fifty per cent (54.44%) of the selected rural pregnant women were pregnant for the second time and 37.77 per cent of the respondents were conceived for the first time.

Few (7.77%) of the respondents have gone for third pregnancy and four and above pregnancies (2.22%). The major reason might be due to the recorded abortions among the respondents.

Parity

Parity is defined as the number of times that a pregnant woman has given birth to a fetus with a gestational age of 24 weeks or more, regardless of whether the child was born alive or was stillborn. The data was presented in the form of frequencies and percentages based on the following types of parity:

Nullipara: A woman who has never carried a pregnancy beyond 20 weeks is nulliparous.

Primipara: A woman who has given birth once is primiparous.

Multipara: A woman who has given birth two, three, or four times is multiparous.

Table 5: Distribution of respondents based on the parity of respondents

Parity	Frequency	Percentage
1 st conception	34	37.77
Nulliparous	1	1.11
Primipara	12	13.33
Multiparous	2	2.22
Abortions	41	45.55
Total	90	100

From the above results, among the total ninety respondents 34 (37.77%) pregnant women were conceived for the first time and 41(45.55) respondents had abortions. So, from the remaining 15 respondents, 13.11 per cent were primiparous, 2.22 per cent were multiparous and only 1.11 per cent were nulliparous.

The reason for one nulliparous case might be due to the negligence and delay of on time hospital care during the labour time.

Live births: Live births depict the total number of living children pregnant women had. Based on the number of living children, data was presented in the form of frequencies and percentages.

Table 6: Distribution of respondents based on the number of live births

No. of live births	Frequency	Percentage
1	48	53.33
2	8	8.88
3	0	0
1 st conception	34	37.77
Total	90	100

Results revealed that among the total ninety respondents, 53.33 per cent of them had single live births and 8.88 per cent of them had two live births.

2.4 History of abortions

Abortion is operationally defined as loss of woman's

pregnancy at any point of time throughout the pregnancy. The results were presented in the form of frequencies and percentages.

Table 7: Distribution of respondents based on history of abortions (n=90)

S. No	Abortions	Frequency	Percentage (%)
1.	1 st conception	34	37.77
2.	No abortion	14	15.55
3.	Single abortion	38	42.22
4.	2 abortions	3	3.33
5.	3 abortions	0	0
6.	4 abortions	1	1.11
Total		90	100

Results shows 42.22 per cent of the respondents had single abortion followed by 37.77 per cent of the respondents has aborted during first conception and 3.33 percent and 1.11 per cent of the respondents had 2 and 4 abortions respectively.

The probable reason might be due to their individual obstetric complications and other external factors. Hence, focus should be on these types of pregnancy cases by the Government by undertaking programmes on various precautionary measures.

Obstetric complications

An obstetric complication is defined as an acute condition arising from a direct cause of maternal death, such as antepartum or postpartum hemorrhage, obstructed labor, postpartum sepsis, complications of abortion, pre-eclampsia or eclampsia, ectopic pregnancy, and ruptured uterus, or indirect causes such as anemia, malaria, and tuberculosis.

Table 8: Distribution of respondents based on obstetric complications

Obstetric Complications	Frequency	Percentage
1st conception	34	37.77
Nil	14	15.55
PCOD	3	3.33
Thyroid	1	1.11
Cesarean or instrumental delivery	34	37.77
Other complications (Hypertension, eclampsia, breech or transverse presentation and prolapse)	4	4.44
Total	90	100

Results revealed that thirty four (37.77%) rural pregnant women were conceived for the first time and fourteen (15.55%) of them didn't had any obstetric complications. Among the remaining forty two respondents, majority (37.77%) of them had cesarean or instrumental delivery and negligible number was noted for thyroid, PCOD and other pregnancy complications.

The probable reason might be due to lack of awareness on various obstetric complications of pregnancy and immediate health care to be taken at the time of emergency among the rural folk. Lack of education, Socio-economic status of the family also plays a key role on occurrence of more number of obstetric complications.

Place of previous delivery

Place of previous delivery is operationally defined as the place of last delivery conducted either in institution or non-institutional.

Table 9: Categorization of respondents based on their place of previous delivery (n=90)

S. No	Place of previous delivery	Frequency	Percentage (%)
1.	1 st conception	34	37.77
2.a	Institutional	53	94.64
2.b	Non-institutional	3	3.33
	Total	90	100

From the table 4, it is evident that among the total ninety respondents, thirty four pregnant women were conceived for the first time and the remaining 56 were conceived for second time or more. Among the 56 respondents, place of previous delivery of the 53 (94.64%) pregnant women was conducted at institutions like hospitals and sub-centers and only 3

(3.33%) women had their delivery at home by the traditional attendants.

The results revealed that non-institutional deliveries have been reduced to a greater extent due to continuous efforts and incentives by the Government in the form of cash and kind to the pregnant women.

In order to issue birth certificates to children Government has made compulsory to provide the details of institutional delivery, this might be the contributing factor for increase in institutional deliveries.

Type of activities

Based on the activities of the pregnant women, they were classified into three groups i.e Sedentary, Moderate and Heavy workers

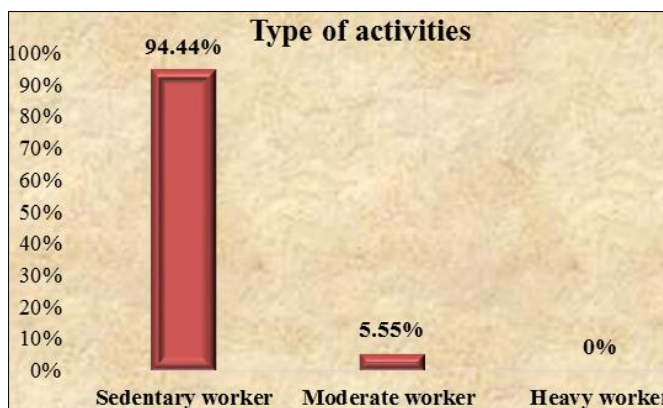


Fig 1: Pregnant women based on their activities

The above graph indicates that a great majority (94.44%) of the women were categorized under sedentary workers who were involving in activities like home making, teaching, nursing etc. while very few (5.55%) per cent were under moderate workers category involved in activities like agriculture and allied areas. None of them involved in heavy work during pregnancy.

Findings inferred that majority of the family members showed great care and concern towards the respondents and avoiding them to involve in heavy work during the period of pregnancy.

Birth spacing

Birth spacing is operationally defined as how soon after a prior pregnancy a woman becomes pregnant.

Table 10: Respondents based on birth spacing (n=90)

S. No	Spacing	Frequency	Percentage (%)
1.	1 st conception	34	37.77
2.	3 months -1 year	10	11.11
3.	1-2 years	29	32.22
4.	3-5 years	11	12.22
5.	6-10 years	1	1.11
	Total	90	100

Findings from the table showed that 32.22 percent of the respondents had 1-2 years birth spacing. Almost an equal per cent (12.22% & 11.11%) of them maintained 3-5 years and 3 months to 1 year spacing respectively and only 1.11 per cent of them were found in 6-10 years spacing.

In rural Indian scenario, birth spacing is not strictly followed due to lack of knowledge and ignorance coupled with various assumptions and customs regarding birth spacing and

pregnancy.

Conclusion

Few (5.55%) of the pregnant women were married below the age of 18 years and a great majority (87.77%) of the rural pregnant women were married between the age group of 18-25 years and a few (6.66%) were married in the age group of 25-35 years.

Very few (16.66%) rural pregnant women had consanguineous marriages while 83.33 per cent of pregnant women had non-consanguineous marriage. Age at first conception among the rural pregnant women was between the age group of 15 to 35 years which is an indication of declination of child marriages. More than fifty per cent (54.44%) of the selected rural pregnant women were pregnant for the second time and 37.77 per cent of the respondents were conceived for the first time. Few (7.77%) of the respondents have gone for third pregnancy and four and above pregnancies (2.22%). Among the total ninety respondents, 53.33 per cent of them had single live births and 8.88 per cent of them had two live births.

A great majority (94.44%) of the pregnant women were sedentary workers and involved in activities like home making, teaching, nursing etc. A great majority (94.64%) of the pregnant women had their previous deliveries in institutions like hospitals and sub-Centre's. Nearly fifty per cent (42.22%) of pregnant women had single abortion and 32.22 percent of the respondents had 1-2 years of birth spacing. Obstetric complications recorded that fourteen (15.55%) of them didn't had any obstetric complications, majority (37.77%) of them had cesarean or instrumental delivery and negligible number was noted for thyroid, PCOD and other pregnancy complications.

References

1. GoI. Special bulletin on maternal mortality in India. 2015-17. Sample Registration System of India. Retrieved from the website 2017. (www.censusindia.gov.in).
2. Park K. Park's Text Book of Preventive and Social Medicine. M/s Banarasidas Bhanot, Jabalpur. 22nd edition. page449-488.
3. Patel VD, Puwar BT, Sheth JK. Utilization of antenatal care services in the Gandhinagar (rural) district, Gujarat. National Journal of Community Medicine 2013;4(1):104-109.
4. WHO. Women's health: Across age and frontier; World Health Organization, Geneva 1992.
5. Sikder SS, Labrique AB, Ullah B *et al.* Accounts of severe acute obstetric complications in Rural Bangladesh. BMC Pregnancy Childbirth 2011;11:76.
6. Unadkat SV, Yadav S, Mehta JP, Parmar DV, Dhaduk KM. Demographic Characteristics and Reproductive Profile of Pregnant Women in Jamnagar District. National Journal of Community Medicine 2013;4(3):418-423.