

## RAMIFICATION OF COMPLICATIONS OCCURRING DURING PREGNANCY

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**ABSTRACT: Objective.** This sampled survey tries to answer the question “To find the pregnancy related complications rate among rural Women of Reproductive Age (WRA) during pregnancy in Village Shah Bollah”. **Methods:** Structured Questionnaire technique was implemented to collect information. This tool is focused on such question which helped to gather the information on the complications which occurred during pregnancy. The data was collected with the help of LHW after taking verbal consent of targeted females. **Results:** 75.3% (N=73) of the respondents used Hospital facilities for their last delivery. 11% vaginal bleeding, 20% anemia, 15% severe abdominal pain, high grade fever 7%, 18% severe headache, only 2% loss of consciousness, swelling of lower limbs was recorded 12%, fast heart beat 8% and child does not move responded by 7% was recorded during pregnancy (N=73). **Conclusion:** The effectiveness of social mobilization and attitudinal change towards safe birthing strongly correlates with the intensive efforts carried out by Government and Line Departments which surely has led to bring a change in traditional mind sets of intended beneficiaries in rural areas.

**Key words:** Complications, Pregnancy, LHW, Delivery, WRA

### INTRODUCTION

There are an estimated 4 million neonatal deaths and 500,000 maternal deaths worldwide each year [1,2]. The vast majority of these deaths occur in developing countries, where 43 percent of births are attended by traditional birth attendants, the proportion generally being higher in rural areas. Training traditional birth attendants was a central component of the Safe Motherhood Initiative launched by the World Health Organization, the United Nations Children’s Fund (also known as UNICEF), the United Nations Population Fund, the World Bank, and other organizations, but the lack of evidence from randomized, controlled trials to inform decision making has prohibited widespread implementation of such training [3,4].

Complication during pregnancy and after pregnancy is globally accepted terminology in health sector. Awareness about pregnancy complications was improved after the implementation of Government and Line Department Projects (LHW Program and MNCH program) at ground level. Media role is no doubt did successful effort to spread awareness at local level.

Globally, every minute, at least one woman dies from complications related to pregnancy or childbirth – that means 529 000 women a year. In addition, for every woman who dies in childbirth, around 20 more suffer injury, infection or disease – approximately 10 million year [5]. women each

Most maternal deaths are avoidable as the health care solutions to prevent or manage the complications are well known. This includes well-functioning health system that provides accessible and high quality care from household to hospital level. Egyptian health officials have long been concerned about the country’s preventable maternal deaths, with good reason. According to Egypt Demography and

health Survey, slightly more than one quarter of Egyptian pregnant women do not receive antenatal care. However, among those who receive antenatal care only one third of them received advised about signs of obstetric complications and where and when to seek medical assistance [6].

Organized data on routine health outcomes do not exist in rural Pakistan. The World Health Organization’s estimate of maternal mortality in Pakistan (350 per 100,000 live births in 1995) was modeled from projections of deaths of adult females [7]. In Pakistan, more than 89 percent of deliveries, and 80 percent of maternal deaths, occur at home, and 80 percent of deliveries are attended by only a traditional birth attendant [8,9]. Only 1 in 20 women with complications of pregnancy or childbirth reaches a facility with emergency obstetrical care. Infant mortality is estimated at 82 per 1000 live births [10].

Global attention to maternal health and safe motherhood has grown significantly in the past decade. Reproductive health problems account for more than a third of the total burden of disease of women aged 14-44, compared with only 12% for men. The WHO estimates that half a million women die annually from pregnancy-related causes and that 99% of these deaths occur in developing countries [11]. In Pakistan, the recently reported maternal mortality ratio (MMR) is 340/100,000 live births as compared to 13/100,000 for developed countries [12]. The Maternal Mortality Survey in three provinces of Pakistan conducted by The Aga Khan University had indicated a range of MMR from as low as 281 in Karachi to 673 in Khuzdar, Baluchistan [13]. This gap in pregnancy related deaths between developing and developed countries signify the disparity in human development index. The huge toll of morbidity resulting from neglected or inadequately managed obstetric complications is far greater than mortality, often leading to

grave consequences like formation of various fistulae, reproductive tract infection and infertility [14].

In the 1990s, it became widely accepted that training traditional birth attendants was likely to cause only a small reduction in maternal mortality [4,15]. A recent review suggested that training may improve the knowledge, attitudes, and behaviors of traditional birth attendants [16], but effects on neonatal mortality could not be adequately assessed owing to incomplete reporting and the inadequate quality of available studies [17].

An overwhelming majority of maternal mortality and morbidity are avoidable through timely access to basic maternity care supported by adequate emergency obstetric care; for which early recognition of the problem at the family level is crucial. There is a cluster of socio-cultural, economic, technical and administrative barriers preventing or delaying timely access to appropriate health care, leading to her death [18]. The dearth of information in Pakistan highlights the delayed referral as a key risk factor for maternal deaths in urban Karachi. Often, the severity of the women's condition is unrecognized by the family members that leads to insufficient care and delays in referral to an appropriate health facility [19,20]. Furthermore, it is often customary for a woman in a developing country to obtain permission from her husband or some other male relative to go to a hospital [20]. Delay in acquiring permission may even lead to her death. The lack of emergency transport is undoubtedly the major constraint to accessibility, mostly in the rural areas [21].

Pregnant women are cared for on the basis of risk assessment in the traditional approach to antenatal care [22]. The key question that the research was tried to answer is:

*“To find the pregnancy related complications rate among rural Women of Reproductive Age (WRA) during pregnancy”*

## PATIENTS and METHODS

In this survey close ended questionnaire tool was used to collect the information from females of study area. Every female in the targeted area between ages 18-45 years, ever married have an equal chance to be a part of this study. The criteria of ever married defined as those females are major source of real information as compared to unmarried females. On ground LHW visited the houses of the females to collect the information after taking their verbal consent. LHW explained the purpose of the study to women and after taking their consent, she collected information. Another reason for LHW selection because she is well known lady in her community and every single woman knows about her profession and her input in health sector. For this study catchment population of single LHW working under the supervision of BHU Hanjra in Tehsil and District Gujrat (Pakistan) was selected. Sample size was drawn by estimating proportion of females knowing about the danger signs of pregnancy to be 25% (not knowing 75% with referred to existing data) taking confidence level 95%, absolute precision 10%. This sample was calculated by using

the WHO sample calculation software. After calculation 73 was the sample size for this study.

Closed ended questionnaire consisted on basic information of the respondent, which includes her name, age, profession, education and second portion of the tool was based on complication list along with occurrence of these complications during pregnancy.

LHW was trained on the questionnaire first; she knows the objective of the study and then a pre-test done in the same community to cope the level of understanding of LHW on tool. After that she performed data collection.

## RESULTS

**Table: 1 Place of Last Delivery**

Category	Frequency	Percent
First Pregnancy	8	11.0
Hospital	55	75.3
LHV Home	6	8.2
Home	4	5.5
Total	73	100.0

In addition, a question to trace the trend of safe delivery among rural females was added. Result shows the change in behavioral thinking and practices. Mind-set of the peoples is now more inclined toward the use of skilled health services. Above table shows 75.3% of the respondent used Hospital facilities for their last delivery. A study from Nepal showed that a distance of more than one hour to the maternity hospital was statistically associated with an increased risk of home delivery [23].

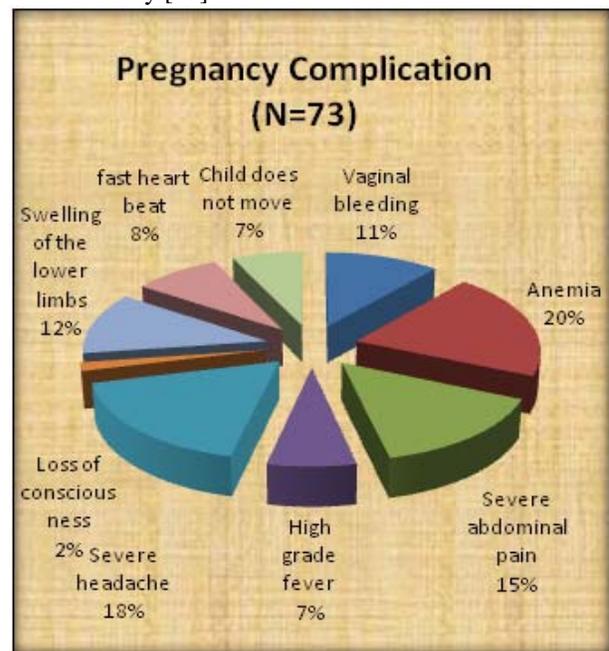


Figure: 1

Above pie-chart is focused on objective of the study. Nine different complications were reported during pregnancy. 11% of the respondent reported vaginal bleeding during pregnancy, 20% anemia recorded, 15% severe abdominal pain experienced by the respondents, high grade fever 7% response, 18% severe headache was recorded, only 2% respondent reported loss of consciousness, swelling of lower limbs was recorded 12%, fast heart beat 8% and child does not move responded by 7% females (N=73). These life-threatening complications are treatable thus most of these deaths are avoidable if women with the complications have timely access to appropriate emergency obstetric care [24].

## DISCUSSION

Obstetric danger signs include persistent vomiting, severe persistent abdominal pain, vaginal bleeding during pregnancy and delivery, severe vaginal bleeding after delivery, swelling of face, fingers and feet, blurring of vision, fits of pregnancy, severe recurrent frontal headache, high grade fever, marked change in fetal movement, awareness of heart beats, high blood pressure, sudden escape of fluid from the vagina, dysuria, oliguria or anuria, prolonged labor, loss of consciousness and retained placenta. Awareness about the significance of symptoms and signs of obstetrics complications may lead to timely access to appropriate emergency obstetric care [25].

Timely decision making is an important source to manage the complications on time. Regarding this research, pregnant females of rural areas were physically stronger due to their active and daily physical home working exercise. Because rural females were physically fit the ratio of complication occurrence was not as higher as normally seen in urban communities. After the successful implementation of LHW, National and MNCH program, health seeking trends among the rural females gradually improving. LHW daily field visit and interaction with her catchment population is a major source to change the traditional thinking of women along with community elders. Distance of health facilities also count to build up the health seeking behavior of communities.

The principle and practice of birth preparedness and complication readiness (BP/CR) in a third world setting where there is prevailing illiteracy, inefficient infrastructure, poor transport system, and unpredictable access to skilled care provider have the potential of reducing the existing high maternal and neonatal morbidity and mortality rates. BP/CR promotes skilled care for all births and encourages decision making before the onset of labor [26]. The BP/CR matrix raises awareness of danger signs, thereby improving problem recognition and reducing delay in deciding to seek care [27].

In existing literature regarding this subject, it is evident that distance to the health facility is one of the major factors resulting in high maternal and neonatal mortality. A study from Nepal showed that a distance of more than one hour to the maternity hospital was statistically associated with an increased risk of home delivery [23]. High rate of complication were seen in the remote areas especially where

the distance from the home to health facility/other health services were not easily accessible.

Awareness of danger signs in pregnancy and labour is an important entry door for skilled birth attendance and referral for appropriate and timely obstetric and newborn care [28,29,30].

## CONCLUSION

The purpose of the paper to study the awareness of the population with safe child birth practices in a remote Punjabi village. It was found that due to awareness level the practices for safe birthing are gradually being improved as compared to the past practices. The target population of the village acknowledged the focused and targeted interventions engineered by relevant stakeholders (LHW Program, MNCH Program and National Program) in the domain of Safe Birthing. In addition, the effectiveness of social mobilization and attitudinal change towards safe birthing strongly correlates with the intensive efforts carried out by Government and Line Departments which surely has led to bring a change in traditional mind sets of intended beneficiaries in rural areas.

## REFERENCES

1. Abou Zahr C., Wardlaw T. Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA. Geneva: World Health Organization, 2004. (Accessed March 15, 2005, at [http://www.who.int/reproductivehealth/publications/maternal\\_mortality\\_2000/mme.pdf](http://www.who.int/reproductivehealth/publications/maternal_mortality_2000/mme.pdf).)
2. Statistical overview of newborn health. In: Saving Newborn Lives Initiative. State of the world's newborns. Washington, D.C.: Save the Children, 2001:44-8.
3. Kamal IT. The traditional birth attendant: a reality and a challenge. *Int J Gynaecol Obstet* 1998;63:Suppl 1:S43-S52.
4. De Brouwere V, Tonglet R, Van Lerberghe W. Strategies for reducing maternal mortality in developing countries: what can we learn from the history of the industrialized West? *Trop Med Int Health* 1998;3:771-82.
5. The World Health Report 2005- make every mother and child count. Geneva, World Health Organization, 2005
6. El-Zanaty F., Way A. Egypt Health Demography Health Survey 2008. Cairo, Egypt, Ministry of Health. Available at: <http://www.measuredhs.com>
7. Making pregnancy safer statistics in EMR. Part 1. 2002. (Accessed March 15, 2005, at <http://www.emro.who.int/rhrn/part1.htm>.)
8. Pakistan Medical Research Council. National health survey of Pakistan 1990-94: health profile of the people of Pakistan. Islamabad, Pakistan: Network Publication Service, 1998.
9. Maternal and infant mortality, policy and interventions: report of an international workshop at the Aga Khan University. Karachi, Pakistan: Aga Khan University, February 1994.

10. Pakistan demographic health survey, 1990-91. Islamabad, Pakistan: National Institute of Population Studies, 1991.
11. Murray T. Huge worldwide toll of maternal deaths largely underreported. *Med. Post*, March 05, 1996.
12. UNICEF; 1998, Statistical tables, State of the world's children, Oxford University Press, 1998; pp.1 20-21.
13. Fikree F. A community-based nested case-control study of maternal mortality. *Int. J. Gynaec. Obstet.*, 1994. 47; 247-55.
14. Iltis Ti, Baqai R, Jafarey SN, et al, Maternal morbidity in the department of obstetrics and gynaecology; *J. Pak. Med. Assoc.*, 1991 ;4 1:223-25.
15. Maine D. Safe motherhood programs: options and issues. New York: Columbia University, Center for Population and Family, 1991
16. Sibley L, Ann Sipe T. What can a metaanalysis tell us about traditional birth attendant training and pregnancy outcomes? *Midwifery* 2004;20:51-60.
17. Sibley L, Sipe TA, Armelagos GH, et al. Traditional birth attendant training effectiveness: a meta-analysis. Washington, D.C.: AED/SARA Project, 2002.
18. Network. Feb. 1994. Access to care saves lives. Thaddeus S. Maine D. Too far to walk: maternal mortality in context. *Soc. Sci. Med.*, 1994;38:10911110.
19. Jafarey SN, Korejo R. Mothers brought dead: an enquiry into causes on delay. *Soc. Sei. Med.*, 1993; 36: 371-72.
20. Fawcus S. A Community - based investigation of avoidable factors for maternal mortality in Zimbabwe. *Stud. Fam. Planning*, 1996; 6: 3 19-27.
21. Fawcus S. A Community-based investigation of maternal mortality from obstetric haemorrhage in rural Zimbabwe. *Trop. Doct.*, 1997; 27: 159-63.
22. JHPIEGO Trainer News. Focused Antenatal Care; Planning and Providing Care During Pregnancy-A Maternal and Neonatal Health Program Best Practice, 2003.
23. R. R. Wagle, S. Sabroe, and B. B. Nielsen, "Socioeconomic and physical distance to the maternity hospital as predictors for place of delivery: an observation study from Nepal," *BMC Pregnancy and Childbirth*, vol. 4, article 8, 2004.
24. WHO: Mother-Baby Package: Implementing Safe Motherhood in Countries. Practical Guide: Maternal Health and Safe Motherhood Programme. In Division of Family Health Geneva: World Health Organization; 1994.
25. EMRO country profile page: <http://www.emro.who.int/emrinfor/index.asp?Ctry=egy> last accessed on August 5, 2010
26. Improving Safe Motherhood through Shared Responsibility and Collective Action. The Maternal and Neonatal Health Program Accomplishments and Results, Jhpiego, Baltimore, Md, USA, 2003.
27. Birth Preparedness and Complication Readiness: A Matrix of Shared Responsibilities, Maternal and Neonatal Health Program, Baltimore, Md, USA, 2001.
28. WHO. 1994. Mother-Baby Package: Implementing Safe Motherhood in Countries. Practical Guide: Maternal Health and Safe Motherhood Programme. In Division of Family Health Geneva World Health Organization.
29. Perreira, K.M., Bailey, P.E., de Bogaletti, E., et al. 2002. "Increasing awareness of danger signs in pregnancy through community- and clinic-based education in Guatemala." *Maternal Child Health Journal* 6(1): 19-28.
30. Killewo, J., Anwar, I., Bashir, I., Yunus, M., Chakraborty, J. 2006. "Perceived delay in health care seeking for episodes of serious illness and its implications for safe motherhood interventions in rural Bangladesh." *Journal of Health, Population and Nutrition* 24(4): 403-12.