PROBLEMS AND FACILITIES IN PRENATAL AND POSTNATAL CONDITIONS TO RURAL WOMEN AT PALOSI, PESHAWAR

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ABSTRACT
This study discusses problems and facilities in pre-natal and post-natal conditions of rural women at Palosi Peshawar, focusing on the various components of pre and post-natal conditions and facilities available in the area. The researcher selected 30 beneficiaries through purposive sampling technique. Questionnaire and interview schedule were used as the tools of data collection. Data was analyzed and conclusions were drawn. Pertinent suggestions were extended to be considered by the policy makers and other related agencies and organizations. The study explores that most of the respondents were unaware about the complications, facilities, problems and precautions for pre and post-natal care. Maximum of the respondents specified for work pressure in joint family, harsh attitude of in-laws, no female doctor/purda, no knowledge of RHS, traditional care, no MCHC, no proper care and visit to home by LHV/W, poverty, ignorance and male dominancy as the social problems in the way of pre and postnatal care in the target area. Most of the respondents pointed out that menstrual disorder, blood pressure, anemia, vomiting and headache were the health problems during pre and postnatal periods. It is clear from the study that some maternity clinics, female gynecologist, FWC/FWW, LHV/W, TBA, contraceptives, proper treatment, medicines and mother child health care facilities were available at pre and postnatal periods, but the respondents were not satisfied. Most of the respondents highlighted that awareness, prescription, precautions/advises, treatment, medicine, contraceptives and checkup as the role of facilitators and service providers in the area.

Key words: Facilities, Pakistan, Palosi, Poverty, Pre and post natal, Problems, Rural community

INTRODUCTION
Reproductive health is a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulating fertility which are not against the law, and the right to access appropriate health care services that will enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Park, 2001).

Reproductive health review of Pakistan
Pakistan ranks behind most developing countries in the reproductive health risk index. Pakistan has one of the lowest records in female health and education and its fertility rate of 4.07 and population growth rate of 1.9 is considerably higher than other Asian countries including Bangladesh, India and Sri Lanka (NIPS, 2000).

One in 38 Pakistani women dies from pregnancy related causes as compared to 1 in 230 women in Sri Lanka. Almost one half of women are anemic throughout their pregnancies. Maternal mortality is estimated as 350-400 per 100000 births. Approximately 80% deaths are due to direct obstetric causes. Hepatitis is the most frequently cited indirect cause of maternal death. About 12% of deaths are due to induced abortion (NIPS, 2000).

Pakistan is one of the few countries in the world where men outnumber women. This unfavorable ratio is mainly a consequence of excess mortality of young girls and women in the childbearing age. Infant mortality and morbidity associated with pregnancy related conditions are high and the rate of infant mortality from all causes is one of the highest in Asia. The extent of reproductive tract infections in Pakistan has not been documented. Studies in a comparable setting suggest that women suffer a substantial but silent burden. Reproductive tract infections including sexually transmitted diseases can cause pelvic inflammatory disease, entopic pregnancy, infertility and chronic pain and also increase women’s susceptibility to HIV infection.
Cancers of the breast and reproductive tract constitute a significant proportion of cancers seen in Pakistan. A study involving 5 hospitals in 4 provinces found 19% of women had cancers of gynecological causes. Cancer of the breast is the most common, accounting for 20% of all cases (NIPS, 2000).

Women’s disproportionate poverty, low social status and reproductive role expose them to high health risks, resulting in needless suffering, many preventable deaths and disability. This unfortunate situation can no longer be ignored (NIPS, 2000).

Provision of reproductive health services benefits women as they are prone to several problems throughout their life (at every stage of their life cycle). Females often suffer with micro-nutrient deficiencies in childhood and adolescence that could lead to serious problems like, anemia and iodine deficiency, which often lead to the death of the mother and/or baby. Young girls are also at risk of teenage pregnancies due to early marriages, hence, at high risk of maternal mortality. Married women who have had closely spaced pregnancies nutritional depletion which is compounded by physical, financial, and emotional stresses. Even after age 35 women continue to become pregnant and face the high risk of maternal mortality and later the problems of menopausal syndrome and deficiencies. The burden of disease estimated on various factors leading to diseases and disabilities over lifetime, clearly shows that such a burden arising out of maternal and prenatal issues is still higher than factors like TB and respiratory infections put together. For a woman risks are added, among other things, by each pregnancy, process of childbirth, takes more responsibility of fertility regulation especially using hormonal methods, are more vulnerable to reproductive tract infections than men, besides experiencing violence trauma and gender based sexual abuses. Men, too, experience ill health related to reproductive system but to a lesser degree than women. Men’s role in reducing women’s reproductive ill-health is fully recognized in order to evolve strategies and activities highlighting their responsibilities (NIPS, 2001).

The health status of women in Pakistan is directly linked to women’s low social status. Pakistan’s poor position internationally is seen in UNDP’s Gender related Development Index (GDI) 2000, where Pakistan currently ranks 135 out of 174 countries. In terms of health status, the figures are galling. Some 30,000 women die each year due to complications of pregnancy, and 10 times more women develop lifelong, pregnancy-related disability. Rural women’s health is generally poorest due to the lack of health facilities and skilled health providers. For example, the maternal mortality ratio in predominantly rural Balochistan is 800 maternal deaths to 100,000 live births, compared to the national average of 340 per 100,000 (UNICEF, 1997).

The untimely death or disability of a woman, a tragedy in itself, adversely affects the health of her children, household productivity and the national economy. About 25% of children are born with low birth weight due to maternal problems. Ten percent of children do not reach their first birthday. High fertility, with an average of six children per woman, has resulted in high population growth of 2% per annum. Consequently, improving women’s reproductive health through the use of contraceptives and spacing of children will not only improve women’s health but also reduce population growth and allow women more time to pursue economic activities (UNICEF, 1997).

There are also marked differences between the health status of women and men in Pakistan. For example, malnutrition is a major public health problem in Pakistan that disproportionately affects women and girls. Above 55% girls die between the ages of 1 and 4; in fact the female mortality rate here is 12% higher than for boys. This is a direct consequence of the lower social status accorded to women and girls, who as a result tend to eat less and face additional barriers when accessing health care. Women, girls and infants most often die of common communicable diseases such as tuberculosis, diarrhea, pneumonia and tetanus, which could have been easily prevented and treated. The high prevalence of communicable diseases and malnutrition is not only related to poor living conditions, but also to the lower social status of women and girls. In addition, because of social stigma and gender norms, as many as fifty % of women suffer from recurrent reproductive tract infections, Consequently, poor women’s health in Pakistan is as much a social as medical problem. Underlying factors here are the lack of awareness of, and attention to, women’s health needs; women’s lower education and social status; and social constraints on women and girls, including the practice of seclusion (UNICEF, 1997).

Reduction of child mortality and morbidity are important priorities and a big challenge for the Pakistan. The %age of severe and moderate under-5 malnutrition is 32%, and the high infant mortality of 92 per 1,000 reflects the poor status of child health in the country. In the target communities and districts, most of the health indicators are even poorer than the
national statistics. Most of these problems are preventable or manageable at the community level with simple health interventions, such as the promotion and support of exclusive breastfeeding (0-9 months), the introduction of locally available complementary foods and the continuation of breastfeeding for two years or more (UNICEF, 1997).

Reproductive health facts (Worldwide)
Worldwide, an estimated 250 million lives are lost every year as a result of reproductive health problems. The poor disproportionately bear the consequences of poor reproductive health; especially impoverished women and young people. There are glaring disparities in access to reproductive health care between rich and poor, within and among countries (UNFPA: The World Health Report, 2005).

Pre and postnatal care in Pakistan
Quality prenatal care can contribute to the prevention of maternal mortality by detecting and managing complications and risk factors, including anemia and sexually transmitted disease. About 35% of mothers who had given birth in the last three years went for pre-natal consultations during their last pregnancy. The attendance rate was much higher in urban (63%) than rural areas (26%). In rural Pakistan, the two most commonly cited sources were government hospital/clinic (42%) and private hospital/clinic (37%). Tetanus toxoid injections are given to women during pregnancy to protect infants from neonatal tetanus, a major cause of infant death that is due to primarily unsanitary conditions during childbirth. In addition these injections protect women from developing tetanus themselves. Two doses of tetanus toxoid during pregnancy offer full protection. However, if a woman was vaccinated during a previous pregnancy, she may only need a booster to given full protection. Five doses are thought to provide lifetime protection. Some 46% of mothers had received a tetanus toxoid injection either during their last pregnancy or a previous pregnancy compared with 39% in the 1998-99 survey. Almost all of the Women who had protected births had received two or more injections during their last pregnancy. The vast majority of births, some 78%, take place at home. In rural areas, some 86% were at home compared with 55% in urban areas. The most commonly cited source of assistance in rural areas was a trained dai (40% of cases), followed by traditional birth assistant (21%) and family member/relative (20%). A much larger proportion of local birth attendants are reported as trained in 1998-99 and 2001-02 compared with 1996-97. This presumably reflects the ongoing trained program for traditional birth attendants, which seems to be succeeding in improving the level of qualified attendance at births (NIPS, 2001).

Prenatal care position
The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available to a more comprehensive level of obstetric care in case of an emergency. Up to 15% of all births are complicated by a potentially fatal condition, and women attended by trained attendants are more likely to receive treatment early, when the situation can still be controlled. Yet in the developing world today, only 58% of all deliveries take place with the assistance of a trained attendant (Pakistan Ministry of Health, 1996).

Experience shows, however, that the training of birth attendants needs to be part of a broader strategy, including functioning referral systems and backup professional support. Skilled attendants alone cannot effectively reduce maternal mortality they need to be linked up with a larger health care system with the facilities, supplies, transport and professionals to provide emergency obstetric care when it is needed. Skilled attendance is one key indicator used in measuring progress in reducing maternal mortality (Pakistan Ministry of Health, 1996).

Prenatal care should also include; immunization against tetanus, iron tablets, multiple micronutrient supplementation, hookworm treatment, diagnosis and management of sexually transmitted and urinary tract infections early detection and management of complications, and general health problems that can also be identified through prenatal care (Ahmad, 1998).

Postnatal scenario-maternal and newborn health
Of the 130 million babies born every year, about 4 million die in the first 4 weeks of the neonatal period. Newborn deaths account for nearly 40% of all deaths in children under five. Within the neonatal period, mortality is very high in the first 24 hours after birth. Newborn deaths are closely related to the health of the mother and availability of skilled attendants at delivery and postpartum care. Malnutrition, resulting in premature and low-birth weight infants, is a major risk factor. Early pregnancy is also a risk factor: Babies born to adolescent mothers are 1.5 times more likely to die before their first birthday than if they were born to older women. Adolescent girls face the highest risk of premature delivery, a major factor in newborn deaths. Because their bodies are not fully mature, they are also at risk of obstructed labor;
which often results in the infant’s death. Globally some three quarters of neonatal deaths happen in the first week after birth. Almost all (99%) neonatal deaths are in low- and middle-income countries, and about half occur in the home. The highest numbers of neonatal deaths are in south-central Asia and the highest rates are generally in sub-Saharan Africa. In sub-Saharan Africa, less than 40 % of women deliver with skilled care and in South Asia the figure is less than 30%. Across 40 countries with Demographic and Health Survey data, more than 50 % of neonatal deaths arose after a home birth with no skilled care between 1995 and 2003 (Tinker, 1998).

Post-natal consultation rates were much lower than the pre-natal rates. Only 9 % of mothers received a post-natal check up within six weeks of delivery during their last pregnancy. Urban areas had higher rates than rural areas, though both were low. The three most commonly cited sources of postnatal care in rural areas were private hospital/clinic (39%), government hospital/clinic (29%), and traditional birth attendant at home (19%). There was very little difference between regions and provinces. By 6 months, some 84 % of mothers were given the child semi-solid foods (NIPS, 2001).

MATERIALS AND METHODS
The research study was conducted at U.C. Palosi, District Peshawar focusing on the prenatal and postnatal problems in the study area. The social problems related to prenatal aspect were work pressure, harsh attitude of in-laws, non availability of female doctor, no knowledge of RHS, traditional care, no MCHC, improper care by LHV/W, poverty, ignorance and male dominancy. Health problems included menstrual disorder, blood pressure, anemia and headache. On the other hand facilities aspect were also studied which included availability of maternal clinics and female gynecologist, FWC / FWW, LHV/W, TBA, use of contraceptives, proper treatment, medicines and mother child health in the postnatal period.

According to DCR 1998 Peshawar the total population of married women in Palosi village are 332; the researcher selected 30 women among them through purposive sampling technique in the target FWC. The research was based on primary as well as secondary data. Interview schedule was used as a tool of data collection for illiterate respondents while questionnaire was used for educated respondents.

RESULTS AND DISCUSSION
Table I and Fig. 1 indicates that 53.3% respondents specified for work pressure, 46.7% for harsh attitude of in-laws, 56.7 % for no female doctor/ purda, 45.5% no knowledge of RHS, 65% for traditional care, 55.2% no MCHC, 55.3% for no proper care by LHV/W, 55.3% specified for poverty, 51.5% for ignorance and 70.5 specified for male dominancy as social problems in the way of pre and post natal care in the target area.

Table II and Fig. II depicts that 33.3% respondents specified for menstrual disorder, 63.3% for blood pressure, 51.7% for anemia, 50.5% for vomiting and 50.1% specified for headache as the health problems during pre and post natal periods.

Table III and Fig. 3 shows that 33.3% respondents specified for maternity clinics, 3.3% for female gynecologist, 51.7% for FWC/WW, 50.5% for LHV/W, 50.1% for TBA, 25.5% for contraceptives, 29.9% for proper treatment, 50.1% for medicine and 33.3% specified for mother child health care as the facilities available at pre and post natal periods.

Table IV and Fig. 4 highlights that 33.3% respondents specified for awareness, 3.3% for prescription, 51.7% for precautions / advices, 50.5% for treatment 50.1% for medicine 25.5% for contraceptives and 29.9% specified for checkup as the role of facilitators and service providers in the area.

CONCLUSION
The study indicates that most of the respondents were unaware about the complications, facilities, problems and precautions for pre and post-natal care. Maximum of the respondents specified for work pressure in joint family, harsh attitude of in-laws, no female doctor/ purda, no knowledge of RHS, traditional care, no MCHC, no proper care and visit to home by LHV/W, poverty, ignorance and male dominancy as the social problems in the way of pre and post natal care in the target area. The study also depicts that most of the respondents specified for menstrual disorder, blood pressure, anemia, vomiting and headache as the health problems during pre and post natal periods.

It is clear from the study that some maternity clinics, female gynecologist, FWC/FWW, LHV/W, TBA, contraceptives, proper treatment, medicines and mother child health care facilities were available at pre and post natal periods, but the respondents were not satisfied due to the non availability at the hour of need. The study also highlights that most of the respondents specified for awareness, prescription, precautions / advices, treatment, medicine,
contraceptives and checkup as the role of facilitators and service providers in the area.

RECOMMENDATIONS
Most of the women especially in rural areas are unaware about their health both at pre and post-natal stage. Women should be given education free of cost, so they can be made aware about their health as well as their children.

Women should be aware about the importance of FP and RH and should try to aware their husbands and in-laws also about its importance. There should be seminars, group-discussions and home-visits by service providers.

Mostly, women of rural area cannot go to hospitals or clinics, which are situated in far-flung areas. For this purpose LHVs / LHWs should visit home in order to give them proper guidance concerning their health and awareness about FP and RH.

Modern medical equipments should be provided to the health clinics in rural areas so that these people could also benefit from them.

There is a shortage of trained staff members in clinics especially in rural areas. The staff members like LHVs/LHWs, vaccinators, FMTs, MMTs and all others should be trained in a proper manner so that they can treat and guide the people in proper way.

Most of the people living in rural areas are not financially sound to buy expensive medicines. So government should provide free medicines to the needy people.

Table I. Social problems during pre and postnatal periods

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Source: Field Data
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Source: Field Data

REFERENCES