PRE AND PERINATAL CARE PRACTICES ADOPTED BY SLUM WOMEN

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B.Sc. (Home Science)

DISSERTATION

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CANDIDATE'S DECLARATION

I, hereby declare that the disertation
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V. L. Kharwade

Parbhani (Kharwade V.L.)

Date : 12/12/98

CERTIFICATE-I

This is to certify that. the dissertation entitled "**PRE AND PERINATAL CARE PRACTICES ADOPTED BY SLUM WOMEN**" Submitted in partial fulfillment of the requirement for the award of the degree of **MASTER OF SCIENCE (Home Science)** in Child Devlopment and Family Relationship is a piece of the result of bonafied research carried out by **Ms. VIJAYA LAXMANRAO KHARWADE** Under my guidance and supervision. I also certify that the dissertation or part there of has not been previously submitted by for a degree of any university.

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CERTIFICATE-II

This is to certify that the dessertation entitled " **PRE AND PERINATAL CARE PRACTICES ADOPTED BY SLUM WOMEN** Submitted by Ms. **V IJAYA LAXMANRAO KHARWADE** to the Marathwada Agricultural University, in partial fulfillment of the requirement for the degree of **MASTER OF SCIENCE (Home Science)** in the subject of Child Development and Family Relationship has beeen approved by the students advisory committee after oral examination in collaboration with the external examiner.

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C O N T E N T S

INTRODUCTION

Chapter - 1

INTRODUCTION

Mother is the origin of human life, whether she gives birth to a male or female a baby. But only healthy mothers can produce healthy children who are not only of parents property but also nation's property. Such healthy children are natural resources and also valuable property of family and also build up healthy society and nation. Therefore, there is a great need to protect and care of such children not noly from the begining of their life (i.e. from conceptiom) in their mothers womb but also during birth and after birth specialy in early days (Early neonatal period) of their life. the care of women during prenatal and perinatal and postnatal period is the care of the baby as it is paracite on the nother for all her/his needs. the continuing care of the mother during and after pregnancy is a precondition for the healthy and well being of the child.

Hytten and Lietch in 1964 stated that pregnancy is a physiological condition in which the foetal growth is accompained by extensive changes in maternal body composition and metabolism. During pregnancy the mother has to meet her own and also her growing foetus needs as her physical and mental health during and after pergnancy has profound effects on status of her foetus in uterus and infant after birth. The baby before and after it's birth is totally depend on mother

for his/her physical, psychologica , nutritional and health needs.

Nutitious diet during pregnancy is one of the most important factors in achieving a sucessful outcome of pregnancy in terms of healthy baby and maintanenace of her own health. The developing foetus receives it's nutroents through the mother's body and depenct on her for an adequate prenetal diet. Therefore, maintenance of an optimum nutritional status of expectant mother is of at most important as the overall development of a child is determined to a great extent by the type of nourishment it receives right from conception Various studies have revealed a direct relationship between maternal diet and the nutritional status of the new born (Ebbs et al 1941, Hanumanth Rao, 1972, Nin 1980) on the outcome of pregnancy was assessed by Nin (1980) and reported that the proportion of infants weighing less than 2.5 Kg at birth was higher among the infant born to severely and moderately undernourished pregnant women. A healthy mother can not only gives birth to a healthy baby and provides abundant milk for her baby, but also can take care of her baby because the herself is fit. ICMR in 1990 recomanded about 300 extra calories a day during the last trimester of pregnancy, but in India many mothers of poor communities conitnue to do hard work through out pregnancy.

Socio-economic status and education affects the health and nutritional status of a pregnant woman because in low

socioeconomic status they are unable to take proper care of their health and nutrition due to lack o money. Dass Gupta et al (1950) found that there was a high incidence of premature births occured among mothers coming from lower socio-economic group. Kaur in 1991 stated that balanced diet, regular medical check-up including tetanous immunization, weight gain, BP check-up and iron folic acid tablets and her mental health during pregnancy are equally important to determine the progress of pregnancy and foetel wellbeing.

Maternal age is another factor which decide the outcome of pregnancy and health status of women for pregnancy. Between 20 and 35 years of age are considered the right optimum time for women to bear children. Women in 20 and 35 years have fewer complication in pregnancy and also have easier labours and deliveries than either older or younger mothers (Rough and Shettles 1971)

Mothers emotional state has indirect effect on Mother's health, there is no direct neural connection between the mother and foetus that would directly communicate the matners emotional state of the foetus. However, a women does experience hormonal changes in her body under states of high emotional arousal, adrenal glands secrete harmones can pass through the placenta. Thus indirectly the mother's emotional state does register in the intrauterin environment. In an

extensive study Stott and Latchford and chronic ,il ness i children of mothers under stress during pregnancy.

Anthropometric measurment helps to acess nutritional status and health status of pregnant women. A mother should not be weighed less thar 38 Kg. in wiehght and should not be less than 145 Cm ir hieght. Based on experience in anthropometry and it's relation to reproductive performance, out off points have been developed to identify the pregnant women at high risk. Long term under nutrition in pregnant woman manifests as lower mean body weight, lower mean height and lower manifests as lower for height ratio (Swaminathan M. 1985). These indices are considered to be the indicators of past nutritional status of pregnant woman. Prema (1978) found that height and weight of pregnant woman had an effect on birth weight of infants and of the two, effects of maternal weight was found to be more pronounced.

Spacing between two pregnancies affects health status of pregnant woman. Two or three years spacing between two issues is considered necessary for both the health of the mother and well being of the child. If a women becomes pregnant before she is fully recovered from bearing previous child, there is a higher chance that her new born baby will be born too early and too light in weight (Ghosh 1989). A mother's baby needs two years to recover fully from pregnancy and child birth. The rick to the mother's health is greater if the next birth

follows too closely up on the last Mukharjee and Sethare (1970) stated that up to three years of spacing, the birth weight of infants was found to be less when the spacing between two pregnancies was less than 2 to 2 and 1/5 years Maternal diseases affects the health of the pregnant woman and it's outcome. Some viruses and bacteria that cause diseases in the pregnant women can cross the placent and invade the problem to the developing baby. Depending on the time during pregnancy maternal desesses can cause varying degrees of birth defects. Infact 80 per cent of all children with AIDS were infected during pregnancy (The health information Network 1987).

The slum Dwellers population in Parbhani district was 1,15,972 and only in parbhani town it was 78,122 (Survey report of Muncipal Council, 1992). Generally slum are observed to overcrowed, congested and unhygienic. They are distinguished by poverty and non-literacy. Due to povery and illiteracy, the slum pregnant women and their family are unaware about the proper care practices during pregnancy and after delivery. Therefore, it was felt to study about the prenatal and perinatal care practices adopted by slum women in parbhani town with following objectives.

1 To study the background variables of slum pregnant women

2 To study the selected aspects of care like diet, health (Physical and Menatl', work load etc. taken by women during Pregnancy and after delivery.

3 To study the selected dimensions of perinatal history of slum women

4 To study the feeding practices adopted by the slum women for their neonates.

5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome.

REVIEW OF LITERATURE

Chapter - 2

REVIEW OF LITERATURE

Mother is the origin of human life, whether she gives birth to a male or female a baby. But only healthy mothers can produce healthy children who are not only of parents property but also nation's property. Such healthy children are natural resources and also valuable property of family and also build up healthy society and nation. Therefore there is a great need to protect and care of such children not noly from the begining of their life (i.e. from conception) in their mothers womb but also during birth and after birth specialy in early days (Early neonatal period) of their life. the care of women during prenatal and perinata and postnatal period is the care of the baby as it is paralite on the mother for all her/his needs. the continuing care of the mother during and after pregnancy is a precondition for the healthy and well being of the child.

A comprehensive review of literature is a must in any research endeavour as it provides a sound theorotical frame work for research. It further provides insights into the methods and procuces to be used to reach the objectives of the research and finally to work out a basis for interpretation of findings. The available literature has been organised systematically according to the objectives and presented below under different heads.

2.1 To stduy the background variables of slum pregnant women.

2.2 To study the selected aspects of care like health (Physical and Menatl), diet, work load etc. taken during Pregnancy and delivery

2.3 To study the selected dimensions of perinatal history of slum women

2.4 To study the feeding practices adopted by the slum women for their neonates

2.5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome

2.1 To stduy the background variables of slum pregnant women

Pendse and Giri (1957) studied on pregnancy care practices in rural Rajasthan on 200 women and found that 66.5 percent of the respondents had been married in their childhood or before attaining menaurche. Only 7.5 per cent had married at the age of 18 years or more, that is, after attainding the legal age for marriage.

Simon et al (1990) studied on adoloscent pregnancy and low birth weight methods. their study results showed that children born to pregnant women having the age of 20 were hevier as compared to the children born to the pregnant women who had more than one child during their adolescence.

Ghosh et al (1971) studied on the effect of maternal age (i.e < 20 years, 20-35 years and > 35 years) on the birth weight of neonate. It was observed that the youngest mothers in the sample (<20 years) had babies 131 gms lighter than those of the reference category (20-35 years). This was statistically significant (p < 0.01). But though the older mother (> 35 Years) had babies 8 gms lighter than the referance category. The difference was not significant. Thus there was a trend of increasing birth weight with advancing maternal age till the age of 35 years. After the age of 35 years, this trend disappeared.

Dhall and Bagga (1995) studied on the effect of maternal age on the birth weight of neonates and they found out that the women who delivered between 30 and 42 weeks of gestation revealed that there was significant effect of maternal age, parity, height weight and religion upon birth weight.

Padam Singhvi (1989) conducted a study on care during pregnancy and he found that 80 per cent of the women became pregnant in the first six months after their marriage.

Pendse and Giri's (1983) study results revealed that the respondents had attained menarche at the age between 13 and 15 years and more than half (54.5 %) of them had experienced the first child birth within one to three years of their menarche i.e. approximately between 15 to 17 years while 38 per cent and 7.5 per cent had achieved motherhood 4-6 and 7-9

years after attaining menarche respectively. The reasons given by the women for their marriage and child birth were firstly for the reasons of security and secondly because it is felt that the earlier the women became pregnat proves her fertility.

A Longitudinal study on 357 pregnant women of kenys in relation to out come of pregnancy by kusin (1979) revealed that the mean weight of the selected pregnant women was 55.4, 55.5 and 57.6 Kg at 3 to 4, 5 to 6, and 7 to 9 months of pregnancy respectively. Weight gain was about 1.5 Kg from 3 to 6 months and about 3.1 Kg from 7 to 9 months of pregnancy

Moller et al (1989) conducted a study on maternal weight, weight gain and term in the rural tanzanian village of Iiula and they found that African women with a total pregnancy weight gain of 6 Kg, that maternal weight 24 hour post partum was equal to weight at 14 weeks of gestation.

Najiar and Rowland (1976-80) Studied on Anthropometric referance data and prevalence of over weight and they found out the average height of Indian women as documented in some studies is 150 cm which is 13.7 cm less than the average height of women in USA.

Desetty and Patram (1997) conducted a study on preparation to parenthood by educated mothers consisting of the sample of 104 urbar mothers and found that irrespective of the educational status 87-97 precent of group-1 and group

2 mothers stated that various aspects of preparation is a must for parenthood. The reason given by group-1 and group-2 to mothers for preparing one self to parenthood respectively were it is necessary for bringing up children in a proper way (100 % each); followed by for proper fullfilment of children's need (97 % and 48 %); to plan for children's future (82 % and 34 %); to learn about parental responsibilities (46 % and 26 %); to make alternative arrangements for child welfare (30 % and 14 %); and to avoid complications in upbringing children in future (35 % and 23 %); However, a meagre percentage (3 % and 12 %) of mothers respectively in group-1 and group-2 stated that preparations are not required to enter parenthood for the reasons that they felt to have enough experience and knowledge about it and have alternate arrangement for child welfare. Significantly more number of graduated mothers stated favourable opinions ard proper reasons for preparations to parenthood than their counter parts.

Jesurathnam Devarapalli (1993) studied on 'maternal care and obstetric practice among the korda Dora Tribe and found out the various reasons for having a child to a married couple. konada dora stated that children are on economic asset for the family, they help their parents even from the tender age of five years. The girls help their mother in the household work while the boys he p their fathers in the field and in gathering fire wood and minor forest products

rearing cattle. Male children are preferred for they continue the family line, succession and interfearance are also passed through the male children.

Daragaih et al (1996) studied on status of 'women and value of children' and noted that people want to have children because they contribute to the family in many ways both economically and socially. Around one third of the respondents have reported that 'old age security' was the major motive for wanting children. Slightly more than one fifth (21 %) of the respondants expected help from children to carry out household work. Around 19 percent felt that respect or prestige in the society was the major motive for having children. About 12 percent of the sample expected help from children to do their farm work/business. Negligible proportion of the respondents opined that children are needed to get companionship.

Pendse and Giri (1983-84) study on pregnancy care practies in rural Rajasthan Indicated that digrosis of pregnancy was usually done by the respondents themselves or some times by the elderly women of the household ard their diagnosis was based on certain commonly known signs and symptoms such as amenorrohoea (In the case of 65 percent of the respondents); Nausea and vommiting (26.5 percent); change in taste of food i.e.likes/dislikes (2 percent), quicking (15 percent) and foetal movement (5 percent).

Singhvi (1989) carried out a study on care during pregnancy reported that the first sign of pregnancy is the cessation of the menses 90 percent of the pregnant women stoped menstruating and other early symptoms included nausea and vomiting and 50 percent of such ladies suffered from these symptoms.

Devarapalli (1993) studied on "Maternal care and obsteric practice and among the konda Dora Tribe" observed that the Konda Dora detected conception by the stoppage of the monthly menstrual cycle. The pregnant women first reveals this to the elder women in the family and then to others in her peer group.

Kakkar et al (1991) studied on availability of antenatal and perinatal care in an ICDS area of Rajstan near Jaipur. The study included 136 lactating mothers out of them most of the mothers (93.4 %) were between 18 and 35 years of age while 2.2 % mothers were below 18 years and 4.4 % were above 35 years. Antenatal check-up was done first time during I st and last Trimiester of 11 %, 39.7 % and 22.0 % mothers respectively. Most of the lactating mothers (66.2 %) received tetanus toxoid completely during pregnancy.

Bhardwaj et al (1988) studied on maternal care recepectively and its relation to perinatal and neonatal mortality in rural area. The study includes 212 pregnant women and during follow-up scores were alloted to each of the

services rendered and antental status of pregnant women. Depending on the score MCR was classified as high (11 to 8) moderate (7 to 4) or poor (3 ro Ø). Perinatal and neonatal death were recorded and an inverse relationship between MCR and perinatal and neonatal mortalities was observed significantly, no perinatal or neonatal deaths occured in women with high MCR. One of most important cause of high PNMR and neonatal mortality rate in developing countries is poor MCR i.e. under utilization of even the existing maternal health services.

Shrinivas and Venkatesh (1982) studied on maternal care receptivity and reported that PNMR in women with poor, moderate and high MCR grading was 143, 58 and 56 respectively perinatal mortality rates in relation to frequency of antenatal care were compared in a study conducted by WHO in south east Asia and it was shown that with no antenatal care, PNMR was 97 where as it was only 5 after full antenatal care and neonatal mortality rate 79, 28 and 26 in women with poor moderate and high MCR grading respectively.

Kumari (1990) stated that in India 50 percent of mothers received no antenatal care and most of deliveries occures at home.

Shankar (1962) Studied on the dietary intake and nutritional status of pregnant and nursing women and he found that 46 percent of 394 pregnant women attending antenatal clinics at Hydrabad were found to be anaemic.

Maitra et al (1985) Studied on 'care of mothers and infants with risk approach strategy' initiated by the Indian council of medical research and found that amongst those pregnant women who availed the referral medical services, the outcome of pregnancy was better as compared to those women who did not. For example the prevalence of low birth weight was 26.2 per cent in those women who had availed the referral medical services as compared to those pregnant women who did not, where the incidence was significantly higher being 35.4 per cent.

Prema (1981) studied on effect of maternal nutrition on intrauterine growth retardation and she studied weight gain of 476 women attainding antenatal clinics at Baroda during pregnancy and result indicated that the mean weight gain during pregnancy was 11 Kg for women of upper income group. On the other hand, women from low income group body weight not more than 6 Kg during pregnancy.

2.2 To study the selected aspects of care like diet, health (Physical and Menatl), work load etc. taken by women during Pregnancy and their delivery.

A study on some traditional practices of neonatal care and their effect was carried out by Tripuram (1992) He found that loctagogues are traditionally given to nursing mothers nearly evry where in different prepration. Usually Ghee, milk, ajwain, sanuf, dry fruits ladoos and other ingrediants

preparations are given. Post partum restrication of normal diet is widely poevalert, the perioc of restrication varring from two days to two months.

Aruna Kumari and Satya vani (1994) they reported that along with the consumption of poor quality diet, the prevailling food beliefs had a strong hold on the nutritional status of the pregnant women. Foods like egg, guava, chiken, papaya, certain green vegetables are not consumed by the pregnant women due to fear of abortion, fits, heat and cold in the body and it was also found that these beliefs were not income based.

Aruna Kumari and Satya vani (1994) studied on serum zinc status of the pregnant women from low and heigh income grcups. A sample of 80 women in the 3 rd trimester of pregnancy were taken for the study. Rice was the staple food for the women from both the income groups.

Gupta and Sharma (1980) conducted a survey on food consumption pattern of pregnant women in Hissar (Haryana). They reported that the dietary intake by the pregnant women was inadquate and also noticed that the women rarely consumed green leaf vegetables and animal foods and that of some of same time the intake of ghee and milk by them was found to be very high.

Madhunath (1974) studied on the diet and nutritional status of pregnant and lactating women of the urban slum area

of Hydrabad and reported that 80 per cent of the women surveyed were not aware of the increased food requirements during pregnancy. Her data on daily food intake of pregnant women also indicated very low intake of all the food items.

Ardharpurkar (1990) studied on nutritional and health status of selected pregnant women of Parbhani and found that the mean values of pregnant women of above poverty line groups was more than that of pregnant women of below poverty line group.

In Agrwal et al's (1987) study on nutritional status of rural pregnant women in Bihar and Uttar pradesh and found that 17.4 % and 10.8 % pregnant women weighed <40 Kg, 75.1 % and 60 %, weighed <45 Kg, respectively.

Umesh Kapil et al (1996) studied on Iron deficiency Anemia in pregnancy and reported that there was anemia prevalance of 92 per cent amongst women in second trimister of pregnancy. A low dietary Iron intake of 12.4 $\pm$ 9.1 mg per day which was less than half of the recommended dietary intake . Low dietary intake of iron secondary to low socio economic status as reported is the primary cause of iron defeciency anemia.

Patnam et al (1993) studied on several health care practises of pregnant women and their influncing factors in rural and urban areas of Marathwada region by interveiwing randomly selected 360 rural and 150 urban nursing women.

Nausea, odema aneamia, indigestion and body pains were there commonly reported health problems. Urban pregnant women were better cared than their counter parts in rural area.

In an extensive study, Stott and Latchford (1976) found a greater increase in behaviour disorder and chronic illness in children of mothers understress during pregnancy.

Sosa et al (1980) stated that it is difficult to attribute all of these disorders solely to the effects of prenatal emotional stress in the mother, since the same stress may be present postnatally to affect the social and emotional environment of the baby. The presence of an emotionally supportive person during labor and delivery has been shown to significantly reduce the lenght of labour and signs of fetal distress.

In early study carried by sontag (1966) it was found that when mothers were emotionaly upset there was a large increase in fetal activity. Even through maternal distress may have been of shown, duration of the fetal activity lasted for several hours.

Sontag et al (1969) studied on the fetal and maternal cardiac response to environmental stress and reported that when prolonged emotional strain effects endocrine balance, anxities may carry over into the period of the newborn and seriousaly affect adjustments to postnatal life. The infant

may show hyperactivity, which prevents its adjustiny of to feeding and sleeping patterns, or it may cry excessively.

Sontag (1966) studied on implications of fetal behaviour and environment for adult personalities and he was found that children whose mothers were undergreat stress during pregnancy also shown nore "freefloating anxiety" although they can still perform their daily routines, such anxiety has an adverse effect on their ability to learn, to remember, and to reason to their full capacities. As a result, they seem to be less bright than they actually are.

Kaur (1991) studied on care of the mother to be the role of the father and he found that the genral health care of a pregnant women is very much necessary because mother's physical and mental health affects the unborn baby of pregnant women who is nursing inside, beside balance diet regular medical check-ups and her mental health are equally important.

Ramdenee et al (1993) studied on 'Immunoglobulin G and complement C_3 levels in pregnancy induced Hypertension'. In this study the 'Immunoglobulin G (Ig G) and complement C_3 (c_3) were measured in the maternal as wel cord blood sera of 30 cases of pregnancy induced hypertension (PIH) as wel as nine controls with normotensive pregnancy. A deprassion of Ig G as wel as C_3 level was observec in the maternal as wel as cord sera of the mothers with PIH. This findings reveals

decreased immulological status of both mothers and her offsprings in PIH irrespective of the gestation and intrauterine growth status.

Factors that seemed to influence the prevalence of anemia included were socio-economic status, dietary pattern, degree of urbanisation, educational background, accessibility to helath care facilities (Ministry of Health and Family Welfare Govt. of India, New Delhi, 1989).

Terberg (1977) studied on women in management of research view and observed that working women have found it difficult to do justic to both roles due to limited time and energy at their disposal. Too much work and less time for rest render them physical and mentaly tired leading to inferiors and reduced outputs.

Suseela et al (1970) reported that most of the mothers (72 %) had taken up emploment for improving the financial condition of the families and others for personal intrest and spend time usefuly more than 80 percent of the non employed mothers participated fully in all aspects of child rearing but employed mothers participated their partly or rearly in most of the areas of child rearing.

Vora (1959) studied on working mother in the textile mills of Baroda and effects of emploment on family life. It was reported that the economic necessary is the main

factor motivating women to take up employment. Employed women generally have to perform dual role of a housewife and a wage earner. They remain over burdened and exhausted with various responsibilities of house and job.

Ramanamma and Usha (1978) studied on resolution of role conflicts among educated and employed women and stated that majority women took up employment to get additional income to make family life more comfortable or because the income brought to home by the spouse or other members of the house was not adequate.

Sheela and Jyoti (1996) studied on impact of maternal labour force participation on nutritional status of mothers. A sample size consisting of 300 mothers belonging to 100 each of working group (WG) partially working group (PWG) and non working group (NWG) was selected. Main occupation of mothers in WG was agriculture labour (72 %) and in PWG majority of them work in their own fields. Some took up self employment like sewing (24 %) and petty business (18 %).

Pendse and Giri (1983) studied on special care during advanced pregnancy and reported that out of 200 sample only 67 respondents (35.5 %) had taken special care during advanced pregnancy almost two-third (66.5 %) did not get any such care. The main reasons for not taking extra care during advanced pregnancy were that household and field duties had

per force to be attended to, rest was considered unnecessary, or that physical and manual work were belived to facilitate delivery.

In 1990 Mishra stated that Indian women from the bedrock of our economy. they provide about 50 percent of agricultural labour and more than 70 percent of the workforce in such low technology industries as clothing, jute, carpet, handicrafts etc. And they represent over two-third of the "Informal" economic sector in India in the form of an army of street vendors, artisans and domestic servant.

2.3 To study the selected dimensions of perinatal history of slum women

Agarwal et al (1997) studied on weight gain during pregnancy-A key factor in perinatal and infant mortality and they reported that poor weight in pregnant women with limited health facilities, heavy household work load, illiteracy, low income could achieve acceptable, levels of PMR (24.9) IMR (47.3) SBR (2.7) and LBW (7.4 %)

Edouard (1985) Study conducted on the epidemiology of perinutal mortality and found that low birth weight (L.B.W.; <2.5 Kg) and perinatal mortality are important public health problem in developing countries.

Movalankar et al (1991) conducted a study on levels and risk factors for perinatal mortality in ahmedabad they

reported that low maetrnal weight was an important risk factor for PNM and LBW.

Kapoor et al (1995) carried out a on study perinatal mortality in urban slum in Lucknow on 966 deliveries and found that out of 966 deliveries 930 were live birth, 36 still birth, 21 early meonatal deaths and 57 perinatal deaths. Premature births were 99 of 930 live births (10.7 %) It showed that perinatal mortality rate was higher at extrems of maternal age and parity with low socio-economic status, bac obstetric history, inadequate antenatal check-ups, prematurity and deliveries by untrained personel.

Soudarssaname et al (1992) studied on infant mortaltiy in pondechary and noticed that out of 8185 children 222 infent death occurred in the period under study giving an IMR of 27.1 per 1000 live birth. The post-neonatal mortality rate was significantly higher among males. Acute respiratory infection and diarrhaea diseases accounted for 45 % of all infant deaths. Prematurity, birth asphyxia and low birth weight were the main causes for death in the neonatal period where as acute respiratory infection and diarrhaea diseases were the main causes in the post neonatal period.

Agrawal and Agrawal (1987) studied on early childhood mortaltiy in Bihar and Uttarpradesh and reported that a neonatal death rate of 74.6 in UP and 94.5 in Bihar. They also observed that it varies from 52.4 to 128 in Bihar and

from 59.Ø to 128 in UP. However based on hospital statistics, PNMR in India varies from 5Ø to 15Ø or even more as compared to 1Ø in swedan.

Tsreing (1988) study revealed a very remarkable aspect of infants care in Thimpu. According to her most of the infants (14 out of 21) had been delivered at home by their fathers. Only in four cases neighbourers or relatives were present to assist the father. In 1Ø cases he conducted delivery alone. The investigater stated that was told that sometimes children in the house assist the father in delivery.

According to Chaudhary (199Ø) in a country nearly 7Ø percent of deliveries took place in home.

Kumari (199Ø) stated that in India 5Ø percent of mothers receive no antenatal care and most of deliveries occur at home.

Aruna Kumari and Satya vani (1994) they reported that along with the consumption of poor quality diet, the prevailling food beliefs had a strong hold on the nutritional status of the pregnant women. Foods like egg, guava, chiken, papaya, certain green vegetables are not consumed by the pregnant women due to fear of abortion, fits, heat and cold in the body and it was also found that these beliefs were not income based.

2.4 To study the feeding practices adopted by the slum women for their neonates.

From a Breastfeeding practices adopted by 1050 mothers and observed by Banapurmath et al in 1996 in village of central Karnataka that only a meagre (0.3 percent) of mothers initiated breast feeding within one hour of birth. There was considerable delay in initiating breast feeding, prelacteal feeds were routinly given to all babies and nearly one third of mothers discarded colostrum.

Banapurmath and Selvamuthukumarasamy (1995) studied on breast feeding and the first breast feeding and the first breast feeds correlation of initiation pattern to mode of delivery in 1279 hospital delivered babies and found that more number (61-85 %) of mothers who delivered vaginally gave 4-6 breast feeds in the first day, as compared to only 11.4 % of cesurean section mothers. Half of the mothers who had normal vaginal delivery initiated breast feeding within the first 4 hours where as only 1.2 % of those who underwent cesarean section breastfed within the same time socio-demographic status, literacy, parity and sex of the baby did not influence the breastfeeding practices like administration of prelacteal feeds initiation of the first breast feed and the number of breast feeds given in the first 24 hours.

Pandit et al (1993) studied the factors influencing initiation of breast feeding in an urban set-up on 100 women.

The results indicated that only 6 % of the mothers startwd breast feeding within two hours. Mothers with family income less than Rs 1500 per month breastfed their babies earlier than the mothers with a higher income. Futher, it also noted that more mothers who delivered normally breastfed their babies within 24 hours than mothers who underwent caesarean section. It was also found that illiterate mothers initiated breast feeding earlier than literate mothers. Most of the mothers were not clear and not aware about the ideal time for initiation of breast feeding.

Sing et al (1997) conducted a study on infant feeding and weighing practices in some semi-arid rural areas of Rajsthan. In the present study the samples were 328 rural mothers residing in 38 villages among sample women. the results shows that it was a comman practice to deprive their children from breast milk during the first 2 to 3 days only about 23.0 % of mothers initiated breast feeding within 24 hours of birth, while 53.7 % within two days. Nearly 24.0 % did not initiate even upto 2 whole days. this delayed initiation of breast feeding was found to be associated with a number of factors, misconception about 77.0 % of women discarded colostrum due to different reasons 42.7 % women considered it harmful to the infant 30.7 % discarded either due to their existing social custom or tradition, however 26.6 % discarded due to birth. Some mothers thought that it was a dirty old deposited milk in the breast and that would make their children ill.

In Kakkar's et al. study the results indicated that majority of the deliveries were conducted at home (78.6 %) Initiation of breast feeding was done within 6 hours of birth by 17.2 % lactating mothers while 28.3 % mothers started breastfeedings even after 48 hours.

Srivastava (1954) studied on breast feeding pattern in neonates and stated that out of 1000 mothers from sample 982 were breast feeding at the time of intervies. The reasons given by the 18 mothers (1.8 %) for not breast feeding were poor milk output, breast disease, lactation failure with previous babies, sick babies and sick mothers, only 0.5 % mothers started breast feeding within 6 hours of birth, with almost half starting on the third day, 48 hours after birth out of 79 mothers who initiated breast feeding on or after the fourth day, 52 had undergone lower segment cesarean section. colostrum was discarded by 82.89 % of mothers.

A study on feeding practices in infants of Bhil Tribe in Thanua district of Madhya Pradesh was done by Taneja and Gupta (1998). The study includes 430 households of 67 villages across Jhabua and they found that only 18.3 % mothers breastfed their child immediately after birth. 21 % mothers started breast feeding their child on the 3 rd day after delivery 54.2 % mothers started breast feeding their child on the fourth day. Majority (77.3 %) of mothers did not give colostrum to the newborn for several reasons. Prominent among them were the beliefs that colostrum is not

good for the baby and it is not easily digestable.

Bahl (1979) observed in his study that 84 per cent mothers breast fed their neonates after 12 hours of delivery. These mothers belived that colostrum was not good for babies health that the babies would not be able to digest it. Some of the mothers could given no reason for late feeding but simply followed the traditional saying that first milk was not good for the infant.

Bhal and sing (1982) did not notice the practice of administering ghutti and other prelacted foods among rural people of Himachal Pradesh and also reported 82 per cent of them were put to breast within six hours of births.

2.5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome.

Shah and Shah (1972) observed that multiparaus mothers with pregnancy weight of 38 Kg or with a height of 145 cm below, gave birth to low birth weight babies.

Reports from UNICEF (1987) -Indian council of Medical Research showed that particularly in the Indian subcontinent where LBW rates are 30-50 % which are among the highest in the world.

Associated with such a high rate of low birth weight is a high rate of perinatal mortality the official figure of 56 perinatal death per 1000 birth for Indian.

Walter (1976) studied on the estimation and interpretation of attributable risk in health research and found that the overall effect of lower height and weight depend on the poor birth outcomes, we estimated attributable risks for maternal height and weight.

Collaborative perinatal project in the USA 5 % of mothers had prepregnancy weights less than 45.5 Kg and 13 % had weight less than 50 Kg.

Anderson (1989) studied on relationship between maternal nutrition and child growth in rural india and found that mean weight gain during pregnancy in india is only about 6 Kg.

Ferraz et al studied on determinants of preterm delivery and intrauterine growth relation in north east Brazil and they found that association of low birth height (<150 cm) with increased risk of IUGR/ but not with preterm birth.

Krasorec and Anderson (1991) conducted a study on maternal nutrition and pregnancy outcomes; Anthropometric assessment and they reported that the overage height of reproductive age female is $\leq$ 150 cm (India, Bangladesh, Indonesia and Colombia) and prepregnancy weight <40 Kg, poor pregnancy outcomes (incidence or low birth weight (LBW) and

neonatal mortality rate) is usually documented.

Garn and Pesick (1982) studied on "relationship between various maternal body mass measures and size of the newborn." The results showed that pre-pregnancy weight of LBW, and birth weight varibility than various other height and weight indices in general, higher the pre-pregnancy weight. The lower is the incidence of prematurity ($\leq$ 38 wk gestation) and there is decrease in incidence of very low birth weight ($\leq$ 3ØØ g).

Evans and Leonard, (1976) studied on prematurity, postmaturity and Intrauterine growth retardation and found that women during pregnancy are generally belived to be nutritionally at risk. There abviouse energy and nutrient costs arising not only from enlargement of the deposition of a substntial energy reserve in the form of fat. Severe maternal malnutrition in early pregnancy is known impair the linear growth and weight gain of foetus.

Sen, (1956) studied on the Indian new born reported that the birth weight of an infant was found to be less when the age of pregnant women approached 4Ø years.

Mukharjee and Biswas (1959) reported that tendency for the low birth weight of infants was reversed with increasing age of the pregnant women.

A study conducted by Mukherjee and Sethna (1975) revealed that the birth weight of infants was found to be

less when the spacing between two pregnancies was less than 2 to 2.5 years.

Dhall and Bagga (1995) studied on maternal determinants on birth weight of North Indian babies at the Nehru hospital, Chandigarh over a period of two years and it was noted that there was increase in birth weight with increase in maternal height. While studying the samples maternal height was divided into 4 groups <145 cm, 145-150 cm, 151-155 cm and > 155 cm. It was seen that the birth weights in mothers < 145 cms tall and between 145-150 cms were 155 gm and 37 gm less than those of the reference category (151-155 cms). Similarly the babies of mother > 155 cms tall were 93 gams heavier than those of mothers 151-155 cms tall. This findings is similar to the findings of Buckfield et al, Dougherty and Jones and Fung et al.

Dhall and Bagga (1995) studied on maternal determinants of birth weight of north Indian babies and reported that there is a definate relation between maternal weight and baby's weight. the mean birth weight increases significantly with increasing maternal weight. While studying maternal weight was categorized into 4 groups <50 Kg, 51-60 Kg, 61-70 Kg and > 70 Kg out of which 51-60 Kg was taken as the reference category. The babies of mothers weighing <50 kg were 187 gms lighter than those between 51-60 kg. Those mothers between 61-70 kg and > 70 Kg were 83 gms and 293 gms heavier respectively.

Ghosh et al (1977) reported that 42.8 percent of incidences of low birth weight babies in mothers with height of less than 140 cm even Bhatia (1985) noticed a relationship between low birth weight with maternal height indices.

A study was taken by sarma et al (1997) on prediction of birth weights from body weights of newborns and weights of 47 new born were recorded daily from the day of birth for seven days and observed that the birth weights were regressed on the weights of the babies taken on the 2 nd day to the 7 th day. The study results showed that the mean birth weights steadily reduced from 2528 g on the day one to 2505 g on day three and there after they gradually increased to 2647 g on day seven. Standard deviation of the body weights varied from 391 gm to 419 gm. The co-efficients of determination steadily decreased from 95 % on the second day to 86 % on the seventh day and the standard error of the estimate steadily increased from 84 g to 154 g.

Kushwaha et al (1990) stucied on pregnancies in adolescents, fetal neonatal and maternal outcome. The study included 24000 couples out of it 430 were adolescent married girls, 242 (56.3 %) became pregnant during the study period. Ninteteen (7.8 %) were below 15 years and 110 (45.5 %) and 113 (46.7 %) pregnancies were in the age group of 15-17 years and 17-19 years respectively. The incidence of low birth weight babies was 67.3 % of all live births. Infection during neonatal period, congenital anomalies and birth

injuries were seen in 26.6, 8.6 and 13.1 % new born respectively. Neonatal mortality rate was 136.2 % of live births.

Mathews et al (1995) studied on birth weight standards for south Indian babies. The study included 1803 births and they found that the mean (SD) maternal height in 1803 births was 153.9 (0.16) cm. The mean (SD) birth weight of infants born to women whose height was in the interauterrine range (150-158 cm) was 2945 (516)g. The mean (SD) birth weight of infants born to women shorter than 150 cm was 2847 (480)g while that of infants born to women taller than 158 cm 3026 (524)g. These differences were statistically significant. Multiple regression analysis of data from these 1803 births showed that gestational age and its sex of the infant. birth order and maternal height contributed significantly to birthweight, This quardratic eduation explained 18 % of variation in birth weight.

A longitudinal study was taken by Shidnal and Pushpa (1990) to know the changes in weight on each day from birth to fifteen days. The study results indicated that the mean number of days of initial weight loss was 1.91 days with a weight loss of 5.76 per cent and the mean number of days to remain birth weight was 5.23 days. The loss in weight was maximum (104.67 g) on the next day of birth and gain in weight was noticed from third day further it was also seen that the total gain in weight was 310 gm from second day to

15 th day. While total loss in weight was 140.0 gm from birth to second day.

Karn and Panrose (1952) studied the birth weight of infant in relation to maternal parity. The average birth weight of infants in high parities (8 and more) was about 1 lb more than the average birth weight of first born child.

Mukharji and Biswas (1959) found a progressive increase of the average birth weight with parity up to the fourth order.

A study was conducted by Devidas et al (1976) to investigate the birth weight and to find out the influence of environmental and socio-economic factors, on birth weight of 500 new borns belonging to different socio-economic background. The result indicates that the mean birth weight of 500 infant regardlesses of different income is 2.79 Kg. As the mother's age, literacy level and income of the family increases the increase in birth weight of their babies was striking.

MATERIALS AND METHODS

Chapter - 3

MATERIAL AND METHODS

The present study is on "Pre and perinatal care practices adopted by slum women" was carried out in Parbhani town of Marathwada region, in Maharashtra. The materials and methods used in this study are discussed under following heads

1 Location of the study

2 Selection of the sample

3 Selection of tools and techniques

4 Modes of data collection

5 Statistical analysis

3.1 Location of the study

For the study entitled prenatal and perinatal care practices adopted by slum women three slum colonies out of ten slums i.e. Rahul nagar, Ambedkar nagar, Kadrabad plot were randomly selected from Parbhani town because of their near by distance and their easy approach to the investigator.

3.2 Selection of the sample

A random sample of 41 pregnant women who entered in seventh month of their pregnancy were identyfied from three random slum colonies of Parbhani town of Marathwada region, Maharashtra for the study purpose. All these selected 41 women were divied into two groups on the type of their

parity. Out of 41 pregnant women 16 women were beloned to group-1 (Primigravidas) and the rest 25 to group-2 entered in seventh month of pregnancy (multipara). The investigator visited the related sample slum women four times during the study period. Out of four visits two visits were made to the sample women during pregnancy period (enrolment of women who entered in seventh month of their pregnancy was done in the initial visit and in second visit all these enrolled women who interviewed were observed in second visit to obtain the detail information on their pregnancy and other two visits were made by the investigator to the respondent on first and seventh day of their delivery).

Though initially the investigator collected the information from 41 women during their pregnancy regarding the care taken by them, due to the death of one neonate within half an hours of its birth the perinatal care history was available on 40 cases.

3.3 Selection of tools and techniques

for studying prenatal and perinatal care practices adopted by slum women following tools and techniques were used

1 Interview schedule

2 Naturalistic Observation

3 Anthrometic measurments

4 National growth standards

5 International growth standards

3.3.1 Interview Schedule

A structural open ended interview schedule was formulated to eliciti the infomation about various aspects of prenatal and perinatal care practices adopted by slum women which included were family background history of pregnancy, preparation to parenthcod. Health (Fhysical and Mental) diet, work load, feeding practices of neonates, and profile of neonates to finalization of the interview schedule it was prestested by conducting pilot survey on five slum pregnant women. Later necessory modifications and additions were made in it in order to over come the limitations and difficulties experienced in the pilot study (Annexure-I).

3.3.2 Naturalistic observation

Beside interviewing the women during their pregnancy and after delivery naturalistic observation was done on all the sample selected women to find out reliability and validity of the information obtained from insights of the prenatal and perinatal care preactices

3.3.3 Anthropometric measurments

The anthropometric measurments of pregnant women (Annexere-II) i.e. height and weight and length, weight and circumferamces of head, chest and arm of the neonates (Annexre-III) were taken as per the standard procedure followed by the researcher who was given adequate training in it before proceeding the work.

3.3.4 National growth standards

For assessing the physical growth status of slum neonates, Indian data on growth norms (Birth to six years) published in Indian Pediatrics (April 1994 issue) based on multicenter studies conducted on a scientific basis by Dr. D.K. Agrawal and others (Shah 1994) were used.

3.3.5 International (NCHS) growth standards

To assess the status of growth of the slum neonates, internationally accepted NCHS (National Center for Health Statistics) standards were used which were recomanded by WHO.

3.4 Modes of data collection

The data were collected by the investigator from women (during pregnancy and after delivery) of selected slum families by personal interview method using structured interview schedule besides naturalistic observation and taking antropometric measurments of pregnant women and neonates (at their respective homes and in hospitals) as per the standard procedures.

3.5 Statistical analysis

Correlation was carried out as per the standard procedure given by Snedecor and Cochron (1969) to test relationship between dependent variables (such as neonates weight, length, head, chest and arm circumference, and independent variables such as gender, ordinal position,

colestrum feeding, education, family monthly income, type of pregnancy, maternal age, mother's anthropometric measurments and mother's employment.

Students 't' test (Snedecor and Cochron, 1969) was used to compare the percentages of two groups, (Group-1 primigravida, and Group-2 Multipara) by using following farmula

$$t = \frac{(P_1 - P_2)}{\sqrt{P_1\frac{(1-P_1)}{n1} + P_2\frac{(1-P_2)}{n2}}}$$

General activity and time spending pattern of slum pregnant women of the one to seven month and eight to nine months groups by using the farmuls given below

$$t = \frac{|\bar{D} - \emptyset|}{\sqrt{\frac{\left(D^2 - \frac{(\Sigma D)^2}{n}\right)}{n(n-1)}}}$$

$$\bar{D} = \frac{\Sigma D}{n}$$

n - total number of samples

D - difference between avtivities of two groups

$\bar{D}$ - Total number of difference between activities of two groups

RESULTS AND DISCUSSION

Chapter - 4

RESULTS AND DISSCUSSION

The study entitled "Pre and perinatal care preactices adopted by slum women in Parbhani town" was carried out in three randomly chosen slum colonies from Parbhani town, Parbhani district of Marathwada region. The study was carried out with specific objectives in order to study the Pre and perinatal care practice adopted by pregnant women of selected slum families. The collected data were pooled, tabulated and analysed discussed under the following heads

1 To stduy the background variables of slum pregnant women.

2 To study the selected aspects of care like diet, health (Physical and Menatl), work load etc. taken by women during Pregnancy and delivery.

3 To study the selected dimensions of perinatal history of slum women

4 To study the feeding practices adopted by the slum women for their neonates.

5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome.

4.1 Background variables of slum pregnant women

The findings regarding background variables of slum pregnant women are given in table 1-7.

4.1.1 Family background Information of slum pregnant women

It is evident from table 1 that majority (58 %) of slum women belonged to nuclear and small size families. While the rest of them were from joint and middle size families.

Table 1 Family backrgound information of slum women

background information	Percentage of women (41)	
Family Type		
Nuclear	58.53	
Joint	41.47	
Family size		
Small (1-4)	58.53	
Middle (5-8)	41.47	
Family Monthly Income (Rs)		
1000-2000	31.70	
2000-3000	41.46	
3000-4000	26.84	
Literacy of couples	**Husbands (41)**	**Wives (41)**
Non literates	34.14	65.86
Primery school educated	4.87	2.44
Middle school educated	21.95	29.26
H.S.C. educated	17.07	2.47
S.S.C. educated	17.07	-----
Graduate	4.87	-----
Occupation		
Daily wages	39.02	21.95
Vegetable/fruit venders	19.51	4.89
Auto/bus drivers	17.07	-----
Maids/Servants	26.82	12.19
House wives	-----	60.97

Most of the women (41 %) were found to have their family monthly income in the range of Rs 2000 to Rs 3000 where as 31 percent women families monthly income was found to be in the range of Rs 1000 to 2000 and 26 percent women had their family income per month was between Rs 3000 and 4000.

With regard to literacy level most of the slum pregnant women (65 %) as compared to their husbands were non-literates. About 21 percent husbands and 29 percent of wives were found to have education upto middle school level. Relatively higher percent (17 %) husbands than their wives (2.44 %) were educated till HSC, none of the wives and 4 to 17 percent husbands were graduates and educated upto SSC.

About occuption higher percentage (above 60 %) of women were found to be housewives. As compared to wives (21 %) most of the husbands (39 %) were working as daily wages on the farm. A meagre percentage of wives (4.89 %) and 19.51 percent husbands became stree venders, seventeen percent husbad were found to be bus/auto drivers.

Twelve per cent women were forced to become maids by doing various jobs like cooking, sweeping, mopping and cleaning utensils in other houses on payment basis.

4.1.2 Information about the selected aspects of slum women

Information about the selected aspects of slum women is depicted in table 2 it is found from the table 2 that irrespective of the group majority of (above 48 %)women got

Table 2 Information about the selected aspects of slum women

Information about women	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Age at marriage (Yrs)			
10-12	-----	4.00	-----
12-14	-----	8.00	-----
14-16	50.00	48.00	0.12^{NS}
16-18	43.75	40.00	0.19^{NS}
18-19	6.25	----	-----
Age at first conception (Yrs)			
14-15	6.25	----	-----
15-16	81.25	32.00	3.67**
16-17	12.50	40.00	0.85^{NS}
17-18	-----	12.00	-----
18-20	-----	16.00	-----
Current age of women (Yrs)			
15-16	6.25	-----	-----
16-18	81.25	16.00	5.30**
18-20	12.50	28.00	1.32^{NS}
20-26	-----	56.00	-----
Interval between two issue (Yrs)			
Below one	62.50	60.00	0.12^{NS}
One to two	37.50	40.00	0.19^{NS}
Spacing between two issue (Yrs)			
Below one	-----	4.00	-----
One to two	-----	96.00	-----
Two to Three	-----	48.00	-----
History of abortions			
No abortions	100.00	80.00	1.73^{NS}
Natural abortion	-----	20.00	----
Anthropometric measurments during pregnancy			
Weight (Kg)			
Below 46	6.25	-----	-----
46-50	12.50	4.00	2.19*
51-55	43.75	36.00	0.44
56-61	37.50	60.00	-----
Height (cm)			
145-150	18.75	36.00	1.32^{NS}
150-155	81.25	64.00	1.23^{NS}

NS - Non significant, * - Significant, ** - Highly significant

married when they were 14 to 16 years old young girls. Where as 40 percent of group 2 and 43 per cent of group 1 women said that their ages at the time their of marriage were between 16 and 18 years. A small per cent of (4-8 %) group 2 women were found to be married in their teenage i.e. 10 to 12 and 12 to 14 years respectively. Only in group-1, 6 per cent women got married after attaining the legal age for marriage (18-19 years). In both the groups all the sample women (except 16 percent of group 2 women) were found to have became pregnants first time before they could reach the legal age for the marriage was below 18 years i.e. 14-15 years (6.25 %), 15-16 years (81.32 %) 16-17 years (12.40 %) 17-18 years (12 %). This clearly shows that these years are not ideal ones for child bearing for women of below 18 years which may further create complications in mothers as well as in their babies. When the sample pregnant women were interviewed about their current ages, majority of group 1 women (18 %) and group-2 (56 %) women said that right now their ages were between 16-18 years and 18-20 years. None of group-2 and a small percent of group-1 (6 %) women were found to be in the ages of 15 to 16 years. At the time of interview 12 to 28 per cent group-1 and group-2 women were found in the age group of 18 to 20 years (16 %).

With regard to interval between marriage and first issue above 60 percent women from both the groups found to have received their first baby before completion of their 1st marriage aniversary. This shows that before the couple adjust

to each other they were forced to enter into parenthood. While the rest of the women (32 %) became pregnant after one to two years of their marriage.

For spacing between two issues in group-2 a large percentage of women (96 %) were found to have maintained one to two year spacing between two issues. While 4 per cent women had below one year gap between two issues theis clearly indicate that these women could not get the sufficient time to regain their health. The ideal spacing period i.e. 2-3 years between two issue was maintained by 48 percent of the women.

About the history of abortions in group-2 80 percent women had successful pregnancies where as 20 percent of them were the victims of the natural abortions in 1st trimister of their previous pregnancies.

With regard to anthropometric measurments of pregnant women taken in the 3 rd trimister of pregnancy about weight most of group-2 women (60 %) and 37 per cent group-1 womens weights were falling between 56 and 61 Kg and it was followed by 51-55 Kg in 36-43 percent, 46-50 Kg in 4 to 12 per cent women. None of multipara and only 6 percent primigravida women had the weight of below 46 kg about. About the height irrespective of the group majority (above 64 %) women were having the height found in the range 150 and 55 cm while the remaining women's height was between 145 and 150 cm. The study results are in line with the findings stated by

Pendse and Giri (1953 and 1983), Ghosh et al (1971), Najiar and Rowland (1976-80), Kusin (1979), Mollar (1989), Padam and singhvi (1989), Simon et al (1990).

Statistically there was no significant difference between group-1 and group-2 women about the selected aspects of their pregnancies except for the parameters i.e. weight below 46 Kg current age 16-18 years and age at first conception between 15-16 years.

4.1.3 Opinions and reasons of slum women about preparation to parenthood

Table 3 illustrates the opinions and reasons of slum women about preparations to parenthood. It is clear from the table that 12 per cent of group-1 women and almost double to its percentage of group-2 women (28 %) felt that preparations are essential before they could become parents for various reasons like for proper fulfilment of children's needs (100 %), planning for children's future in a better way (10 % and 100 %) and to avoid complications if arrived (100 %), for knowing about their roles as parents in bringing up their children in better way. However it is indicated from the table that relatively higher percentage of group-1 women (87 %) than group-2 women (72 %) stated that preparations are not necessary for parents to takeup the responbilities as parents in parenthood. The reasons stated by them were child bringing up is a easier job (all in group-1 and 66 % in group-2), received sufficient experience and knowledge of

parenthood (14-22 group-1 and group-2) and availabilty of support received from mother/ mother in-law/ older children and husbands (in group-1 14 % and in group-2 22 %). The study results are in accordance with the results stated by Daragaih et al (1996) and Desetty and Patnam (1997) in their studies

Table 3 Opinions and reasons of slum women about preparations to parenthood

opinion and reasons about preparation to parenthood	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Preparations are essential to parenthood	**12.50**	**28.00**	**1.32^{NS}**
Reasons			
Proper fulfilment of children's needs	100.00	100.00	-----
Planning for children's Future	100.00	100.00	-----
Avoding of complications	-----	-----	-----
Knowing about parent roles	100.00	100.00	-----
Preparations are not essential to parenthood	**87.50**	**72.00**	**1.21^{NS}**
Child bringing up is easier	100.00	66.66	4.63^{NS}
Having sufficient experience and knowledge	-----	72.22	-----
Availability of good family support	14.28	22.22	0.66^{NS}

NS- Non significant

Statistically there was no signifiacnt difference between group-1 and group-2 pregnant women in their opinions and reasons about preparations to parenthood.

4.1.4 Reasons stated by slum women for conceving a baby

Table 4 Reasons stated by slum women for conceving a baby

Reason of women	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Experienc motherhood	68.75	-----	-----
Have a companion to herself	31.25	-----	-----
Have a support of child in old age	18.75	100.00	0.76^{NS}
Get an heir for property	25.00	64.00	2.69**
Continue family line	12.50	80.00	3.89**

NS - Non significant, ** - Highly significant

Table 4 indicates the reasons stated by slum women for conceving a baby. It is reavealed from the table 4 that none of group-2 women and majority of group-1 (about 69 %) slum women expressed their derive to have children as to experience motherhood. Only in group-1 31 percent women wanted children as companions to them and also to avoid loneliness. Relatively higher percentage of women in group-2 than women in group-1 gave reasons for having children were to have a support of child in old age (100 % -18 %) to get owner of their property in future after them (64 % - 25 %) and wanted specially son to continue the family line (80 % - 12 %). The results are going with the results stated by Daragaih et al (1996) and Desetty and Patnam (1997) in their studies.

Highly significant difference was noted between group-1 and group-2 womens intensity of having babies for the reasons like to get an heir for property and to continue family line.

4.1.5 Awareness of slum women about confirmation of pregnancy and expected date of confirment

Awareness of slum women about confirmation of pregnancy and expected dates of confinment is depicted in Table-5. It is very clear from the table that all the sample group-1 and group-2 women said that the diagnosis of their pregnancy was usually done by themselves. In addition all group-1 women

Table 5 Awarness of slum women about confirmation of pregnancy and expected dates of confinement

Awarness of pregnant women	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Realization of being conceived based on			
Self analyses	100.00	100.00	-----
Foetal movement	6.00	12.00	0.134^{NS}
Amenorrhoea	100.00	80.00	-----
Nausea and vomitings	25.00	48.00	1.56^{NS}
Food Dislike	25.00	48.00	0.16^{NS}
Conversation with Experienced women	100.00	-----	-----
Awarness of first day of last menstrual cycle			
Known	31.25	28.00	0.20^{NS}
Unknown	68.75	72.00	0.27^{NS}
Expected dates of delivery			
Correctly Known	31.25	28.00	0.20^{NS}
Incorrectly Known	68.75	72.01	0.27^{NS}

NS- Non significant

took the opinion of elderly/experienced women for confirmation of their pregnancies through causal conversation with them. Based on certain common signs and symptoms such as amenorrhoea (100 % in both the groups), nausia and vomitings (25 % group-1 and 48 % group-2), food dislikes (25-48 % group-1 and group-2) and foetal movement (6 % of group-1 and 12 % of group-2) etc. made women realization of being conceived.

A large percentage of group-1 (68 %) and group-2 (72 %) women could not able to recollect the first day of their last menstrual cycle and were also ignorat about the expected dates of delivery. Slightly more percent of group-1 women (31 %) than their counterparts (28 %) in group-2 were could remember about the exact date of first day of last menstrual period and also expected dates of delivery. This clearly shows that these women were very much concern about their unborn babies. The results are similar with the findings stated by Pendse and Giri (1983-84) and Singhvi (1989).

Statistically there was no significant difference between group-1 and group-2 women in awareness of slum women about confirmation of pregnancy and expected dates of their delivery.

4.1.6 Reasons of slum women for undergone and not for undergone antenatal check-ups at health clinics

Reasons of slum women for undergone and not for undergone antenatal check-ups at health clinics are shown in

Table 6 Reasons of slum women for under going and not for going antenatal check-ups

Details about antenatal Check-ups	Percentage of women (41)		't' Value
	Group-I (16)	Group-II (25)	
Antenatal Check-ups			
Under gone	87.50	88.00	0.66^{NS}
Not under gone	12.50	12.00	0.73^{NS}
Reasons for under going antenatal check-ups	n=14	n=22	
Confirmation of Pregnancy	14.28	-----	-----
Getting nutrient Suplements	14.28	-----	-----
Known to progress of pregnancy	14.28	-----	-----
To be feel comfortable and avoid tension and complications	14.28	-----	-----
Maitain good health	14.28	-----	-----
Taking TT Vaccination	100.00	100.00	-----
Reasons for not under going antenatal check-ups	n=2	n=3	
Scared of doctors	100.00	100.00	-----
Health chek-ups is unnecessary	50.00	66.66	0.35^{NS}
No aliments	50.00	33.33	0.38^{NS}
No money for it	-----	66.66	----

NS- Non significant

table 6. As evident from table 6 that irrespective of the group a large majarity (about 88 %) of slum women had gone for antenatal checkups. While the rest of the women (12 %) did not go for any sort of check-ups. Among the women who had gone for antenatal check-ups stated the main cause for visiting the health clinics was to take Tetanus injection. In group-1 only two women had gone to health clinics for confirmation of their pregnancy, for geting nutrient supplements, knowing the progress of pregnancy to be feal comfortable and to avoid tensions and complications in pregnancy, maintain good health etc. Reasons enlisted by the women who had not gone for antenatal check-ups were like they scared of doctors, felt health ckech-up was not necessory as the pregnancy is a natural process and it will end up naturally, no ailments were found in them throughout the pregnancy and no money for it etc.

The significat difference is not found in reasons of group-1 and group-2 women for and not for undergone antenatal check-ups at health clinics.

4.1.7 Details given by slum women about antenatal check-ups

Table 7 indicates the details given by slum women about antenatal check-ups. It is very clear form the table 7 that all group-2 respondents and around 85 percent group-1 women had visited civil hospital for antenatal check-ups only once through out their pregnancy. Where as 14 percent group-1 women used to go to private maternity clinics, regularly once in a month for antenatal check-ups.

Table 7 Details given by slum women about antenatal check-ups

Reason of women	Percentage of women (41)		't' Value
	Group-I (16)	Group-II (25)	
Duration between antenatal Check-ups			
Only once in pregnancy	85.71	100.00	0.53^{NS}
Every Month	14.28	-----	----
Health clinic where antenatal check-up done			
Private	14.28	-----	----
Civil Hospital	85.71	100.00	0.75^{NS}
Enligntined about antenatal Check-ups by			
Comunity health worker	100.00	100.00	----
Family member	35.71	54.54	1.14^{NS}
Nieghbours	28.57	9.00	0.44^{NS}
Types of antenatal check-ups			
Blood pressure	14.28	-----	-----
Weight gain	14.28	-----	-----
Urine test	14.28	-----	-----
TT vaccinnations	100.00	100.00	-----
Nutrient supplements tonic/tablets.	100.00	-----	-----

NS- Non significant

Regarding the people enlightened pregnant women about antenatal check-ups, irrespective of the group all the sample women were found to have been motivated by community health workers of their areas and it was followed by family members like mother/ mother in-law (35-54 % group-1 and group-2); and neighbours (28 % group-1 and 9 % group-2).

About types of antenatal check-ups all the sample pregnant women in both the groups received tetanus injections while tonics, ironfolic acid tablets were taken by none of group-2 and all of group-1 women during their pregnancies. Of group-1 women only two women (a small percent 14 %) were found to have undergone to health clinics for BP check-ups confirmation of weight gain and urine test etc. The findings are similar with the findings stated by Pendse and Giri (1983-84), Kumari (1990) and Kakkar et al (1991). Not similar with the results stated by Srinivas and Venkatesh (1982) Bhardwaj et al (1988) in their study.

Statistically the non significant difference found in group-1 and group-2 women in having duration between antenatal check-ups.

4.2 The Findings about the selected aspects of care like diet, health (Physical and Menatl), work load etc. taken during Pregnancy and after delivery.

The findings about selsected aspects of care like diet, health (Physical and Mental), work load are given in table 8-16

4.2.1 Meal and timing pattern of slum women during pregnancy and after delivery (within a week)

Meal and time pattern of slum women during pregnancy and after delivery (within a week) is given in table 8. It is clear from the table that all the selected sample women after

delivery were found to have had tea daily in the morning between 7 am to 8 am, but before delivery out of 41 majority (60 percent) of the sample pregnant women had the habit of taking morning tea daily. Of the total sample women thirty nine percent of them some times used to eat bread/biscuits, along with their morning tea. Where as after delivery all these sample women were forced to eat laddu made out of dry fruits. Sweets made with alive seeds were also consumed by 14 percent lactating women within a week after their delivery.

In the late morning around 9 to 11 am all pregnant women daily used to eat jawar roti with techa (green chilli chatni i.e 56 %) and dhal (36 %). For a change sometimes chapati was consumed by all pregnant women with seasonally available vegetable curries (100 %), dhal (63 %), green chilli chatani (43 %), egg in the form of curry/omlet (39 %). Kichadi was also another food item consumed by 29 percent women for a change. After delivery all lactating mother were given jawar roti with vegetable curry, ghee for the whole week daily, but sometimes food items like kichadi and chapati were also given to all these nursing mothers. Dhal was consumed by 46 percent women sometimes and 54 per cent rarrly during the postnatal period.

In the afternoon all the sample women during pregnancy and after delivery used to take their lunch around 12 pm to 2 pm. is found that Jawar roti was the staple food daily for all pregnant women and were eaten with vegetable curry (100 %). While in 4 to 14 percent pregnant womens lunch rice and

Table 8 Meal and timing pattern of slum women during pregnancy and after delivery

Consumed foods and timing	Percentage of women (41)					
	During pregnancy			After delivery (within a week)		
	Often	Some times	Rarely	Often	Some times	Rearly
Early morning (7-8 am)						
Tea	60.97	--	--	100.00	--	--
Tea with bread/ Biscuits/toast	39.02	--	--	--	2.43	--
Dry fruit laddu	--	--	--	--	100.00	--
Alive sweet	--	--	--	--	14.63	--
Late morning (9-11 pm)						
Khichadi	--	26.26	--	--	100.00	--
Chapati	--	100.00	--	--	100.00	--
Jawar roti	100.00	--	--	100.00	--	--
Vegitable curry	--	100.00	--	100.00	--	--
Techa (green chilli Chatni)	56.09	43.90	--	--	--	--
Dal	36.58	63.41	--	--	46.34	53.64
Omlet/boiled egg	--	39.02	--	--	--	--
Ghee	--	--	--	100.00	--	--
Afternoon (12-2 pm)						
Chapati	--	100.00	--	12.19	87.80	--
Jawar roti	100.00	--	--	87.80	12.19	--
Vegetable curry	100.00	--	--	56.09	43.90	--
Dal	14.63	85.36	--	43.90	56.09	--
Techa (green Chilli chatni)	--	100.00	--	--	--	--
Rice	4.87	59.12	--			
Ghee	--	--	14.63	100.00	--	--
Kheer	--	--	100.00	--	--	100.00
Mutton curry	--	36.92	--	--	--	--
Seasonal fruit	--	--	100.00	--	--	--
Evening (4-5 pm)						
Tea	100.00	--	--	100.00	--	--
Chiwada	--	9.75	--	--	--	--
Biscuits	--	9.75	80.84	--	--	--
Late evening (7-9 pm)						
Jawar roti	100.00	--	--	100.00	--	--
Chapati	--	100.00	--	--	100.00	--
Vegetable curry	9.75	90.24	--	53.65	46.36	--
Dal	90.24	9.75	--	46.36	53.65	--
Rice with milk/Ghee	--	--	--	--	100.00	--
Kheer	--	--	--	--	100.00	--

dhal preparations were observed. Sometimes the sample pregnant women used to have chapati with thecha (100 %) and it followed by dhal (85 %), rice (59 %) and mutton curry (39 %). About nursing mother's lunch daily compulsory food items of jawar roti was found in afternoon meals of most of the lactating (87 %) women and it followed by vegetable curry (56 %), dhal (43 %) rice (60 %) chapati (12 %) and ghee (100 %) only on special occations like festivals some times the food items like chapati (87 %), dhal (56 %), vegetable curry (43 %), jawar roti were seen in their lunch and ghee was consumed by all lactating mothers very rarely.

In the evening around 4 to 5 pm tea was taken daily by all the respondents through out their pregnancy and even after their delivery. While a small percentage of pregnant women (9 %) were found to be observed sometimes to had chiwada and biscuits along with their tea.

In the late evening around 7 to 9 pm were the fixed hours for all the women in pregnancy and after delivery to have their dinner. Jawar roti was the daily food item for pregnant and lactating women with dhal (46-90 %) and vegetable curry (53-9 %), sometime all lactating women were used to have chapati with ghee (100 %), dhal (53 %) and vegetable curry (46 %). For a change sometimes Kheer made out of rava/Savya was also one of the food item generally consumed by all lactating mothers while lactating all mothers were made to add ghee in the meal at night.

Under foods consumed rarely by women during pergnancy and after delivery were seasonal fruits, (100 %) Kheer (100 %), ghee (100 %) and dhal (53 %). The findings of the study are in line with the findings stated by Madhunath (1974), Gupta and Sharma (1980), Tripuram (1992) and Satyavani(1994) about rice was a Staple food was not going with the present study result.

On the whole it is concluded that jawar is staple food for all slum pregnant and lactating women chapati was the next food item after jawar roti consumed. Sometimes in a day by all the respondents through out their pregnancy and even after delivery. All the sample women were found to have eaten vegetable curry or dhal only once in a daily tea was a common drink consumed by all the sample women twice in a day. Seasonal fruits were consumed by all pregnant women rarely i.e. when they were available where as after delivery ghee and dry fruits laddu were the main daily food items to be included in the diet of lactating mothers.

4.2.2 Encountered health problems and health care of slum women during pregnancy

Encountered health problems and health care of slum women during pregnancy are shown in table 9. It is evident from the table that irrespective of the group all the sample women faced one or the other health problem throughout their pregnancy. Slightly higher percentage of group-2 women than group-1 women found to have faced health problems were severe

Table 9 Encountered health problem and health care of slum women during pregnancy

Health problem and health care	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Health Problem			
Oedema	12.50	16.00	0.36^{NS}
Severe nausia	12.50	4.00	2.19 *
Vomittings	25.00	36.00	0.71^{NS}
Abdominal pain	12.50	12.00	----
Backahe	37.50	36.00	0.06^{NS}
General weakness	56.25	28.00	1.82^{NS}
Acidity	6.25	12.00	3.46**
Health care Modes of treatinf ailments			
Household remedies	87.50	100.00	----
Consulting private Gynocologist	12.50	----	---
Stoped outside work temporarly	----	16.00	----
Diet care			
Special diet	50.00	48.00	0.12^{NS}
Normal diet	50.00	52.00	0.12^{NS}
Rest			
Sufficient	62.50	76.00	0.94^{NS}
Insufficient	37.50	24.00	0.87^{NS}

NS - Non significant, ** - Highly significant * - significant

nausea (12-4 %). abdominal pain (12.50-12 %), back pain (37.36 %) and general weakness. while it was reverse in case of percentages of group-1 and group-2 women for other health problems like oedema (12-16 %) vomitings (25-36 %) and acidity (6-12 %). The similar results were stated by Patnam et al (1993) about the comman health problems in their study.

With regard to the type of health care it was observed that all group-2 pregnant women and most of the group-1 (87-50 %) women were found to have adopted household remedies mentioned in table 8 for treating comman health problems. A small percentage of group-1 women (12-50 %) consulted private gynocologist where as they had any sort of health problems this shows the concern of pregnant women about their unborn babies. None of group-2 werefound to have gone to the doctor for medical help. Sixteen percent of women in group-2 reported that they stopped doing work outside temporarily as it was impossible for them to continue the work anymore.

In terms of diet relatively higher (50 %) percent of womer in group-1 than group-2 women found to have taken special diet like leafy vegetables and seasonal fruits during pregnancy. While in group-2 (52 %) slightly more percent of women than group-1 women (50 %) followed the pattern of taking regular diet. This may be the concern and knowledge of the pregnant women and other family members about the importance of nutrotion during pregnancy. Similar results were found from the study of Dasard (1990).

About rest higher percentage (76 %) of group-2 women than group-1 women (62 %) took sufficient rest in Pregnancy period. While the rest of the women (24 %, 37.50 %) could not find time for sufficient rest. The findings are going with the results mentioned by Pandse and Giri (1983) from their studies.

Statistically there was no significant difference between group-1 and group-2 women in having health problems and health care, diet care and rest except in respect of health problems like acidity and severe nausia. Significantly higher percentage of group-1 women than group-2 women suffered from severe nausia and it was vice versa in case of acidity. All the women did not face any health problem after delivery for a week.

4.2.3 Emotional status of slum women during pregnancy

Emotional status of slum women during pregnancy is depicted in table 10. It is noted from the table 10 that irrespective of the group all the sample women experienced happy and unhappy events. All group-1 women and 80 per cent group-2 women found to have been felt happy when they came to know that they conceived. The custom of celebrating function exclusively for women who became pregnant after marriage was arranged for all group-1 pregnant women in the 7 th month of their pregnancy made them felt very much happy. None of group-2 and 12 percent group-1 and 16-12 per cent (group-2 and group-1) women found to have been felt very much happy for getting special food from family members/ relatives/

neighours and also for special privilages given for them during pregnancy.

Table 10 Emotional status of slum women during pregnancy

Awarness of pregnant women	Percentage of women (41)		't' Value
	Group-I (16)	Group-II (25)	
Good for			
Being conceived	100.00	88.00	----
Getting special food	12.50	16.00	0.13^{NS}
Getting special privilages	12.00	----	----
Celebrating functions exclusively for her sake	100.00	----	----
Not good for			
Fear of begetting female baby	81.25	100.00	6.57**
Fear of difficult labour	50.00	20.00	2.03*
Fear for not getting discountinued job	12.50	20.00	0.70^{NS}
Fear for begetting maldeveloped baby	12.50	---	---
Unwanted pregnancy	---	4.00	---
Increassed domestic work load	---	16.00	---
Frequent family rows	100.00	100.00	----

NS-Non significant, * - Significant, ** - Highly significant

It is observed from the table that one or other events made all the sample women to under gone some sort of stress. Frequent quarrels between husband and wife between daughter

in-law and mother in-law about one or the other simple issue was a cause for created mental tension in all the sample women in both the groups. Family member's indifference attitude towards female baby was also another main cause for all group-2 and majority (81 %) of group-1 women to have tension throughout their pregnancy. Relatively higher percentage of group-1 women (50 %) than group-1 women expressed that they were vary much scared of delivery. Above 12 percent group-1 women and 20 percent group-2 women were seemed to be in depressed condition due to the fear of not getting discontinued job after taking long leave for the sake of delivery. Fear of begetting maldeveloped baby was the another concern for 12 percent group-1 women to be worried. Unwanted pregnancy and the overburden of domestic work also made 4 and 16 percent women to be felt unhappy about this. The results are in line with the findings stated by Sontag (1996), Sosa et al (1980), (1981) and Kaur (1991) in their studies.

Statistically highly significant difference was noted between group-1 and group-2 women about the fear of getting a female baby and also significant difference was found between them in case of fear of difficult labour.

4.2.4 Physical and Mental changes noticed by pregnant slum women in depression

Physical and mental changes noticed by pregnant slum women in depression are illstrated in table 11. It is observed from the table that some physical as well as mental

changes noticed by all the selected pregnant women in them through out their pregnancy. Regarding physical changes majority of pregnant women (56 %) from group-2 said that they used to express their anger by beating their elder children and other changes were followed by felt fast feotal movement (group-1 16 % and grcup-2 12 %) and did not feel like eating which made to miss one time meal (4-12 in group-1 and group-2). Crying (in group-1 6 % and group-2 12 %) when beaten by their husbands in terms of mental changes all the sample women from both the groups became nervous about the gender

Table 11 Changes noticed by slum women during pregnancy

Physiacl and Mental Changes	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Physical Changes			
Fast feotal movement	6.25	12.00	3.46**
Missed one time meal	12.50	4.00	2.19*
Beating own children	----	56.00	----
Crying	6.25	12.00	3.46**
Mental changes			
Nervousness	100.00	100.00	----
Irritation	12.50	12.00	----
Uneasy feeling	31.25	16.00	1.09NS
Fatigue	6.23	12.00	3.46**
Depression	12.50	16.00	0.36NS
Disinterest in any work	12.50	40.00	0.73NS

NS-Non significant, * - Significant, ** - Highly significant

of their unborn baby specially female and during pregnancy. A Large number of women from group-2 (40 %) and only 12 percent women from group-1 found to have disintrest in work followed by uneasy feeling (16 % - 31 %), fatigue (12 %, 6.23 %), depression (16 %, 12.5 %) and irritation (12 %, 12.50 %) by the mothers of group-2 and group-1 respectively. The study results are in line with the findings mentioned by Sontag (1966-69), Sosa et al (1930), (1981) and Kaur (1991) in their study.

Highly significant difference was found in respect of feotal movement, missing of meal, fatigueness and crying of mothers in two groups.

4.2.5 Generl activity and and time spedning pattern of slum pregnant women.

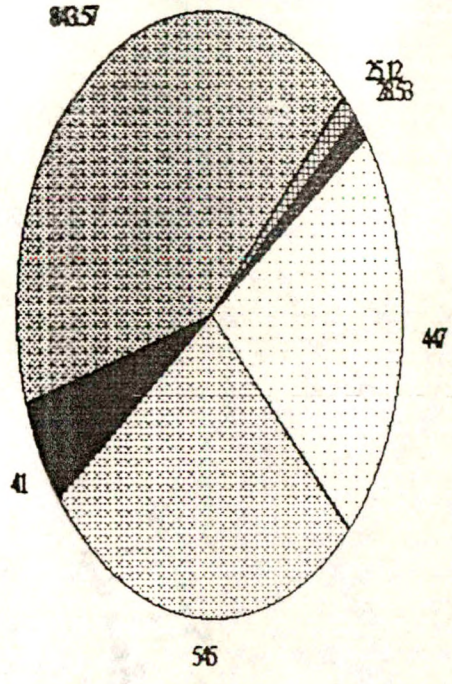
General activity and time spending pattern of slum pregnant women are noted in table 12 and illustrated in Fig.1 and Fig 2 All the activities generally performed by the women during their pregnancy specially from 1 to 7 month and from 8 to 9th month were classified under different heads such as personal care, meditation, domestic work, wages work, afternoon rest/map and sleep. Majority of the women in first two trimisters of their pregnancy spent their maximum time (mean 23±3.4 hours) i.e 20-30 minutes on their personal care activities like brushing, bathing, eating, and grooming etc. and where as the similar trend was observed even in the last trimister. The maximum mean 18.4±2.94 time of 15-20 minutes

Table 12 General activities and time spending pattern of slum pregnant women

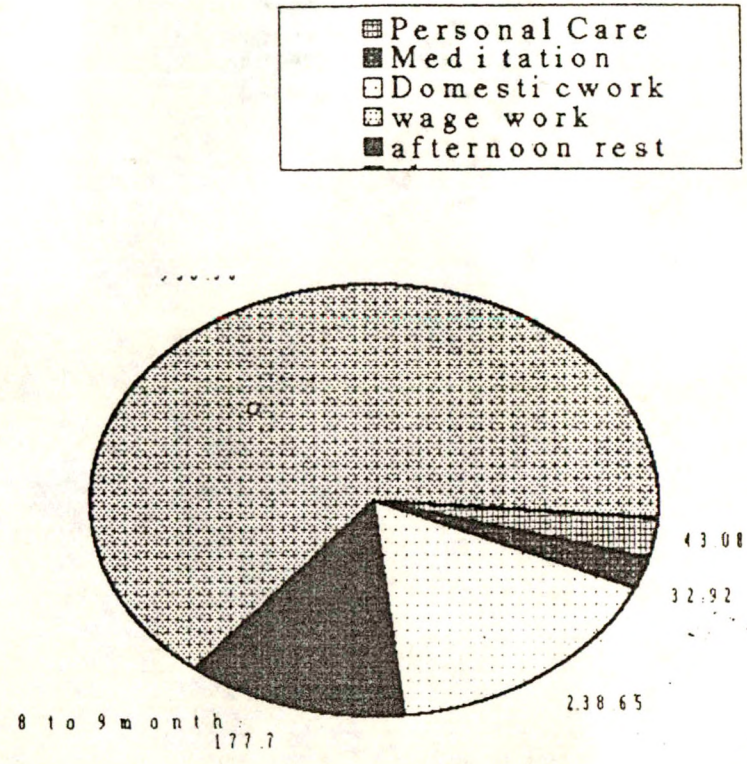
Mean time spent (minutes)on various activities

Adults	1 to 7 Month										8 to 9 Month											
	15-20	20-30	30-60	60-100	150-200	250-350	450-580	8 to 9	9 to 10	overall mean	20-30	30-60	60-90	120-140	140-175	300-400	400-470	10 to 11	11 to 12	overall mean	't' test
		1	2	3	4	5	6	(hrs)	(hrs)									(hrs)	(hrs)	time + SD	Values
Personal care 41	17.27±2.89 11(26.83)	28±3.49 30(73.17)	-	-	-	-	-	-	-	25.12±3.19 41	25.45±7.81 11(26.83)	24±881 30(73.17)	-	-	-	-	-	-	-	43.08±8.31	0.98^NS
Mediatation 41	18.4±2.94 25(60.97)	28.33±3.59 6(14.63)	40±4.93 7(17.07)	86.67±9.43 3(7.33)	-	-	-	-	-	28.53±5.22 41	2.6±9.42 25(60.97)	35.38±7.43 13(31.70)	80±8.43 3(7.33)	-	-	-	-	-	-	32.92±8.42	0.97^NS
Domestic work 41	-	-	-	-	-	331.75±11.43 16(39.03)	532.4±17.32 25(60.97)	-	-	447±14.37 41	-	-	-	129.58±6.48 24(58.54)	162.8±0.89 7(17.07)	554±8.83 10(24.39)	-	-	-	238.65±5.42	0.99^NS
Wage work 16	-	-	-	-	-	-	545±18.49 16(100.00)	-	-	545.00±18.49 -	-	-	-	-	-	-	-	-	-	-	-
Afternoon rest / nap 41	-	-	40±7.34 9(21.96)	87.14±9.43 7(17.07)	180±10.43 25(60.97)	-	-	-	-	133.41±5.92 41	-	-	-	-	-	363±8.89 10(24.39)	450.32±23.03 31(75.61)	-	-	177.70±15.98	0.99^NS
Sleep 41	-	-	-	-	-	-	-	8.33±0.49 6(14.63)	97.14±9.43 35(85.37)	9.51±4.96 41	-	-	-	-	-	-	-	10.5±0.93 10(24.39)	11.54±01.37 31(75.61)	11.29±1.15	1.00^NS

(NS :- Non Significant)



1 to 7 Month



8 to 9th Month

General activities and time spending pattern of slum pregnant women (over all time in minutes)

were utilised by 60 per cent of women till 7th month of their pregnancy on medication by involving themselves in doing puja and listening relious books etc. and other things, followed by 14 per cent for 20-30 minutes (28.33 ±3.59), 17 per cent for 30-60 minutes (40.00±4.93) and 3 per cent (86.6±9.43 for 60-100 minutes. On domestic work like cleaning and stacking utensiles, preparing food, washing cloths, sweeping, mopping and buying vegetables etc. The mean time 331.75±11.43 of (250-350) minutes and 532.4±17.32 (450-580)minutes were alloted by 39 and 60 per cent women during seven months of their pregnancy while for the same job in the period of 8-9 months pregnancy, the thimings were 120-140 minutes (129.58±6.48) 140.175)1.62±0.89) and 300-400 minutes (554±8.83). Sixteen out of 41 sample women till 7th months of their pregnancy were found to have been involved in doing various kinds of jobs on payment basis were like cleaning vessel washing cloths, sweeping and mopping in others house and selling vegetables etc. The mean time spent on this activity was 1545.00 ±18.49 (450-580) minutes. Majority (85 %) of the women said that they used to sleep for 9 to 10 hours in the night (97.14 ± 9.43) till 7th month of pregnancy after that till 9 th month of pregnancy the maximum mean timings were 10.50 ±0.93 (10-11 hours) and 11.54±1.37 (11-12 hours) were noted for sleep by all the sample women. Women during the pregnancy of 8 to 9 months, They spent their more time i.e. mean of 177.70±15.98 minutes on afternoon rest/nap as compared to the time spent during 1 to 7 months pregnancy

because 31 women came to their mothers house for delivery as they were having less responsibility of household work in mothers house. All the women stopped their wage work during the last month of their pregnancy. These findigns are similar with the findings of Terberg (1977) and Pendse and Giri (1983) indicated in their studies.

Statistically there was no significant difference between time spent for activities of pregment women in 1 to 7 month of pregnancy and 8 to 9 morth of pregnancy.

4.2.6 Details on employment of slum pregnant women

Details on employment of slum pregnant women are depicted in table 13. It was recored from the table 13 that most of the (87 %) pregnant women tookup the employment for suplimenting their family income while the rest (12.50 %) of them involed in jobs for meeting their self demands like cosmetics, clothes, going to movies etc.

About the entry to employment majority of women (43-70 %) sait that they started going out for outside work since they were too young i.e. 5 years old as helpers to their mothers and it was followed by 18 percent in 12-14 years, 25 percent in 14-16 years and 12 percent in 16-18 years respectively. With regard to current status of employment it is obivious that most of the women (75 %) were forced found

Table 13 Details on employment of slum pregnant women

Details of employment	Percentage of women (16)
Reasons for taking up employment	
Supplementing family income	87.5Ø
Meeting self demands	12.5Ø
Entry age to employment	
Since above 5 years	43.7Ø
12-14	18.75
14-16	25.ØØ
16-18	12.5Ø
Current status of employment	
Continued	75.ØØ
Discontinued	25.ØØ

to have continued their work till nineth month of their pregnancy while the rest (25 %) of women discontinued their work after they entered in the eighth month of their pregnancy. The results are similar with the results got from from studies conducted by Vora (1959) and Suseela et al (1970).

4.2.7 Employed slum women's earnings and their utility

Table 14 indicates the slum womens earnings and their utility. It is noted from the table that out of 41 sample women only 16 women were employed by taking various jobs like farm labour and fruit vegetable vender and servent/maid.

Table 14 Employed slum womens earnings and their utilities

Earnings of women and their utilities	Percentage of women (16)
Earnings per moth (Rs)	
500-1000	43.75
1000-1200	56.25
Utilities of earnings	
Personal needs	50.00
Family provisions	31.25
Child education	43.75
Child health	43.75
House rent	50.00
Saving	43.75

About earnings majority (25-56 %) of the women earned money per month from Rs 1000 to 1200 while the rest of 43 percent women's monthly earnings were between Rs 500 to Rs 1000 With regard to utility of earnings, 50 percent of women utilised their earnings for fulfilling their necessities like payment of house rent and it was followed by 43 percent on childrens education, health and on family savings, by 31 percent on buying provisions for the family. The study results are in line with the findings stated by Suseela et al (1970), Misra (1990) and Sheela and Jyoti (1996).

4.2.8 Expenditure incurred by slum families on account of pregnancy and pregnancy related functiosn

Table 15 illustrates the expenditure incurred by slum families on account fo pregnancy and pregnancy related functions. It is found from the table that all the sample families found to have spent money from Rs 100 to Rs 400 on buying seasonal fruits and leafy and other vegetables specially for the sake of pregnant women. This shows the families concern about the unborn baby.

For transport 26 per cent families found to have spent the amount between Rs 15 and Rs 50 on rikshaw/auto when ever pregnant women visited to the hospital for health check-ups. Regarding medicine majority of the slum families (about 88 %) invested money Rs 15 to Rs 150 for buying medicines of pregnant women and also on doctor's fee.

In terms of functions and customs above 39 percent families followed the custom of celebrating functions specially for pregnant women like choli programme (In this programmes pregnant women were given new dress, green bangle and sweets in front of the invited guests) in the 7 th or 9 th months of their pregnancy. For this these families spent nearly Rs 200 to Rs 300.

Table 15 Expenditure incurred by slum families on account of pregnancy and pregnancy related functions.

Details of employment	Percentage of women (41)
Special diet	**100.00 (41)**
100	4.87
120	2.43
130	4.87
140	12.19
145	12.19
150	7.31
155	4.87
160	2.43
175	7.31
180	2.43
195	2.43
200	7.31
230	4.87
245	9.75
250	4.87
300	2.43
320	2.43
350	2.43
400	2.43
Transport account	**17.07 (11)**
15	26.82
16	9.09
18	9.09
20	9.09
25	9.09
30	9.09
35	9.09
40	9.09
45	9.09
50	18.19
Medicine	**87.80 (36)**
15	61.11
30	33.33
100	2.77
150	2.77
Function/Ceremonies	**39.20 (16)**
200	62.50
230	25.00
250	6.25
300	3.25

4.2.9 Expenditure incurred by slum families on account of delivary and delivery related functions

Table 16 indicates the expenditure incurred by slum families on account of delivery and delivery related functions. The results in the table indicated that all the Sample families spent money in the range of Rs 50 to Rs 900 on account of delivery fee and also for hospital stay.

Majority of the families (41,46 %) found to have spent money from Rs 100 to Rs 250 on buying ingredients like dry fruits for making laddus specially for Lactating women.

Most of the slum families (63 %) incurred money of Rs 15 to Rs 40 on transport for taking pregnant women to hospital for the sake of delivery. where as only two families were forced to spend money on buying medicine prescribed by the doctor specially for neonates.

A large percentage of families (97 %) spent money from Rs 50 to 540 on celebrating function like Pachwi satvi and on buying ornaments like silver jyoti and gold jyoti and cloths of newborn.

Table 16 Expenditure incurred by slum families on account of delivery and delivery related functions

Expenditure incurre on item (Rs)	Percentage of women (41)
Special food	**100.00 (41)**
100	7.31
120	19.51
130	41.46
150	26.48
200	2.44
250	2.44
Delivery fees	**100.00 (41)**
50	58.55
100	7.33
150	17.07
200	12.19
800	2.43
900	2.43
Transport account	**63.41 (26)**
15	30.76
17	11.53
19	19.25
20	11.53
24	7.69
25	3.84
30	11.55
40	3.84
Medicines	**4.87 (2)**
100	50.00
150	50.00
Functions and cermonies/crnaments and cloths of new born	**97.56 (40)**
50	42.50
60	50.00
200	5.00
240	2.50

4.3 To study the selected dimensions of perinatal history of slum women

4.3.1 Perinatal history of slum women

Table 17 records the perinatal history of slum women. It is seenfrom the table that majority (52.ØØ %) of group-2 women delivered their babies in their respective homes where as most of group-1 women (75 %) availed civil hospital sevices for the same purpose. None of group-2 women and a small percentage of group-1 women had gone to private maternity clinics for delivery purpose. Availing medical facilities for the delivery was observed relatively more in group-1 than group-2 women this clearly shows their concern about their unborn babies. All the sample women irrespective of their number of gestation gave birth to a normal and full term babies without any complications faced during delivery process. A large percent of group-1 women deliveries were done by paramedical stall while in group-2 majority of women (52 %) opted for trained dai/mid wife for the same. The table findings are not same with the results mentioned by Tsering (1988), Choudhary (199Ø) and Kumari (199Ø) in their research studies.

Highly significant difference was found between group-1 and group-2 womens of perinatal history except for the type of delivery.

Table 17 Perinatal history of slum women

Perinatal History of women	Percentage of women (41)		't' Value
	Group-I (16)	Group-II (25)	
Delivery place			
At home	12.50	52.00	3.10 **
At civil hospital	75.00	48.00	2.71**
At private clinics	12.50	----	----
Delivery type			
Normal and full term	100.00	100.00	----
Delivery performed by			
Doctor/Nurse	87.50	48.00	2.98**
Trained dai/Mid wife	12.50	52.00	2.95**

** - Highly significant at P < 0.01 level

4.3.2 Traditional beliefs and customs observed by slum women during pregnancy and after delivery (within week)

Traditional beliefs and customs observed by slum women during pregnancy and after delivery (within a week) are detailed in table 18. It is observed from the table 17 that all the sample women more or less found to have followed traditional beliefs during pregnancy and also after delivery. All the sample pregnant women avoided eating cetain fruits like papaya, banana with the intension that these fruits may cause for abortions, and they stopped drinking hand pump water due to the reason of hard for digestion (10 %).

Table 18 Traditional belief and customs observed by slum women during pregnancy and after delivery (with a week)

Traditional beliefes and customs	Percentage of women (41)		't' Value
	During Pregnancy (41)	After Pregnancy (41)	
Avoids			
Drinking hand pump water	9.75	----	----
Papaya/banana fruits	100.00	----	----
Heavy load lifiting	100.00	100.00	----
Fast walking	100.00	100.00	----
Enterprayer room/ place god/visiting temple	----	----	----
Semisolid dhal + Curries	----	----	----
Going out of home	----	100.00	----
Fallowed			
Try to comsume more amount of food	100.00	100.00	----
Resting in afternoon	100.00	----	----
Visiting temples/families	78.04	----	----
Using foot ware for not to get cold	----	100.00	----
Plugging and covering ears to protect the health	----	100.00	----
Tieing xloth waist belt to have good shape	----	100.00	----
Massaging body daily (using coal heat application to waist)	----	100.00	----
Using boiled water	----	100.00	----
Instructed by			
Own self	60.97	60.97	----
Daia	----	12.19	----
Mother/Mother in-law	39.02	43.09	0.03^{NS}
Relatives	14.63	7.31	1.02^{NS}
Neighbour	26.82	12.19	1.66^{NS}

NS-Non significant,

All the sample women during pregnancy and after delivery (within week) avoided lifting heavy things and fast walking. After delivery all the sample women did not enter prayer room/temple as per the instructions of elders, avoide semi solid dhal and curries in their diet and they also stopped going out of the home for a period of a week.

With regard to followed instructions all the sample women during their pregnancies even after delivery (within a week) were insisted to consume more food. Doing puja/ visiting temples was avoided by most of pregnant women. Mostly in all afternoons specially during pregnancy all the pregnant women used to take naps. After delivery all of them started using footwear for the reason of not catching cold, plugging cotton in the care and convering ears with soft cotton cloth around the head to protect the health, tieing the waist belt for maintencance of good figure, massaging body, drinking boiled water etc. Coal heat application to waist was done by 30 percent of nursing women. From all these traditional customs it is very clear that all these women and their level best to take care of themselves. Regarding instructions more or less all the women were instructed by one or the members either from family/outside the family, about what to and what not to follow in pregnancy and after delivery. Conversations with elderly experienced women and personal observations made about 60 percent women to follow certain things and things to be avoided during

pregnancy and after delivery. Thirty nine percent pregnant women and fourty three percent nursing mothers were instructed by both mother/ mother in-law regarding the customory practices. Relatively higher percent of pregnant women than nursing women received instructions from relatives (14-21 %) and neighbours (26-12 %) for the same.

After delivery only 12 women were given special instructions by dais about the care part of themselves and their new borns. The results are going with the results indicated by Aruna Kumari and Satya Vani (1994) in their study.

Statistically there was no significants difference between pregnant and nursing women in taking instruction from different people.

4.4 To study the feeding practices adopted by the slum women for their neonates.

4.4.1 Type of prelacteal feeds given to slum neonates.

Type of prelaceal feed given to slum neonates is illustred in table 19. It is observed from the table that all the mothers from group-2 and majority (87.5Ø %Ø mothers from group-1 fed their neonates with one or the other similar types of prelacteal feeds after their birth. Only 2 women from group-1 did not feed their neonates with the prelacteal food because the doctor advised them to breast feed their neonates within an hour of their birth insted of giving any

prelacted food. Majority of the mothers from both the groups (62.5 % group-1, 35.7 % group-2) gave cow milk to their neonates as prelacted food followed by honey (28.57 % group-1 ,8.34 % group-2). Twenty one percent mothers from group-1 and 16 percent of mothers from group-2 were found to have offered honey combined with castor oil to their neonates and 14 percent mothers from group-1 and 12 percent mothers from froup-2 fed their neonates with honey, castor oil and cow milk in combinations. Findings were drawn from the studies conducted by Bhale (1982) and other stduy done by Banapurmath et al (1996).

There was no Significant difference found between two groups in giving pre lacteal foods to their neonates.

Table 19 Type of prelacted feeds given to slum neonates

Perinatal History of women	Percentage of women (40)		't' Value
	Group-1 (16)	Group-II (24)	
Prelacted food given	**14(87.50)**	**21(100.00)**	**0.74^{NS}**
Honey	4(28.57)	2(8.34)	0.79^{NS}
Cow milk	5(35.71)	15(62.50)	0.69^{NS}
Honey and castroil	3(21.44)	4(16.66)	0.26^{NS}
Honey/castoroil + cow milk	2(14.28)	3(12.50)	0.18^{NS}
Not given prelacted foods	**2(12.50)**	---	-------

NS- Non significant

4.4.2 Colostrum feeding practices adopted by slum women and their reasons

Table 20 illustrates colostrum feeding practices adopted by slum women for their neonates and their reasons. It is obivious from the table that irrespective of the group a large (87.5 %) percentage of women fed colostrum to their neonates on first day they were motivated by doctors/ nureses/ dais. While the rest of group-1 and group-2 (12-16 %) mothers did not feed colostrum to their neonates for

Table 20 Colostrum feeding practices adopted by slum women and their reasons

Colostrum feeding Practices	Percentage of women (40)		't' Value
	Group-1 (16)	Group-II (24)	
Feed colostrum on first day	87.50	83.33	0.35^{NS}
Reasons			
Advise by doctors/ Nurse/Dais as it is best for babies health			
Not feeding colostrum	12.50	16.67	0.02^{NS}
Reasons			
Impure and stale milk			
Leads indigestion			
Customary Practices			

NS- Non significant

reasons as the colosturm is impure and stale milk, lead to indigestion and just as customary practices. The findings are accordance with the results given by Bhale (1979), Sing et al (1997) and Gupta (1998) in their studies.

Significant difference was not found in feeding colostrum to their neonates.

4.4.3 Breast feedings practices adopted by slum women for their new borns

Table 21 indicates breast feeding practices adopted by slum women for their newborn. It is noted from the table that relatively higher percentage of group-1 women (87.5 %Ø than group-2 women (83.35 %) started breast feeding their neonates on the day they born only. Among them most of group-2 women as compared to group-1 women (57 %) breastfed their newborn at right time i.e within an hour of their birth while the rest of them started slightly late i.e. within 4-6 hours and after 1Ø hours. Late commencement of breast feeding i.e. on 2nd and 3rd day was observed relatively higher percentage of group-2 women than group-1 women.

About the duration of breast feeding, it was noticed that majority of mothers in both the groups (above 87 %) fed their neonates for the length of 15-2Ø minutes. While the rest of the newborns were on breast feeding for 2Ø-3Ø minutes. Regarding the frequency of breast feeding, it is revealed that 6-8, 8-1Ø, 1Ø-12 breast feeds in a day were given to their neonates by 18-4 percent, 56-62 percent and 25-33 percent mothers from group-1 and group-2.

Table 21 Breast feeding practices adopted by slum women for their new borns

Perinatal History of women	Percentage of women (40)		't' Value
	Group-I (16)	Group-II (24)	
Day of commencement of Breast feeding			
on the day born	87.50	3.39	0.35^{NS}
Within an hour	57.14	80.95	0.16^{NS}
Within 4-6 hours	21.43	19.05	0.01^{NS}
After 10 hours	21.43	----	----
On 2nd day of delivery	6.25	8.35	0.16^{NS}
On 3rd day of delivery	6.25	12.50	0.34^{NS}
Duration of breast feeding			
15-20	93.75	87.50	0.06^{NS}
20-30	6.25	12.50	0.34^{NS}
Frequency of breast feeding in a day			
6-8	18.75	4.18	0.82^{NS}
8-10	56.25	62.46	0.37^{NS}
10-12	25.00	33.36	0.55^{NS}
Type of breast feeding			
Demanded	12.50	12.50	----
Scheduled	87.50	87.50	----

NS- Non significant

About the type of breast feeding irrespective of the group most of the mothers (above 87 %) fed their babies as

per their wish. While the rest of the mothers fed their babies after babies started crying and moving head. The findings are coinciding with the findings stated by Bhal and Sing (1982) and Banapurmath and Seluamuthkumaraswamy (1995) and apposite results found by Banapurmath et al (1996) from their studies.

Non significant was found between group-1 and group-2 women in adopting breast feeding practices for their neonates.

4.5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome.

4.5.1 Profile of slum neonates.

Table 22 gives the information about the rpofile of slum neonates. It is evident from the table that babies born to all group-1 women were first born where as all group-2 newborns were included in groups were later borns depending on their birth order like 2nd 3rd and 4th. Regarding the gender in group-1 majority of (56 %) new born were female babies where as it is vice versa in case of group-2 neonates (52 % male neonates). Irrespective of the group all neonates cried immediately after their birth which made parents and other family members to be happy. All the neonates in group-1 except one born were alive.

Table 22 Profile of slum neonates

Profile of slum women	Percentage of neonates (41)		't' Value
	Group-1 (16)	Group-II (24)	
Ordinal position			
First born	100.00	----	----
Later born	----	100.00	----
Gender			
Male	43.75	52.00	0.81^{NS}
Female	56.25	48.00	0.50^{NS}
Birth cry present	**100.00**	**100.00**	----
Status of life			
Alive	100.00	96.00	2.92**
Dead	----	4.00	----
Health problems of neonates			
No problem	15.00	21.00	0.64^{NS}
Problems	1.00	3.00	3.46**
Fever	----	12.50	----
Pores	6.25	----	---

NS- Non significant, ** - Highly significant at P < 0.01 level

The causes attricuted for the death of that baby may be mother's underage (16 years) at the time of her delivery and due to less spacing (1st year) between 1st and 2nd delivery.

Regarding health problems of neonates relatively most of group-1 neonates (93 %) than group-2 (87 %) neonates didnot

face any health problems. Only one newborn (6 %) from group-1 had fever after 2 days after their birth and three newborn babies from group-2 (12 %) newborn babies developed pores on the stomach.

Statistically there was no significant difference between first group and second group in case of gender and presence of birth cry. But there was highly significant difference between group-1 and group-2 neonates incase of live status and health problems of neonates.

4.5.2 Reasons of slum women for being happy and unhappy ot the outcome pregnancy

Table 23 gives the reasons of slum women for being happy and unhappy at the outcome of pregnancy. It is indicated from the table that slightly more percentage of (52.ØØ %) group-2 mothers than group-1 mother (43.75 %) were happy at the outcome of pregnancy for having normal delivery and begetting male babies.

Most of the mothers in group-1 (56 %) than their counterparts in group-2 (48 %) were found to be unhappy. however begetting female babies and death of a newborns were the main causes for their unhappiness.

Statistically no significant difference was found between Ist and IInd group mothers for being happy and unhappy at the normal outcome of pregnancy.

Table 23 Reasons of slum women for being happy and unhappy at the outcome of pregnancy

Perinatal History of women	Percentage of women (41)		't' Value
	Group-1 (16)	Group-II (25)	
Being happy reasons	43.75	52.00	0.56^{NS}
Having normal delivery			
Be getting male babies			
Being unhappy reasons	56.25	48.00	0.56^{NS}
Be getting female babies			
Death of new born			

NS- Non significant

4.5.3 Comparison of mean anthropometric measurments of slum neonates with norms

Means of anthropometric measurments of slum neonates are given in table 24 and are illustrated in Fig.3. All the sample male neonates were found to have slightly higher mean weight, lenght and circumference of head, chest and arm as compare to the female neonates mean anthropometric measurments. It is indicated from the table that all the means of anthropometric measurments of male as well as female neonates on the day of their birth like weight (2.89-2.26 Kg), Length (48.4-46.4 cm), circumference of head (32.65-31.85 cm), chest (31.05-30.10 cm) and arm (7.75-7.35 cm) were below NCHS standards and also Indian standards.

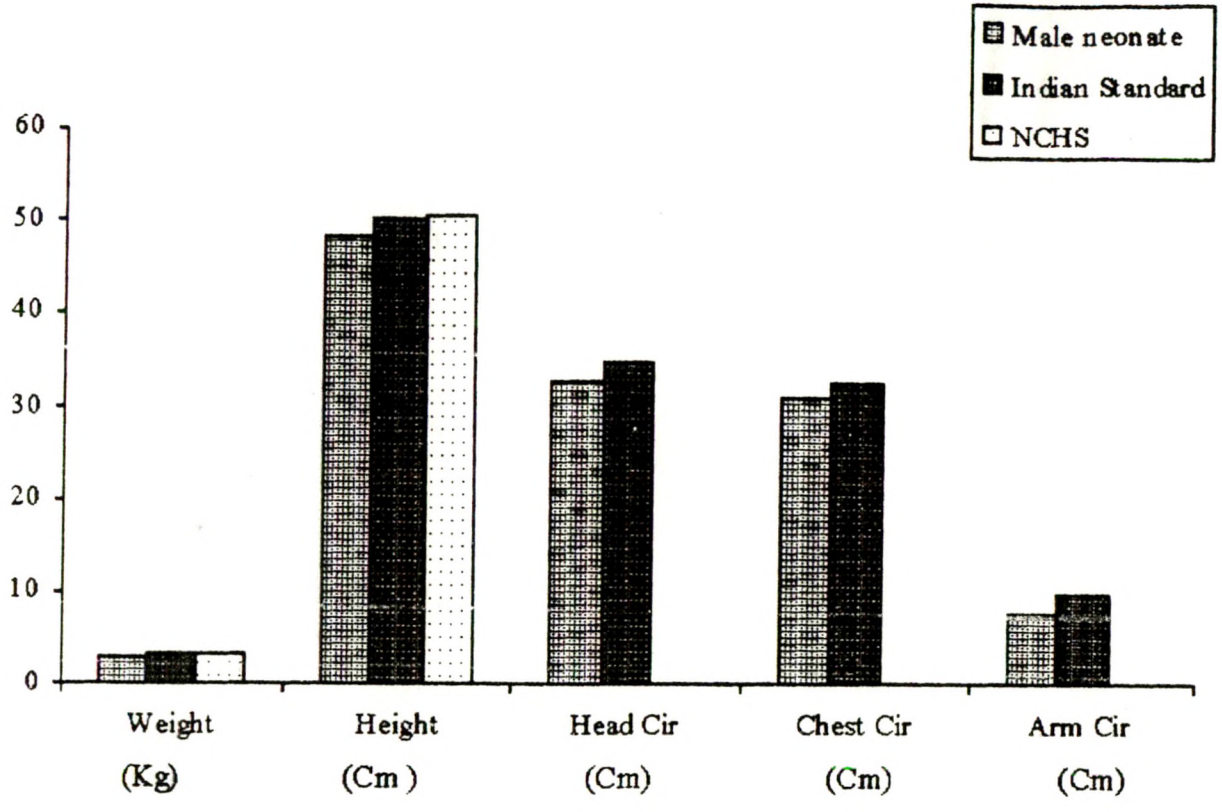
Statistically there was highly significance difference between female and male neonates mean anthropometric measurments and national and international standards.

Table 24 Comparison of mean anthropometric measurments of slum neonates with normas

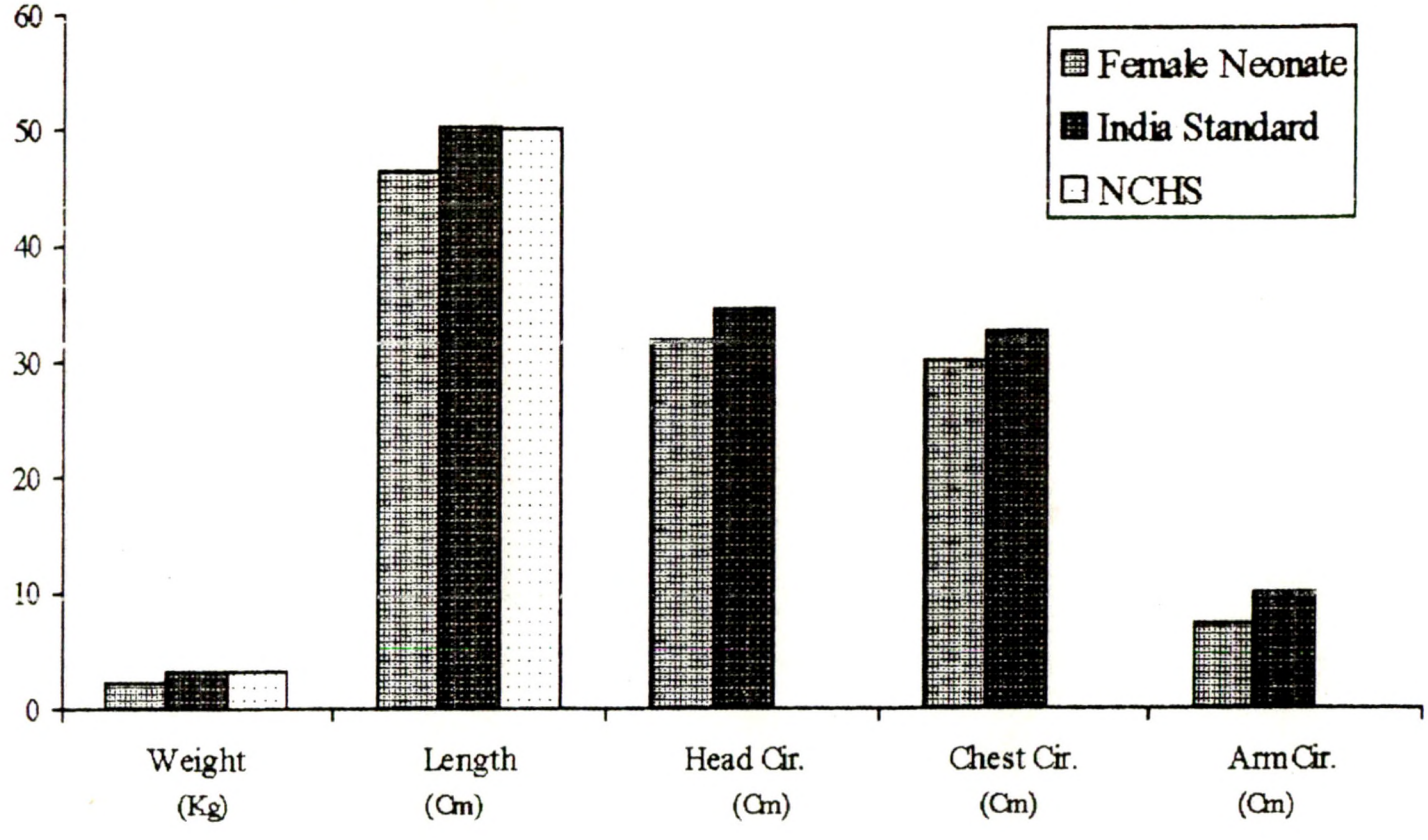
Antheropometric Measurments (AM)	Means of anthropometric measurment		Standard norms			
			National		International	
	male (20)	Female (20)	male	female	male	female
Weight (kg)	2.89±1.30	2.26±0.22	3.1	3.2	3.3	3.2
Lenght (cm)	48.40±2.46	46.4±2.28	50.4	50.3	50.5	49.9
Head circumference (cm)	32.65±1.10	31.85±1.31	34.8	34.6		
Chest circumference (cm)	31.05±0.97	30.1±0.76	32.60	32.40		
Arm Circumference (cm)	7.75±0.86	7.35±0.73	9.8	9.9		

t values

Anthropometric measurments	Male Vs National	Male Vs International	Female Vs National	Female Vs International
Weight (Kg)	2.80*	3.28**	2.94*	3.68**
Lenght (cm)	3.98*	3.35**	3.60**	4.24**
Head circumference (cm)	3.26**		4.21**	
Chest circumference (cm)	5.70**		6.26**	
Arm circumferenc (cm)	6.00**		8.00**	



Anthropometric measurments of male neonates



Anthropometric measurments of female neonates

4.5.4 Descresed mean weights of slum neonates in a week

It is observed from the table 25 that the mean birth weight of female and male neonates were 2.26 kg and 2.89 Kg where as on 7 th day the mean weights of the smae sample neonates when measured were 2.Ø3 Kg and 2.58 Kg respectively. There was steady decrease in there weights till 7 th day of their birth. This decrease is attributed to 1Ø to 11 per cent (22Ø g, 3Ø3 g) in female and male neonates respectively. It was also found that the reduction in mean weights of male neonates was relatively more than female neonates. The similar findings were found in the studies done by Shindal and Pushpa (199Ø) and Rameshwar sarma (1997).

There was significant difference between the mean weight of female neonates on the first day and seventh day of their birth and also mean weight of descrease of male and female neonates. No significant difference was found between mean weight of male neonates on first and seventh day of their births.

Table 25 Decreased mean weight of slum neonates in a week

Gender	Mean weight (Kg)		't' values	Decrease mean weight (g)	't' Values
	Ist day	7th day			
Female	2.62	2.Ø3	2.79**	Ø.22	3.Ø3*
Male	2.89	2.58	1.79NS	1.79	

NS - Non significant, ** - P < Ø.1 , * - P < Ø.Ø5

4.5.6 Correlation between anthropometric measurments of slum neonates and their selected background variables

Table 26 indicates the correlation between anthropometric measurments of slum neonates and their selected background variables. A simple correlation analysis was worked out between anthroponetric measurments of slum neonate and their selected background variables. scrutiny of data (Table 26) revealed that dependent variable of length was significantly positively coreleted with in weight (r=Ø.479), head circumference (r=Ø.469), gender of neonate (male neonates) (r=Ø.5ØØ), Later born neonates (r=Ø.578), colostrum feed neonates (r=Ø.532). There was significant and positive correlation between dependent variable of neonates weight and their lenght (r=Ø.479), head circumference (r=Ø.44Ø), gender (both male (r=1.ØØ) and female (r=1.ØØ)), Ordinal position (first born (r=1.ØØ), latern born (r=1.ØØ)), colostrum feeding (r=1.ØØ), and not feed (r=1.ØØ). The positive correlation coefficient between neonates head circumference and their weight (r=Ø.44Ø), length(r=Ø.469), gender (male (r=Ø.433)), ordinal position (latern born (r=Ø.711)), and colostrum fed neonates (r=Ø.44) The significant positive correlation between neonates birth weight, length, head circumference and gender, ordinal position and colostrum feeding have been reported by many investigators like Karn and Parrose (1952) Sen (1956), Mukharjee and Biswas (1959) in their studies.

Table 26 Correlation between anthropometric measurments of slum neonates and their selected background variables

Independent Variables	Correlation coefficient 'r' values dependent variable		
	Length	Weight	Head circum-ference
Weight	Ø.479**	----	Ø.44Ø**
Length	----	Ø.479**	Ø.469**
Head circumference	Ø.469**	Ø.44Ø**	
Gender			
Male	Ø.5ØØ**	1.ØØ**	Ø.433**
Female	Ø.Ø45NS	1.ØØ**	-Ø.36ØNS
Ordinal position			
First born	-Ø.164NS	1.ØØ**	-Ø.191NS
Later born	Ø.578**	1.ØØ**	Ø.711**
Colostrum			
Fed	Ø.532**	1.ØØ**	Ø.441**
Not fed	Ø.ØØØNS	1.ØØ**	-1.ØØNS

NS- Non significant, ** - Highly significant at P < Ø.Ø1 level

4.5.7 Correlation between amthropometric measurments of slum neonates and their mother's background variables

Correlation between anthropometric measurments of slum neonates and their mother's background variables are depicted in table 27. Regarding dependent varible of length the result indicated that there was positive significant correlation between neonate,s length and their mothers' background

Table 27 Correlation between anthropometric measurments of slum neonates and their mothers background variable

Independent Variables	Correlation coefficient 'r' values dependent variable		
	Lenght	Weight	Head circum-ference
Education			
Non-literate	Ø.227^{NS}	Ø.6Ø6**	Ø.231^{NS}
Literate	Ø.386*	Ø.7Ø6**	Ø.3Ø4^{NS}
Family Income			
1ØØØ-2ØØØ	Ø.3Ø2^{NS}	Ø.3Ø2^{NS}	Ø.316^{NS}
2ØØØ-3ØØØ	Ø.392^{NS}	Ø.613**	Ø.312^{NS}
3ØØØ-4ØØØ	Ø.4Ø6^{NS}	Ø.712**	Ø.361^{NS}
Type of pregnancy			
Primigravida	Ø.Ø92^{NS}	Ø.192^{NS}	Ø.141^{NS}
Multipara	Ø.212^{NS}	Ø.321^{NS}	Ø.342^{NS}
Maternal age			
16-2Ø	-Ø.2Ø1^{NS}	-Ø.321^{NS}	-Ø.219^{NS}
2Ø-26	Ø.412^{NS}	Ø.689**	Ø.398^{NS}
Mothers anthropo-metrci measurments			
Weight kg			
51-55	Ø.281^{NS}	Ø.629**	-Ø.Ø28^{NS}
56-61	Ø.452*	Ø.962**	Ø.262^{NS}
Height cm			
145-15Ø	-Ø.183^{NS}	Ø.269^{NS}	Ø.Ø19^{NS}
151-155	Ø.4Ø6^{NS}	Ø.821**	Ø.446^{NS}
Employment			
Employed	Ø.249^{NS}	Ø.289^{NS}	Ø.326^{NS}
unemployed	Ø.269^{NS}	Ø.384*	Ø.528**

NS - Non significant, * - Significant ** - Highly significant

variables like literacy (r=Ø.386*), weight in the range of 56 to 61 Kg group (r=Ø.452*). About neonate's weight the positive and highly significant correlation coefficient was found between newborns weight and their mother's education (nonliteracy, r=Ø.6ØØ** and Literacy level) (r=Ø.7Ø6**), Family monthly income of (Rs 2ØØØ-3ØØØ r=Ø.613**), Rs 3ØØØ-4ØØØ (r=Ø.712**), ages (in the range of 2Ø-26 years r=Ø.689**), weights (falling in the group of 51-55 Kg r=Ø.629** and 56 Kg r=Ø.962**), Height (151-155 cm group r=Ø.821**) and unemployed (r=Ø.384*). Statistically there was no corelation between neonates head circumference and their mother's background variables except unemployement. The results are going with the findings stated by Walter (1976), Decidas et al(1976) Kushwaha et al (199Ø), Jai and Joynkar (1982), Dhall and Bagga (1995), Mathews et al (1995) in their research studies.

SUMMERY

Chapter - 5

SUMMARY

Mother is the origin of human life, whether she gives birth to a male or female a baby. But only healthy mothers can produce healthy children who are not only of parents property but also nation's property. Such healthy children are natural resources and also valuable property of family and also build up healthy society and nation. Therefore, there is a great need to protect and care of such children not noly from the begining of their life (i.e. from conception) in their mothers womb but also during birth and after birth specialy in early days (Early neonatal period) of their life. the care of women during prenatal and perinatal and postnatal period is the care of the baby as it is paralite on the mother for all her/his needs. the continuing care of the mother during and after pregnancy is a precondition for the healthy and well being of the child. In the light of above it is proposed to study the prenatal and perinatal care practices adopted by slum women with the following objective.

1 To stduy the background variables of slum pregnant women.
2 To study the selected aspects of care like diet, health (Physical and Menatl), work load etc. taken by women during Pregnancy and after delivery.
3 To study the selected dimensions of perinatal history of slum women

4 To study the feeding practices adopted by the slum women for their neonates

5 To study the general profile of the neonates and the association between prenatal care of slum women and neonatal outcome

For the study a stratified random sample of 41 pregnant women from three slum colonies of Parbhani town were chosen who entered in the seventh month of their pregnancy. All these seleceted 41 sample women were divied into two groups on type of their parity. Out of 41 pregnant women 16 women were belong to group-1 (primigravidas) and the rest 25 to group-2 (multipara).

For studying prenatal ard perinatal care practices adopted by slum women the tools and techniques used were interview schedule, naturalistic observation, anthropometric measurments of sample pregnant women and their neonates 'weight (Kg), length (cm), circumference of head, chest, arm (cm)). The anthropometrci measurment of neonate were compared with the national and internaltional growth standards (NCHS). The collected data were pooled, tabulated, and statistaclly analysed. The findings of the study are summerised under the fo lowing heads

5.1 Background variables of slum pregnant women

1. Majority of slum sample women belonged to ruclear and small size families. Most of the women (41 %) had their family income ranging from Rs 2000 to Rs 3000. About literacy

level of the couples around 66 per cent wives and above 34 per cent husbands were non-literates. Regarding the occupation a higher percentage of women (61 %) were house wives and rest of (39 %) them entered in the job field on payment basis. All the sample womens' husbands were found to have taken various types of job such as daily wagers on the farm, fruit/vegetable vendors, auto/bus drivers and servants.

2. Irrespective of the group a large majority of the sample women got married and became pregnant before they could complete the age of 18 years and they also entred the parenthood too early i.e. below 18 years. Most of the women (above 60 pre cent) did not get sufficient time between their marriage and their first issue which is essential to take the role of spouse and parent. Most women (96 %) from group-2 were found to have 1 to 2 years spacing between two issues but ideal spacing period i.e. 2 to 3 years was noted only in some women (48 %). About 80 per cent women had sucessfull pregnancies and rest of the women had natural abortions previously. Majority of group-2 women (60 %) and 37 per cent group-1 women had weight between 56 and 61 Kg. While in group-1 43 per cent women and in group-2 36 per cent women found to have the weight of 51 to 55 Kg. About height most of the womens (above 64 %)heights were falling in the range of 150 to 155 cm.

3. Majority of women (72-87 %) irrespective of their groups did not feel necessaty of preparation to parenthood

because they thought that up bringing children is easier, had sufficient knowledge and availability of good family support. Only 13 per cent women from first group and 28 per cent from second group felt that preparations are necessory before they entered into parenthood for various reasons like for proper fulfillment of children's needs, planning for their future, for avoiding complications and knowing about parental roles.

4. Majority of women from group-2 and group-1 expressed their wish to have a child for continuing family line and to experience motherhood respectively and other reasons stated by rest of other women were to have a companion, to have a support of child in old age and to get an heir to family property.

5. All the sample women from both the groups diagnised their pregnancy by themselves based on certain common signs and symptoms such as amnorrhoea (100 %), nausia, vomitings, food dislikes and foetal movements. Only in group-1 all the women got the knowledge about their pregnancy through the conversation had with elderly/experienced women. Irrespective the group only few women were aware of the first day of the last menstrual cycle and also expected dates of their delivery.

6. Irrespective of the group a large majority (88 %) of slum women had gone for antenatal check-ups for various reasons while the rest of the women did not visit to

health clinics for antenatal check-ups because of fear of doctors. They felt no need of health check-ups as pregnancy is a natural process, absence of ailements in them and no money for going it.

7. Eighty eight per cent women from both the groups visited health clinics only once through out their pregnancy and very few women (12 %) visited it regularly once in a month. All the women got motivation from community health workers, family members and neighbours for going to antenatal check-ups regarding blood pressure, weight gain, urine test tetans injection and nutrient suppliments etc.

2 Selected aspect of care like diet, health (physical and mental), work load etc taken by women during pregnancy and after delivery

1. Irrespective of the group higher percentage of women had morning tea with three times meal such as first meal in the late morning including jawar roti, dal, vegetable curry, some times followed by chapati, khichadi, techa, chilli chutni, boiled egg and ghee. More over same pattern was followed at afternoon meal and in the evening meal in addition with rice , kheer mutton curry and seasonal fruits. Majority of women after pregnancy took special food like dry fruit laddus and ghee.

2. All the sample women from both the groups faced one or the other health problems through out their pregnancy.

Major of them was backache (37 %, 36 %) faced by group-1 and group-2 respectively and other health problems faced by them such as vomitings, general weakness, oedema, severe nausia, acidity and abdominal pain. Only few women (12.50 %) consulted private gynocologists while more women adopted household remedies for treating their minor health problems. Near about 50 per cent women from both the groups took special diet during pregnancy and rest of the women just followed the pattern of taking regular diet. Higher percentage of women from both the groups took sufficient rest during this period while some women (24 % , 37 %) could not find sufficient time for rest.

3. Irrespective of the group all the sample women experienced happiness and unhappiness throughout their pregnancy. All the sample women from the both groups felt happy when they to know that they conceived and other reasons for making them happy were celebrating special functions for them, to get special food and for special previlages given during pregnancy. Frequent quarrels between husband and wife and with other family members, fear of begetting female baby, fear of overburdon of work, difficult labour, fear for not getting of domestic work of discontinued job were the reasons for creating mental tension in them.

4. Some mental and physical changes in all the pregnant slum women observed by themselves when they were in depression. Physical changes noted were anger towards

children, foetal movement, missing of one time meal and mental changes observed in them were such as nervousness, irritation, uneasy feeling, fatigue, depression, disintrest of doing any work and crying.

5. Out of 41 sample women, only 16 women were employed. Most of them (87 %) took up employment for supplementing their family income and few of them for meeting their self demands like cosmetics, clothes, going to movies etc. and Most of the pregnant women entered the employment when they were young i.e. since five years old and continued their employment till now. The employed womens monthly income ranged from Rs 500 to Rs 1200 and those women spent their money on house rent followed by childrens education and health , on buying family provisions, on personal things and alloted on savings.

7. All the sample families from both the groups spent money on account of pregnancy and pregnancy related functions. Majority of them spent Rs 100 to Rs 400 on buying seasonal fruits, leafy and other vegetables and the amount Rs 15 to 150 on medicines, Rs 200 to Rs 300 on functions and ceremonies like choli programme. Only few families spent Rs 15 to 50 on ricksaw for taking women to the hospital for health check-ups.

8. Irrespective of the group all the sample families spent money on account of delivery and delivery related

functions. Majority of the families (41 %, 46 %) spent money from Rs 100 to Rs 250 on buying ingrediants like dry fruits for making laddus followed by delivery fees (Rs 50 to 900), Transport (Rs 15 to 40) medicines (Rs 100 to Rs 150) and on functions, ceremonies and on ornaments and clothes of newborns (Rs 50 to Rs 240).

3. The selected dimensions of perinatal history of slum women

1. Majority of women from group-1 gave birth to babies at civil hospital and group-2 women used home for the delivery and very few women from group-1 visited priviate clinics for delivery. All the sample women from both groups had normal deliveries after completed full term in the sample women's deliveries were performed by doctors /nurses/ trained dais and by mid wife.

2. Irrespective of the groups all the sample women were found to have followed traditional beliefs and customs during pregnancy and after delivery. They avoided eating papaya, semi solid dhal and curries, lifitng heavy load, entering prayer room, and going out of home during pregnancy, After delivery. All the sample nursing mothers consumed more amount of food (100 %) rested in the afternoon, visited temples etc. All from group-1 women used foot ware to avoid cold, plugging cotton and covering ears to protect the health, tieing cloth waist belt to have good shape, adopted

massaging the body dailly and drinikng boiled water. All these instructions were given to all the sample women by their mother/mother in-law/ relatives and neighbours.

4. The feeding practices adopted by slum women for their neonates

1. Near about all the sample mothers irrespective of their group gave prelacteal foods to their newborns such as honey, cow milk, honey and castor oil, honey, castor oil and cow milk. Only two women did rot give any type of prelactal foods to their babies as they received advice from doctors.

2. Majority of sample mothers from group-1 (87.5 %) and group-2 (83.33 %) fed colostrum to their neonates on the advice of doctors/nurses/dais as they felt it is best for babies' health, rest of the women did not feed colostrum to their newborns for various reasons like colostrum is impure and stale milk and it leads to indigestion.

3. Majority of group-1 and group-2 mothers breast fed their newborns on the day they born i.e. within an hour. Few of them breastfed their newborns within 4-6 hours it was followed by after 10 hours. Very few mothers from both the groups started breast feeding on 2nd and 3rd day of their delivery. Most of the women from both groups breast fed their babies for 15-20 minutes and very few women for 20-30 minutes more over all the mothers from group-1 and group-2

breast fed their babies for 8-10 and 10-12 times in a day and fixed schedule was followed for breast feeding.

5. The general profile of the neonates and the association between prenatal care of slum women and neonatal outcome

1. Profile of slum neonates showed that all the neonates born to group-1 mothers were first borns and group-2 neonates were 2nd and 3rd born. Regarding the gender in group-1 majority of the mothers (56 %) gave birth to female babies where as it is vice versa in case of group-2 mothers. Irrespective of the group all neonates cried after their birth and all were alive except one. Very few neonates fecd health problem like fever and pores on the stomach.

2. Out of the sample women near about half of the mothers in both the groups became happy for having normal delivery and begetting male babies and rest of the mothers were unhappy for begetting female babies and due to the death of neonate within half and hour of their birth.

3. On a comprision of mean anthropometric measurments of slum neonates with norms showed that all male and female neonates mean on the day of the birth weight, length, circumference of head, chest and arm were significantly below the NCHS standards and also Indian standards given for neonates.

4. It was found that there was steady decrease in weight of male as well as female neonates from the day of birth to the seventh day of the birth. It was attributed to 10-11 per cent (220 g , 303 g) in female and male neonates respectively. Significant difference was found in mean weight of female neonates on the first day and seventh day of their birth and also between male and female neonates mean weights of first and seventh day of their delivery.

5. The results showed that there was significant and positive co-relation between dependent variable of neonates' weight and their length, and head circumference, gender, ordinal position, colostrum feeding and also positive co-relation coefficient was found between neonates' head circumference and their gender (male) and colostrum feeding.

6. The results indicated that there was positiove significant co-relation between neonates length and there mothers' background variables like literacy, weight in the range of 56 to 61 Kg. About neonates' weight the positive and highly significant co-relation coefficient was found between new borns' weight and their mother's education, family monthly income, weight (falling in the group of 51 to 55 Kg and 56 Kg) and height (151-155 cm group) and unemployment.

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APPENDICES

Appendix-1

PRE AND PERINATAL CARE PRACTICES ADOPTED BY SLUM WOMEN

Background information of the subject.

1. Name and address :

2. Place :

3. Caste :

4. Type of family : (Nuclear/ Joint/ Extended)

5. Size of family : (Small / Medium / Large)
(below 4) (4-8) (above 8)

6. General information about family members

Sr. No.	Relation with Subject	Age	Education	Occupation	Income Monthly
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

7. What was your age at the time of

a) Marriage

b) Conceving first time.

8. How many times did you conceive so far ?

9. Give the details about total pregnancy :

Sr. No.	Age of the woman	Order of Pregnancy	Length of Pregnacy	Status of pregnancy		
				Continued	Discontinued	Reason
1.						
2.						
3.						
4.						
5.						

10. How many childrens do you have ?

11. Have you lost any child if yes, age reason to loss life

12. Do you remember the first day the menstrual cycle ? Yes/No

a) If yes give the details

First day: Confinement date:

b) If no, When did you know that you were pregnant

1 Self analysis through symptoms

Missing menstration Cycle (1 2 3 4 month)

Severe vonitings and nausea ( )

Morning seakness ( )

Feel giddy ( )

2) Through pregnancy tests in the hospital ( )

3) Discussed with experienced woman ( )

4) do you know how to calculate the date of delivry.

13. Anthropometric measurments of the pregnant women

Weight (Kg) _____

Height (cm) _____

14. Is this Prgnancy/newly born a wanted one Yes/ No

If yes, why? give reasons

a) Voluntarly	During Pregnancy	After Pregnancy
Reasons		
Strong desire to experience to become mother		
Right age to give birth to a baby		
Any other		

b) By force of

1. Husband/ Mother/ Own parent / Older child

Reasons

To continue family line

To have support to old age

To have the owner for family property

To have company for self/ first child

Any other

c) If no, Why? give reasons

Poor financial condition

Health problem of Mother/ Husband/ Children

Failure of contraceptives

Any other

15. Whom did you consult throughout your pregnancy period and reasons for it

a) Doctor	Reasons
General	Near by hospital

Private and practioner	Popularity
Gynocologist (male/female)	Availability of doctor
Homeopathic	Wll equipped hospital
Ayurvedic	Nature of Doctor
Any other else	Faith in doctor
	Known person
	Suggested by Mother/ Mother in-law/ Neighbour Friends/Husbands
	Any other

b)

1. Priest	To have the good health of foetus
	To have normal delivery
	To have the male baby
2. Elderly woman	Experience women
3. Dais	Fair about hospital and hospital equipment
	In our family home delivery always made
4. Mother/ Mother in-law	Experienced and taken extra care
5. Husband/ Father	He support and build up the confidence
6. Neighbour	Because they help us

16. Give details about your visiste to hospital during pregnancy

Period	Purpose	Advice Given	Followed		Unfollowed	
			Yes	Reasons	No	Reasons
First Trimister	Urine Test	Avoid sexual Intercourse				
Second Trimister	Weight gain Checkup B.P.Level H.B.Level	Drugs Iron Calcium Nutritious diet				
Third Trimister	Sonography Foetal Health check-ups Taken Tetanus vaccine	Reducing Laborious work continued to routine job rest regularity in visiting doctor				

17. Did you face any health problem/ complication during Pregnancy ? Yes/No

If yes give details of it

Details of health problems

Health Problem	Trimister			Treatment Received from	Followed		
	I	II	III		Fully	Partially	rearly
Odema							
Severe Nausia							
Vomiting							
High B.P.							
Low B.P.							
Bleeding							
Severe Infection							
Constipation							

Health Problem	Trimister			Treatment Received from	Followed		
	I	II	III		Fully	Parti-ally	rearly
Abdominal pain							
Burning in vagina							
Backache							
General weakness							
Digestion							
Acidity							

18. How did you feel through out your pregnancy? Yes/No
    Happy of unhappy

    1 If happy, Reasons Unhappy reason

19. Do you know that our psychological condition has any influnence on unborn baby ? Yes/No

    1 Did you since any changes in you when you are happy or unhappy

    2 How did you express you feeling.

20. Diet Schedule of pregnant women

Meal	Time	Food items	Frequency		
			Often	Some times	Rarely
Break fast					
Mid morning					
Lunch					
Shacks					
Dinner					

21. Did you add or avoid any food other than normal diet during pregnancy? Yes/No

a) If yes, what all

Food items	Trimister			Reasons
	I	II	III	
Added				
Avoided				

B) If yes Who advised them

1. Self decision
2. Own Mother
3. Mother in-law
4. Friends
5. Neighbours
6. Dais
7. Doctor
8. Any other else from your family

22. Did you receive any special instruction during pregnancy Yes/No

If yes

Restrictions	Trimister			Reasons
	I	II	III	

23. List out the general routine activities carried out by you in a day through out your pregnancy

Type of work	Trimister		Approximately Time alloted
	1 to 7 month	8 to 9 month	
Personal work			
Prayer God			
Cleaning house			
Washing dishes			
Washing clothes			
Sweeping			
Mopping			
Dusting home			
Helping children with home work			
Bathing baby			
Changing children's cloth			
Playing games with children			
Cooking food and preparing meals			
Disciplining children			

Type of work	Trimister		Time
	1 to 7 month	8 to 9 month	
Maintaining contact with relatives			
Taking children to out			
Attending other children			

24. Did you reduce/ stop completely/ Partially any of the above activity — Yes/No

If yes what all and why give reasons who adviced you and when

25. Do you work outside the home — Yes/No

a) If yes give the nature of job

1. Farm work
2. Construction work
3. Running kirana shop
4. Selling fruits and vegetable
5. Doing work in others house
   - i. Cooking
   - ii. Cleaning utensils
   - iii. Washing house
   - iv. Cleaning house
   - v. Looking after child

b) If yes since when you are working

1. since childhood
2. After marriage
3. After conceving a child

c) Give reasons for work taken out side by you.

1. Financial problem
2. Habit of doing the job before pregnancy
3. Unemployment of husband
4. Bad habits of husband/ Handicaped/ illness of husband
5. Childrens education
6. Force of husband/ In-laws/Any other

7. Any other

d) How much do you earn ?

26. What do you do with that money?

1. Hand over the total/some amount to husband

2. Spend

1. On self

Personal grooming

Cloths

Cosmetics

Chapples

Recreation

2. On children

School fees

Play material

Cloths

Tution fees

3. On family

Grocery

Vegetable and fruits

House rent

27. Is preparations necessary for parenthood Yes/No

a. If yes give reasons

1. To rear children in better way

2. To guide children in proper way

3. To understand children

4. To fulfill needs of children

5. To avoid future complications in rearirg children

6. To make alternative arrangements

7. For better parenting skills

8. To make future plans for children

9. Any thing else please mention

b. If no give reasons

1. Child rearing is easy

2. Having enough experience of rearing child

3. Avalability of arrangement in taking care of child

4. Got enough of information in rearing child

5. Leave benefit

6. Husband and in-law support

7. Friend's support

8. Parental support

9. Any other

28. What all points one has to consider before becoming a parent

Age of the Mother/Father or both

Health of the mother/ father of both

Time to allot for bringing up a child

Financial expenditure and position

Emotional and mental preparation

After setting critical family matters

After complition of education

After settelment in job

Social support system for bringing up childre

1. Spouse support

2. in-laws support

3. Grand parent support

4. Relative support

5. Servent support

6. Day care centre

7. Knowledge about growth and development of child from women

   Mother

   Mother in-law

   Siblings

   Friends

   Teacher

   Neighbour

   Consultant specialist

   To atained short term training related to child development

   Courses school/college

1. PROFILE OF NEW BORN/NEONATES

	At birth	First week
1. New born's Weight	Kg.----------	Kg.----------
2. Length	cm.----------	cm.----------
3. Head Circumference	cm.----------	cm.----------
4. Chest Circumference	cm.----------	cm.----------
5 Midarem circumferernce	cm.----------	cm.----------

2. Are you Happy/Unhappy

If happy why ?

1. Normal birth of the baby
2. Wanted baby (female/male)
3. No. complication in delivery
4. All family members are happy is satisfied
5. Not additional expenditure on delivery
6. Any other

If unhappy why?

1. Premature baby
2. Low birth weight baby
3. Birth of female/male child
4. More expenditure on delivery
5. Because of caesarian
6. Disinterest of family members (Husband/Mother/Mother in-law/Childern)

3. Background information of the delivery

1. Where did you have delivery

Home/Civil hospital/Private hospital/Onfarm/Any other

If at home, where did yours delivery take place

On cot/Floor/Floor covered with old cloths

2. What type of delivery you had

Normal/breech/Forceps/Ceasarian

3. Who performed delivery

Doctor/Trained dai/Untrained dai/Experienced women any other

4. Did your neonate cry immediately after the birth Yes/No

If yes, How?

1. Slow
2. Irregular
3. Good
4. Strong cry

If no what was done accordingly

5. Feeding practices

1. Did you give any prelacteal food to the neonate Yes/No

a) if yes, what did you give and why

Prelacteal	Reasons
Honey	
Caster oil	
Honey+Caster oil	
Any other	

b) Who fed?

Mother/Mother in-law/Other women/Yourself/Anyother

2. Did you breast feed the neonate Yes/No

a) If yes when did you start

From the day of delivery

On second day

On third day

On fourth day (Mention the hours if possible)

b) Reason for breast feeding

Customary practice

Good for babies health

Convenient for both mother and baby

Hygienic

Costs nothing

Easy for digestion

Nutritious

Any other

3. Did you have practice of feed the colostrum? Yes/No

a) If yes why did you feed the colostrum

Customary

Equal to nector

b) If no, reasons for not feeding it.

Dirty milk

Harmful for the baby

Heavy for the baby

Stale milk

stored milk

Neonate was not able to suck thats why collected and discarded.

Any thing else

6. What a action you have taken

4. Diet schedule of delivered women

Meal	Food item	Time	Day						
			1	2	3	4	5	6	7
Break fast									
Mid morning									
Lunch									
Snacks									
Dinner									

5. Did you add any foods other than normal diet after delivery? Yes/No

If yes, which are those

Special food	Reason
1. Dry fruits Ladoos	
2. Shera	
3. Ghee	
4. Alive	
Avoid to take Extreme chilli	
Sore things	
Sweet thing	
Solid food	
Bitter gourd	

6. Did you recive any special instructions after delivery Yes/No

If yes, which are those

Restriction	Reasons	Advise	Day/Month
Avoiding			
1. Drinking plain water			
2. Lifting heavy things			
3. Fast body movement			
4. Stop doing puja			
5. Not going out			
6. Attending funeral fuction			
Follow up			
1. Masaging the body			
2. Up the body (wait)			
3. Ties the cloth around the stomach			
4. To cover the head plug ears with cotton cloth			
5. To wear footwear			

Appendix-II

Anthropometric measurments of mothers

	Weight Kg.	Height cm
1.	55	150
2.	53.2	152
3.	55	152
4.	53	151
5.	55	153
6.	54	151
7.	53	150
8.	54	151
9.	52.2	153
10.	52	151
11.	49	149
12.	53	150
13.	52	149
14.	49	155
15.	53	152
16.	50	145
17.	52	151
18.	47.4	151
19.	51	149
20.	52	150
21.	61	152
22.	60	151
23.	59	152
24.	56	152
25.	57	154
26.	58	151
27.	56	152
28.	56	145
29.	59	152
30.	58	151
31.	57	154
32.	59	152
33.	56	155
34.	58	155
35.	56	149
36.	58	148
37.	56	153
38.	57	154
39.	56	152
40.	57	149
41.	45	151

Appendix - III

Anthropometric measurment of neonates

	Weight	Length	Head circum-ference	Chest Circum-ference	Mid arm circum-ference	7th day weight
1.	2.500	43	31	28	8	2.240
2.	2.450	47	32	30	6	2.200
3.	2.500	47	32	30	7	2.230
4.	2.250	46	32	30	7	2.200
5.	2.500	45	32	30	7	2.230
6.	2.450	48	32	30	8	2.200
7.	2.250	47	31	30	7	2.025
8.	2.450	51	32	30	7	2.195
9.	2.250	42	32	30	8	2.020
10.	2.450	47	31	30	8.2	2.200
11.	2.000	47	32	30	6	1.800
12.	2.450	48	31	30	8	2.195
13.	2.250	46	34	32	8.5	2.015
14.	2.000	48	33	32	7	1.790
15.	2.250	41	31	30	7	2.015
16.	2.000	48	32	30	8	1.785
17.	2.000	45	32	30	7.5	1.800
18.	2.000	46	32	30	6	1.790
19.	2.250	47	31	30	7.5	2.020
20.	2.000	49	32	30	8	1.800
21.	3.800	48	33	32	9	3.420
22.	3.500	52	34	31	9	3.150
23.	3.500	50	34	31	8	3.160
24.	2.500	47	31	30	7	2.248
25.	2.750	48	33	31	8	2.470
26.	3.000	48	32	31	9	2.700
27.	2.500	48	34	32	7	2.250
28.	2.500	49	32	31	7	2.250
29.	3.250	49	34	32	8	2.925
30.	3.250	52	33	32	9	2.700
31.	2.750	47	32	30	7	2.462
32.	3.000	49	32	30	8	2.700
33.	2.500	48	34	32	8	2.249
34.	3.000	50	33	31	8	2.700
35.	2.500	45	33	31	7	2.250
36.	3.000	52	33	32	8	2.685
37.	2.500	48	32	31	7	2.245
38.	2.750	47	33	31	7	2.470
39.	2.500	48	30	32	8	2.249
40.	2.750	43	31	28	6	2.475
41.	-----	--	--	--	-	-----