Original research article

Demographic Profile of Booked and Unbooked Cases of Pregnant Women at a Tertiary Care Hospital.

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Abstract

Introduction: In Indian continent when a female becomes pregnant after a successful meet of a healthy sperm and an egg it is considered to a demarcation of new happy beginning for the married couple. In anticipation of new incoming baby physical and psychological developments starts to occur in women's life. These changes would but obviously need medical help to land up in a effortless and well deserved post-natal period.

This study was undertaken to observe demographic values of pregnant women coming to hospital which may benefit further strategies of health care sector for making a healthier tomorrow.

Material methods: All the patients who were getting admitted during their labour were finally considered for the collection of data. Primarily subjects were provided with informed and written consent to participate in the study after that patient's demography data was recorded to make the final observations. While recording data primarily age, height and weight of the patients were recorded amongst booked (496) and unbooked (508) categories. Then starting with history of present illness obstetrical history, residential address (Urban ,rural), literacy of both husband and wife with optimal educational level, occupation, religion, distance of home from hospital and socio-economic status of the patient was recorded on a pre-structured case record form.

Conclusion: By providing the standard maternity and child care services much can be done for betterment of women. Improving the literacy status of the women and providing proper transport and communication help in better utilization of antenatal care services. Reference centers should be developed close to the homes with well-equipped clinical facilities, proper instrumentation and trained staff which will benefit the outcome of pregnant women to make a healthier India.

Key words: Demographic profile, Cases , Pregnant Women.

Introduction

In Indian continent when a female becomes pregnant after a successful meet of a healthy sperm and an egg it is considered to a demarcation of new happy beginning for the married couple. In anticipation of new incoming baby physical and psychological developments starts to occur in women's life. [1]These changes are also related with many discomforts and unduly changes in day-to-day activity of the female. Most common forms of discomfort occurring

include nausea and vomiting cased early popularly known as morning sickness; dizziness, headache, heaviness after meal and so on.[2, 3]

In females the duration of occurrence of these signs and symptoms varies on a larger scale. These aberrant feelings can be well controlled by following simple remedies given by an obstetrician. [4, 5] Antenatal care in its extensive sense is so not a contemporary notion. Explanation of some extra attention in pregnancy is portrayed in Sushrut Samhita. Further it has added Pregnancy a physiological phenomenon of the life of every woman may convert into an irreversible obscenity if not taken care of.[6] Appreciating the un doubtable role of antenatal care in pregnant women and knowing its positive outcomes in post-natal period it should be routinely practiced. In our country till date many of the females are deprived of these facilities provided by govt. free of cost. There are many causes laying behind this like social taboos, illiteracy, poverty and lack of awareness.[7]As a result, these females go as unbooked to labor room making them more harassed in post-natal period side by side hampering health of a new born.[8]Therefore, we have under taken this study to observe demographic values of pregnant women coming to our hospital which may benefit further strategies of health care sector for making a healthier tomorrow.

Materials and Methods:

The present study is carried out in department of Obstetrics and gynecology at a tertiary care center hospital. Present study is hospital based cross sectional; observational, prospective study carried out in the duration of September 2021 to September 2022. In present study a total of 1329 patients were selected out of which total of 1004 patients agreed to participate in study after providing their written and informed consent.

All the patients who were getting admitted during their labour were finally considered for the collection of data. Primarily subjects willing to participate in the study were provided with informed and written consent to participate in the study after that patient's demography data was recorded to make the final observations. While recording data primarily age, height and weight of the patients were recorded. Then starting with history of present illness obstetrical history, residential address, literacy of both husband and wife with optimal educational level, occupation, religion, distance of home from hospital and socio-economic status of the patient was recorded on a pre-structured case record form. Require data was collected using Microsoft office Excel 2013 and statistics was done using graph pad prism 8 wherever required to make the final outcome.

Results:

Primarily study protocol was described to the patients and information regarding recording of their demographic data was provided and finally data was recorded on pre-structured case record form. Amongst total 1004 pregnant women 508 patients were unbooked and 496 patients were booked. Considering the principal demographic data of the patients like age, height and weight of all females admitted to the hospital following observations were made as depicted in table. 1

Table 1: Primary demographic data of the pregnant women. NS- not significant, S-significant.

	Booked	Unbooked	p value
Age (Years)	24.9 ± 3.67	22.66 ± 4.56	0.2 NS
Height(centimetre)	142.65 ± 6.87	141.48 ± 8.04	0.08 NS
Weight (Kilograms)	64.03 ± 8.75	61.24 ± 6.72	0.12 NS

From above table it is clear that no demarcating differences were found statistically significant amongst the booked and unbooked pregnant women coming for labour hence these groups are statistically comparable. Considering other parameters like distribution of pregnant women with age, their gravidity, parity, residential area, literacy, education of pregnant women and their husband, distanced of residence from hospital, occupation, history of immunisation and religion were calculated and tabulated in table. 2 as:

Table 2: Demographic data of pregnant women.

	Booked n=496	Percentage	Unbooked n=508	Percentage
Age (Years)				
16-20	85	17.14	117	23.03
21-25	290	58.47	289	56.89
26-30	107	21.57	92	18.11
31-35	14	2.82	10	1.97
Gravidity				
Gravid 1	243	48.99	228	44.88
Gravid 2	134	27.02	166	32.68
Gravid 3	100	20.16	68	13.39
Gravid 4	9	1.81	29	5.71
Gravid 5	7	1.41	12	2.36
Gravid 6	2	0.40	3	0.59
Gravid 7	1	0.20	2	0.39
Parity				
Nulliparous	244	49.19	258	50.79
Primi	165	33.27	148	29.13
Multi	87	17.54	99	19.49
Grand multi	0	0.00	3	0.59
Residential area				
Urban	172	34.68	96	18.90
Rural	324	65.32	412	81.10
Literacy				
Literate	428	86.29	326	64.17
Illiterate	68	13.71	182	35.83
Education of Pregnant women				
Primary school	46	9.27	63	12.40
Middle school	107	21.57	115	22.64
High school	186	37.50	142	27.95
Graduate	53	10.69	6	1.18
Post graduate	36	7.26	0	0.00
Total	428	86.29	326	64.17
Education of Husband's of pregnant women				
Primary school	25	5.04	37	7.28
Middle school	52	10.48	106	20.87
High school	229	46.17	238	46.85
Graduate	110	22.18	39	7.68
Post graduate	56	11.29	13	2.56

Illiterate	18	3.63	67	13.19
Total	490		500	
Occupation of pregnant women				
House wife	327	65.93	410	80.71
Farmer/ daily wedges working	107	21.57	98	19.29
Professional	62	12.50	0	0.00
Religion				
Hindu	197	39.72	139	27.36
Muslim	256	51.61	322	63.39
Others	43	8.67	47	9.25
Distance of residence from hospital				
< 25 km	402	81.05	228	44.88
25-50 km	45	9.07	164	32.28
50-75 km	41	8.27	94	18.50
> 75 km	8	1.61	22	4.33
Socio-economic status				
Income > 5000 Rs	308	62.09	298	58.66
1000-4999 Rs	151	30.44	146	28.74
< 1000 Rs	37	7.45	64	12.59

Inclusion criteria:
Booked cases: Those ANC patients making a minimum of 3 antenatal visits during the course of pregnancy at PHC, CHC, TBA, District hospital, private hospital or at Govt facilities with complete case records were considered.

1. Unbooked cases: All other cases who were having less than 3 or no visit to ANC clinics were considered as unbooked cases.

Exclusion Criteria:
1. Those pregnant women having known case of complicated labour.
2. Not willing to participate in the present study.

Discussion:
In present study we had considered pregnant women admitted to a tertiary care hospital. Nearly 496 cases were booked and had visited ANC clinic for at least 3 times or more during their pregnancy and 508 unbooked cases were included for this study. When basic demographic data like age, height and weight were considered there was no significant amongst the booked and unbooked cases hence both the groups were comparable.Total of 290 (58.47%) cases amongst the booked category and 289 (56.89%) amongst unbooked category were lying in the age group of 21 to 25 years of age. Maximum age of the patient attending the hospital was in the age group of 31 to 35 years with average of 2% cases lying in this group amongst both the categories. Similar results were observed by Delahoy MJ who has depicted the relation of pregnancy in female with their reproductive age groups and made a statement about 20-25 years of age group. 9 Considering the gravidity and parity of the pregnant female majority of the female that is 243 (48.99%) were gravid for the first time of all pregnant booked women's category and 228 that is 44.8% of the females were unbooked category. In present study we found in a maximum of gravidity 7 with an average of 0.3% in both the groups. Demarcating the importance of first pregnancy and its importance given by society as portrayed by Danish N. [10] While considering the parity majority of the cases 50% were nulliparous lying in the category women among both the groups; while average of 18%

women were having multiparity. Depicting changes in terms of social progress of the society towards having only a single child. In present study most of primary gravida were booked which reveals that first pregnancy is given special attention while no weightage was given to grand multipara remained unblock showing large family norms still exists in rural areas and among related population who do not avail health care system. Apart from these previous successful pregnancy outcomes gives false sense of security to multi-para who made them to neglect antenatal care and go for home delivery or to perform ill practices. Also, responsibility of large family size becomes an obstacle for pregnant women to attend antenatal clinics as depicted by Munan R. [11] Considering the residential area of the pregnant female the booked category total of 172 (34.68%) female were residing in urban area while 412(81.10%) unbooked pregnant females were residing in rural area which clearly demarcates differentiation between booked and unbooked categories among the pregnant female showing the need of increasing the social education in rural areas. Lack of antenatal health care services in rural areas; inaccessibility to antenatal clinics contributes mainly to non-registration of rural mothers in antenatal clinics. Similar inputs for antenatal care amongst pregnant women were provided by Finlayson K which may enhance the positive outcome of antenatal work systems.[12]Considering the literacy nearly 428 (86.29%) booked females were literate while 182 (35.83%) females were illiterate demarcating the difference between the two categories showing need the time to make more females literate. Illiteracy and socio-economic status along with awareness are the major contributing factors for the urban mothers remaining unbooked. Need of educating pregnant women was also depicted by Mojoyinola J further making a statement to educate the pregnant women at least to identify herself about any upcoming illness and to visit hospital in time so that future consequences of the disease complications can be prevented.[13]Considering education of the women majority of the booked cases have studied the high schools which is ranging 186 (37.5%) and we also found that 36 (8%) of our pregnant women wear post graduate in booked category. While considering the unbooked category majority the females were having the high school grades (27.95%) literacy but they belong to unbooked category showing the need of the time to make social awareness amongst these females. On the contrary considering the education of husbands of this pregnant women majority of the husbands among the booked category of the females were having their education up to their high schooling which is nearly 229 (46.17%) while amongst the unbooked category majority of the husbands were having their education up to high schooling but their wives were in unbooked category (46.85%) making the social dilemma about the hospitalised delivery. Similar findings were given by Essam N further adding to it said that this education could help female to get rid of unplanned pregnancies and complications during the pregnancy.[14] Literacy and educational status of pregnant women inferences registration as they are more health conscious and aware of antenatal care needs. Literate females utilize health care system and facilities more often. Women with higher secondary and above education status remain booked may be explained in terms that all the education being primary factor and promoting registration number of other factors like social, geographical, cultural and family traditions affect the registration of the mothers in antenatal clinic as suggested by Naseri N. [15]Considering the occupation of the pregnant women nearly 327 that is 65.93% of the female were house wives in booked category. Occupation housewife pregnant women is known to neglect antenatal care but moreover manual worker on daily wages basis are still words in shaking and then care. Professional women who have higher education on to be regular in their ANC visits. Raru TB has also suggested that professional women are having 2.34 times more chances of visiting ANC clinics as compared to other females clearly demarcating role of education amongst the pregnant women.[16] Considering the religion majority of the women amongst the booked category were Muslims

(51.67%). Similar study was done by Das A providing various aspects of Indian Muslim pregnant mothers and their utilisation of health care system saying that literacy of husband-wife and their economic status playing a crucial role towards outcome in health care systems.[17]While observing the distance of the residence from the hospital having the distance of the residence less than 25 km from the hospital were 402 (81%) amongst booked and 228 (44%) amongst unbooked category were observed who were residing nearer to the hospital. When we observed the social economic status of the pregnant women, we found that majority of the female coming to the tertiary care hospital were having their income less than 5000 rupees which was 308 (62.09%) amongst the booked category and 298 (58.6%) among the Unbooked category. Economy is having its direct relation with what a pregnant women would get in her pregnancy tenure. Hence highly essential and suitable medication and proper infrastructure should be provided to these females as suggested by Kriplani S. [18]

Conclusion:

we conclude that there are many factors which determine the pregnancy outcome and many of them are rectifiable which will help in evading so many maternal deaths. By providing the standard maternity and child care services much can be done for betterment of women. By considering demographic profile of pregnant mother for many years is evident that morbidity and mortality can be reduce my adequate antenatal care facilities to the pregnant mothers. Improving the literacy status of the women and providing proper transport and communication help in better utilisation of antenatal care services. Reference centres should be developed close to the homes with well equipped clinical facilities, proper instrumentation and trained staff which will benefit the outcome of pregnant women to make a healthier India.

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