CHAPTER II

REVIEW OF RELATED LITERATURES

SOCIOECONOMIC CHARACTERISTIC:

Many studies have shown that there is closed relationship between socioeconomic status and utilization of antenatal care service. Some results indicated that education, social class, family income and occupation were also important factors for the health service utilization.

Blondel, B., Kaminski, M. and Breart, G et al. (1980) noted that socio-economic status was also an important factor, women who are considered at high risk due to their unfavorable social situation do not obtain antenatal care during pregnancy.

As noted in the **WHO report (1993)**, maternal mortality in most developed nations has now been reduced to as low as 5 to 20 per 100,000 live births, while in the developing countries it still ranges from as high as 50 to 2,000 per 100,000 live birth. The main reason for such high rate of maternal mortality in developing countries is due to poor socioeconomic status, illiteracy and ignorance, etc.

Joseph, CL. (1989) described that women who do not obtain adequate prenatal care significantly reduce their chances of a favorable pregnancy outcome. Because interventions aimed at circumventing unfavorable pregnancy outcomes, such as low birth weight, are most effective during prenatal care, there is a need to identify sociodemographic characteristics which are associated with a delay in the onset of such care.

In many studies, it was shown that the socioeconomic status of pregnant women is associated with antenatal care attendance. Some of these study findings are as follows:

1 AGE:

Chisholm, DK. (1989) found that teenagers were more likely to seek ANC later than women 20-24 years old. On the other hand, women over 35 were fewer in number, but also more likely to be late enrolles.

Swenson et al (1993) observed that women who were under the age of 30 were more likely to get prenatal care than were those over 30 years of age.

Blondel, Kaminski, Breart, et al. (1980) noted that social status was an important factor independent of women's demographic characteristics. Late attendance of antenatal care was the problem for women of high parity and low education level while those low parity have had high numbers

of visits during pregnancy compared to the average.

2. EDUCATION:

Cullver et al observed that the pregnant women whose education were higher than intermediate level sought professional antenatal care more than the pregnant women with lower education levels. This clearly indicated an association between education levels and antenatal care seeking behavior. Those who were illiterate or those who had lower education than primary level did not attend any antenatal care services before delivery. So the study concluded that those of low education level had fewer antenatal visits than the average.

Elizabeth, Thong, Tileu, et al (1993) found that the utilization of prenatal care services by women in developing countries in that the majority of women received their prenatal care for non physician health provider. Also similar to other research found that the women's educational level significantly affected on the utilization of prenatal services. Women with higher level of education might be more aware of the benefits of prenatal care and consequently more likely to use it.

3. OCCUPATION:

Malee Charoenmuang. (1990) noted that the pregnant women who worked as housewives seemed to have the more antenatal care services than the other occupation groups.

This might be related to their ability to manage their own time to attend antenatal care service. Besides, they had more free time to attend the services and to receive knowledge on antenatal care through mass communication. So that they had gained more knowledge on how to take care of themselves during pregnancy and they were also concerned about the importance of antenatal care attendance. The study found that other groups (laborer, farmer and business) who had less antenatal care attendance might be so much engaged in earning their living, so they did not have enough time to attend antenatal care service.

OBSTETRICAL FACTORS OF PREGNANT WOMEN AND ANC ATTENDANCE:

1. AN EXPERIENCE OF PREGNANCY:

Blondel, Kaminski, Breart et al. (1980) observed that the experiences of previous pregnancies played a complex role in influencing the attendance of antenatal care. This might explain why such care remained inadequate for some of the groups of women. High parity women were most likely to fail in attending early care. They relied on the experiences gained during previous pregnancies and also they often had practical problems which made it difficult for them to undertake the visits. The greater their number of children the greater gap between their estimation of how much antenatal care was needed and their actual uptake. The atmosphere in which pregnancy developed also played an important part. A

planned pregnancy, the acceptance of the forthcoming child, family and professional stability and complications of previous pregnancies were elements leading to better attendance of antenatal care.

Campananella, K., Korbin, J.E and Acheson et al. (1993) concluded that primiparas who experienced symptoms such as severe morning sickness, bleeding, or dizziness started prenatal care earlier, in the second month on average. In general, with increasing parity, the women sought prenatal care later.

2. OBSTETRIC COMPLICATION DURING PREVIOUS AND PRESENT PREGNANCY:

Puengrat Boonayanurak. (1986) noted in her study that mother who tended not to make use of available prenatal service possessed a low perceptual level of vulnerability to seriousness of pregnancy complication which caused a state of psychological unreadiness towards prenatal attendance. This might be due to the lack of awareness towards those complications by the pregnant women or they still lacked of warning from health personnel. Other women (such as those over 35 years of age) were more likely to suffer from chronic problems such as persisting hypertension or diabetes which complicated pregnancy and delivery and might account for greater perinatal mortality. These unwanted complications as well as other abnormal conditions could be prevented by

skilled antenatal care.

Jill and Louise et al. (1993) found that the most important factor in determining use of formal prenatal care in either the professional/dominant or folk/alternatives sectors was the presence of symptoms perceived to be serious. The pregnant women made decision about when to begin prenatal care is depend on their feeling good, there is no reason to begin prenatal care in the first trimester, either with physicians or midwives. The study result showed that the pregnant women used prenatal care if a problem arose, such as bleeding.

ACCESSIBILITY OF ANC SERVICES AND ANTENATAL CARE ATTENDANCE SERVICE:

1. DISTANCE:

Malee Charoenmuang. (1990) described that there is negative association between ANC attendance of the pregnant women by distance from home to antenatal care services and number of ANC attendance. The pregnant women who stayed far away from ANC services used ANC more than those who stayed near services. The study mentioned that the pregnant women who stayed far away from ANC services did not mind about the distance. In fact, they intended to get better ANC services. Some study resulted that most of pregnant women attended antenatal care clinic during the first, second and third trimester of pregnancy respectively. Where the medical

facilities are available even with free charge, hardly at the distance of about one kilometers those pregnant women had inadequate ANC attendance.

2. **TRANSPORTATION:**

Jill and Louise et al. (1990) noted that transportation was more powerful impediment to seeking prenatal care. Most of women perceived transportation is a particularly problem. Many studies showed that the women who perceived that the transportation was convenient used the health services more than those who perceived that the transportation was non convenient.

Yen Ren-Ying, (1989) stated that the strong influence of public transport, inspite of the insignificant relationship between the distance to ANC clinic among rural women, suggested that if women had the means to get to the service, they will do so. The study finding also suggested that the availability of services as well as accessibility determined utilization of services.

WHO/FHE Report (1989) described that the wide variations in the proportion of women receiving prenatal care existed both between and within geographic areas. In a significant number of countries, and especially in rural areas, the percentage receiving prenatal care (by trained a attendant) exceeded the percentage receiving skilled

intrapartum care. This discrepancy between high levels of supervised delivery care coverage may be related to geographic inaccessibility due to lack of transport and the distances and time necessary to travel once a women goes into labor.

Ramesh, P. (1992) observed that maternal mortality in the developed nations has been considerably reduced, but it was still very high in developing nations. An objective of primary health care was to give maximum benefit to pregnant women especially at the "door steps of the community". Therefore, antenatal care as the strategy as tactics to reduce the maternal mortality and morbidity. And antenatal care service must be available widely and must be within easy access of the community.

The objective of obstetrics is that every pregnancy should culminate in a healthy mother in possession of a healthy baby. The present concept of antenatal care goes beyond medical supervision. It includes the education of the girls and women to understand the potential benefit of antenatal care, and provision of dietary and social conditions conducive to health. So when a women becomes pregnant, she has already prepared physically and psychologically to undergo medical care from the very early stage of pregnancy.

HEALTH SERVICES FACTORS ASSOCIATED WITH ANTENATAL CARE ATTENDANCE:

Islam and Nielsen. (1993) noted that reasons for the reluctance of mothers to use MCH clinic facilities were the unfriendly attitude of health personnel who sometimes demanded money for the services offered, clinic operating only during the busy hours of family work.

1. WAITING TIME TO ATTEND ANTENATAL CARE:

Puengrat Boonayanurak (1990) found that the pregnant women intended to attend antenatal care even though the waiting time for antenatal care service ranged widely from less than one hour to three hours.

2. BLUE CARD MEMBERS AND UTILIZATION OF ANC SERVICES:

Soraj Prasad (1988) noted that rates of seeking care regarding to antenatal visits, the attendance were significantly higher with blue cards members than in non blue cards members.

KNOWLEDGE, ATTITUDE AND PRACTICE OF PREGNANT WOMEN OF ANTENATAL CARE:

Malee Charoenmuang (1990) found that pregnant women who had higher intellectual level of knowledge on antenatal care would have more ANC attendance than those who had lower intellectual level of knowledge on antenatal care, since the

pregnant women with good knowledge on antenatal care had more concern on the importance of ANC attendance.

Rautava. (1989) noted that those women who refused to participate were not significantly occupationally different from the study subjects. Practically all pregnant women in Finland use maternity health care services. However, those with low childbirth knowledge needed more health counselling and largely characteristics by the same factors that identify mothers in other countries who do not use such services. This finding emphasizes the importance of wide coverage of antenatal care. Mothers with low childbirth knowledge were more often than those with high knowledge, unemployed, somewhat younger, living near or with their parent, less educated.

They felt that they had no education in child rearing. They smoked more than those who had higher knowledge both before and during pregnancy. They had less physical exercise, ate more fatty foods and less vegetables. A low level of childbirth knowledge seemed to be associated with the risks in health connected behavior, which had important implication for prenatal health education.

Chisholm, DK. (1989) stated that regarding the value of antenatal care and early booking, early bookers were more likely to state their importance to women who visited their own general practitioner more than two months after their last

period gave range of reasons for delaying. Some reasons for delay in consulting health personnel were identified, including uncertainty about the pregnancy and in some cases because it was unwelcome.