

Maternal Health Complications During Pregnancy Period: A Sociological Study

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Abstract Background: Health of women is one very broad area of concern within sociology of health and maternal health is a specific area of interest within the larger domain of health of women. Because of the high frequency of newborn, child, and maternal mortalities in India, the idea of maternal health has become a prominent issue. Maternal health is a key indicator of women's health and social status. Although motherhood is often a positive and fulfilling experience, for many women, it is associated with suffering, ill health and even death. **Methods:** The aim of this study is to find out the maternal health complications during pregnancy period among women. This study is conducted in Aligarh city of Uttar Pradesh, India. The fieldwork was carried out over a period of nine months and thirty-one pregnant women who had undergone their first antenatal check-up either in October 2019 or November 2019 and registered with the ASHAs were identified as samples for this study. A case study method was used for collection of data and in-depth interviews were conducted with the respondents. Thematic analysis was used to analyze and interpretation of the interview transcripts and field notes. **Results:** Drawing from the analysis of the interviews conducted with the thirty-one respondents, it was found that out of the thirty-one cases there were fourteen cases where nutritional level of respondents was less and they were undernourished. There were four cases in which respondents had a problem of hypertension during their pregnancy. Nineteen of the thirty-one cases included respondents who were diagnosed with anemia throughout their pregnancy period. Several other complications were also found. **Conclusion:** Women have a right to good physical and mental health. To achieve the global goal of improving maternal health and to save women's lives we need to do more to reach those who are most at risk.

Keywords Pregnancy Period, Acute and Chronic Illness, Malnutrition, Anemia, Still-birth

1. Introduction

Health is a universal goal for mankind but the requirements related to good health are different in different stages of human life. Despite having several common issues, health problems, requirements and goals vary along with gender. Health of women is one very broad area of concern within sociology of health and maternal health is a specific area of interest within the larger domain of health of women. Because of the high frequency of newborn, child, and maternal mortalities in India, the idea of maternal health has become a prominent issue. "Maternal health is a key indicator of women's health and status. Maternal health refers to the health of women during pregnancy, childbirth and postpartum period. Although motherhood is often a positive and fulfilling experience, for many women, it is associated with suffering, ill health and even death. Throughout human history, pregnancy and childbearing have caused death and disability in both women and neonates"

[1].

According to a report published by UNICEF (2019), the Health Assembly adopted in 2012 a 'Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition' and six global nutrition targets are to be achieved by 2025 including the reduction of stunting, wasting and overweight in children, the improvement of breastfeeding, and the reduction of anemia and low birth-weight [2]. According to WHO (2019), to minimize the number of maternal and newborn fatalities, Safe Motherhood has been declared a worldwide priority. In 2017, over 810 women died per day from avoidable illnesses throughout the globe, with pregnancy and delivery problems being the major causes of maternal fatalities. In low- and middle-income nations, almost 94 percent of all maternal fatalities occur [3].

Furthermore, roughly 5.3 million children under the age of five died worldwide in 2018, the majority of them from avoidable causes, with 2.5 million fatalities occurring in the first month of life [4]. Despite implementing a number of reproductive and child health programs, India continues to be one of the leading causes of maternal and newborn mortality worldwide. In 2015–2017 [5], India's maternal mortality rate was 122 deaths per 100,000 live births, while the neonatal mortality rate was 23 deaths per 1000 live births

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[4]. Insufficient maternity and neonatal healthcare-seeking is blamed for the high rates of maternal and newborn fatalities. Although India has achieved significant progress in institutional deliveries over the last two decades, further progress is needed to meet the Sustainable Development Goal (SDG) objectives for maternal and child mortality rates by providing excellent reproductive care for women and regular vaccination programs for children. Active care and thorough monitoring of pregnant and postpartum women, as well as newborns, might possibly save a huge number of maternal and neonatal fatalities. As a result, proper mother care is critical in reducing the risk of pregnancy and birthing problems. In this setting, it's critical to have a sense of how mother and child healthcare is accessible and used throughout the present public health crisis.

Efforts have been undertaken over the last few decades to provide expert birth attendance, with the goal of lowering maternal and infant deaths owing to complications. The quality of care provided during childbirth is critical to lowering maternal mortality [6]. Over 70% of maternal fatalities worldwide are caused by pregnancy and delivery problems such as hemorrhage, hypertensive disorders, sepsis, and abortion. Preterm delivery, suffocation, intra-partum peri-natal mortality, and neonatal infections account for almost 85% of infant deaths. Furthermore, studies demonstrate that effective and high-quality treatment prevents these problems and is expected to greatly decrease maternal fatalities, stillbirths, and neonatal deaths. Poor nutrition and unsanitary living conditions, take a toll on women's health, resulting in a variety of ailments. In addition, unskilled *dais* performed births and abortions at home, resulting in terrible health [7]. Maternal mortality is a severe problem for women in the poorer sectors of society [8]. Anemia is most common among Indian pregnant women. Anemic women had a greater chance of poor pregnancy outcomes such as early delivery, low birth weight, and pregnancy termination. There is a U-shaped link between maternal hemoglobin concentration and poor birth outcomes, which leads to an increased risk of preterm delivery [9]. About 38.8% of mothers had CMDs. Maternal CMD was shown to be more common among women who were older, from a poorer socioeconomic background, came from a nuclear family, had little or no education, housewives, and had more children [10].

Maternal health is complex, influenced by various genetic, social and economic factors, infections and environmental conditions, many of which may affect the fetal growth. Physiological adaptations result in improved utilization of nutrients either through increased absorption, decreased excretion or alterations in metabolism [11]. According to Khanna, pregnancy is a period of great physiological stress for the woman as she is nurturing a growing fetus in her body. Fetal development is accompanied by many physiological, biochemical and hormonal changes occurring in the maternal body which influence the need for nutrients and the efficiency with which the body uses them [12]. A pregnant woman needs special attention and nourishment for both

herself and the baby growing within her womb. In terms of nutrition, the mother should cultivate good eating habits. Nutrient consumption is critical for a healthy pregnancy [12]. A well-balanced diet before conception contributes to a healthy pregnancy. The period of development in the womb is critical for the health of the child, both at birth and long afterwards. One of the most important risk factors at this stage is maternal nutrition; inadequate nourishment increases risks of a wide range of gestational and peri-natal problems [13]. Poor maternal nutrition has a negative impact on pregnancy and delivery outcomes under-nutrition is an important factor responsible for low birth weight which is an important factor for high infant and maternal mortality rate [14-17]. The change to westernized diets and an increasing reliance on energy dense, poor nutrition foods has resulted in an increase in maternal overweight and obesity in Egypt [18] and a high diet of red meat is linked to an elevated risk of Gestational Diabetes Mellitus (GDM) during pregnancy [19].

From 130 per hundred thousand live births in 2014-2016 to 122 per hundred thousand live births in 2015-2017, India's Maternal Mortality Ratio (MMR) has decreased. According to the most recent Sample Registration System (SRS) 2016-2018, there was 113/100,000 live births declining by 17 points, from 130/100,000 live births in 2014-16. The progress is largely due to key government initiatives such as the *Janani Shishu Suraksha Karyakaram* (JSSK) scheme, which includes free maternity services for women and children, a nationwide rollout of emergency referral systems and maternal death audits, and improvements in health service governance and management at all levels. However, teenage and illiterate moms, as well as those who live in remote locations, have a substantially higher risk of dying during delivery. Every day, over 800 women die from avoidable causes associated with pregnancy and delivery throughout the world; 20% of these women are from India. In India, it is estimated that 44,000 women die each year as a result of avoidable pregnancy-related causes. According to WHO (2019), the major complications that account for nearly 75% of all maternal deaths are; severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), and complications from delivery and unsafe abortion [3].

2. Conceptual Framework

2.1. Maternal Health Issues or Concerns that a Woman may Have Throughout Her Pregnancy

The following are some of the most frequent maternal health issues or concerns that a woman may have throughout her pregnancy:

Nausea and Vomiting: In the words of Saxena, nausea in pregnancy may be due to nervous disturbances, placental protein intoxication or due to de-arrangement in carbohydrate metabolism; morning sickness of early

pregnancy can be improved by small and frequent meals. Fairly dry and consisting chiefly of easily digested energy foods such as carbohydrates are more readily tolerated. Liquids may best be taken between meals instead of with food [20]. If the condition develops to hyperemesis-gravidarum, a severe prolonged persistent vomiting, peripheral parental nutrition and careful oral feeding is essential. Skim milk is better tolerated than whole milk. Fruits and vegetables can be given. Fatty rich foods, fried foods, excessive seasoning, coffee in large amounts and strongly flavored vegetables may be restricted or eliminated if the nausea persists or if the patient complains of heartburn or gastric distress [11].

Constipation: According to Khanna, constipation is normal during the latter half of pregnancy. Hormonal changes in pregnancy tend to increase relaxation of gastrointestinal muscles. Pressure of the developing fetus on the digestive tract may make elimination difficult at times. Limited activity and exercises, insufficient fluid intake, insufficient bulk in the diet can also be other causes. In addition, regular habits of sleep, rest, work and recreation are important in relieving constipation [12].

Anemia: According to Sifakis, anemia is one of the most frequent complications related to pregnancy. The word implies a decrease in the oxygen-carrying capacity of the blood and is best characterized by a reduction in hemoglobin concentration. This may be either relative or absolute. It is known that there is a larger increase in plasma volume relative to red cell mass in almost all pregnancies [21]. Anemia during pregnancy also may contribute to perinatal morbidity and mortality by increasing the likelihood of intrauterine growth retardation (IUGR) and preterm delivery. The more severe the anemia, the greater the risk that the mother will deliver a low weight baby due to IUGR. The association between birth outcomes and anemia is strongest in early pregnancy suggesting that pre-pregnancy improvements in iron status are warranted. Anemia is directly related to risk of preterm delivery, inadequate gestational weight gain, and increased perinatal mortality [9]. According to Mousumi Gogoi, epidemic of anemia is considered to be a significant threat to pregnant women or women in child bearing age. Anemia is one of the major nutritional health disorders affecting a significant proportion of the population not only in developing countries but also in developed countries. This threat is more alarming in developing countries where poverty, illiteracy may contribute to high risk for causes of anemia [9].

Maternal Malnutrition: Obstructed labor, early or low-birth-weight infants, and postpartum hemorrhage are all risks of maternal malnutrition. Severe anemia during pregnancy has been related to a higher risk of death during childbirth. Low birth weight is a major cause of infant death. Malnutrition during pregnancy may have an impact on future generations' health. Adolescent females are at a significant risk of maternal mortality, pregnancy-related problems, and the delivery of low-birth-weight children due to the nutritional needs of pregnancy. Taking care of teenage girls'

dietary requirements helps them transition into adulthood and prepare for reproductive duties. To establish a suitable intrauterine environment for the growing child, women must have optimal nutritional status before and throughout pregnancy [22]. Prenatal and postnatal care should include maternal nutrition education, which should highlight the use of fortified staples, animal-source foods, dietary variety, and supplementation to enhance diet quality [23].

Iodine Deficiency Disorder: The phrases endemic goitre and cretinism have been replaced by the terminology iodine deficient diseases (IDD). Pregnant women and children under the age of five are the most vulnerable. Iodine deficiency causes decreased thyroid hormone synthesis and stimulation of thyroid-stimulating hormone (TSH) production. Globally, it is estimated that 740 million individuals are deficient in iodine, 300 million have goitre, and 20 million have brain impairment as a result of maternal iodine deficiency during fetal development [24].

Vitamin A Deficiency Disorders: Vitamin A deficiency diseases (VADD) affect mostly youngsters and pregnant women. Vitamin A deficiency affects an estimated 250 million children globally, the majority of whom are in underdeveloped nations. In children and pregnant women, VADDs are linked to an elevated risk of morbidity and death [25].

Zinc Deficiency: Zinc deficiency has therefore been shown to be a key driver of diarrhea and pneumonia, although data on its function in malaria and development retardation is inconsistent. It has also been linked to pregnancy and birthing problems, low birth weight, and increased infectious disease morbidity and death. Specific preventative and curative micronutrient treatments are required in populations where sufficient micronutrient consumption is not achievable [26].

Urinary Tract Information: A bacterial infection of the urinary tract is called a urinary tract infection (UTI). A urinary tract infection (UTI) is characterized by discomfort or burning while using the toilet, fever, weariness, or shakiness, a need to use the bathroom often, pressure in their lower abdomen, urine that smells unpleasant or appears murky or crimson, and nausea or back pain in women. Some women have bacteria in their bladders but are oblivious to the fact. Their health care provider will most likely test their urine early in pregnancy to see whether this is the case, and if antibiotics are needed, they will be prescribed.

Mental Health Condition: During and after pregnancy, some women feel depression. A low or sad mood, a lack of interest in enjoyable activities, changes in food, sleep, and energy, difficulties thinking, focusing, and making choices, feelings of worthlessness, humiliation, or guilt, and ideas that life is not worth living are all symptoms of depression. When many of these symptoms appear at the same time and linger for more than a week or two, it's most likely depression. Depression may make it difficult for a woman to care for herself and her unborn child if it continues throughout pregnancy [27].

Hypertension (High Blood Pressure): Hypertensive

disorders of pregnancy, an umbrella term that includes pre-existing and gestational hypertension, preeclampsia, and eclampsia, complicate up to 10 percent of pregnancies and represent a significant cause of maternal and perinatal morbidity and mortality [28]. A pregnant woman and her baby are at risk for issues if their blood pressure is improperly regulated before and throughout pregnancy. It's linked to a higher risk of maternal problems including preeclampsia, placental abruption (when the placenta separates from the uterine wall), and gestational diabetes.

Obesity and Weight Gain: According to Shub et al., overweight and obesity are common problems with an increasing worldwide incidence. Maternal obesity and excessive gestational weight gain (GWG) have well recognized associations with pre-eclampsia, gestational diabetes mellitus (GDM), instrumental or operative delivery, failed induction, fetal macrosomia, neonatal hypoglycemia, perinatal mortality and infant and childhood obesity. In addition, maternal obesity is the single most common modifiable factor in stillbirth in the developed world [29].

Hyperemesis Gravidarum: During the first three months of pregnancy, many women experience nausea or vomiting, sometimes known as "morning sickness." The sudden rise in blood levels of a hormone called HCG (human chorionic gonadotropin), which is secreted by the placenta, is thought to be the cause of nausea and vomiting during pregnancy. Hyperemesis gravidarum, on the other hand, happens when a pregnant woman has intense, continuous nausea and vomiting, which is more severe than "morning sickness." This might result in weight loss and dehydration, and treatment may be required [30].

Miscarriage: A miscarriage, also known as a spontaneous abortion, is the loss of a fetus before the 20th week of pregnancy. It usually occurs during the first three months of pregnancy, or the first trimester. Miscarriage symptoms vary depending on the stage of pregnancy of the woman. Some of the symptoms of miscarriage include heavy spotting, vaginal bleeding, severe stomach discomfort or cramping, and so on. During pregnancy, the woman's body gives hormones and nutrition to her growing baby; most first-trimester losses occur when the fetus does not develop correctly; numerous underlying health issues and lifestyle behaviors may also interfere with the fetus' development. Poor diet or malnutrition, drug or alcohol abuse, uncontrolled diabetes, hormone imbalances, and obesity are among the problems. Miscarriage risk rises with age. According to the Mayo Clinic, the chance of miscarriage is 20% at age 35, 40% at age 40, and 80% at age 45.

Heartburn: According to Saxena, heartburn is a common complaint during the latter part of pregnancy. In most cases, this is an effect of pressure of the enlarged uterus on the stomach which in combination with the relaxation of the esophageal sphincter, results in occasional regurgitation of the stomach contents into the esophagus. This can usually be relieved by limiting the amount of food consumed at one time and drinking fluids between meals. Sitting upright after meals for at least 3 hours before lying down may also help

[11].

2.2. Social Determinants of Maternal Health

According to Hamal et al., maternal health remains a serious public health concern in India, with considerable inter- and intra-state disparities in maternal health care usage and maternal fatalities. Economic position, caste/ethnicity, education, gender, religion, and culture were shown to be the most significant structural determinants in maternal health care usage and maternal mortality in India [31].

Structural Factors: In India, the most often related structural determinants of maternal health care utilization were poverty or economic position, caste/ethnicity, maternal education, husband's education, gender, and religion. The job position of women and the profession of their husbands were also linked to or influenced maternal health care utilization in certain research.

Economic Status: In India, poverty or economic status, which is generally defined in terms of quality of living, family income, and other factors, has a big influence on maternal health. Increased family income is linked to increased utilization of maternal health services.

Caste: In India, belonging to socially and economically backward castes such as scheduled castes (SC), other backward class (OBC) and even scheduled tribes (ST) was linked to reduced usage of maternal health services.

Education: In India, women's education has continuously been linked to the utilization of maternal health services. In comparison to illiterate women, the usage of ANC and PNC was greater among women with elementary, secondary, and high school education.

Gender: In India, maternal health was impacted by gender, notably women's poor status (in terms of autonomy and decision-making) and son preference. In India, women who had more autonomy were more likely to utilize maternal health services. Gender norms that tolerate violence against women affected maternal health; women who experienced any type of violence throughout their pregnancy were less likely to give birth in a hospital than those who did not.

Religion: Muslim women were less likely than Hindu women to have more than four ANC visits. In rural Delhi, Muslim women are more likely to give birth at home. In urban slums of eight Indian cities, Christian and Sikh women, on the other hand, were more likely than Hindu women to have more than three ANC visits [31].

Family or Household Factors: The utilization of maternal health services was shown to be linked to family structure or size, especially joint and big family sizes. When compared to women who lived in nuclear or small households, those who lived in mixed families were more likely to use PNCs. Women who had stronger ties with their husbands were more likely to have ANC check-ups and institutional births in nuclear households. The health status- or need-related characteristics that were identified to impact maternal health care usage in India were history of problems and unfavorable pregnancy outcomes. According to research conducted in rural Uttar Pradesh, women who had past

pregnancies/delivery problems were three times more likely to deliver in health facilities than those who had no such history. Research conducted in rural Karnataka indicated that women having a history of newborn fatalities were more likely to seek PNC services than women without such a history.

Psychosocial Factors: In India, psychosocial variables impacting maternal health service usage included perceptions of care, such as the benefits and quality of maternal care, and fear of health treatments like as surgery or caesarean sections. In India, almost 34% of women said they didn't deliver in hospitals because they didn't believe it was essential, and another 6.5 percent said they didn't because they didn't know what to expect. In other situations, in rural Rajasthan, women did not seek treatment since society views pregnancy and delivery as a regular occurrence rather than a life-threatening event. Communities' perceptions of supernatural healing also influenced their willingness to seek treatment in an Odisha health institution. Women did not believe that ANC was useful since they had seen other women in their areas deliver regularly without it. Pregnancy and labor are more likely to be seen as typical occurrences by women who have had past routine home births without difficulties. According to studies, women view home birth to be safer since they feel caesarean sections are done needlessly in hospitals and that they pose a bigger danger.

3. Objectives and Methodology

The aim of this study is to find out the maternal health complications during pregnancy period among women in the research area. This study is conducted in two localities which are Civil Lines and Old City situated in Aligarh city of Uttar Pradesh. The research area was purposively selected keeping in mind the nature of the study, the heterogeneous population where women of all class, education, caste and religion were present, and the feasibility of getting the best and maximum data at each level of the maternity period. The fieldwork was carried out over a period of nine months and forty four pregnant women who had undergone their first antenatal check-up in either the month of October or November 2019 and registered with the ASHAs were identified. Out of the total respondent, two did not agree to participate, three had a miscarriage in their second or third month of pregnancy and eight were not present in the city during the fieldwork due to covid-19 situation then lost touch, leaving a total of 31 respondents to be included in this study. This study uses an interpretivist method to examine the actor's perspective and how the social milieu impacts the actor's perceptions and meanings. Due to the exploratory nature of the research and the need for a thorough understanding of maternal health complications among pregnant women, a case study method and in-depth interviews was employed. Thematic analysis was used to examine the interpretation of the interview transcripts and field notes. During the interpretation stage, the investigator avoided using the names of the informants,

preferring to employ pseudonyms.

4. Findings

4.1. Acute and Chronic Illness of the Mother

Many women experience health problems during pregnancy, child birth, and their post-partum period. These complications can involve the mother's health, the fetus's health or both. Even women who were healthy before getting pregnant could experience complications. These complications may make the pregnancy a high-risk pregnancy. Some common health issues of pregnancy or acute and chronic illness of the mother include, but are not limited to, the following: hypertension, gestational diabetes, under-nutrition, preterm-labor, iron-folic deficiency (anemia), hyperemesis-gravidarum, depression and anxiety, eclampsia, and other complications. Drawing from the analysis of the interviews held with the thirty-one respondents, it was found that out of the thirty-one cases there were fourteen cases (Case no. 1, 2, 3, 9, 10, 11, 15, 16, 17, 18, 19, 20, 27, and 28) where their nutritional level was less, and they were undernourished. There were four cases (Case no. 3, 7, 15, and 28) in which respondents had a problem with hypertension during pregnancy and there were nine cases (Case no. 2, 8, 10, 11, 16, 17, 18, 19, and 24) in which the respondents had low blood pressure. Nineteen of the thirty-one cases (Case no. 1, 2, 3, 8, 9, 10, 11, 15, 16, 17, 18, 19, 20, 21, 24, 25, 27, 28, and 29) included respondents who were diagnosed with anemia throughout their pregnancy. As Case no. 16 shared her experience and said, *"I have faced many complications during pregnancy like anemia, under-nutrition, hyperemesis gravidarum (extreme nausea, vomiting) and low blood pressure. I had pain in the lower section of my body from the beginning of pregnancy. I used to have pain all the time in the lower sections for ninth months during pregnancy"*. Similarly, Case no. 15 told about her acute health issues which were faced by her during her pregnancy; she said, *"From the 3rd month of pregnancy, I had a problem of vomiting, insomnia, hypertension, mood swings, CTS (Carpel Tunnel Syndrome) and acidity. Due to the complication of CTC, I started having problems of numbness, tingling and weakness in arms and head from the seventh month of pregnancy"*. We have discussed other health issues of women further in this paper.

4.2. Under-Nutrition of the Mother

During field work, out of the thirty-one cases there were fourteen cases (Case no. 1, 2, 3, 9, 10, 11, 15, 16, 17, 18, 19, 20, 27, and 28) in which their nutritional level was less than the recommended dietary allowance and they were malnourished. The way it has been reviewed in this paper earlier, being malnourished not only has a bad effect on the health of the mother, but it also has a very bad effect on the health of the child. As we have seen in Case no.11, to avoid having an operation, she did not pay attention to her food and

drink at all due to which she faced many difficulties during pregnancy. She thought that if she consumes less food, her child would not be very healthy, and then she would avoid the operation and her child-delivery will happen normally. She used to avoid eating a lot of things due to problems related to acidity and blood pressure, and simultaneously she did not want to eat healthy by herself as she wanted to avoid gaining more weight during pregnancy. Similarly, Case no. 16 was also undernourished; out of five pregnancies that she had experienced, there were two stillbirths and one infant death; the child was malnourished (underweight) and died three months after birth. Case no. 16 was malnourished, her health was getting affected a lot, and her unborn child was also having negative health effects. Despite that, she stated, *"I have faced two stillbirths and one infant death, and this is God's will; we were punished for our sins"*.

4.3. Hypertension

A healthy lifestyle is a very important factor responsible for avoiding any disease and bad health effects. There were four cases (Case no. 3, 7, 15, and 28) in which respondents had a problem with hypertension in their pregnancy. Case no. 3 said, *"My diet has been very bad during pregnancy. I was denied many food items due to my health complications. I like to eat oily food, but later I know it hurts health. Eating oily food increases weight, blood pressure and a lot of diseases occur. That is why I stopped eating oily food. But it was too late"*. Similarly, Case no. 7 said, *"I had a problem of severe hypertension from the seventh month of pregnancy. My blood pressure was high. For this, the doctor gave me the medicine but this problem lasted till the ninth month. Due to this problem my baby was underweight. The doctor told me that hypertension has a negative impact on the baby's growth"*. The maternal health outcome of the four case studies is not healthy. Everyone has had a caesarean section due to medical complications (severe hypertension) and all four had poor nutritional food intake.

4.4. Gestational Diabetes

During fieldwork, there were two cases (Case no. 3 and Case no. 24) in which respondents had gestational diabetes during their pregnancy. In Case no. 3, the interview was done after her first ANC and the respondent was not diagnosed with gestational diabetes. The respondent said that her gestational diabetes was diagnosed in her fifth month of pregnancy and for this she had taken proper medical treatment and due to this health problem, she had to compromise her diet. Case no. 3 said, *"I was having a problem of gestational diabetes. I had limited options to eat, there were some fruits which were denied to me. I was denied many food items due to my health complications"*. Similarly, when Case no. 24 was interviewed, she was not diagnosed with gestational diabetes until she was six months pregnant. But she was diagnosed with gestational diabetes during her seven-month pregnancy, due to which her food intake was also severely affected. And her overall maternal health

outcomes had not even arrived. Case no. 24 said, *"I had a problem of gestational diabetes in pregnancy. In my first two trimesters I used to eat lots of food without any restrictions but from my seventh month problems due to gestational diabetes started"*. In this case the woman had the problem of stillbirth, which was a big loss for her and her family.

4.5. Hyperemesis-Gravidarum (Extreme Nausea and Vomiting Lead to Weight Loss)

Drawing from the analysis of the interviews held with the respondents, it was found that out of the thirty-one cases, seven cases (Case no. 1, 8, 9, 16, 17, 20, and 27) have had hyperemesis gravidarum. As Case no. 1 stated, *"I had hyperemesis gravidarum (extreme nausea and vomiting leading to weight loss) during my whole pregnancy"*. As we all know, the condition of women in pregnancy is never stable. Similarly, their health problems keep on changing according to their trimesters. During field-work it was seen that in almost all the cases, women had problems with nausea and vomiting. But according to her trimester, that problem was also being treated. These seven cases were such that they had this problem throughout their pregnancy and due to this, their pregnancy outcome was not desirable. In few cases, there was low birth weight and in few other cases, women were found to have inappropriate weight gain due to hyperemesis-gravidarum. Case no. 8 said, *"I had extreme nausea and vomiting leading to weight loss. So, I have taken so many medicines, due to which I have had more side effects. My skin is very itchy and sometimes I also face trouble breathing"*. She had faced five month pregnancy miscarriage; it was a big loss for her and her family. Case no. 9 said, *"I had a problem with hyperemesis-gravidarum (extreme nausea and vomiting leading to weight loss). There were no complications at the time of child delivery but my baby was under-weight. Baby weight was 1.9 kg. I had lost my weight in pregnancy due to extreme nausea and vomiting. So, my child could not grow well"*. Due to this problem, women's health is being affected, and their pregnancy outcome is also very much adversely affected.

4.6. Women Diagnosed with Anemia

During field-work, out of the thirty-one cases, nineteen cases (Case no. 1, 2, 3, 8, 9, 10, 11, 15, 16, 17, 18, 19, 20, 21, 24, 25, 27, 28, and 29) were identified with anemia in their pregnancy. Failure to take iron supplements during pregnancy was shown to be a major contributor to anemia. According to the study's results, those who did not take iron supplements throughout pregnancy developed anemia. During the fieldwork out of the nineteen cases in which respondents were diagnosed with anemia there were eight cases (Case no. 3, 8, 11, 17, 18, 20, 21, and 27) in which respondents did not take proper iron folic supplements throughout their pregnancy and developed the problem of anemia. As Case no. 3 said, *"I ate prescribed medicine for gestational diabetes and hypertension during pregnancy, but I did not take iron tablets as I used to vomit after eating that"*.

Similarly, Case no. 8 stated that after eating iron tablets, she used to get a burning sensation on her chest, due to which she did not take iron folic tablets. Case no. 20 said that she used to vomit so much throughout her pregnancy, due to which she could not eat anything, so she could not even eat these tablets. However, conflicting findings have emerged from this study; education has a significant role in gaining nutritional information and many studies support this theory but it is not necessary that anemia would be discovered lesser among educated women and more frequently in illiterate women. Out of all cases, the level of education was low in twelve cases (Case no. 1, 8, 9, 11, 16, 17, 19, 20, 21, 24, 25, and 29). Due to the low level of education, women did not have knowledge about many things like what to eat during their pregnancy, how to stay physically active or how to follow a healthy lifestyle. If a woman is identified as anemic during pregnancy, she has to face many more complications as with Case no. 8, Case no. 11 and Case no. 24. Case no. 8 had a miscarriage in the fifth month. Case no. 24 said, *"I had a lot of complications in this pregnancy. I used to have a lot of weakness and I also had a problem of anemia. So, this time I went to a private hospital for treatment and this time I had a stillbirth due to my anemic condition"*. Similarly, pregnancy of Case no. 11 was also very complicated and with that her pregnancy outcome was very hurtful. Being anemic or undernourished was responsible for the outcome of the pregnancy. During field-work, few cases emerged who belonged to the lower class and were identified as anemic; either they had complications during pregnancy or their maternal health outcome was not good, such as Case no. 1, 11, 16, 17, 19, 21 and 29. As Case no. 17 said, *"Our financial condition was not good, so we could not buy fruits and non-vegetarian items very easily, and I did not eat anything in first trimester. I used to have lot of vomiting, so I could not eat much"*. Due to poor intake of food, she has a negative impact on her child's health; her child was under-weight after delivery. Similarly, Case no. 19 said, *"We did not have much money so we were not able to buy eggs, desi ghee, dry fruits and fruits and therefore could not eat much"*.

4.7. Miscarriage

During field-work, out of total number of the cases, four cases were those who had a miscarriage in their second or third months of pregnancy. In three cases, women did not allow the researcher to talk further due to their miscarriage which was held in their second and third months. That's why those three cases were dropped at the same time. Case no. 8 had a miscarriage in her fifth month so her complete case study has been done. Out of thirty-one cases, this is one such case in which respondent had a miscarriage and faced a lot of problems due to the COVID-19 pandemic. She said, *"I used to go to the doctor every fifteen days for a checkup. (Last week of March) At the end of fifth month of pregnancy my lower section was painful. But no doctor was available because of the lockdown. We tried very hard but no doctors could be found. Then I went to the midwife's house for treatment. She told me that the baby's position had changed*

and she also asked me to do an ultrasound. It was the month of April. No doctor was available for the entire month because of COVID-19 related lockdown. We hardly had an ultrasound done on 30th April at a private clinic. The ultrasound report showed my baby had been dead for a month. For a month my baby was dead in my stomach". The fetus remained in her stomach for a whole month and it had contracted so much that it was stuck in her stomach. If a little more time had passed, she would have faced very miserable circumstances.

5. Conclusions

Women have a right to good physical and mental health. Women's health refers to their emotional, social, and physical well-being, and it is influenced by their lives' social, political, and economic contexts, as well as a variety of socioeconomic aspects. To achieve the global goal of improving maternal health and to save women's lives we need to do more to reach to those who are most at risk, such as women in rural areas, urban slums, poorer households, adolescent mothers, women from minorities and Scheduled Caste and Schedule Tribe groups. However, coverage of all life saving health interventions and practices remains low due to gaps in knowledge, policies and lack of availability of resources. Access to healthcare services is often dependent on families' or mother's economic status and where they reside this keeps the vulnerable even more vulnerable.

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