CHAPTER I

INTRODUCTION

1. Background

Human being needs birthing to run the cycle of life and death. To make this cycle complete, women need to cross the stage of pregnancy, delivery and motherhood. Unfortunately, during this normal course many women lose their lives because of the complications related to pregnancy and childbirth. Worldwide, nearly 600,000 women between the ages of 15 and 49, which is known as a reproductive age group, die each year as a result of complications arising from pregnancy and childbirth. Most of the deaths could be avoided if preventive measures were taken and adequate care was available (WHO, 2001). Alarmingly, 99% of this maternal mortality occurs in developing countries. About 80% of maternal deaths are due to 5 direct causes. These are: postpartum hemorrhage, puerperal sepsis, unsafe abortion, obstructed labor, and hypertensive disease of pregnancy. Many of them can be prevented if women have access to basic medical care during pregnancy (UNFPA/UNICEF, 2001).

Women and children are the integral part of the world population and are more vulnerable to ill health. Maternal death is a tragedy for children, for families and for the communities as a whole. Often women are caregivers and educators for the children. When a mother dies, surviving children suffer the most. Sometime these children may die within a few years. Motherless children are likely to get less health care and education as they grow up (Win, 2001). Improving women's health is important both socially and economically because the health of women not only

confined to the mother herself, but also has a major impact on the survival and quality of life of their children. Moreover, women contribute their workforce both at home and outside home.

2. Situation of Maternal Health in Nepal

The situation of maternal and child health in Nepal is very poor. Thousands of women die and another thousands suffer each year due to pregnancy related problems. Maternal death accounts for 27% of all reproductive age group deaths in Nepal. Among them, 90% deaths take place in rural settings. Although 62% deaths occur after delivery, most of them are preventable. Almost deliveries (92%) are home based. Family member attends more than 50% of labors. They all, who attend a labor, are untrained. Only 1 out of 10 birth takes place in a health institution (DHS/N, 1998). The iron deficiency anemia rate in pregnancy in Nepal is 74.5%. Among all this poor health status the antenatal care seeking rate in Nepal is also less then 29%. (DHS/N, 2000).

There is a proverb in Nepal that "father's death make children partial orphan but mother's death make them a completely orphan". But, in the same country maternal mortality ratio (MMR) remains 539/100000 live births (DHS/N, 2001). This number is very high not only from the view point of a developed country but also in comparison to neighboring countries such as Thailand 43.9/100000 live birth (DOH/T, 1999) and Sri Lanka 30/100000 live births (WHO, 1999).

The National Safe Motherhood Programme guidelines in Nepal recommended at least 4 visits during pregnancy. The first visit shoud be made soon after when the women realizes she is pregnant, or within 16 weeks of pregnancy. Overall, one is two women

receive antenatal care, but only 29% receives it from the health institutions. Most Nepalese women who receives antenatal care get it at a late stage in their pregnancy. Only one in seven (14%) women make four or more visits during entire pregnancy. The median duration of pregnancy at first visit is five months (NDHS, 2001).

3. Situation of Maternal Health in Thailand

Thailand is a developing country. It has a very good status of maternal health compared to its neighbouring and most of other Asian countries. Other basic health indicators are also in a good condition.

Table 1 The percentage of antenatal care (at least 4 times) visiting by pregnant women in Thailand (1997 – 2001)

Region	1997	1998	1999	2000	2001
Central	57.13	69.49	70.80	82.83	80.08
Northeastern	82.01	99.94	89.46	84.90	80.45
Northern	84.62	82.85	75.27	73.36	78.33
Southern	80.50	76.70	55.98	72.79	74.94
Whole Country	76.26	85.00	75.17	78.99	78.49

Source : Maternal and Child Health Group, Bureau of Health Promotion, Department of Health, Thailand.

In the health indicators, Thailand's maternal mortality ratio is 44 per 100,000 live births (UNICEF, 2002); infant mortality rate is 24.6 per1000 live births; women receiving at least 4 prenatal care from trained person is 75.4% (it increased to 78.49% in 2001); delivery by trained health persons is 95.8%; and iron deficiency anaemia in pregnancy is 12.9 % (DOH/T, 1999). According to the public health standard, MMR has been declined each year, but the reported figure of maternal deaths might be

underreported and lower in fact (MOPH, Thailand, 2000). In the contrast to the above figure, Thailand's government figure is much better. In the whole country, the average maternal mortality ratio was 12.90 in 2001.

One important policy in public health of Thailand is to reduce maternal and infant deaths as much as by promoting mother and child health.To ensure the desirable health of the Thai population, Thailand has set 9 different objectives for its Eighth National Health Development Plan. One of them is "to ensure the health status of families with an emphasis on pregnant women, infants and children". It shows that pregnancy and maternal health is a most priority area of the country.

4. Problem Significance and Rationale

Antenatal care is considered as a simple but the best method to identify early signs of risk in pregnancy and to prevent them. It promotes health status of not only of mothers but also of fetus, new born and children. "One of the most significant inroads we can make in the fight to further reduce infant mortality is to address the preventable deaths that occurs during first days of life. The most effective way to prevent these deaths is by ensuring safe pregnancy for all" Carol Bellamy, Executive Director of UNICEF. It can help to prevent risk during pregnancy. Every visit in routine ANC clinic helps to reduce maternal morbidity and mortality. Furthermore, ANC also supports or contributes to gaining knowledge and to developing skills on safe delivery towards the self-sufficiency. It helps to prevent the maximum numbers of maternal mortality that occurs during or after delivery (Win, 2001; Fuetes et.al., cited in Paudel, 1998).

WHO Technical Working Group (1994) has recommended minimum of four antenatal visits for a normal pregnancy. The minimum requirements of four ANC are for: a) health promotion: advice on nutrition and health care, counseling on danger signs and to help to plan for the birth; b) assessment: history taking, physical examination and screening tests; c) early detection and management of complications, prevention of malaria, hook worm and tetanus; and d) treatment and conditions management of anemia, STD and other diseases.

It is obvious that the minimum level of ANC use can prevent a large number of mothers from having complications and other hazards during pregnancy, during delivery and even during the postpartum period.

So that, the complete use or at least 4 antenatal visits is required for pregnant women. In Thailand, almost 96% of pregnant women come to health institution for delivery, in the other hand, about 75%-80% pregnant women complete required minimum antenatal care visits. There are only 20-26% pregnant women nationwide failing to complete utilization of antenatal care (DOH/T, 2002). There might have a several factors related to the utilization of antenatal care by the pregnant women in Thailand.

Therefore, after taking above facts into account, it is found important to study about the factors related to the utilization of antenatal care. In spite of its distinct feature, the study finding from Thailand may help to improve maternal health indicators in Nepal. It will also helpful to look at the related characteristics of women regarding the use of antenatal care services. So, this study was intended to look at the factors related to the utilization of antenatal care among pregnant women at the Regional Health Promotion Centre 1, Bangkok, Thailand.

5. Research Question

What are the factors related to the utilization of antenatal care among mothers delivered at the Regional Health Promotion Center 1, Bangkok, Thailand?

6. General Objective

To determine the factors related to the utilization of antenatal care among mothers delivered at the Regional Health Promotion Center 1, Bangkok, Thailand.

7. Specific Objectives

7.1 To describe the general characteristics, social support, and status of pregnancy of the mothers.

7.2 To determine the mothers' knowledge of, attitudes toward and satisfaction with antenatal care.

7.3 To determine the relationship between the frequency of utilization of antenatal care and the following variables:

-General characteristics;

-Social support;

-Status of pregnancy;

-Satisfaction with ANC clinic;

-Knowledge of ANC; and

-Attitudes toward ANC;

8. Variables

8.1 Independent Variables

a) General characteristics: Age; education; occupation; marital status; family income; husband's education and occupation; parity; and information exposure.

b) Social supports

c) Status of pregnancy

d) Satisfaction with ANC clinic

e) Knowledge of ANC

f) Attitudes toward ANC

9. Dependent Variable

Utilization of antenatal care

10. Operational Definitions of the Terms

1. Antenatal care: A health promotional program given during the pregnancy period. This covers various components such as health promotion activities, general assessments, early detection and management of complications, treatment and referral as required.

2. Utilization of antenatal care: Antenatal care clinic visit by the pregnant women. At least 4 times ANC visits is required for the normal pregnant women, which should be- first visit at any time before 16 weeks, second in 26 weeks, third in 32 weeks, and forth in 36^{th} weeks of pregnancy.

3. Social support: In this study, social support means aid and/or assistance received by the pregnant women during her antenatal visit. The support received by respondents may be from husband, mother, friends or other people. Generally, there are four types of social supports:

a) Emotional support, which includes expression of empathy, love, trust and caring;

b) Instrumental support, which includes tangible aid and services;

c) Informational support, which includes information, advice and suggestions related to antenatal care and pregnancy; and

d) Appraisal support, which includes the information that is useful for self-evaluation.

4. Status of pregnancy: It refers to the respondent's last pregnancy, whether that was intentional or not. If the women really wanted to be pregnant, it is called planned pregnancy.

5. Satisfaction: In this study, satisfaction refers to the respondent's perceptions toward antenatal clinic they have visited during the last pregnancy period. The time that is available for them, the services that are provided for them, and the behavior of the health workers toward respondents are included in it.