PRE AND POST NATAL COMPLICATIONS AMONG THE SLUM DWELLERS AT MIRPUR AREA

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Abstract:

Maternal Mortality is one of the crucial issues not only in Bangladesh but also in developing countries. In developing world, a woman dies in child birth and the cause of death enter on her medical record is hemorrhage, or eclampsia, anemia, hypertension or perhaps sepsis etc if she is hospitalized, otherwise the causes are known as maternal death. Such a record gives the impression that the women death is a tragic misfortune, chance event and the risky process of child birth itself. This is a false impression. Maternal mortality should not be viewed as a chance event. It is a chronic disease developing over a long period and the outcome of a pregnancy is profoundly influenced by the circumstances of a women's life by the economic and environmental conditions in which she lives as well as her social status .The study was conducted among 100 mothers who delivered recently and were living in Dhaka city at Mirpur slum areas in Bangladesh. The aim of the study was to determine the causes of maternal complexities and what condition they undergone during antenatal, delivery and postnatal period. A survey questionnaire including both open ended and close ended questionnaire was used as a tool for data collection. Findings of the study show that vulnerable socio-economic condition and low level knowledge about reproductive health are the main causes of complications. Moreover it is intensified by the early marriage system in Bangladesh. Thus this paper suggests that the effective awareness through education and income generating activities of women are needed for the betterment of reproductive health in such slum areas.

Key words: Ante- natal care, Post- natal care, Risk pregnancy, Morbidity, Obstetric fistula

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1. Introduction:

Maternal complication is one of the severe problems not only in Bangladesh but also in developing countries. No one knows exactly, how many women suffer from different kind of complications as a result of becoming pregnant, most of them is poor and their deaths are neglected. In developing world, a woman dies in child birth and the cause of death enter on her medical record is hemorrhage, or eclampsia, anemia, hypertension or perhaps sepsis if she is hospitalized otherwise the causes are known as simple maternal death to everybody. Such a record gives the impression that the women death is a tragic misfortune, chance event unrelated to anything but the risky process of child birth itself. This is a false impression. Maternal mortality should not be viewed as a chance event. It is a chronic disease developing over a long period and the outcome of a pregnancy is profoundly influenced by the circumstances of a woman's life by the economic and environmental conditions in which she lives as well as her social status. A woman's status is often described in terms of her income, employment, education, health and fertility as well as the roles she plays within the family, the community and society.[1] Most of the maternal deaths can be prevented through the application of preventive approaches e.g. identification and referring of high risk pregnancies, provision of antenatal and postnatal care through a maternal and child health based family planning services and extensive traditional birth attendant training programme for providing delivery services.

This study was conducted to find out the reasons of maternal complexities in pre-natal and post natal period prevalent in Dhaka City Corporation particularly among the people at Mirpur slum areas.

2. Background of the study:

With impressive progress made in recent years, Bangladesh is one of few developing countries on track to achieve Millennium Development Goal 4 to reduce child mortality.

[1] Royston Erica and Armstrong Sue. (1989). "Preventing Maternal Deaths", World Health Organization, Geneva. P45

Between 2004 and 2007 child mortality has fallen from 88 per 1,000 live births to 65 per 1,000 live births. However, despite this encouraging trend, neonatal mortality in Bangladesh is still high, accounting for more than half of all under-five deaths and more than two-thirds of infant deaths.[2] An estimated 120,000 newborns die every year in Bangladesh. The share of neonatal deaths to infant mortality has increased over the period 2002-2006, largely because there has been little progress in preventing neonatal deaths. Poor neonatal health and under-nutrition of both mothers and children could affect the current success in improving child survival.

The reduction of maternal mortality has been much slower than child mortality and Bangladesh still records a high maternal mortality ratio, with 320 deaths per 100,000 births. This means that about 12,000 women die from pregnancy or childbirth related complications every year - more than 30 every day. Moreover, a malnourished mother is very likely to give birth to a low birth weight baby, a major underlying cause of death for newborns. Bangladesh has one of the world's highest rates of adolescent motherhood, based on the proportion of women under the age of 20 giving birth every year. 28% of adolescent women (age 15-19) are already mothers with at least one child and another 5 % is pregnant.[3] The number of deaths among adolescent mothers is double than the national average. These high mortality rates are underpinned by the fact that 85 per cent of women give birth at home, most with unskilled attendants or relatives assisting. The low status of women, poor quality and low uptake of services are some of the reasons for this situation. Because most births occur at home without skilled attendants, there is a high death rate of children under one month. Almost 80 per cent of neonates do not receive post natal care from a trained provider within six days of birth.[2]

The first week of life is the most critical time for a newborn; three in four newborn deaths occur within the first week, almost 50 per cent of them within 24 hours, often at home and with no contact with the formal healthcare system. The major newborn killer is infection (52%) followed by birth asphyxia/unable to breath at birth (21%) and low birth weight/pre-term deliveries (11%).[4] Among the women and children who survive complications during childbirth, many are left with crippling disabilities that often cause them to be ostracized from the community.

[2] (Bangladesh Demographic Health Survey, 2007).
[3] (Bangladesh Maternal Health Services and Maternal Mortality Survey 2001).
[4] (Bangladesh Demographic Health Survey ,2004)

Basic data Statistics from The State of the World's Children 2007, BDHS and MICS[5]	
Maternal mortality ratio (deaths per 100,000 births)	320
Births for women aged 15-19 (per 1000)	127
Neonatal mortality rate (deaths per 1,000 births)	37
Pregnant women who received antenatal care at least once from a medically trained provider (%)	52
Births delivered at home (%)	85
Delivery assistance from medically trained providers (%)	18
Treatment for complications from medically trained provider	42

Source: All Statistics from UNICEF State of the World's Children 2009 report and BDHS 2007.

3. Understanding the Causes of Maternal Mortality and Morbidity:

[5] Statistics from UNICEF State of the World's Children 2009 report and BDHS 2007.

Maternal mortality refers to those deaths which are caused by complications due to pregnancy or childbirth. These complications may be experienced during pregnancy or delivery itself, or may occur up to 42 days following childbirth. For each woman who succumbs to maternal death, many more suffer injuries, infections, and disabilities brought about by pregnancy or childbirth complications, such as obstetric fistula. In most cases, however, maternal mortality and disability can be prevented with appropriate health interventions. Some of the direct medical causes of maternal mortality include hemorrhage or bleeding, infection, unsafe abortion, hypertensive disorders, and obstructed labor. Since most maternal deaths occur during delivery and during the postpartum period, emergency obstetric care, skilled birth attendants, postpartum care, and transportation to medical facilities are all necessary components of strategies to reduce maternal mortality.

Efforts to reduce maternal mortality and morbidity must also address societal and cultural factors that impact women's health and their access to services. Women's low status in society, lack of access to and control over resources, limited educational opportunities, poor nutrition, and lack of decision-making power contribute significantly to adverse pregnancy out comes. Laws and policies, such as those that require a woman to first obtain permission from her husband or parents, may also discourage women and girls from seeking needed health care services – particularly if they are of a sensitive nature, such as family planning, abortion services, or treatment of STIs (Sexually Transmitted Infections). One traditional practice that affects maternal health outcomes is early marriage. Many women in developing countries marry before the age of 20. Pregnancies in adolescent girls, whose bodies are still growing and developing, put both the mothers and their babies at risk for negative health consequences. The consequences of maternal mortality and morbidity are felt not only by women but also by their families and communities. Children who lose their mothers are at an increased risk for death or other problems, such as malnutrition.

Loss of women during their most productive years also means a loss of resources for the entire society. Ensuring safe motherhood requires recognizing and supporting the rights of women and girls to lead healthy lives in which they have control over the resources and decisions that impact their health and safety. It requires raising awareness of complications associated with pregnancy

and childbirth, providing access to high quality health services (antenatal, delivery, postpartum, family planning, etc.), and eliminating harmful practices.[6]

4. Objectives and Methodology of the study:

4.1 Objectives of the study:

1. To explore the socio-economic factors that is related to maternal complications.
2. To find out information regarding antenatal and postnatal care of the mother.
3. To collect data on mothers knowledge about reproductive health.

4.2 .Methodology of the study:

The study was conducted at Mirpur area in Dhaka city from 2011 March-2012 June. Data were collected from few slums at Mirpur. One hundred mothers of new born babies were selected to collect data. They were selected following purposive sampling procedure. Interview schedule was used to collect data. The interview schedule included both open ended and close ended questions. After survey, the questionnaire were checked for rectifying errors, omissions, inconsistencies and edited. Then data were tabulated by simple statistical measures.

5. Justification of the study:

In every society, women during pregnancy and children particularly during their infancy have been considered worthy of receiving particular attention, There are valid reasons for this special care of a pregnant women having double benefits first to her as adult member and secondly to her offspring. The reasons for placing special emphasis on the pre-natal period is that this is a period of particular physical stress on the life of a women and undesirable influences in this period may affect her own health and the health of her child. The emphasis should also be

[6] http://www.policyproject.com/pubs/MNPI/Bangladesh_MNPI.pdf

given on post natal period because if proper care is not taken after delivery that also poses danger to mother and her child. Impairments of a women's health may have adverse effect on the health of other family members too. Major causes of death include hemorrhage, abortion, eclampsia, puerperal sepsis and obstruct labor. Poor women are illiterate; they have no knowledge about life threatening complications, so they suffer from various kinds of complications. Despite the preventive approaches taken up so far, maternal mortality and complications continue to remain high in Bangladesh.

6. Results and Discussion:

6.1 Socio-Economic and Demographic factors:

Socio-Economic Features	N	%
Age(in year)		
<20	12	12
20-24	46	46
25-29	28	28
30-34	10	10
35+	4	4
Total	100	100
Educational level		
Illiterate	55	55
Primary	43	43
Secondary	2	2
Total	100	100
Respondent's Occupation		
Home maker	21	21
Garments worker	9	9
Maid servant	67	67
Others	3	3

Socio-Economic	N	%
Age at Marriage		
<18	32	32
18-20	68	68
Total	100	100
Number of children		
1-2	80	80
3-4	14	14
5-6	6	6
Total	100	100

Total	100	100
Husbands occupation		
Van/Rickshaw puller	30	30
Security Guard	13	13
Small shopkeeper	12	12
Hawker	10	10
Day laborer	10	10
Hotel boy	8	8
Carpenter	4	4
Unemployed	3	3
others	10	10
Total	100	100
Monthly Family income		
3001-4000	12	12
4001-5000	17	17
5001-6000	13	13
6001- 7000	58	58
Total	100	100

Source: Field work from 2011March-2012 June

Socio-economic and demographic background of the study population shows that 46 per cent mothers were from age group (20-24). It means that because of early marriage practice most of the women became pregnant between the age group (20-24). Among them majority of the mother had second pregnancy. The educational level reveals that the complications were high (55%) among the illiterate. Occupation of the respondents indicates that majority of the maternal complexities facing mothers (67%) were maid servant with low income. Only a small portion of them were engaged in garment's factories (9%) and (21%) were home maker. Among the respondent's 58 per cent monthly family income was taka (6001-7000). Now a day's it is impossible for those families to fulfill their basic needs by this scanty income let alone their

maternal care. Moreover we saw that the rest of the respondent's monthly family income was less than that. It was not possible for them to meet their maternal health necessities. 100 per cent of the respondents were married to less than the age 20. It indicates that the early marriage system is acute in the society. Because of early marriage, they conceive earlier, so disproportion between the size of the infant –head and the mother's pelvis is most common among these very young mothers.[1] The data reveals that majority of mothers (80%) have 1-2 children.

6.2. Ante-natal Care:

Checkup in antenatal period	N	%
< 4 times	26	26
4-5 times	10	10
6-7 times	16	16
8-10 times	4	4
No checkup	44	44
Total	100	100
Taking tetanus injection		
Took Tetanus	16	16
Don't took Tetanus	54	54
Their lack of realization	26	26
Lack of conveyance	4	4
Total	100	100
Taking Nutritious food		
For lacking of money	31	31
Nausea	4	4
Prejudice of not eating excess food	7	7
Have taken some nutritious food	58	58
Total	100	100
Rests and maintaining personal hygiene		

Didn't take for household work	60	60
Didn't take for garments work	10	10
Didn't take for helping in husbands work.	9	9
Have taken rest and maintain personal hygiene	21	21
Total	100	100
Complications during pregnancy		
Abdominal plain, fever	17	17
Blurring of vision, head ache, excess vomiting	15	15
Bleeding	12	12
White discharge	9	9
Jaundice	8	8
Hypertension	6	6
Eclampsia	5	5
Tuberculosis	2	2
No problem	26	26
Total	100	100

Data shows that 26% of the respondents had checked up less than 4 times and 44% of them didn't take any check up during antenatal period. They suffered from various problems in antenatal period and post natal period as well. The study shows that 54 per cent of the respondents didn't take tetanus injection and 26 per cent didn't know about tetanus only 16 percent pregnant mother took tetanus injection. We can say that, in spite of having free maternal health services of government and NGOs majority of the respondents didn't take tetanus because of lack of knowledge about it. 31per cent respondents could not take nutritious food for lacking of money. A large number of respondents informed that they have taken enough food containing insufficient nutritious particles. Though it is essential to take rest and maintain personal hygiene, majority of the respondents have failed to take rest because of their occupation and household work. Generally these mothers give birth to underweight baby. It is striking that 74% mother had

one or more complications during pregnancy. Only 26% were free from complications. The most commonly reported complications are blurry of vision, headache, excess vomiting, abdominal pain and fever.

6.3 Post-natal Care:

Delivery place	N	%
At home	81	81
Hospital	1	1
Health center	18	18
Total	100	100
Causes of not going to hospital		
Ignorance	23	23
Indifference of husband	46	46
Lack of money	31	31
Total	100	100
Assistance in delivery		
Dai	72	72
Doctor	3	3
Family member	8	8
Nurses	17	17
Total	100	100
Complications in delivery and after delivery		
Retained placenta	19	19
Excess bleeding and rapture uterus	12	12
Prolonged laborer	9	9
Hands and feet come first.	11	11
Eclampsia	7	7
Paralysis and high pressure	9	9

Premature labor	4	4
White discharge and urine infection	3	3
Tetanus	1	1
Weak	25	25
Total	100	100

Research data shows that 81% of the delivery took place at home while at the hospital only 1%. An unhygienic condition at home is not safe for delivery. As a result they are facing various kinds of complications in postnatal period. We can say that though Govt. ensures many hospitals and health centers in urban areas the study women prefer home delivery due to most of the time ignorance, indifference of husband and sometimes lack of money. They informed two or many causes for their not going to hospital. One significant phobia is noticed among the respondents that they thought they had to face cesarean section if they had gone to hospital. A cesarean is a surgical procedure in which one or more incisions are made through a mother's abdomen and uterus to deliver one or more babies, or rarely to remove a dead fetus.[7]In many cases, with increasing frequency, a child birth is achieved through caesarean section, the removal of the neonate through a surgical incision in the abdomen, rather than through vaginal birth.[8] In 2010-2011 a study was conducted in 25 clinics in Dhaka city which reveals that in October total delivery was 594 among the total delivery 513 was cesarean while normal delivery was 74 and 7death[9]. So we see a significant resemble between the respondents phobia and existing delivery system in the hospital and clinic. One strongest cultural barrier which prevents them from going to hospital for delivery is that their mother and previous generation have given birth "naturally" from generation to generation. The proportion of hospital birth shows no relationship with the number of antenatal checkup. Women who receive antenatal checkups are more likely than other women to deliver in hospital because their antenatal care provides advised them to do so. We notice 56% receive antenatal checkups and only 1per cent delivered at hospital. In fact it shows a

[7]"Fear a factor in surgical births". The Sydney Morning Herald. 2007-10-07.
[8] "Fertilization". http://www.vivo. Colostate. Edu/hbooks/pathphys/repord/fert/fert.html.

[9] Ahasan Monjurul Md, Rahman Monzur, Patwari Quadir Shahidul & Haq Mahbubul Md "Survey on the Status and Condition of Mother During Child Birth", Journal of Dhaka International University, 2011.

reverse relation. Those who delivered at home among them 72% took the assistance of dais or TBA (Traditional Birth Attendant). We observe 75% have several problems in delivery and after delivery. It is the result of taking the assistance of traditional and unskilled dais and family members. Dais cannot manage any complications and cannot provide hygienic practice. We glimpse 19% of the respondents suffer from retained placenta. These are the results of early marriage. 25 per cent respondents informed that they felt weak after delivery it seemed to me that they are suffering from severe anemia. Thus we can conclude that though post natal care is important, there is a concentration of women amongst the poorest of economic stratum who under goes without adequate postnatal care. As a result these mothers and their neonate suffer from various problems.

6.4. Mother's knowledge regarding Reproductive Health:

Age of risk pregnancy	N	%
Don't know	64	64
Wrong	20	20
Half correct	10	10
Correct	6	6
Total	100	100
Taking extra food during pregnancy		
Know	65	65
Wrong	19	19
Don't Know	16	16
Total	100	100
Feeding Saldudh		
Yes	97	97
No	3	3
Total	100	100
Proper knowledge about birth spacing		

Have knowledge	33	33
Have no knowledge	67	67
Total	100	100

Majority of the study women (64%) did not have knowledge about the age of risk pregnancy(less than 20 and more than 35). The second largest number of the respondents (20%) gave wrong answer about risk pregnancy. 65 per cent of the respondents didn't know that they must have to take extra nutritious food during their pregnancy. It means though it is essential to take nutritious food during pregnancy most of them were ignorant about it. Majority of them (67%) didn't have knowledge about proper birth spacing. 97 percent mother feed their baby saldudh and only 3% did not feed their baby. This data do not show any pattern of relationship with other data. This may be a result of propaganda through television.

7. Conclusion and Recommendations:

This research finds that level of utilization of services pertaining to antenatal and postnatal periods is very negligible among the slum dwellers. The role of socio-economic factors in services utilization is clearly evident in study area. The average answer of the questions means their economic vulnerability and lack of knowledge. It can be said that education, occupation and all the key variables had role for the maternal complications. Govt. tries to increase the economic condition of the people who live on a low income and health. Family welfare should play an important and influential role to raise the level of knowledge of mothers by organizing group discussion elaborately, effectively and attractively on antenatal and postnatal care which is the only universally proved and genuine factor to reduce the maternal morbidity and mortality among the slum dwellers. As per the findings drawn out through the study, following recommendations are made to improve the situation:

1. Income generating activities of male should be increased. Female employment for income should also be promoted, as we got the information that for lacking of money they could not afford nutritious food.
2. Education on reproductive health should be emphasized, so that they will be able to take greater responsibilities to improve not only their health but also their child's health.

3. Study should be done to change the perception and attitude of males and adult decision making family members regarding the maternal health.
4. Making people aware of the harm of early marriage and teenage pregnancy.
5. Aware people about proper birth spacing.

References:

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6. http://www.policyproject.com/pubs/MNPI/Bangladesh_MNPI.pdf
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