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DESCRIPTIVE STUDY ON PREGNANCY REGISTRATION AMONG RURAL WOMEN RESIDING IN JAMMU AND KASHMIR

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ABSTRACT

Health and its practices are entwined with the deepest complexity of social existence, pervading the realms of politics, economics, and religion,and invariably linked to dimensions beyond the body, such as interpersonal, familial, and community relationships. According to anthropologists, explanations of the causes and patterns of health and sickness typically transmit value judgments, notions of right and wrong, accountability and blame, as well as explain what is ethically at stake in health definitions and failures. Medical anthropology research, built on historical and cultural assessments over a long period of time, reveals a wide range of differences in health metaphors and meanings. The present study was undertaken with the goal of assessing the knowledge of women in the reproductive age group residing in rural areas of Jammu and Kashmir regarding knowledge and utilization patternof various maternal health services provided by the Govtandassessing the sources of their information. The study included four hundred rural women in their reproductive age group using a multistage cluster sampling and door-to-door survey. The results revealed that about 70% of rural women were aware of the need for early registration of pregnancy and the importance of antenatal care. And more than 60% of all village women availed antenatal services from govt facilities. The study results also revealed that the major source of their information regarding maternal health was ASHA workers followed by other health care workers.

KEYWORDS: Maternal Health Services, Ante-Natal Care (ANC), Delivery.

INTRODUCTION

The most valuable possession in a man's life is his health. It is a basic human right and one of the most important aspects of human life. In terms of community development, health is a major source of worry. To improve one's quality of life, it is critical that everyone has affordable access to the necessary health care services. The right to good health also includes control over one's health and body, as well as access to sexual and reproductive information and services free of

violence and discrimination. The field of health is as wide and complex as the entirety of human existence. It is a multifaceted notion that encompasses an individual's physical, mental, social, psychological, and general development (cited by Bircher, 2005). WHO defined health in 1986 as a resource for everyday life rather than the goal of existence? The term "health" refers to a positive concept that emphasizes social and personal resources as well as physical abilities. In most cultures, health is not a major concern. In fact, as part of its culture, every community has its own definition of health. Health is not merely a biomedical phenomenon, but also one that is influenced by the people involvedin social, psychological, cultural, economic, and political variables. The World Health Organization's preamble to its constitution provides a commonly accepted definition of health, which is as follows: "Health is more than just the absence of sickness or weakness; it is a state of total bodily, mental, and social well-being." One of the most basic human rights is the right to health. One of the most important measures of human life is health. Community development has traditionally placed a premium on health. It is critical to take advantage of the health care and family welfare services available to all residents to improve one's quality of life. Health care services are being expanded and improved by policymakers all around the world.Individual and group realities are organized, recounted, challenged, and in every sense lived as social trajectories in anthropological perspectives on health (Kleinman, 1995)."Reproductive health is a condition of total physical, mental, and social well-being, not just the absence of sickness or infirmity in all things relevant to the health of the multi-dimensional reproductive system and its activities and processes," according to the World Health Organization (U.N., International conference on population and development, 1994). On October 15, 1997, the Reproductive and Child Health (RCH) Program was inaugurated across the country. This program aspires to achieve a situation in which women can control their fertility, go through pregnancy and childbirth safely, and have successful pregnancies that result in the mother's and child's survival and well-being. Couples will also be able to engage in sexual activity without fear of becoming pregnant or developing sexually transmitted diseases.India has implemented severalprograms to strengthen and improve the quality of services available to control fertility as effectively as feasible. Researchers and social scientists have identified a few variables that contribute to this, including poor accessibility, lack of infrastructure, poor quality of care in the way providers handle clients, lack of faith in the services, and so on. However, the

impact of these factors on service consumption differs depending on the recipients' characteristics, attitudes, and perceptions (Verma et al 1993). The 9th five-year plan has brought together all the previous plans' relevant programs, such as Child Survival and Safe Motherhood (CSSM) and Maternal and Child Health (MCH). Because RCH services are targeted at women of reproductive age, their use is likely to be influenced by socioeconomic and other personal characteristics of women, such as education, modernization, and women's access to resources such as empowerment, knowledge, attitude, and habits. As a result, healthcare delivery, which is essentially a technological and managerial process, must be considered in terms of epidemiology and social factors. Even though women and children in the developing globe face similar health issues related to reproductive behavior and child mortality, the most pressing concerns differ from area to region and population to population. Better health facilities and the use of reproductive health services can help improve maternal health and reduce infant mortality, both of which are eight-millennium development objectives for India (WHO, 2013).

BACKGROUND: MATERNAL HEALTH SERVICES

Maternal health refers to a woman's physical and mental well-being during pregnancy, delivery, and the post-natal (post-delivery) phase. During pregnancy and delivery, this covers a woman's physical, mental, and social well-being. Ante-Natal Care (ANC), Institutional Delivery (ID), Post-Natal Care (PNC), and Family Planning (FP) are all healthcare aspects of maternal health services. Maternal health, according to the World Health Organization (WHO), refers to women's health during pregnancy, childbirth, and the postpartum period. The following are the basic components of maternal health services:

ANTE-NATAL CARE (ANC)

Ante-Natal Treatment (ANC) is the care a woman receives during her pregnancy to help guarantee a healthy pregnancy outcome. Antenatal care ensures the health of both the mother and the baby, as well as prepares women physically for labor, delivery, and the postpartum period. All pregnant women must receive basic and specialty treatments at healthcare facilities. Antenatal care visits begin when the pregnancy is confirmed and continue every four weeks for the first seven months of pregnancy, then every two weeks until the baby is born. Registration of pregnant women at health institutions, at least three antenatal care visits to health institutions during pregnancy, iron prophylaxis for pregnant women, two doses of Tetanus Toxoid (TT)

vaccine, routine check-up (abdominal examination, Blood Pressure (BP), Urine testing &fetal growth monitoring), detection & treatment of anemia, and management & referral of high-risk pregnancies are all included in ANC services. The goal of ANC is to discover any potential difficulties in pregnant women early on and to take efforts to prevent complications during pregnancy through nutritional supplement recommendations, physical tests, and regular medical checkups. Regular antenatal care assists women in their physical and mental preparation and allows them to relax during pregnancy and after delivery, while also reducing maternal and neonatal morbidity, abortions, birth deformities, and Low Birth Weight (LBW) babies. Because complications during pregnancy and childbirth are unexpected and can develop without warning, targeted ANC aids in the early detection and treatment of illnesses, improving maternal outcomes. Preventing eclampsia and anemia requires early detection and treatment of high blood pressure and anemia. ANC provides an opportunity to promote high-quality healthcare by counseling and educating pregnant women about their own and their children's health. According to the World Health Organization (WHO), every pregnant woman should have at least four ANC visits during her pregnancy.

DELIVERY

The delivery of a baby is an important part of maternal health care. Because all pregnant women are at risk of life-threatening complications, many of which are unpreventable and unanticipated, institutional delivery is beneficial in avoiding any issues during birth. It's also important to make sure that the delivery is done by a Trained Birth Attendant (TBA) or under the supervision of a skilled medical practitioner so that potential difficulties can be identified and treated quickly. If deliveries are made at home, the five cleans principle must be followed, namelyclean environment, clean hands, cleanblade, clean surface, andclean thread. These are beneficial in preventing infections or sepsis during the delivery process, as well as a lack of care that could result in the death of the mother, child, or both. Assistance with the commencement of breathing, warming, resuscitation, prevention of birth asphyxia, hygienic cord care, prompt nursing, and referral to higher facilities in case of emergency are all common areas that need to be determined shortly after delivery.

POST-NATAL CARE (PNC)

The post-natal period is defined as the time following the birth of a child and lasting for at least 40 days. It is currently that the mother's body returns to normal; consequently, it is critical that mothers receive care during this time. More than 60% of maternal deaths, according to Gill, occur during the postnatal period. When a mother dies, her newborn child faces significant morbidity and mortality risks. As a result, PNC can mean the difference between life and death for both the mother and the child. Routine visits to the health center following childbirth, exclusive breastfeeding, child immunization, maintaining warmth, early identification of danger signs/complications, and quick referral are all examples of post-natal care.During the post-natal period, services such as family planning, maternal and child nutrition, immunization against Vaccine-Preventable Diseases (VPD), hygiene and sanitation, child-rearingcounseling, and infection prevention, including HIV and STIs, are provided, according to the United States Agency for International Development (USAID).

In developing nations, bleeding, infections, and hypertensive problems are the most common causes of maternal mortality during the postpartum period (Matthews Matha 2005). These harmful disorders can be detected during a post-partum checkup of the mother and treated accordingly. Delays or omissions in Post-Natal Care can be dangerous to both the mother and the newborn, resulting in death or impairment; therefore, every mother-woman should visit a healthcare facility at least three times after birth to avoid difficulties.

RESEARCH METHODOLOGY

Research is a method of studying events or facts to discover new or hidden information about a specific discipline in a systematic and organized manner. In general, research can be defined as a process of watching, thinking, experimenting, and determining answers to problems that occur in one's mind.

Research Approach: - Quantitative research approach

Research Design: - Descriptive design.

THE SAMPLE DESIGN

A sample is a subset of the population under investigation. It depicts many people and is used to make inferences and draw conclusions about them. It's extensively used in the social sciences to get the information you need about a population without having to measure everyone. Samples

are examined to learn more about the whole. It can be defined as a group of respondents chosen from a broader population for the purpose of a survey when dealing with people. For the purposes of this research, the sample was drawn using a multistage random sampling process. To begin, the Civil Surgeon Office provided a list of communities within each rural health block. In Jammu & Kashmir, there are villages spread among six rural health blocks. The initial stage of the sampling involved selecting ten communities from each of the six health blocks. The first village was picked by lottery from a list provided by the Civil Surgeon's office, and the remaining villages for sampling were chosen at random by selecting the tenth village from the list. The research covered sixty villages in all. In the second step of the sampling, five women (pregnant or postpartum) from each village were purposefully picked to satisfy the study's objectives. A total of 400 women were chosen as part of the study's sample. If five respondents could not be found in any of the villages, the sample was drawn from the next village on the list.

Sampling Technique

Tostudy rural populations the researcher used the Multistage Cluster Sampling method. Cluster sampling is a method of probability sampling that is often used to study large populations, particularly those that are widely geographically dispersed. In cluster sampling, the researcher dividedthe population into smaller groups known as clusters. Then the desired sample was randomly selected from among these clusters to form a sample.

POPULATION

Target Population: In this study target population include all women in reproductive age group residing in Jammu and Kashmir

Accessible Population: In the present study accessible population is randomly selected 400 women in the reproductive age group (18yrs -45yrs) residing in selected rural areas of Jammu and Kashmir.

RESULTS AND DISCUSSION

TIME OF PREGNANCY REGISTRATION

Registration of pregnancy is a significant part of Antenatal care as early enlistment makes it conceivable to have a thought regarding the pre-pregnancy wellbeing of a lady. It tends to be finished by taking note of the baseline data, for example, weight profile, BP, and Urine testing.

What's more, it is likewise seen that early Antenatalvisits additionally give a thought regarding the exact estimation of the expected date of confinement, particularly in ladies who are uncertain of their last menstrual period.

The goal of Antenatal Care (ANC) is to ensure the health status of pregnant women, early identification of any deviations, and therapy of pregnancy-related illnesses as well as any other clinical issues. It additionally gives an open door to pregnancy-relatedbits of advice and counseling. Early enlistment at an Antenatal facility is essential. Be that as it may, most pregnant ladies enter late into an Antenatal registration program, particularly in emerging nations like India (Patel, Rupani, and Patel 2013). Remembering the significance of early enrollment, World Health Organization (WHO) suggests that pregnant ladies in non-industrial nations ought to look for Antenatal registration within the initial four weeks of pregnancy (Carroli, 2001). Prior to knowing the hour of enrollment of pregnancy, surveying the degree of familiarity with respondents about the planning of pregnancy registration is basic. The information relating to mindfulness about pregnancy registration and the use of these services have been depicted and introduced in the table.

TABLE:1TIMEOFPREGNANCY REGISTRATION

Timeofpregnancyregistration							
Health Blocks→	Pancheri	Ramnagar	Dalsar	Chenani	Panjar	Tope	Total
Responses ↓	Awareness Level						
1st trimester	41(58)	49(82)	51(73)	45(80)	38(54)	36(51)	260(65)
2nd trimester	21(30)	9(15)	11(16)	15(20)	19(27)	25(36)	100(25)
last trimester	8(12)	2(3)	8(11)	--	13(19)	9(13)	40(10)
Total	70(100)	60(100)	70(100)	60(100)	70(100)	70(100)	400(100)
	Utilization pattern						

1sttrimester	25(35)	12(20)	24(34)	17(28)	33(47)	7(10)	118(29.5)
2ndtrimester	45(65)	35(58)	40(57)	38(63)	37(53)	43(61)	238(59.5)
Last trimester	--	13(22)	6(9)	5(9)	--	20(29)	44(11)
Total	70(100)	60(100)	70(100)	60(100)	70(100)	70(100)	400(100)

Figuresin parenthesis represent the percentage

The table shows the block-wise appropriation and familiarity with usage examples of respondents regarding the time of pregnancy registration. In general, 70% of the respondents knew that pregnancy ought to be registered during the first trimester of pregnancy followed by 25% of the respondents who expressed that pregnancy ought to be enlisted during the second trimester and 10 percent of the respondents knew that pregnancy ought to be registered in the last trimester of pregnancy. Block-wise circulation of the information uncovers that out of 65% of the respondents who knew that pregnancy ought to be enrolled during the first trimester, a larger part for example 82% of the respondents were from Ramnagar followed by 73% of the respondents from Dalsar, 80% from Chenani, 58% from Pancheri, 54percent from Panjar and 51 percent of the respondents were from Tope. Out of 23.33 percent of the respondents who knew that pregnancy ought to be registered during the second trimester, a larger part for example 40% of the respondents were from Tope followed by 32% of the respondents from Pancheri, 28% from Panjar, 20% from Chenani, 12% from Dalsar and eight percent of the respondents were from Ramnagar. Among 6.67 percent of the respondents who knew that pregnancy ought to be registered during the last trimester of the pregnancy, 16% of the respondents were from Panjar followed by eight percent of the respondents from Tope, six percent each from Pancheri and Dalsar, and four percent from Ramnagar. None of the respondents from Chenani expressed that pregnancy ought to be registered during the last trimester. The information embraces that a greater part of ladies in rural areas of District Udhampur knows about the correct time of pregnancy registration. One of the investigations led to familiarity with pregnant ladies in ruralTamil Nadu uncovered that more than 50% of respondents knew that pregnancy ought to beregistered during the first trimester (Elavarasan, Padhyegurjar, and Padhyegurjar, 2016). One

more review directed in 34 locales in country India, finished up the presence of low knowledge about pregnancy registration. (Chandhiok, Dhillon, Kambo, and Saxena, 2006). To the extent that the information on the schedule of genuine pregnancy registration is concerned, the table shows that a larger part of thesample 63% of the respondents got their pregnancy registeredduring the second trimester of the pregnancy followed by 29.5 percent respondents who got their pregnancy enlisted during the first trimester. Block-wise dissemination uncovers that 65% of respondents from Pancheri, block got their pregnancy registered during the second trimester. Out of 66% of the respondents who got their pregnancy enlisted during the second trimester, the greater part of thesample 70% of the respondents were from Pancheri, Ramnagar and Dalsar followed by 66% of the respondents from Chenani and Tope and 54 percent of the respondents were from Panjar block. Out of 26% of the respondents who got their pregnancy registered during the first trimester, a greater part for example 16% of the respondents were from Panjar, 30% from Pancheri, 28% from Dalsar, 24% from Chenani, and 10 percent of the respondents each from Tope and Ramnagar blocks. Among eight percent of the respondents who got their pregnancy registered during the last trimester, the greater part for example 20% of the respondents were from Tope, 16% from Ramnagar, 10% from Chenani, and two percent of the respondents were from Dalsar block.

The explanations behind not getting pregnancy registration early for example during the first trimester despite having awareness were that they had apprehension about some hostile approach. A few respondents were told by the older ladies of the family not to unveil their pregnancy status to anybody as revealing the pregnancy status could harm the pregnancy. This shows that in the current Techno Era some odd still exist among rural ladies This finding is a lot lower than the discoveries of the review completed by Metgud, Katti, Mallapur, and Wantamutte (2009) in rural areas of North Karnataka which uncovered 98.5 percent early enlistments in the review region. In the current review, eight percent of ladies were registered during the third trimester. This is like the findings of a review where 5.38 percent of the respondents got themselves enlisted in the third trimester of pregnancy (Metgud et al., 2009). In a review directed in Ghaziabad, 49.7 percent of respondents had registered in the third trimester, 35.8percent in the first trimester, and 14.5percent of the respondents in the second trimester (Singh, Chauhan, Singh, Bhatnager, and Idnani, 2013). One more review led in Rohilkhand Region of India

observed that only one-fourth of the ladies were registered before about four months of pregnancy. (Srivastava, Mahmood, Mishra, and Shrotriya, 2014).However, as opposed to the discoveries of the current review, one of the examinations conveyed by Kaur, Gupta, and Kaur (2015) presumed that 90.1percent of the respondents were enlisted inside the first trimester followed by 9.9 percent of the respondents whose pregnancy was enrolled in the second trimester.

SOURCEOFINFORMATIONABOUTTHEPREGNANCYREGISTRATION

Knowing the source of data for early registration of pregnancy is similarly significant. It is applicable to know the job of an Accredited Social Health Activist (ASHA) in spreading awareness separated from relatives, neighbors, and companions. By and large, it is seen that Accredited Social Health Activists (ASHA) assume a huge role in maternal medical care in rural regions. The Accredited social wellbeing dissident, regularly called (ASHA), is a female worker chosen from the local area, after a short preparation on local area wellbeing (MOHFW, 2005-12). The ASHA program started by the NRHM (presently National Health Mission) plans to produce and empower the investment of the local area at grass root levels to work on maternal wellbeing (Joshi and George, 2012). Licensed ASHA workers spread awareness on well-being and urge the local area to use the health services accessible. The work and obligations of ASHA make them solid mainstays of the National Health Mission methodology to address the Millennium Development Goals (MDG) on health-related markers (Bajpai, Dholakia, and Towle, 2013). In this way, to concentrate on the use of maternal and child health services it becomes applicable to gather information with respect to the source of information of the respondents. In the current review, the responses have been ordered under subgroups - Mothers, Mothersparents-in-law, neighbors, health workers,and Accredited Social Health activists (ASHA). The information relating to the data source about pregnancy registration has been acquired and introduced in the table.

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TABLE-2

SOURCE OF INFORMATIONABOUTTHEPREGNANCYREGISTRATION

Source of informationabout the pregnancy registration							
Health Blocks→	Pancheri	Ramnagar	Dalsar	Chenani	Panjar	Tope	Total
Responses ↓							
Mother	2(3)	--	3(4)	--	2(3)	17(25)	24(6)
Mother-in-laws	9(13)	25(41)	11(15)	3(5)	14(20)	29(41)	91(22.7)
Neighbors	7(10)	--	10(14)	--	15(21)	19(27)	51(12.7)
Health professionals (doctors)	14(20)	27(45)	12(18)	9(15)	32(46)	--	94(23.5)
ASHA worker	38(54)	8(14)	34(49)	48(80)	7(10)	5(7)	140(35)
Total	70(100)	60(100)	70(100)	60(100)	70(100)	70(100)	400(100)

The table shows that a larger part of the respondents for example 35% of the respondents were directed by Accredited social health activists (ASHA) laborers of the separate rural blocks followed by 23.5 percent of the respondents who were directed by other health workers or specialists, 22.7 percent by mother-in-law, seven percent by neighbors and in 6% of the respondents the informersof data were moms. Block-wise dispersion uncovers that among 35% of the respondents where the source of info about pregnancy registration was Accredited Social Health Activists (ASHA), 80% of the respondents were from Chenani followed by 54% from Pancheri, 49% from Dalsar, 14% from Ramnagar, 10% from Panjar and a modest amount of the respondents were from Tope. Out of 23.5 percent of the respondents where the source of info of data about pregnancy registration were health workers or specialists, the greater part for the sample 46% of the respondents were from Panjar followed by 45% from Ramnagar, 20% from Pancheri, 18% from Dalsar and eight percent of the respondents were from Chenani. Out of 22.7

percent of the respondents where the source of info about pregnancy enlistment were mothers by marriage, the greater part ofthe sample 41% of the respondents were from Tope followed by 41% from Ramnagar, 18% from Panjar, 15% from Dalsar, eight percent from Pancheri and eight percent of the respondents were from Chenani.

CONCLUSION

The scope of health and healthcare systems has increased as science and technology have progressed. Diseases that were once thought to be incurable can now be treated more readily and effectively. Health care can be defined as the provision of a wide range of medical services by health professionals, as well as technical and supportive health employees. The opening of hospitals or healthcare centers has an impact on the development of healthcare facilities, as do their proper administration and management. Health has recently been described by academics as the body's ability to adapt to new dangers and illnesses. This reinterpretation is based on scientific and technological improvements, as well as increasing public awareness of health and disease. Among seven percent of the respondents who werethe source of information about pregnancy,and registration were neighbors, a modest amount of the respondents each were from Dalsar and Panjar followed by eight percent from Tope and four percent of the respondents were from Pancheri. A review led by Bajpai et al. (2013) observed that the contribution of Accredited Social Health Activists had a positive result in expanding the level of ladies availing min three Antenatal exams, Immunization, and going through institutional deliveries. As Accredited Social Health Activists (ASHA) can assume an exceptionally critical part in creating awarenessof the requirement for early pregnancy registration, their active participation in caring for pregnancy, on the identification of risk signs during pregnancy and gain insight and thus inspire the pregnant mothers for standard Antenatal check-ups so sufficient preparation should be given to them.

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