

## MATERNAL AND CHILD HEALTH (MCH) SERVICES KNOWLEDGE AMONG RURAL POPULATION OF ETAWAH DISTRICT, UTTAR PRADESH

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### Abstract

*In developing nations, mothers and children together constitute the bulk of the population. While they get the greatest amount of health treatments, prenatal mothers and children have very high rates of morbidity and death. One of the primary causes for this is a lack of understanding about preventative services. The purpose of this research was to determine the degree of knowledge and awareness among pregnant women concerning prenatal care and different elements of newborn and infant care among moms under the age of three.*

**Keywords:** Knowledge, Antenatal care, Infant care, New born care.

### INTRODUCTION

Mother and baby must be seen as a symbiotic entity. This is because throughout the prenatal time, the foetus is a part of the mother, and child health is inextricably linked to maternal health. A healthy woman bears a healthy child. Certain maternal diseases and conditions have an effect on the foetus; following delivery, the kid (6-9 months) is totally reliant on the mother for feeding. As a result, the mother and child are likewise considered as a single entity [1]. Maternal & child health is a collection of comprehensive health care services designed to address the promotive, preventative, curative, and rehabilitative requirements of pregnant women prior to, during, and after delivery, as well as babies and preschool children from birth to age five [2].

The WHO defines maternal and child health services as "promoting, preventing, therapeutic rehabilitation, or caring for mother and child" [3]. Mother health care are critical for reducing maternal and child mortality and morbidity, spacing pregnancies, limiting pregnancy size, preventing communicable diseases, improving nutrition, and increasing health practice acceptability. Maternal health care is divided into three components: antenatal care, intranatal care, and postnatal care [4].

### Antenatal Care

the care given to a woman during pregnancy. It is systematic supervision of women during pregnancy at regular intervals to monitor maternal well-being, fetal well-being and progress of fetal growth. Antenatal care is important to preparation of birth plan and identification of facility for delivery, providing quality of care for well-being of pregnant women and the fetus, identification of maternal and the fetal complication and timely referral and identifying facility for referral [5].

### ***Intranasal Care***

The care of the mother at the time of delivery. It begins with the onset of labor and ends with the 3<sup>rd</sup> stage of labor, intra natal care is important to introduce aseptic technique in delivery and delivery with minimum injury to the infant and mother and readiness to deal with complications like hemorrhage, mal-presentation, cord prolapsed etc. About 95% of deliveries are normal [4].

### ***Postnatal Care***

Postnatal care refers to the care provided to the mother after birth. It is critical to look after the mother to avoid post-partum complications such as puerperal infection, thrombo-phlebitis, and secondary hemorrhage. Post-partum care assesses the quality of breastfeeding and family planning services, as well as the mother's fast return to optimum health [1].

According to the World Health Organization, "Child health is a condition of physical, mental, intellectual, social, and emotional well-being, not just the absence of illness or infirmity." Healthy children live in families, communities, and environments that enable them to achieve their full potential". Children cannot attain optimum health on their own. They rely on adults in their family and community for support [3].

Family planning and reproductive health care, as well as maternal, newborn, and child health services, are included in MCH services. To enhance MCH outcomes, MCH services must be covered. India's government implemented many initiatives, and India's progress toward mother and child health MCH was founded in the early nineteenth century. MCH was a volunteer effort organized by the Indian red cross society's maternity and child welfare department. Several of the programmes and services include Vitamin A prophylaxis (1970), National health policy (1983), Baby friendly hospital initiative (1991), Child survival and safe motherhood (1992), Reproductive child health (1997), Integrated management and new born care and illness (1995), Reproductive child health (2005), National rural health mission (2005), Jannani suraksha yojana (2005), Reproductive child health (2005), National rural health mission (2005), Jannani suraksha yojan Recently, the Indian government launched PMJY and converted sub-centers of health into health and wellness centers. 1

India has a long history of maternal health efforts, with over two decades of dedicated safe motherhood programmes, yet the nation still suffers an estimated 56,000 maternal fatalities each year, accounting for 19 percent of all maternal deaths worldwide. As a consequence of MCH intervention, infant mortality has decreased from an estimated 148/1000 live births in 1951 to 44 in 2012. Maternal mortality in British India, which was estimated at 2000/100000 live births, decreased to 212 in 2007-2009. Overall, the proportion of skilled attendants at birth was just 18.5 percent in 1981, but has risen to 52.7 percent in 2007-2008 [1].

### **OBJECTIVE**

- To assess the knowledge score regarding MCH services among rural population of Etawah District.
- To find association of knowledge score with selected demographic variables of population.

### **REVIEW OF LITERATURE**

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## **RESEARCH METHODOLOGY**

Research methodology refers to controlled investigations related to the ways of obtaining, organizing and analyzing data. This chapter deals with the methodological approach adopted for the study.

### ***Research Design***

"Research design is a plan of how, when, and where data are to be collected and analyzed [22]." Non experimental descriptive design was used to assess the knowledge on MCH services among rural population of Etawah district U.P.

### ***Sampling Technique***

"Sampling technique refers to the process of selecting a portion of population to represent the entire population. Non probability purposive sampling technique is used in study [22].

### ***Sample Size***

In this study, the sample size is 45 relatives of lactating mother's family.

### Tools and Technique

Tool	Technique
PART A- Socio-demographic questionnaire.	Questionnaire 12
PART B- knowledge about MCH services.	Questionnaire 13-33

#### **Description of Tool**

Part –A: demographic data contain 11 items.

Demographic data include age, gender, relation with mother, cast, religion, educational status, type of family, occupation, number of under five children in family, maternal and child health card, accompany of mother during health visit.

The questions are categories in 4-parts, include antenatal, Intranatal, postnatal and services.

Part-B: section contain 4 sub sections related to: -

- Antenatal (10 items)
- Intranatal (3items)
- Postnatal (10 items)
- Services (10 items)
- Scoring system for tool is following All items marked “yes” are score 2

All items marked “don't know” score 1 All items marked “no” score 0 Category of scoring is following Inadequate less than 33marks

Average from34-50 marks Adequate above 51 marks

- **Inclusive Criteria**

1. People age group 18-60 years from selected rural area of Etawah districts.
2. People who are willing to participate in study.
3. People who are present at the time of data collection.
4. People who are able to understand the language.
5. People who are able to listen and speak clearly.

- **Exclusive Criteria**

1. People age below the 18 years.
2. People age above the 60 years.
3. People who are not willing to participate in study.
4. People who are not available during the data collection.
5. People who are not physically and mentally healthy during the time of data collection.

#### **Reliability**

“It is the degree of consistency and accuracy with which and instrument measure the attribute for which it is designed to measure [22].”

The reliability of tool was assessed by Split Half Method. And the calculated value is  $r=0.72$  which indicate that the tool is reliable

#### **Data Collection**

Written permission is obtained from college and gram Pradhan for conducting pilot study and main study. Written consent was also obtained from the study participant. The data was collected by investigator himself.

#### A. Plan For Pilot Study

Pilot study is the trial run study to list practicability, appreciation and feasibility of both study and tool. After getting the formal permission from the concern authority the researcher conducted a pilot study among [5] relative of the lactating mother in July 2019 at village Jhingupur Etawah.

#### B. Procedure of Final Data Collection

After pilot study findings we modified our tools for necessary correction got through the validation of tools. Specially we included the term relatives of lactating mother in place of family members of pregnant mother. Later on, we selected the appropriate village based on mixed population then we took 45 samples from village Niloi by purposive sampling technique. After taking consent we asked their relatives to respond the questions and the responses were noted by the researcher. Data collection was started from first week of September to next week. During these days we visited Niloi every day.

### DATA ANALYSIS AND INTERPRETATION

In this chapter obtained data is analyzed. After analysis data is interpreted in the study findings. Study result will be discussed in relation to study objective.

In the first section

(A) of chapter socio demographic variables of study participants are analyzed. In second section (B) of chapter objective 1 of study is analyzed

In third section

(C) of chapter objective 2 of study is analyzed

#### SECTION: A

In the first section of chapter socio demographic variables of study participants are analyzed.

**Table 1: Frequency and percentage distribution of socio demographic variables of the study**

Demographic variables		
Socio-demographic variables	Frequency	Percentage (%)
<b>AGE</b>		
20-30yr	27	60
31-40yr	7	15.56
41-50yr	8	17.77
51-60yr	3	6.67
<b>GENDER</b>		
Male	17	37.7
Female	28	62.3
<b>RELATION WITH MOTHER</b>		
Husband	13	28.88
Mother-in-law	13	28.88
Father-in-law	2	4.47
Sister-in-law	11	24.44
Brother-in-law	6	13.331
<b>CAST</b>		
OBC	44	97.7
Minority	1	2.3
<b>RELIGION</b>		
Hindu	44	97.7
Muslim	1	2.3
<b>EDUCATIONAL STATUS</b>		
Illiterate	14	31.16
1-5 Standard	2	4.44

Pre-high school and high school	13	28.8
Intermediate	5	11.2
Graduation and post-graduation	11	24.4
<b>TYPE OF FAMILY</b>		
Joint family	38	84.5
Nuclear family	7	15.7
<b>OCCUPATION</b>		
Agriculture	9	20
House wife	18	40
Govt. employee	2	4.4
Private employee	5	11.2
Business	2	4.4
Others	9	20
<b>NUMBER OF UNDER FIVE YEAR CHILDREN IN FAMILY</b>		
1	18	40
2	18	40
3	8	17.7
5	1	2.3
<b>HAVE YOU SEEN MATERNAL AND CHILD HEALTH CARD</b>		
1	37	82.3
2	8	17.7
<b>HAVE YOU ACCOMPANY MOTHER DURING VISIT</b>		
1	25	55.5
2	20	44.5

Table showing that around 60% of total samples were in 20-30 years age group and 17.78% were from 41-50 years age group while 15.56% were from 31-40 years of age group and only 6.67% belongs to 51-60 age group.

The above data shows 84.5% were joint family and 15.5% were nuclear family of the total sample collected.

The data shows only 62.3% were female among all samples and remaining 37.7% were males. Study also includes the data for the percentage of samples in which 82.3% have seen the maternal and child health card and 17.7% have not seen.

The study also shows 55.5% of total samples have visited along with mother to health care facility while 44.5% have not visited along with mother

All the data and sample in which 28.88% represents husband of lactating mother while 28.88% were mother-in-law of lactating mother, 24.44% were sister-in-law and 13.33% were brother-in-law and 4.4% were father-in-law of lactating mothers.

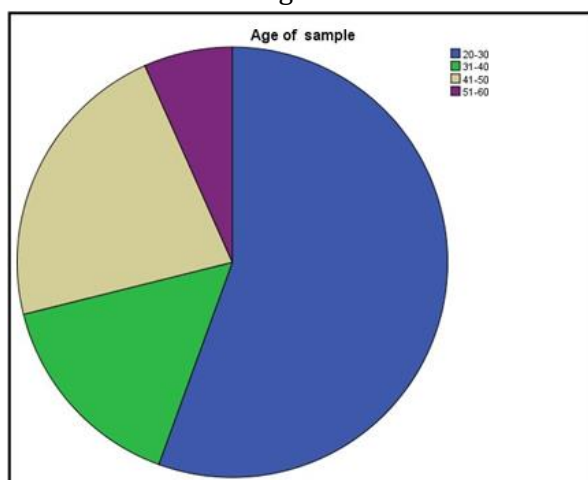


Figure 1: Pie diagram showing frequency distribution of age of population

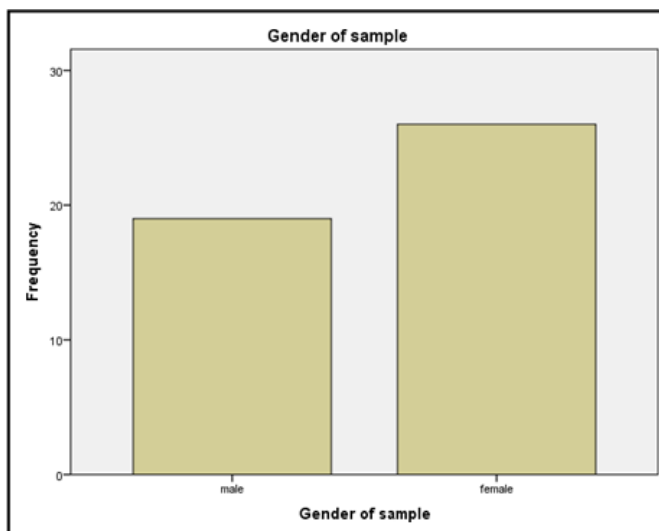


Figure 2: Bar graph showing frequency distribution of gender

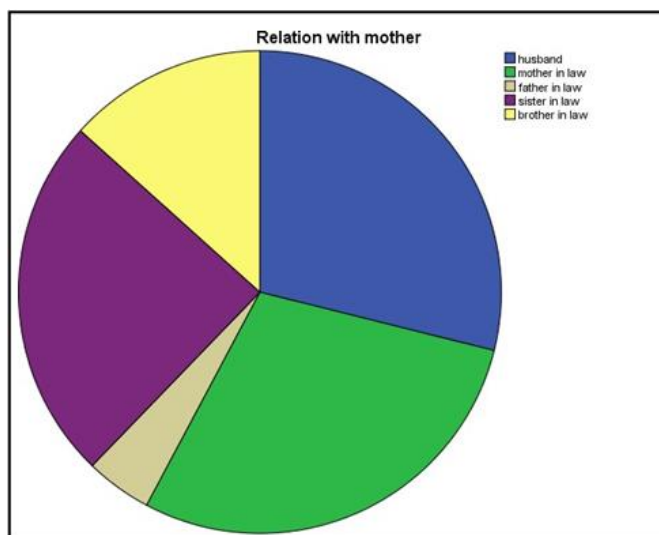


Figure 3: Pie diagram showing the frequency of samples relation with mother

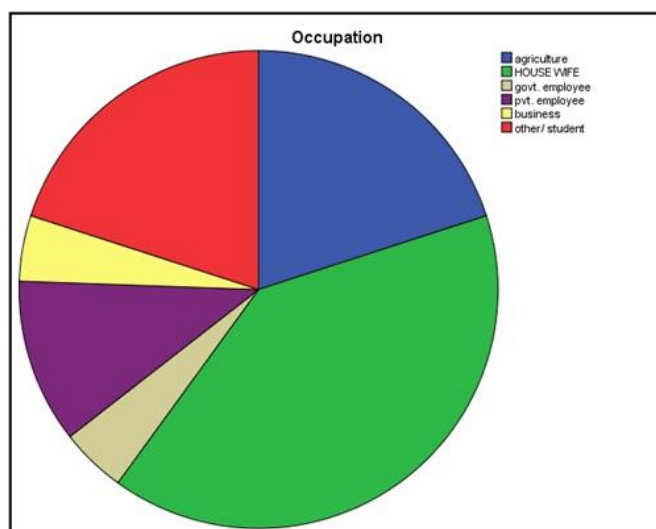


Figure 4: Pie diagram showing frequency of samples with different occupation

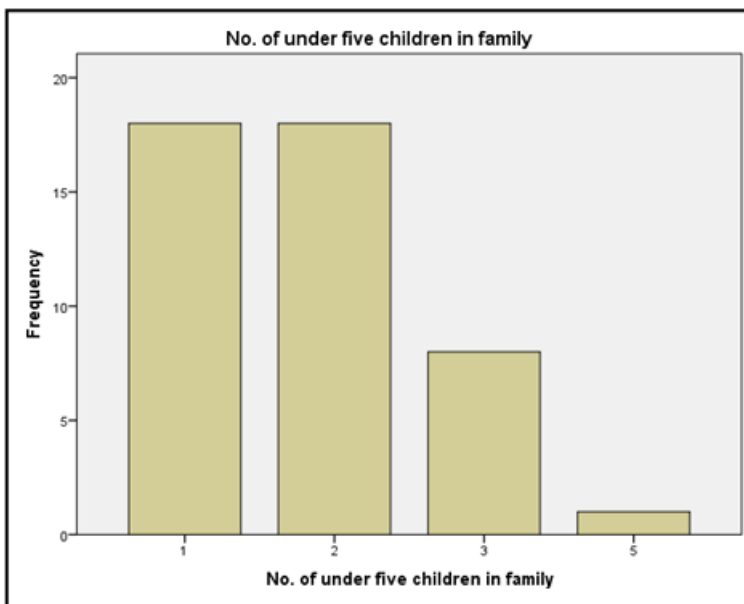


Figure 5: Bar graph showing no. of under five-year children in family of samples

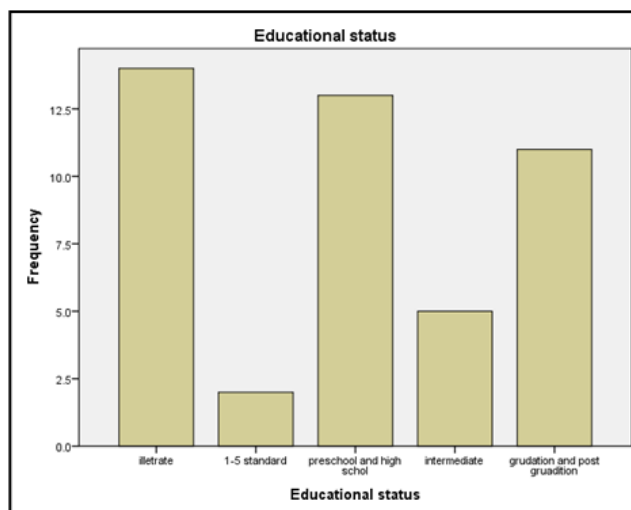


Figure 6: Bar graph showing educational status of the samples

**SECTION: B**

**OBJECTIVE 1: To assess the knowledge score regarding MCH services among rural population of Etawah District.**

**Table 2: Level of knowledge with frequency and percentage**

LEVEL	INADEQUATE	AVERAGE	ADEQUATE
KNOWLEDGE	0	16 (35.6%)	29 (64.4%)

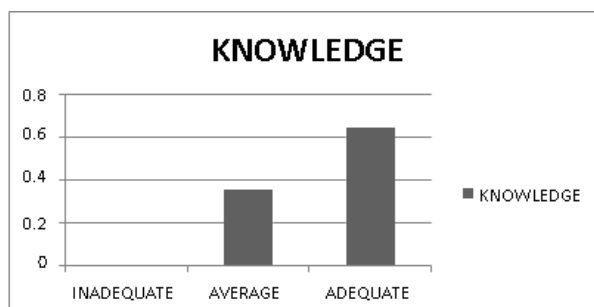




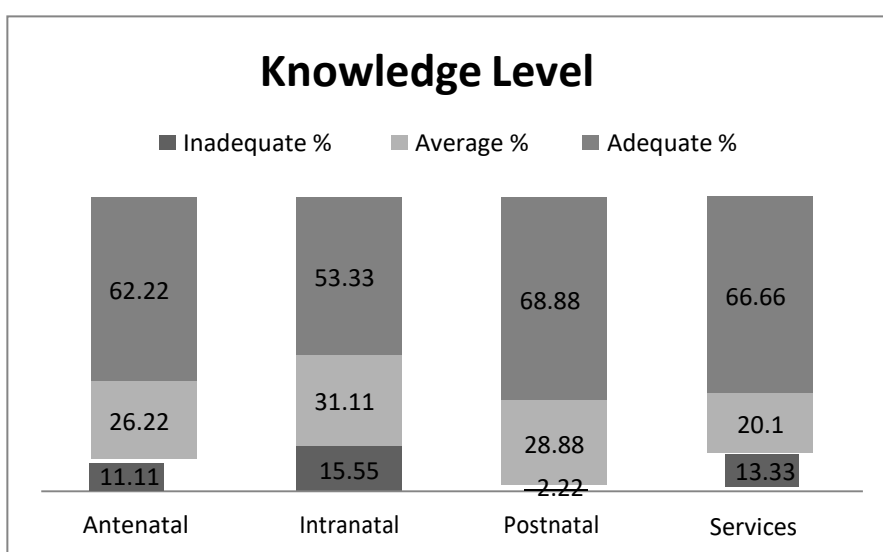
Figure 7: Bar diagram showing level of knowledge of relatives of lactating mother

Above table shows that out of total samples included in study none have inadequate knowledge and 16 samples (35.6%) have average knowledge about MCH services while 29 samples (64.4%) were having adequate knowledge.

**Table 3: Knowledge score of relatives of lactating mothers**

AREAS OF MCH SERVICES	Knowledge level		
	Inadequate %	Average %	Adequate%
Antenatal	11.11	26.22	62.22
Intranatal	15.55	31.11	53.33
Postnatal	2.22	28.88	68.88
Services	13.33	20.1	66.66

The above table shows the different knowledge level of antenatal, Intranatal, postnatal and



service providers. The knowledge level is divided in inadequate, average, and adequate and we found that 11.11% of the antenatal have inadequate knowledge, 26.22% have average while 62.2% have adequate knowledge. While assessing the Intranatal knowledge level we found that 15.55% have inadequate knowledge, 31.11% have average knowledge and remaining 53.3% have adequate knowledge. Talking about the postnatal 2.22% have inadequate knowledge, 28.88% have average knowledge while 68.88% have adequate. While assessing the knowledge level of services we found that 13.33% have inadequate, 20.1% have average knowledge while the remaining 66.66% have adequate knowledge.

**Figure 8: Bar diagram showing knowledge level of relatives of lactating mother of Antenatal, Intranatal, postnatal, Services**

**SECTION: C**

**Objective 2: To find out the association of knowledge score with selected demographic variable among rural population of Etawah district.**

**Table 4: Association between knowledge with selected demographic variable**

S. No	Socio Demographic Variable	Knowledge			
		Chi square test value ( $\chi^2$ )	Df	Chi square table value	Non-significant (NS)/ Significant (S)
1	Age	2.168	3	< 7.82	NS

2	Gender	5.44	1	> 3.84	S
3	Occupation	11.44	5	> 11.07	S
4	Education status	8.543	4	< 9.49	NS
5	Relation with mother	2.579	4	< 9.49	NS
6	Type of family	1.686	1	< 3.84	NS
7	No. of under five year children in family	8.207	3	> 7.82	S
8	Have seen maternal and child health card	6.607	1	> 3.84	S
9	Have paid visit with mother to Hospital/CHC/PHC	3.278	1	< 3.84	NS

NS-Non significant, S- Significant at 0.05 level.

Table 3 shows the association of knowledge level in relatives of lactating mother which is significant with gender, occupation, no. of under 5-year children, and the samples who have seen maternal and child health care and other socio demographic variables like age, relation with mother, type of family, educational status and the samples who have paid or not a visit to hospital/CHC/PHC were found to be non-significant

### MAJOR FINDINGS

- Majority of population of our study consists 60% 20-30 years 17.78 % were 41-50 years age group.
- Mainly our study consists of 62.2% female and 37.8% male.
- 28.8 % were husband of lactating mother and 28.88% were mother-in-law.
- 97.7% were OBC cast and 2.3 % was minority.
- Our study consists of 31.16% of illiterate population and 28.8% were pre high school and high school.
- Study composed of 84.5% joint family and 15.55 were nuclear family
- Our study shows direct relation between as increase in no of under five-year child results in increase in knowledge.
- As the no of visits increase by family with lactating mother to hospital also result in increase in knowledge.
- Housewives which are a major part of the study also shows increase in knowledge with any other occupation included in the study.

### RESULT AND DISCUSSION

- To assess the knowledge score regarding MCH services among rural population of Etawah District.

Our study show that 62.22% population have adequate, 26.66% population have average and 11.11% population have inadequate knowledge regarding antenatal care. The study also reveals that 53.33% population have adequate ,31.11% average and 15.55 % have inadequate knowledge regarding intranatal care. The 68.88% population have adequate, 28.88% have average and 2.22% have inadequate knowledge about postnatal care. The knowledge regarding services provided by Dai, Ashas, Aganwadi show 66.66% population have adequate, 20% have average and 13.33% have inadequate knowledge.

A similar study conducted by Shahnaz Akhtar, Muhammad Hussain, Iram Majeed, Muhammad Afzal on knowledge regarding antenatal care among pregnant women in Rural Area of Lahore

shows similar finding that 64.7% women response yes regarding antenatal care [24].

Another study conducted by S Gopalkrishnan and Rama R on assessment of knowledge regarding essential obstetrics care among rural pregnant women in Kancheepuram District of Tamil Nadu, India. This study reveals that about 46% have adequate knowledge regarding danger signs of pregnancy [25].

Another study conducted by Sandhya Timilsina, Rojana Dhakal on Knowledge on Postnatal Care Among Postnatal Mothers at school of health and allied science, Pokhara university, Lekhnath,

Nepal. The study result shows that 62.76% respondents have average knowledge whereas 36.73% respondents have good knowledge and 0.51% have poor knowledge about antenatal care [26].

- To find association of knowledge score with selected demographic variables of population  
The present findings show that around 22.22% males have average knowledge and 20% have adequate knowledge while 11.11% females have average knowledge and 46% have adequate knowledge.

A similar study conducted by Hamdard Naqibullah and Haneef Anwar a cross sectional study which compares male and female awareness on maternal and children health dimension in an urban setting in Afghanistan in February 2017 also shows same results i.e., men in comparison to women have a significantly low knowledge about MCH services (ANC) [17].

Our findings also shows that 8.88% housewives have average knowledge and 31.11% have adequate knowledge while agriculture as occupation have 8.88% average knowledge and 11.11% have adequate knowledge this tells that in our study among all the occupational variables housewives have greater knowledge than any other similar study conducted by Shrestha Sandhya, Singh Sakun on knowledge regarding prevention of minor accidents in children among mothers attending MCH clinic in 2014 also shows same results i.e. most of the housewives has the average knowledge i.e. 73% regarding MCH services [23].

Other findings shows that as the no. of under five year children increases in the family the level of knowledge also increases, 8.88% families with one under five year child have average knowledge and 31.11% families have adequate knowledge similar study conducted by Cumber Nambile Samuel, Ankraleh, Babara Nkengath on mothers knowledge on the effects of malnutrition in children 0-5 years in Muea health area Cameroon in November 2016 shows similar findings i.e. most families with one, two or more children had knowledge about MCH services (Malnutrition) 73% of families have adequate knowledge, 50% had average knowledge 50% have inadequate knowledge [20].

Also, the samples who have seen the maternal and child health card have higher knowledge i.e. 22.22% have average knowledge while 60% have adequate knowledge while on other hand the samples who have not seen the maternal and child health card 13.37% have average knowledge and 4.44% have adequate knowledge which shows the samples who have seen the card have higher knowledge while who have not seen the card have significant low knowledge

## RESULT

Majority of 62.3% sample were females and remaining 37.7% were male. 40% of samples were house wives, 20% were from agricultural field 11.2% were from the private sector, 4.4% were from the business, 4.4 % were they government employee and the remaining 20% were from

the other field (student). 40% of the samples were having 1 child, 40% were having 2 children, 17.75 were having 4 children and the remaining 2.3% were having 5 children. 82.3% of the samples had seen they maternal child health card while as 17.7 % had never seen the maternal card.

## CONCLUSION

Present study concluded that family with more than one child in family has high knowledge of MCH services as compare to single child family. Study also concluded that family member who has accompanied to mothers during health facility visits and seen the MCH card had high knowledge as compare to other family member of family in rural area.

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