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Risk Assessment Among Pregnant Attending Antenatal Care in Primary Health Care Centers in Al-Nasiriya City at 2018

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Abstract

Background: The study examines the facts and employment of ANC among the women in the reproductive age group in Al-Nasiriya city, ANC services is particularly definitive for enhancing the effectiveness of services for childbirth and introduce best pregnant women's needs of ANC services.

Objectives: To assess ANC services in pregnant women to identify the level of ANC, risk factor prevalence according to score among pregnant attend PHCC for ANC to evaluate the state of each pregnancy, and prevalence, of risk factors.

Subjects and methods: Descriptive cross-sectional study from 15 of January 2018 to the end of august 2018 complete the study, a total of 586 pregnant attending PHCC for ANC in Al Nasiriya city, when I took the data from 9 PHCC of two sectors for 3 month and half month complete sample size, a questionnaire was distributed according to modified Coop land score in addition to sociodemographic status include educational level, socioeconomic level and occupational status, the data analyzed by using SPSS version 23.

Result: According to Coop land score was obtaining as the following:

Low risk 355 (60.6%), high risk 121 (20.6%), extremely high 110 (18.8%), and high risk (include high, extremely high risk) percentage occur more in 2nd trimester, the UTI represent the highest risk factor 28.9%.

Conclusion: prevalence of low risk factors among pregnancy was more than half that reported while high risk pregnancy less than a quarter and the extremely high represent lesser than a quarter, that means need more facilities to improve the state of ANC services in PHCC to more to encourage for attending PHCC and concentrate on high, extremely high risk groups by giving specialized care through ANC and put a plan for them to decrease both complication and death on the fetus and maternal.

Recommendation: study results mandate more facilities to obtain more information that encourages pregnant to visit PHCC and put a plan for a high risk group for specialized care.

Keywords: prevalence, pregnant women, antenatal care, coop land score, weight, height, cross-sectional study, questionnaire, and laboratory results.

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Introduction

"Antenatal care" (ANC) is a combination of monitoring for any problems in mother and fetus, preventive care and treatments, advice health education, and support for pregnant women. Until lately, ANC has been largely unevaluated. There is restricted evidence on specific components of ANC, but there was, at the time of planning the study, little notice of all effects of ANC and delivery care on maternal and their babies, either in developed or in developing countries[(1)].

Prenatal and obstetric care: Prenatal services are provided in primary care centers. Uncomplicated obstetric services can also be given inappropriately equipped and stated centers other than hospitals. Regular prenatal visits are associated with the best maternal and child outcomes [(2)]. Important factors affecting such services include the capacity to provide convenient accessed services, limited wait time and approach to trained clinical providers. Proper ANC helped in meeting the goals set by the Millennium Development Goal (MDG). These goals set for women; to have healthy pregnancies and maternal outcomes and thereby maintain that babies born today as a reserve for the following generation [(3)]. These goals were emphasized in the Sustained Development Goals (SDG) set by the United Nations and approved by the world leaders [(4)].

The World Health Organization (WHO) estimated that worldwide, more than (529,000) women die every year as a result of risk factors related to pregnancy, abortion and childbirth [(5)]. Antenatal risk factors lead also to a heavy burden on neonatal morbidity and mortality [(2)].

Pregnancy and childbirth are great life events. Preconception and prenatal care are not only part of the pregnancy continuous sequence that culminates in delivery, but exert an important influence on pregnancy and delivery. In addition, the postpartum period, and parenthood, should also be counted in the context of women's health throughout the life span [(6)].

An encouraged woman when she believes herself be conceived, to do urine and/or serum pregnancy test by attending community midwife, or her general practitioners (GP), that ensure the pregnancy with easy way approach by primary contact with a health care professional [(7)].

Objectives:

1- Determine the prevalence of pregnant women with risk factors attending at the ANC services at the PHCC in Nasiriya in 2017.

2- Determine the prevalence of each risk factor among pregnant women attending at the ANC services at the PHCC in Nasiriya.

3- Association of these risk factors with different demographic and other studied variables of the pregnant women at the ANC services at the PHCC in Nasiriya.

4- To evaluate the state of each pregnancy at the ANC services at the PHCC in Nasiriya.

Subject & Methods: This study was among PHCC based descriptive cross sectional studies at centers of Al-Nasiriya city started from 15th January 2018 as a present of a proposal for this study and then complete the rest of the study. The data sample was taken from both health care sectors, number of

PHCC choose as 6 PHCC from the 1st sectors and 3 PHCC from the 2nd sector choose by simple randomly way and filled each form according to a questionnaire which consists of sociodemographic status (age, occupation, educational level, socioeconomic status) and modified Coop land score [8] which include (medical history, past obstetric hx and current obstetrical hx) and give a score for each form according to modified Coop land score (8) ranging into low (0 – 3), high (4 – 6) and extremely high ≥7 scores to obtain a status level of each pregnant. The specimen of the study included all pregnant belong to the area of PHCC include those who consider as belong geographical area and exclude those pregnant who refuse, after taking consent to start taking information according to the questionnaire had 3 stages personal history, anthropometric measure and laboratory results. All data sample was collected by researcher by direct interview and filling the form of questionnaires after taking a consent verbally from each pregnant as required ethic approval for research. All data entered by computerized statistical software, SPSS version 23 used in entering of data, which are presented as frequencies, percentages, appropriate statistical tests, multiple Tables were performed, for categorical variables Chi-square used, also Fisher's exact test used when results are shown as Tables and Figures.

According to **Dobson's equation (9)** sample size (n) was calculated :

"$n = Z^2P\ (1\text{-}P)\ /d^2$ " "Z = 1.96 → which is level of significance"

P = prevalence rate
D = Maximum tolerated error = was chosen to represent an accepTable limit.

"According Thi-Qar province at 2017 by national demographic Figures provided by Thi-Qar population was nearly two million 2,132,145 [3.4 % (7249293) represent the annual pregnancy target at 2017]".
No. of women age (15-44) y = 513636
Pregnancy rate = No of pregnant women / No. of women aged (15-44) × 1000

$$\text{Pregnancy rate (P)} = \frac{7249293}{513636} \times 1000 = 14.4\ \%$$

$N = (1.96)^2 \times P \times (1\text{-}P) / D^2$
$\text{Dobson}^{(N)} = 1.96 \times 1.96 \times 0.144 \times (1 - 0.144)/ (0.04)^2 = 295.956$
Sample size N ≅ 296
Then by × 1.8 because the descriptive study
so = 296 × 1.8 = 532.8 ≅ 533
Then by 0.1 for refusal rate
n = 533 × 0.1= 53.3
Then n = 533 + 53.3= 586.3
Sample size = 586
We can calculate the percentage for each center when I calculate the mean for each center for one year ago (2017) multiply by 100 divided on the total mean of these centers that chosen literally then this percent by multiply sample size (N) to obtain how many pregnant took from each center
Then after complete the sample size from 9 centers that chosen for about 3 months and a half from the beginning of May to half of august daily from Saturday to Thursday except Friday, governmental and religious holidays, each morning from 8 AM – 1 PM according to a questionnaire that depends on modified coop land score[8] which include past obstetric history, medical history and current pregnant history in addition to the socio-demographic station, which includes age, occupation, educational level and SES, then give score number for each form according to modified coop land score [8] to assess risk for each pregnant to evaluate what is more risk factor affect pregnant to give the

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resolution to decrease complication and mortality rate and complication on fetus or neonate to decrease death and stillbirth.

Table 1: number of pregnancy attending these health centers every month during 2017 and it's meaning for each center as shown below:

	Health care center	Jan.	Feb.	Mar.	Apr	May	June	July	Aug.	Sept	Oct.	Nov	Dec.	Mean
1.	AlSAder	370	398	314	561	457	325	391	336	300	328	370	292	370
2.	Sumer	187	111	172	140	150	62	150	162	104	99	129	85	129
3.	AlMuhia	68	77	75	85	93	49	76	72	62	67	69	41	69
4.	Aridu	282	260	225	261	181	107	265	248	165	207	219	212	219
5.	AlTadriby	112	108	63	117	132	63	155	156	121	152	124	109	124
6.	Alfidaa	81	75	106	100	100	42	100	75	58	62	88	69	88
7.	AlRasol	253	254	226	234	227	143	161	209	195	238	218	260	218
8.	15Shaaban	138	134	138	135	130	129	159	155	138	144	137	110	137
9.	Karush	147	140	170	184	151	108	165	141	105	155	145	134	145
10.	Total	1638	1557	1489	1817	1621	1028	1622	1554	1248	1452	1499	1312	1499

$$\text{Each center \%} = \frac{\text{mean per year}}{\text{total mean of centers}} \times 100$$

For each center, calculate.

A – sector 1

$$\text{Al sader center} = \frac{370 \times 100}{1499 \text{ (mean sum of centers)}} = 24.69 \cong 25\ \%$$

$$\text{Then X} = \frac{25 \times 586}{100} = 146.5 \cong 147$$

And the same for the rest centers Sumer, Al Muhia, Aridu, Al Tadriby and Al Fidaa .

B - sector 2

$$\text{Al Rasol center} = \frac{218 \times 100}{1499} = 14.54 \cong 15$$

$$\text{Then x} = \frac{15 \times 586}{100} = 87.9 \cong 88$$

And the same for Karush center and 15 Shaaban center.

Results: A total of 586 pregnant women that taken from 9 PHCC for risk assessment the result found that about two thirds (60.6%) of the women attending the antenatal care are at low risk level according to the modified Copland score[12] However, 20.6% of the participants had a high risk score, and almost a similar proportion (18.8%) were at extremely high risk score (Table 1).

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*Urinary tract infection represents the most risk factors among pregnant women attend primary health care centers about 28.9% of total 586 depending on laboratory result in Al Nasiriya city, Thi-Qar/ Iraq then Anaemia prevalence in the present study for mild anemia (hemoglobin level between 6gm. and 10gm.) 27.8 % according to modified Coop land score [8](Table 2).

From(Table 3), about 24.4 had 0 risk factor, 30.9% with 1 risk factor, 17.2% with 2 risk factors, 11.9% with 3 risk factors, 6.5% had 4 risk factors, 4.8% had 5 risk factors, 1.9% had 6 risk factors and > or equal 7 risk factors represent 2.4% that means a decrease in the number of risk factors

Most pregnant women visited the PHCs in the second and third trimesters, while only one-tenth visited the PHC in their first trimester (Table 4).

Table (1): The distribution of the risky pregnant women in Nasiriya in 2018 according to their risk group (n=586), the prevalence of low risk pregnancy was 60.6%, while the extremely high risk was 18.8%.

Risk Group	Freq.	%
Low risk	**355**	**60.6**
High risk	**121**	**20.6**
Extremely high	**110**	**18.8**
Total	**586**	**100**

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Table (2): showed the classification of the risky pregnant women according to the type of risk factors, the most three prevalent risk factors were, urinary tract infection 28.9%, mild anemia 27.8% While the least prevalent risk factors smoking and minor fetal malformation. **(n=586)**

Type of Risk Factors	Freq.	%
Urinary tract infection	128	28.9
Mild anemia Hb less than 10	123	27.8
Abortion 1st trimester	114	25.7
Family history recurrent abortion	84	19.5
CS delivery	74	16.7
Age >35 years	39	8.8
Abortion 2nd trimester	29	6.5
Recurrent spontaneous abortion	29	6.5
RH_isoimmunisation	28	6.3
Gestation hypertension BP more than 140/90	20	4.5
Still, birth neonatal death	18	4.1
Vaginal bleeding 1st trim	18	4.1
hypertension_PE	18	4.1
Gynecological disease	17	3.8
Respiratory disease	16	3.6
Chronic hypertension	15	3.4
Preterm labor pain	15	3.4
Preterm birth less 37 week	9	2.0
Age <16 years	9	35
Oligohydramnios	9	2.0
The fetal anomaly with a heriTable genetic cause	8	1.8
Placenta previa	8	1.8
PE	8	1.8
Thyroid disease	7	1.6
Vaginal bleeding 2nd trim	7	1.6
PPH	6	1.4
polyhydramnios	5	1.1
gestational diabetes	5	1.1
Premature rupture of membrane-less 37 weeks	4	0.9
Prolong labour difficult delivery	3	0.6
heart disease	2	0.5
Pregestational diabetes mellitus	2	0.5
controled_epilepsy	2	0.5
Assisted reproductive technique conception	2	0.5
fibroid	2	0.5
Malpresentation at term	2	0.5
renal disease	1	0.2
Active immunological disease	1	0.2
smoking	1	0.2
Minor fetal malformation	1	0.2

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Table (3): The distribution of the risky pregnant women in Nasiriya in 2018 according to the number of risk factors (n=586), the prevalence of pregnant women with no risk factor 24.4% and with one risk factor was 30.9%, while those and two risk factors were 17.2%.

Number of Risk Factors	Freq.	%
Zero Risk	143	24.4
1 Risk	181	30.9
2 Risk	101	17.2
3 Risk	70	11.9
4 Risk	38	6.5
5 Risk	28	4.8
6 Risk	11	1.9
≥7 Risk	14	2.4
Total	586	100

Table (4): The distribution of the risky pregnant women in Nasiriya in 2018 according to the trimester of pregnancy (n=586) Only 11.9% of the pregnant women visited the PHCs in the first trimester compared to 54.1% and 34% in the second and third trimester, respectively, the distribution of the risky pregnant women according to trimester of pregnancy is shown in this Table. The prevalence of high risk pregnancy was 46.3%, and extremely high 55.5% which was more common in the 2nd trimester (least prevalence among 1st trimester).

Variables	Low Risk Freq.(%)	High Risk Freq.(%)	Extremely High Freq.(%)	Total Freq.(%)	X^2 (P Value)
1$_{st}$ Trimester	**42(11.8)**	**17(14.0)**	**11(10.0)**	**70(11.9)**	**4.181 .382**
2$_{nd}$ Trimester	**200(56.3)**	**56(46.3)**	**61(55.5)**	**317(54.1)**	
3$_{rd}$ Trimester	**113(31.9)**	**48(39.7)**	**38(34.5)**	**199(34.0)**	
Total	**355(100)**	**121**	**110(100)**	**586(100)**	

Discussion

The current study represents a descriptive sectional study that was cross to estimate the prevalence of high risky pregnancy on maternal attending ANC in PHC in Nasiriya and its association with selected socio-demographic characteristics of pregnant women visiting ANC. The sample included pregnant women visiting 9 PHCCs in the city of Nasiriyah (south of Iraq), and thus it might not be possible to generalize the results to all pregnant women in the city.

The study showed that about two thirds (60.6%) of the women attending the antenatal care had low risk level according to the modified Coopland

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score [8] However, a fifth of the participants (20.6%) were in a high risk score, and almost a similar proportion (18.8%) were at extremely high risk score (Table 1), while A higher risky pregnancy rates were reported in a previous study in Saudi Arabia in 1988 among a total study population of 1175 pregnant women; 885 patients (75%) were at low risk, and 290 patients (25%) were at high or extreme risk [10]. These differences may be due to geographical and/ or methodological differences in recording risky pregnancy or might be a true time trend changes.

Most pregnant women visited the PHCs in the second and third trimesters, while only one-tenth visited the PHC was in their first trimester 11.9 %, about half in second trimester 54.1%, about one third in third trimester 34% (Table 4). This proportion was similar to that reported by a study among 1860 pregnant women in Baghdad in 2006 where 13.8% of the visits were in the first trimester while 68.2% and 17.9% were in the second and third trimesters, respectively [11]. This problem is well known in Iraq and other developing countries and needs extensive educational programs to persuade pregnant women to visit the ANC services early in pregnancy.

From (Table 3), about 24.4 had 0 risk factor, 30.9% with 1 risk factor, 17.2% with 2 risk factors, 11.9% with 3 risk factors, 6.5% had 4 risk factors, 4.8% had 5 risk factors, 1.9% had 6 risk factors and > or equal 7 risk factors represent 2.4% that means a decrease in the number of risk factors while study [12] in Al Nasyria of total 1436 at 2010 60.52% with 1 risk factor, 24.87% with 2 risk factors, 11.79% with 3 risk factors and 2.82% with more than 3 risk factors, while a study in Erbil [13], out of total 350 pregnant women in 2013 reported that 30% had no risk factor, 26.4% with 1 risk factor, 25.2% with 2 risk factors, 10% with 3 risk factors, 6.1% had 4 risk factors, 2.3% had 5 risk factors so can conclude the simple difference may be due to difference in sample size

*From (Table 2) When each risk factor was taken alone:

*Urinary tract infection represents the most risk factors among pregnant women attend primary health care centers about 28.9% of total 586 depending on laboratory result in Al Nasiriyah, Thi-Qar in Iraq (Table 2) while in Al Najaf city in 2014 urinary tract infection represent 37% of the total 300 pregnant women at Al Zahraa teaching hospital[14]. So this difference may be due to differences in sociocultural or real geographical difference.

*Aneamia prevalence in the present study for mild anemia (hemoglobin level between 6gm. and 10gm.) according to the modified Coopland score [8], was 27.8 % (Table 2). While in a previous study in 2010 in Nasyria/ Iraq city reported a higher rate of 57.94% from six primary health care centers among a total of 1463 pregnant women followed for two years [26]. A second study in Erbil city in Iraq in 2015 in four primary health care centers including 600 pregnant women reported anaemia prevalence at 46.2% [15]. The explanation for the differences might be a real difference or might be related to a difference in methodology (hemoglobin level was not reported).

*Abortion prevalence in 1st trimester in the present study was 25.7%(Table 2), while a rate of 52.7% was reported in the study among 125 women with abortion in a convenient hospital sample in Qadisiyah city in Iraq in 2015/2016 [16].

*The prevalence of Cesarean section in the present study was 16.7% (Table 2), while in Kurdistan region / Iraq it was 25.4% of all births in 2012 among, and 24.3% of all births (public and private birth centers) in the central and south parts in Iraq in 2012 [3].

Conclusion: 1- Specialized care needs to be given to the mothers having complications at any time (before, during, or after) pregnancy, especially for risky cases; on both fetus and mother sides. A thorough assessment of each

pregnant woman is necessary and when any risk is detected, she should receive specialized care either inside the primary health care centers or by referring to other health institutions (maternity hospital).

2-There is an urgent need to increase the facilities in all primary health care centers like Ultra Sound and Sonic aids to give more information about the state of pregnancy and ensure proper Ante Natal Care.

3- Health education through advising all women and particularly those who have risk factors about the need for increased care and receiving needed treatment for her condition. This responsibility is not upon doctors and health staff but the whole community including schools, media and social communications.

4- An important deficiency was noticed in health education before marriage and before pregnancy. There is an urgent need to ensure the presence of pre-pregnancy counseling in all the primary health care centers and other health facilities.

5- The results from the present study showed clearly the main risks of pregnancy and the benefits of antenatal care services such as early intervention in risky pregnancy. It emphasized the importance of early timing and having at least four antenatal care visits for each pregnancy.

6- Monitoring and supervision is a fundamental step in antenatal care programs and reaching its goal in reducing morbidity and mortality. The Ministry of Health needs to have full and true information about the status of the primary health care centers especially the antenatal care services to ensure safe pregnancies and deliveries. This information database is useful in developing targeted interventions that increase utilization of reproductive health services, especially for pregnant women; and women regardless of their pregnancy

Recommendations : 1 – The health care policy makers, especially the Ministry of Health need to determine and ascertain the size of the problem of risky pregnancy and the need for more specialized care for this group of pregnant women. It is essential to ensure special care provision in the primary health care centers or maternity hospitals and the follow up of these groups after a referral from the health centers to the hospital and the proper feed-back between these facilities.

2- A complete plan and program of antenatal care services are needed with details of goal for each primary health care center according to its catchment area. In addition, proper monitoring and evaluation of antenatal care visit to ensure complete proper antenatal care provision.

3- All the requirements for antenatal care services and antenatal care need to be provided by the health directorate including manpower, equipment, and finances through:

4- There is an urgent need to increase the number of medical staff and concentrate on their training to increase their experience of antenatal care.

5- Ensure on availability of more facilities for each primary health care centers like ultrasound and sonic aids to give more information about each pregnant status and her fetus and to encourage each pregnant woman to have better trust in antenatal care visits and ensure regular timely visits.

6– Health education through raising the awareness of service providers in the health care centers to treat each pregnant woman as a burdened woman and decrease her fears from pregnancy and childbirth.

7– Ensure good laboratory investigation and its availability for each pregnant woman attending the health center.

8– To another researcher of the same study additional number of visits in the questionnaire does not depend on score only.

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تقييم المخاطر بين النساء الحوامل اللائي يحضرن الرعاية الصحية الاولية في مدينة الناصرية للعام 2018

د. زينب حيدر عبد الجبار
د. الاء حسين علي

الخلاصة:

دراسة مقطعيه وصفيه وبائية تدرس ٥٨٦ من الحوامل في محافظة ذي قار في مركز الناصرية على المراكز الصحية ، امتدت الدراسة من الاسبوع الثالث لشهر كانون الثاني ٢٠١٨ حتى نهاية شهر اب ٢٠١٨ ، لدراسة تقييميه للحوامل اللاتي تراجع المراكز الصحية لأخذ رعاية الحوامل وخدمات للحوامل ودراسة تأثير عوامل الخطورة على الحامل وما هو العامل الاكثر انتشارا بين الحوامل وكم نسبة باقي عوامل الخطورة على الحوامل وعلاقة هذه العوامل على الحالة الاجتماعية كالعمر والمهنة ودرجة التعليم والحالة المادية ، كانت الدراسة على ٩ مراكز صحيه من مراكز المدينة : ٦ مراكز صحيه من القطاع الثاني و ٣ مراكز صحيه من القطاع الاول حيث اختيرت عشوائيا ، واخذت جميع الحوامل المراجعات التي تنتمي لذلك المركز معتمدين على الرقعة الجغرافية يوميا ولمدة تقريبا ٣ اشهر ونص في تجميع العينة يوميا من السبت للخميس من الساعة ٨ ونصف صباحا حتى الساعة ١ ظهرا عدا ايام الجمعة والعطل الرسمية ، وكانت نتيجة الدراسة كالتالي : منخفضة الخطورة ٦٠,٦% ، عالية الخطورة ٢٠,٦ % ، جدا عالية الخطورة ١٨,٨% واما بالنسبة اكثر عامل خطورة هو التهاب المسالك البولية بنسبة ٢٨,٩% ويليه فقر الدم بنسبة ٢٧,٨% واكثر فتره وجدت فيها عوامل الخطورة مرتفعة هي الفترة الثانية من الحمل من الشهر الرابع حتى نهاية الشهر السادس ، وهناك علاقه مع الحالة الاجتماعية لهذا كانت ضمن التوصيات للدراسة زيادة ثقافة وعي الحامل قبل الحمل وخلال الحمل .