Prevalence of and factor associated with late first antenatal visit among pregnant mothers in selected hospitals of New Delhi.

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Abstract: *Pregnancy and childbirth are special events in women's lives and indeed in the lives of their families. This can be a time of great hope and joyful anticipation. The primary aim of antenatal visit to achieve at the end of pregnancy; a healthy mother and a healthy baby. The quality of visit is more important than the quantity. Pregnancy requires specialized care generally agreed to preventive activity. Globally, the maternal mortality rate (MMR) fell by nearly 44% over the past 25 years, to an estimated to 216 maternal deaths per 100,000 live births in 2015. Developing regions accounted for approximately 99% (302,000) of this estimated global maternal death in 2015, with sub- Saharan Africa alone accounting for roughly 66% (201,000). These 2015 reports estimated MMR in Cameroon at 596 maternal deaths per 100,000 live births. The aim of this study was to assess the prevalence of late first Antenatal Visit among pregnant mothers and to assess the factors associated with late first Antenatal visit. The methodology used was descriptive research design and purposive sampling technique was used to collect the data. Sample selected was women of the age group 13-35 years of age. Total number of samples collected was 80. Structured questionnaire was to given to the sample and response was collected.*

I.   Introduction
"Healthy mothers and neonates, Are the real wealth of societies"
-Lewis Carroll

Early entry to antenatal care is important for early detection and treatment of adverse pregnancy related outcome. The world health organization (WHO) focused antenatal care model recommends a minimum of four ANC visits and the first visit to be within the first 16 weeks of gestation. Several studies conducted in developing countries which suggest that majority of pregnant mothers start the first ANC visit by their second and third trimester of pregnancy. Various studies have reported factors associated with late entry to ANC these include place of residence, ethnicity, age, education, employment status, parity, intention to get pregnant, use of contraceptive method, economic status, health insurance, and travel time.[1]

Pregnancy and childbirth are special events in women's lives and indeed in the lives of their families. This can be a time of great hope and joyful anticipation. The primary aim of antenatal visit to achieve at the end of pregnancy; a healthy mother and a healthy baby. The quality of visit is more important than the quantity. Pregnancy requires specialized care generally agreed to preventive activity.[2]

Globally, the maternal mortality rate (MMR) fell by nearly 44% over the past 25years, to an estimated to 216 maternal deaths per 100,000 live births in 2015. Developing regions accounted for approximately 99% (302,000) of this estimated global maternal death in 2015, with sub- Saharan Africa alone accounting for roughly 66% (201,000). These 2015 reports estimated MMR in Cameroon at 596 maternal deaths per 100,000 live births.[3]

However, more critical in resources-poor settings is the opportunity that antenatal care providers having transmitting information to pregnant mother: it enables them to recognize problems when they occur, decide when to leave home to seek help; and identify where to go for the attention that they might need. It is important that this information is known not only by pregnant mother, but also by her family. They must be able to look ahead, to be informed and motivated about complication and referral, and be prepared to arranged transport. Antenatal visits can play a critical role in preparing a woman and her family for birth by establishing confidence between the woman and the health-care provider, and by individualizing promotional health message. Pregnant mothers are the source of our future new generation; most pregnant mothers tend to be extremely unaware of their own baby and their health services.[4]

The objectives of this study were to assess the prevalence of late first Antenatal Visit among pregnant mothers and to assess the factors associated with late first Antenatal visit.

II.   Material and Methods

The study was conducted in January 2020. A Non- experimental research approach with Descriptive research design was used to assess the prevalence of late first Antenatal Visit among pregnant mothers and to assess the factors associated with late first Antenatal visit in Badarpur Maternity and Child Welfare Center, Badarpur Border, in New Delhi. Permission from the CHO Badarpur, Principal and ethical clearance from Organizational Review Board was taken before starting the study. Total of 80 samples was taken. Purposive sampling technique was used for data collection. The subjects were given structured questionnaires form to fill and give the responses. Before the questionnaire was given to the participants, consent was taken, aims and objectives were explained to them. A structured opinionnaire was developed to assess the prevalence and factors of late first antenatal visit among pregnant mothers, consisting of two sections.

Section 1 consists of Demographic Performa included 10 items to collect information on subjects demographic characteristics like age of antenatal mother, religion, types of family, marital status, occupation of antenatal mother, educational qualification of antenatal mother, number of childbirths, duration of pregnancy, monthly income of the family, source of information.

Section 2: Structured knowledge opinionnaire consists of 21 point under 4 factors (personal, socio cultural, familial and factors related to health services). The scores were 5,4,3,2,1. The structured opinionnaire criteria considered appropriately was as follows:

Strongly Agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly Disagree (1)

III.Results

Figure 1 to figure 6 depict the important demographic variables about the women like age, religion etc. Figure7 and figure 8 depicts the student nurses collecting data from antenatal women.

Table 1 depicts the factors influencing frequency and percentage distribution of antenatal visit among pregnant mothers. Table 2 depicts the ranking factors influencing late first antenatal visit among pregnant mothers.
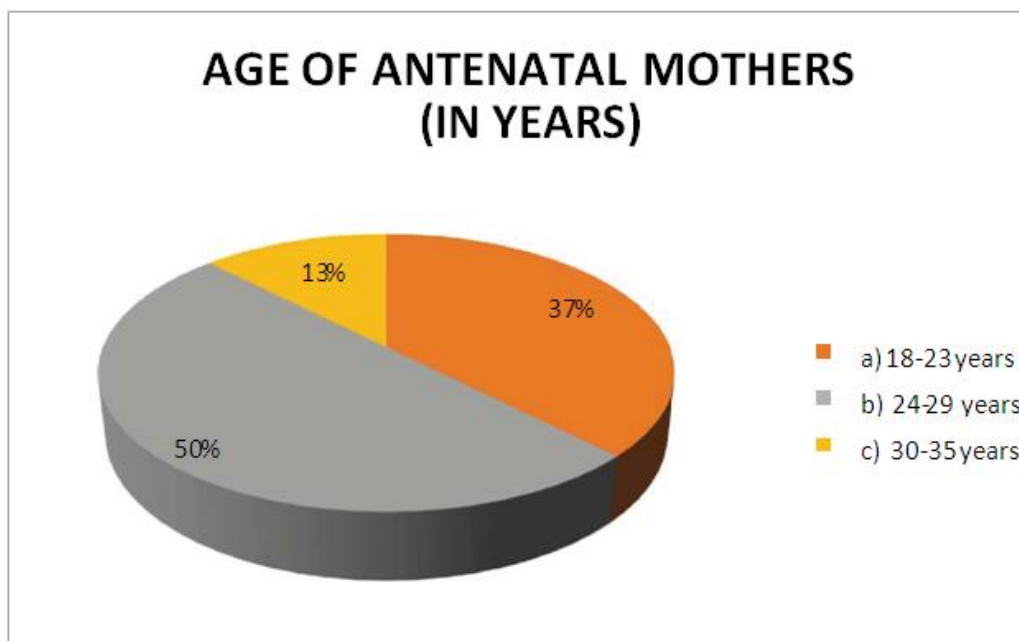
Figure 1: Pie chart showing frequency distribution of age (in years) of antenatal mothers
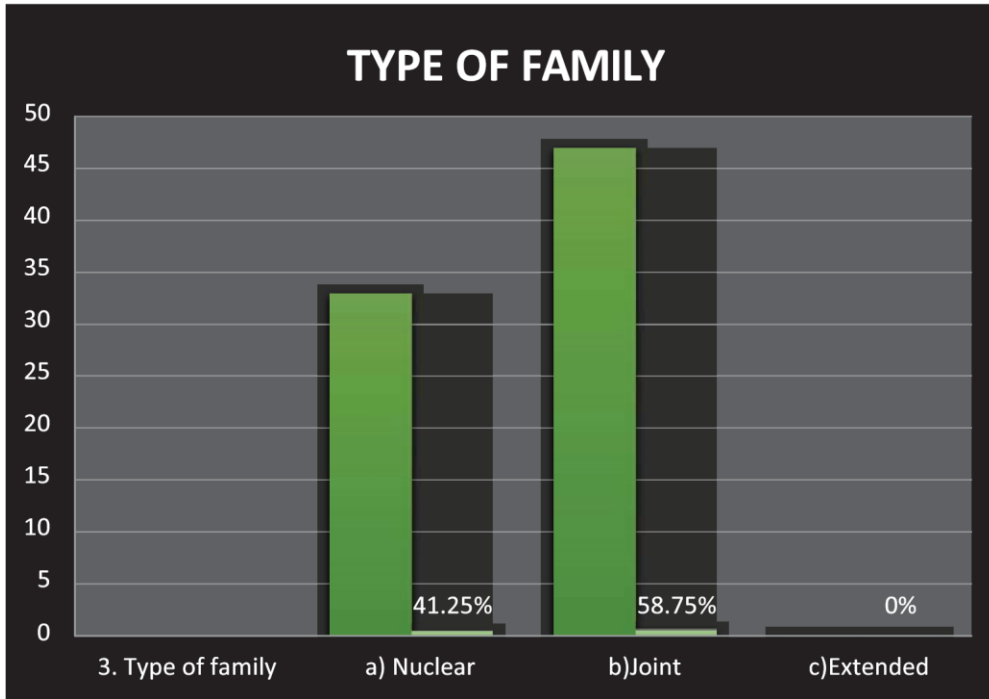
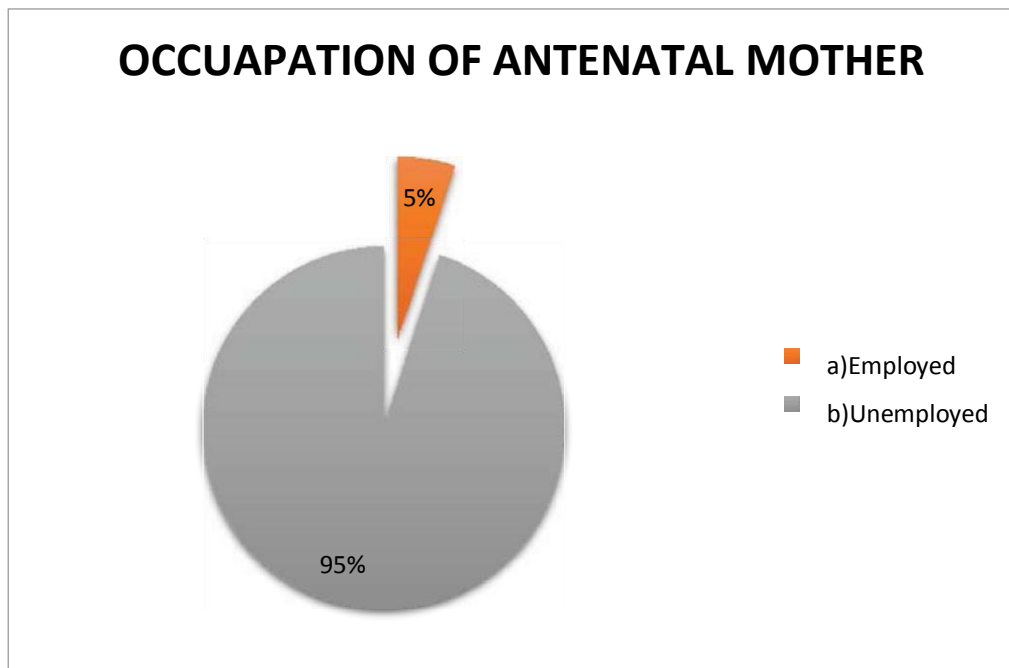**Figure 2: Column graph chart showing frequency distribution of type of family of antenatal mothers.**

Figure 3: Pie chart showing frequency distribution of occupation of antenatal mothers
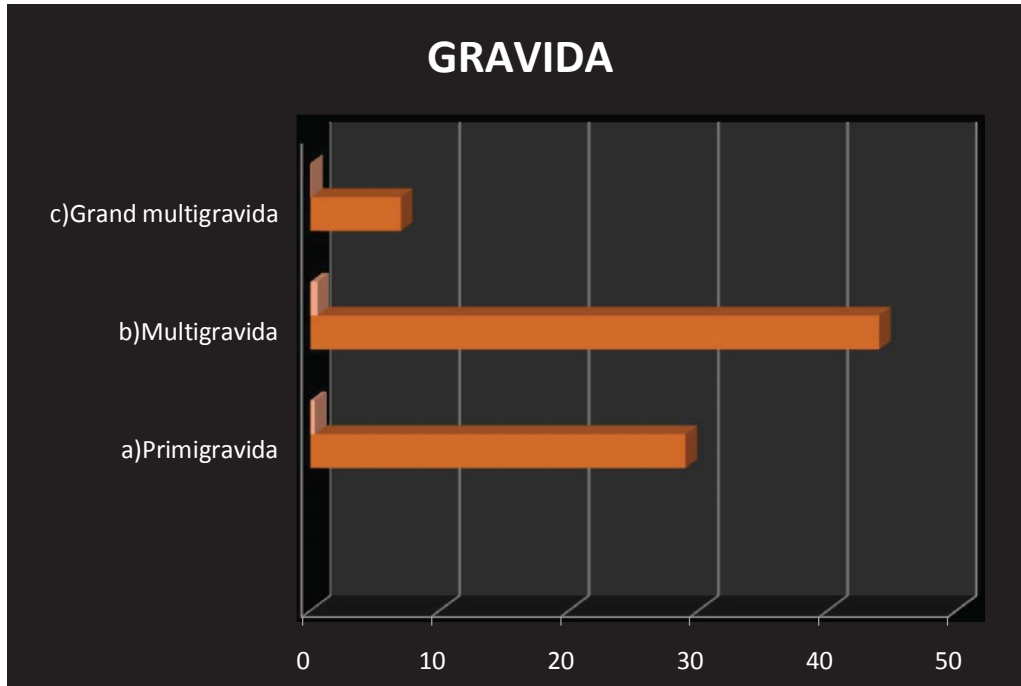
Figure 4: Bar graph chart showing frequency distribution of gravida of antenatal mothers
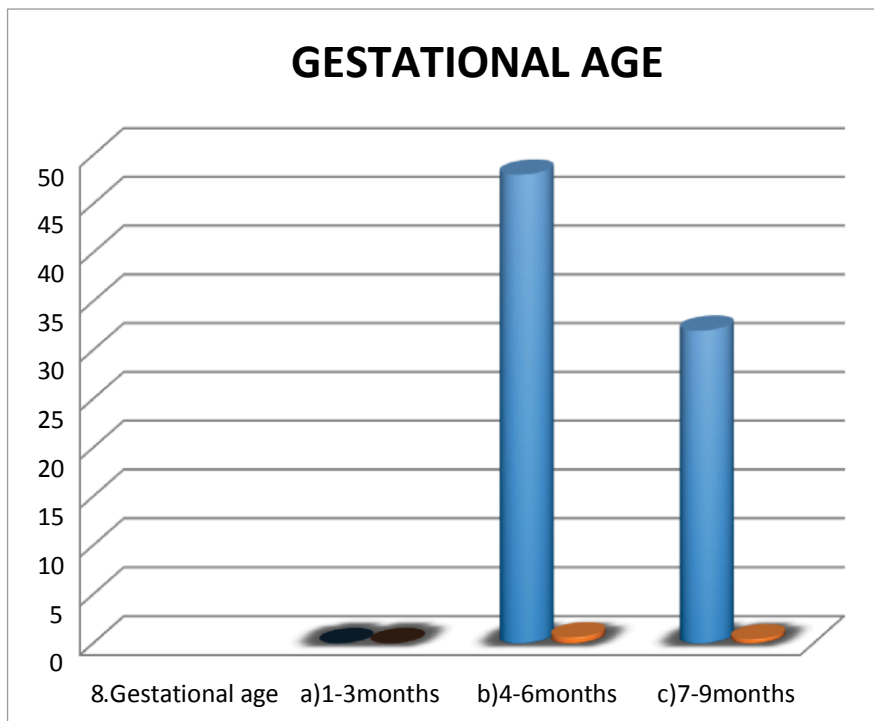

Figure 5: Column graph showing frequency distribution of gestational age of antenatal mothers
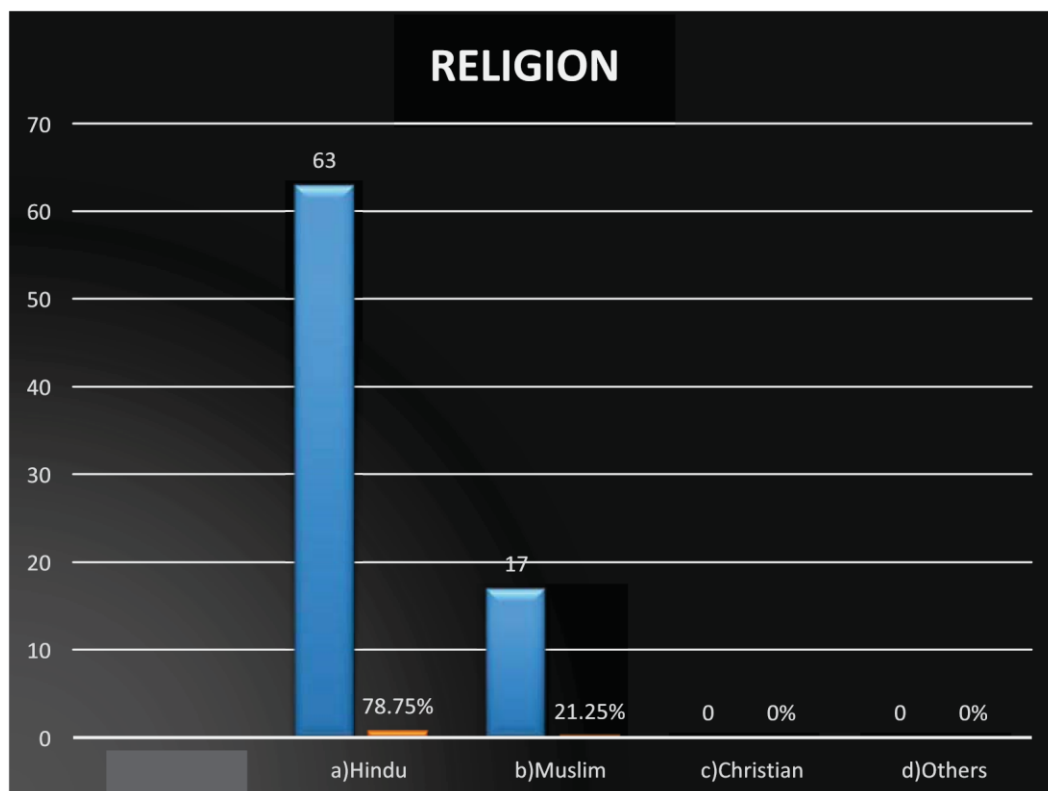
Figure 6: Column graph showing frequency distribution of religion of Antenatal Mothers.

FACTORS	SA		A		N		D		SD	
A. PERSONAL FACTORS	F	P	F	P	F	P	F	P	F	P
1.I have no idea about antenatal care	21	26.25%	25	31.25%	5	0.63%	18	22.50%	11	13.75%
2.I have no one to accompany me to the health centre	9	11.25%	16	20%	5	0.63%	34	42.50%	16	20%
3.I have no family support to take care of my children at home	15	18.75%	3	3.75%	27	33.75%	18	22.50%	17	21.25%
4.I was unaware about my present pregnancy	8	10%	6	7.50%	0	0%	39	48.75%	27	33.75%
5.I thought this was he right time to come for antenatal visit	23	28.75%	25	31.25%	13	16.25%	12	15%	7	8.75%
6.I have no time to go for antenatal visit	2	2.50%	6	7.50%	12	15%	38	47.50%	22	27.50%
7.I feel lazy to go out	2	2.50%	9	11.25%	9	11.25%	30	37.50%	30	37.50%
8.I have never gone for antenatal check-up in previous pregnancy	7	8.75%	10	12.50%	26	32.50%	22	27.50%	15	18.15%
9.I thought I am healthy so there is no need for antenatal check-up	18	22.50%	13	16.20%	6	7.50%	31	38.75%	12	15%
10.I was unaware about foetus gestational age	5	6.25%	9	11.25%	2	2.50%	31	38.75%	33	41.25%
11.I feel shy to visit health centre	0	0%	2	2.50%	4	5%	34	42.50%	40	50%
12.I am unable to go because of my disease/disability(severe morning sickness, HTN, Diabetes).	3	3.75%	4	5%	1	1.25%	22	27.50%	50	62.50%
B.SOCIO- CULTURAL FACTORS:										
1.Telling others about the pregnancy	4	5%	8	10%	5	6.25%	25	31.25%	38	47.50%

will cause harm to feotus									
2.Visiting health centre is not accepted in my culture and religious belief	0	0%	0	0%	0	0%	37	46.25%	43	35.75%
C.FAMILIAL FACTORS:									
1.I have no family support	4	5%	10	12.50%	2	2.50%	29	36.25%	35	43.75%
2.I have no family support to take care of my children at home	3	3.75%	8	10%	13	16.25%	35	43.75%	21	26.25%
3.I have no money to got for antenatal visit	0	0%	1	1.25%	0	0%	33	41.25%	46	57.50%
D FACTORS RELATED TO									
HEALTH SERVICES:									
1. Are you aware about the free antenatal health services	9	11.25%	27	33.75%	9	11.25%	15	18.75%	20	25%
2. I am uncomfortable to visit health centre.	0	0%	6	7.50%	4	5%	40	50%	30	37.50%
3. Health centers are far away from my home	14	17.50%	22	27.50%	3	3.75%	27	33.75%	14	17.50%

Table 1: Showing the factors influencing frequency and percentage distribution of antenatal visit among pregnant mothers.

S.NO.	FACTORS	MEAN	RANK
1.	Factor related to health services	2.5	1
2.	Personal factor	2.4	2
3.	Familial factor	1.9	3
4.	Socio – culture factor	1.7	4

Table 2: Showing the Ranking of factors influencing late first antenatal visit among pregnant mothers.

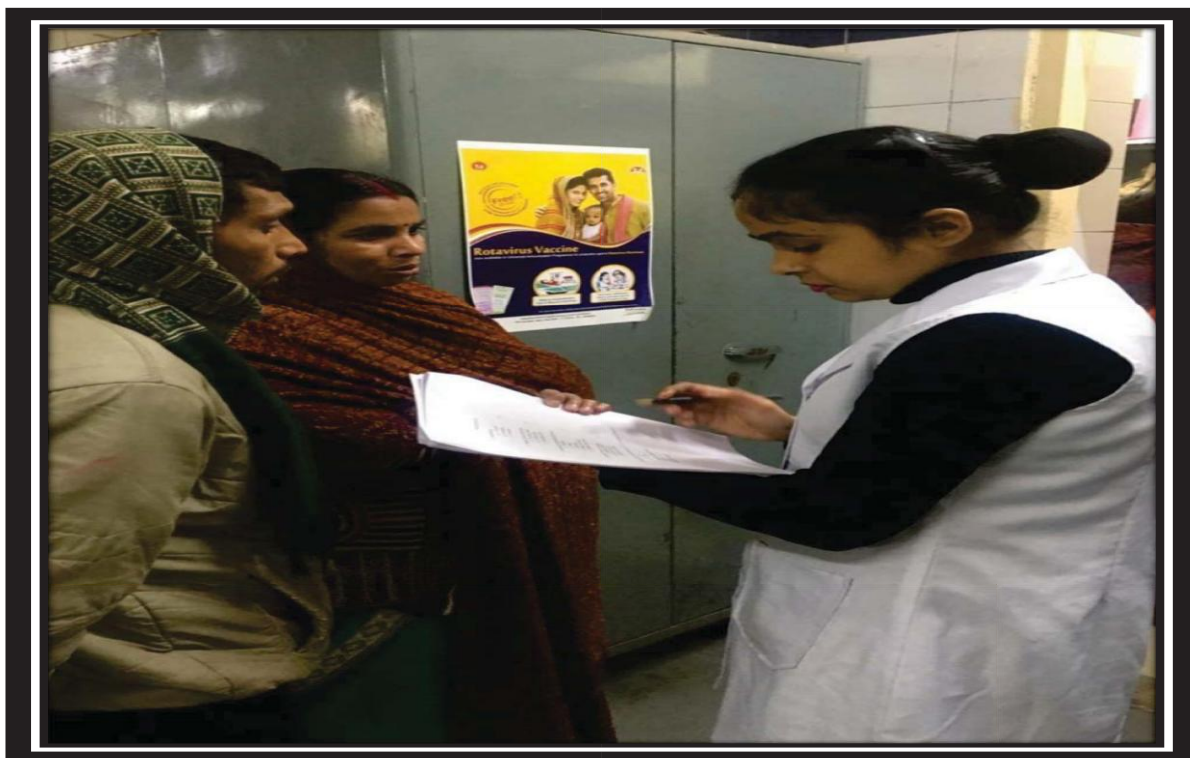**Figure 7: Student Nurses collecting data from antenatal women**

Figure 8: Student Nurses collecting data from antenatal women

IV.   Discussion and Conclusion

The present study findings were revealed in terms of the objectives for the study. Nearly half of antenatal mothers (40; 50%) were in the age group of 24-29years, (30; 37.5%) were in 18-23years, (10; 12.5%) were in 30-35 years. Half of the antenatal mothers (47; 58.75%) were living in joint family,(33; 41.25%) were living in nuclear family. Regarding educational qualification of the antenatal mothers (21; 26.25%) has secondary school education, (20; 25%) has higher secondary education, (14; 17.5%) were graduates and above, (13; 16.25%) has primary schooling and (12; 15%) were illiterate. Nearly half of antenatal mothers (44; 55%) were in multigravida, (29; 36.25%) were in primigravida, (7; 8.75%) were in grand multigravida. Half of antenatal mothers (48; 60%) were in 4-6months gestational age, (32; 40%) were in 7-9 months gestational age. Regarding educational qualification of husband (27;33,75%) in higher secondary education, (17;21.25%) secondary education, (15;18.75%) primary education, (12;15%) were graduates and above, (9;11.25%) were illiterate. Regarding source of information (27; 33.75%) had no source of information about antenatal visit,(29; 36.25%) had source of information from health care team members (12; 15%) had source of information from family and friends.

The present study attempted to assess the prevalence and associated factor of late first Antenatal study among pregnant mothers. The study revealed that 60% of pregnant mothers reported late for their first visit which is in agreement with the study conducted by George F.D. Ruoesinghe in 2014 at South Africa stated that 70.2% mothers reported late to antenatal visit. [5]

Another study which supports the findings of current study was conducted by Daftary and Mehta 1984 The finding depicts that in personal factors (31.25%) have no idea about antenatal care, (42.50%) have no one accompany pregnant mothers at health centre, (22.50%) have no family support, (48.75%) not awared about present pregnancy. In socio- cultural (46.25%) antenatal visit is not accepted in their cultural and religious belief. In familial factor, (43.75%) no family support and in health – related factor (25%) have awareness about free antenatal services. The above findings are similar to those reported by Nigeria and Ethopia. 2010 and 2017 that following factor like personal factor, familial factor are the commonest factor for late Antenatal Visit. [6]

References

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Recommendations

1) Ensuring a positive learning environment by giving a learning situation where student are sheltered from

harm, harassment, ridicule and negative feelings.

(2) Developing the policies of attendance that incorporate accepted procedures, conveying attendance approaches, assuring strategies are reliably authorized, and leading attendance strategy assessment.

(3) Keeping exact records of attendance and computing absenteeism rates at frequent interval to recognize every individual's example of attendance.

(4) Study of the relationship between teacher attendance, student attendance, accomplishment, and behavior.

(5) Study of the relationship between academic building conditions and educational achieve