Chapter – VI

Summary of Conclusions, Findings and Suggestions
Summary of Conclusions

Women’s health status is crucial for the well being of the family in particular and communities in general. In any community mother and children considered priority group in population. In sheer numbers, they comprise approximately 70 per cent of the population in developing countries. J.E. Park and K. Park (1985).

Safe motherhood is the state of well being in which a women approaches child birth with confidence in her abilities to give birth and nurture her newborn. Making motherhood safe requires women’s human rights to be guaranteed protected and respected. Protecting and promoting women’s rights, empowering women to make informed choices and reducing social and economic inequalities are key to safe motherhood.

Safe motherhood means that no women should die or be harmed by pregnancy and delivery. Safe motherhood can be achieved by providing high quality maternal health services to all women during pregnancy, childbirth and the postpartum period. Services to help make motherhood safe include care by skilled who are specially trained in conducting delivery. Emergency care for life threatening obstetric complications, services to prevent and manage the complications of unsafe abortion, family planning methods to enable women to plan their pregnancies and prevent unwanted pregnancies, health education and services for adolescent.

Safe Motherhood Initiative was a milestone in the race to reduce the burden of maternal mortality in all most all the developing countries. Development of Inter –
Agency group and others have outlined clear strategies and specified reduction in maternal morbidity and mortality often refers to the pillars for safe motherhood. They are family planning, antenatal care, obstetric care, postnatal care, sexually transmitted infections, Human Immune deficiency virus (STI/HIV) control.

A number of barriers limit women's access to safe motherhood which include distance and lack of transport, cost, socio-cultural factors. In some settings, a husband's permission is required for women to receive health services, including life-saving care in other, mother-in-law decide whether women can use available services.

Qualified maternal trained health workers must be available and must be rendered quality services. Therefore safe motherhood must be comprehensive in nature. Even when quality health services are available can set in the way the women using these services, such as social, economic and art.

The global safe motherhood was officially launched in Nairobi, Kenya in February 1987. Supported by World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), World Bank, and Non Governmental Organizations (NGOs). The aim of safe motherhood was to achieve a reduction of 50 per cent of maternal deaths by 2000. The various strategies have been adopted to achieve the goal of safe motherhood include Promotion of free prenatal, intranatal and postnatal care and services. Cultural appropriate family planning services including advice and methods. Other strategies include improving the socio-
political and legal status of women, increasing their access to wealth and ending
gender discrimination especially in education and access to health facilities.

Maternal health draws attention of the world on the mother in reproductive age
is considered to be risk. The indicators reveal the different factors that contribute for
maternal ill health globally. They are neglected girl child, low nutritional diet with
poor feeding, childhood marriages and conception, repeated abortions and more
number of deliveries, lack of attention of family members on mother health, socio
economic causes, cultural and traditional causes. Therefore working for the survival of
mother is human right imperative. It also has economic ramifications and is crucial
international development priority.

About 80 per cent of maternal deaths are due to direct obstetric causes and 20
per cent indirect causes. Hemorrhage remains the leading cause for maternal mortality,
accounting for approximately one third of deaths.

Interventions for safe motherhood include Essential antenatal and obstetric
services to all pregnant women have been emphasised all over the world. The
essential care for pregnant women include, early registration of all pregnant women by
12-16 weeks of their pregnancy. Ensure minimum three antenatal visits are to be made
during pregnancy; these will be 20 weeks or as soon as pregnancy is known and
registered. 32 weeks and 36 weeks or once during the last trimester preferably at least
one month before delivery.

For all pregnant women two tablets of iron and folic acid (IFA) for 100 days, if
mother found to be anemic three tablets of IFA for day. In case there is history of
passing worms, give 6 tablets of Mebendazole (1 tablet to be taken twice a day for three days) during the second or third trimester for pregnancy.

To prevent death due to tetanus by 100 per cent coverage of pregnant women with 2 doses of tetanus toxiod and to promote safe deliveries at home level by practicing 5 cleans. Such as Clean hand, Clean surface, Clean razor/blade, Clean cord tie, Clean cord stump. Traditional Birth Attendant required refresher courses and continued supervision for conducting safe and clean delivery at home. Traditional Birth Attendant efforts must be made simultaneously to promote institutional deliveries. Properly trained to refer all complicated cases at the right time and to the right place and watched for increased bleeding and deteriorating general condition after delivery.

Birth spacing and timing of birth are the most important determinations of maternal and child health. Educate mothers and village leaders through mother’s meetings and home visits regarding adopting birth spacing and timing in their own interest. Emphasis will be given on delay marriage and first pregnancy till 20 years of age. Have a minimum birth interval of three years between two successive pregnancies and propagate a two-child family norm. The contraceptive and condoms to be distributed during immunization.

Early identification of complications can prevent many maternal deaths, by educating all pregnant women and their family members regarding danger signs in pregnant women. First level referral centre should be organized to deal effectively with such complications and provide emergency care.
The health interventions are significant in preserving the health of the mother and children. India is the first country launched the family planning program officially in 1952. Family planning has come to stay as a female health and welfare oriented program of contraception. The national population policy of 1976 which highlighted the need for raising the legal age at marriage from 15 to 18 years for female and from 18 to 21 years for male. The objectives of all these programmes were convergent and aimed at improving the health of the mothers and young children and to provide them facilities for prevention and treatment of major diseases. During 1992 these programmes were integrated under Child Survival and Safe Motherhood (CSSM) programme. A Government of India renamed this programme by naming as RCH. The Reproductive and Child Health Program was launched in October 1997 by incorporating new approach to population and development issues, as exposed in the international conference on population and development held at Cairo in 1994. Focusing on the aim of R.C.H. Program has implemented many interventions in RCH Phases I and II which include child survival and safe motherhood intervention and essential obstetric care, emergency obstetric care, 24 hours delivery services, at Primary Health Centers and Community Health centers (PHCs/ CHCs,) medical termination of pregnancy, control of Reproductive Tract Infections (RTI’s) and Sexual transmitted Infections (STD’s). These interventions utilized by people through District Health Care System which consist of Primary Health Care Centers, Community Health Care Centers and the District Hospitals.

National Rural Health Mission has been operationalized from the financial year 2005 – 2006 with a view to work for a period of 7 years (2005 – 2012). The
vision of N.R.H.M to provide effective health care to rural population throughout the
country with special focus on 18 states, viz: 8 empowered action group states (Bihar,
Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Orissa and
Rajasthan) 8 North East states (Assam, Arunachal Pradesh, Manipur, Meghalaya,
By making necessary changes in the basic health care delivery system the mission
adopts a synergic approach by relating health determinants of good health viz: of
Nutrition, sanitation, hygiene and safe drinking water. It also brings the Indian system
of medicine (AYUSH) to the main stream of health care.

Statement of the problem

“Assessment of the Knowledge and Practices of Women for Safe Motherhood :
A Case Study of Kurnool District, Andhra Pradesh, India” has been taken for the
present study.

The overall objective of the present study is to assess the knowledge and
practices of the women regarding safe motherhood in Kurnool district of Andhra
Pradesh.

The specific objectives of the study are as follows:

1. To assess the knowledge of the women regarding marriage, pregnancy, labour
and puerperium.

2. To assess the practices of the women regarding their marriage, pregnancy,
labour and puerperium.
3. To identify the relationship between knowledge and practices of the women regarding safe motherhood with selected variables.

4. To analyze the relationship between practices of women regarding safe motherhood, with selected variables.

5. To suggest appropriate measures to improve the health of the women for safe motherhood.

Hypothesis

Keeping in mind the broad objectives of the study, the following hypothesis have been formulated for this work.

1. There will be significant association between the age of the women and their knowledge and practices about safe motherhood.

2. There will be significant association between the educational status of the women and their knowledge and practices about safe motherhood.

3. There will be significant association between occupation of the women and their knowledge and practices about safe motherhood.

4. There will be significant association between the income of the women and their knowledge and practices about safe motherhood.

5. There will be significant relationship between place of delivery of the women and their practices about safe motherhood.

Kurnool district is selected as universe for this study. Kurnool is one of the backward districts in the Rayalaseema region of Andhra Pradesh. The district is
divided into three revenue division viz. Kurnool, Nandyal and Adoni. In all these three revenue divisions there are 54 revenue mandals and 928 villages.

For selecting the sample for present study, multi-stage and random sampling technique was adopted. In selecting the mandals and villages, random sampling technique was adopted. In the first stage one mandal from each revenue division was selected at random. In the second stage two villages from each mandal were selected randomly. In the third stage 50 women were selected from each village randomly. All put together 300 women were selected. Women who have given birth to at least one child were included in the study. Finally, three mandals covering three revenue divisions, 6 villages and 300 women were selected as sample size for this study. Data was collected with the help of specially designed structured interview schedule. It consists of 3 sub sections. Section I socio economic characteristics of the respondents and fertility background of the respondents. Section II knowledge about marriage, pregnancy, labour, postnatal. Section III practices about marriage, pregnancy, labour, and postnatal. Collected data was analyzed by using descriptive and inferential statistics like percentages and chi-square. The data was presented with the help of appropriate graphical presentations.

Results

1. It is proved that there is a relationship between knowledge on health of the women and health practices in maintaining safe motherhood.

2. Educational status has bearing on the health practices and knowledge about women health which reflects safe motherhood.
3. It is proved that there is a relationship between occupation of the women and health practices and knowledge about women health causing safe motherhood.

4. It is proved that there is significant relationship between income and health practices and there is relationship between knowledge of women health and income.

5. The study results revealed that there is significant relationship between place of delivery which give scope for better health practices and gaining knowledge for keeping safe motherhood.

Finding of the study:

- Among 300 sample respondents, 134 (44.66%) were belong to backward Caste, 120(40%) were Scheduled Caste, 25(8.34%) were Forward Caste and remaining 7 per cent were Scheduled Tribe.

- Majority of the respondents (90.66%) are in the reproductive age group of 21 to 30 years.

- It is observed that 46.60 per cent of respondents were illiterates.

- More than two third of the women 195 (65%) were housewives and 24 per cent were engaged in agricultural work.

- Nearly half (48.33%) of the respondents were belonging to very low income group and about 72 per cent were from low income group and very few number (7%) of women were under high income group.

- About 66.33 per cent of the respondents had family size more than five. Such families were found to be more among Scheduled Tribe Caste.
• All the respondents aware about safe motherhood information through neighbours, mass media and health personnel. About 73.67 per cent women have not participated in health awareness camp. Only 26.33 per cent had awareness about safe motherhood camps.

• About 182 (60.67%) of sample respondents were married by below 20 years of age. Most of the respondents from Scheduled Caste, Scheduled Tribe, Backward Caste respondents have been married below 20 years of age and in Forward Caste less percentage (36%) were married below 20 years of age.

• The majority of the sample respondents (71.00%) had non-consanguineous marriage. Only 29 per cent of the respondents had consanguineous marriage. The consanguineous marriage is high 52 percent are in Forward Caste, and 30.60 percent were in Backward Caste. Insignificant numbers of the respondents are in Scheduled Caste and Scheduled Tribe.

• It was found that 181 (60.33%) of women had first pregnancy between in the age group of 20-22 years and 26 per cent of women had first pregnancy with below 20 years of age. Especially in Scheduled Caste and Backward Caste.

• Only negligible percentage of women (2.40%) had abortion.

• Majority of the respondents (41.60%) had two deliveries and 33 per cent of the women had one delivery and 17.40 per cent had four and above deliveries. It is clear evident that they have adopted small family norm.

• More than two thirds of the respondents (64.67%) given opinion that the right age at marriage was 18 years and 97 (32.33%) have given opinion one can marry even before 15 years of age.
• About 48 per cent of the respondents were aware that consanguineous marriage causes abortions, still birth etc.,

• More than half of the respondents (56.44%) given opinion about the need for HIV test before marriage.

• Three fourth of the respondents (75%) were at the opinion that pre-marriage counselling was required and eleven per cent of the respondents have expressed that it is not required and 14 per cent have not answer.

• In our culture a women status in the family is high with an early delivery, early motherhood. Two third of the respondents (66.67%) given opinion that the ideal age for first pregnancy is 20 to 30 years. Only one respondent given opinion the ideal age for first pregnancy is 36 to 40 years. About 33 per cent have given opinion that the ideal age for first pregnancy is below 20 years of age.

• About 228 (76%) respondents were know about danger signs of pregnancy, like abnormal swelling of face, arms and feet.

• Regarding hours of sleep and rest, 129 (43%) of the women given opinion that 8 hours of sleep at night and 2 hours in the day is required for good health.

• The pregnant mother should take high calories and high protein diet to meet the nutritional demands of mother and foetus. 260 (86.67%) respondents given opinion to take balance diet.

• During pregnancy some habits and activities have to be avoided for safe pregnancy. majority of the respondents 249 (83%) were aware of avoiding alcohol, smoking, tobacco chewing and gutka, bangi and 10 per cent of
respondents mentioned about avoid taking tea 30 (10%), coffee 16 (5.33%) and chewing gum 5 (1.6%).

- Nearly 27 per cent respondents were aware of avoiding climbing upstairs and same percentage of the respondents swimming, 20.66 per cent of the respondents mentioned dancing and 14.34 per cent stated avoiding lifting heavy objects.

- It was observed that 58 per cent of the women know that sexual intercourse should be avoided during first and third trimester of pregnancy.

- More than two fifth of the respondents were know all the investigations. About 75 (25%) of the respondents aware hemoglobin test, 69 (23%) blood grouping, negligible per cent age of respondents 6(2%) know the HIV test.

- Nearly half of the respondents 147(49%) know that the total weight gain during pregnancy 11 to 12 kgs.

- It is interesting to note more than half of sample (57.33%) expressed that three antenatal check-ups are needed.

- Majority of respondents (94.67%) were aware to take T.T. injection during pregnancy. About 89.66 per cent aware the purpose of T.T. injection. More than two third of the respondents 231(77%) expressed that two doses of T.T. Injection should be taken.

- More than two third of respondents (69%) had a correct knowledge about purpose of taking iron and folic acid tablets at least 50 iron and folic acid tablets has to be consumed.
• Knowledge about abnormal pregnancy is vital for women to take efficient care during antenatal period. Only 7 (2.33%) women aware about all the high risk pregnancies and 252 (84%) aware about more than two high risk pregnancies

• The majority of the women had correct knowledge about meaning of safe labour (92%), Safe place for conducting delivery (86.67%) and best person for conducting delivery (96.33%). It shows that majority of the women in all cast categories have correct knowledge.

• More than two third of women (68.33%) given opinion that two deliveries are safe and 44.37 per cent given 2 years of gap required between two deliveries.

• Half of the respondents know all the danger signs during labour and sixty per cent of the respondents know all the problems during labour.

• Regarding solutions used for perineal care. A very few respondents 69 (23%) had a correct knowledge about antiseptic solution used for perienal care. About 73.67 per cent know correctly to use clean cotton cloth and 14.65 per cent know correct the method of washing pads and 88.66 per cent know correct method of drying the pad.

• About 28 per cent of the respondents know to avoid all the physical activities like jumping, climbing, heavy work etc.

• It is observed that more than two fifth of the respondents (47%) given opinion 6 weeks after delivery to start sexual intercourse and 18 per cent given answer 10 weeks after delivery.

• Majority of the women had correct knowledge about purpose of colostrum (53.66%) and initiation of breast milk (67%) within half an hour.
• Regarding practice of HIV test before marriage no one undergone HIV test before their marriage so, people need to motivate on importance of HIV test before marriage.

• Only 10.67 per cent had pre-marriage counseling.

• Majority of the respondents 187 (62.33%) had nausea and vomiting which is minor ailment during pregnancy.

• Majority of the respondents had habit of taking tea and coffee/tea, tobacco chewing.

• Regarding physical activities, climbing upstairs has been avoided by 66 (22%), 14 (4.66%) swimming 5(1.67%) dancing, 116(38.67%) lifting heavy objects were avoided. Majority of the respondents 99 (33%) avoided all the activities.

• About 58 per cent of the respondents are avoided sexual intercourse in the first and third trimester.

• It is observed that antenatal mothers from Forward Caste almost all are visited antenatal clinic compared to Scheduled Caste and Scheduled Tribe and also the number of visits 4 and above are more in Forward Caste in first pregnancy 20 per cent, backward Caste 11.9 per cent, Scheduled Tribe 9.52 per cent, Scheduled Caste 5 per cent. It also shows that, as the number of pregnancies increases, the number of antenatal visits are reduced.

• During first pregnancy, majority of the respondents (9.34%) taken first dose of T.T. injection, (17.34%) taken second dose of T.T. injection. Only 6.34 per cent of women were not taken T.T. vaccine during first pregnancy. During
second pregnancy (33.66%), third pregnancy (10.67%) fourth pregnancy (5%) were taken T.T. injection.

- Antenatal mother during their first pregnancy who have consumed 51 to 100 tablets were 16 per cent in Forward Caste, 8.95 per cent in Backward Caste, 3.33 per cent in Scheduled Caste 4.76 per cent in Scheduled Tribe. Naturally the number of pregnancies increases there is more requirement of iron for pregnant women, but many respondents during their pregnancy neglected to take iron tablets. Only they have shown interest in first pregnancy.

- Below one fifth Scheduled Tribe women in first pregnancy (14.29%) second pregnancy (14.29%), third pregnancy (4.76%) fourth pregnancy (14.29%) were not taken T.T injection followed by Scheduled Caste and backward Caste. Majority of the women in Forward Caste were taken T.T. injections in their pregnancy.

- Above Sixty percent of the respondents had normal vaginal delivery including episiotomy and equal percentage of the women (18.32%) had forceps delivery and (19.69%) had caesarean section and no one had vacuum delivery as it is not practiced in the institutions.

- About 58.39 per cent had institutional delivery and 41.6 per cent had home delivery among them 19.99 per cent had delivery by trained person and remaining 21.65 per cent by untrained person.

- Nearly three fourth of women did not faced any postnatal health problem 217(71%), however 13.67 per cent of women had pueperal sepsis, 5.33 per cent had mastitis, 1.33 per cent had pueperal psychosis and 8.67 per cent
expressed other problems like excessive bleeding. The puerperal sepsis is high in Backward Caste (16.41%), Scheduled Tribe 14.28, and Scheduled Caste (10.83%) Forward Caste 12 per cent.

- About 40.33 per cent of the respondents used hot water to clean the perineum. Only 23 per cent used antiseptic solutions correctly and 68.66 per cent used clean cotton cloth and 10.66 per cent used care free/stay free. Nearly 63 per cent wash the perineal pad with soap and water. Regarding method of drying the pad 82.34 per cent dried under the sun light.

- More than one third of the respondents 112 (37.34%) started sexual intercourse after 3 months. Two fifth of the Scheduled Tribe respondents (42.85%) strictly followed practice of sexual intercourse for a period of 6 months and above. It is observed that Forward Caste respondents have strictly followed the restrictions in participating sexual intercourse compare to Other Caste categories.

- Nearly three fourth of the respondents irrespective of Caste are giving colostrum to their newborns. Only 82 (23.33%) did not given colostrum. Regarding period of breast feeding 47.33 per cent of the women fed their babies for one year through breast feeding and remaining 28.67 per cent given 2 years and 23.34 per cent given 6 months breast feeding.

**SUGGESTIONS**

The findings of the present study may become the basis for building stronger health services in the remote areas in order to achieve the goals of health. To ensure
safe motherhood the following suggestions are made to be useful for planners, policy makers.

- Ensure an efficient administration, monitoring and evaluation system to generate the necessary tools for successful implementation of safe motherhood programme at grass root level in order to improve the qualitative services.

- Augmenting the availability of skilled manpower through various skill based training like skilled birth attendants training of MBBS doctors in life saving anesthetic skills and emergency obstetric care including caesarean section.

- Provision of antenatal and postnatal services including prevention and treatment of anemia by supplementation with iron and folic acid tablets during pregnancy and lactation.

- Organizing village Health and nutrition days (VHNDS) at anganwadi center to impart health and nutrition education to pregnant and lactating mothers.

- Referral system for primary health centers has to be streamlined and strengthened.

- Information, Education, Communication and mobilization activities should be carried out with innovativeness to promote safe motherhood.

- The rigid enforcement of legal measures must be followed strictly to rise the age at marriage of women as the respondents gave the opinion that age at marriage should be more.

- Encourage the community to avoid consanguineous marriages to make them to aware about consequences of consanguineous marriages.

- Institutional delivery should be encouraged and provide necessary infra structure in nearby sub-centers, primary health centers (PHC), Community Health Centers (CHCs) and District hospitals.
Safe birth planning is a key component of strategies to improve maternal and neonatal health in the community. Safe birth planning can be done by involving the experts in conducting delivery.

The proper dissemination of the information regarding safe motherhood will aid to bring about public awareness in safe motherhood which will help to promote healthy practices, positive attitudes, and increase in the utilization of antenatal services. This further leads to reduction in the maternal mortality and morbidity.

Family welfare programme should be given greater emphasis on use of spacing methods which improve family planning performance and the health of mother and children.

Health education programmes may be conducted on perineal care, diet, postnatal exercises and breast feeding. Motivate the mothers about importance of breast feeding and giving colostum. Celebrating breast feeding week. etc.

Awards to best performing doctors, staff nurses, MPH W and ASHA etc.

In a nutshell, the interactions with the people and health personnel pointed out the need for strengthening the information and education systems and for giving further orientation and training to the dais and health assistants, doctors, supplying materials and medicine regularly and reducing the area of operation for the health assistant are the other essential steps to be taken up for the effective functioning of maternity benefit programmes so as to ensure safe mother and child health.