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PROVISION OF MEDICAL INFORMATION TO PREGNANT WOMEN. ACCESS VS ROLE OF HEALTH CARE PROVIDERS

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ABSTRACT

Background: Pregnancy has a unique effect on decisions relating to medication use. Medication safety can often be a great source of concern for women and healthcare professionals alike, leading to decisions that can negatively impact on outcomes .both prescription drugs and OTC products are use by pregnant women,althought much concideration is given to phsychotropic agents bt OTC products should also use with caution Chiropractic evaluation and treatment during pregnancy may be considered a safe and effective means of treating common musculoskeletal symptoms that affect pregnant patients. Compounding this is that evidence regarding the benefits and risks of medication use in pregnancy can often be lacking, contradictory or difficult to interpret and apply to clinical practice. **Methods:** An observational study conducted for 2 months at Services hospital Lahore to get information about the pregnancy and health care facilities obtained by the women in Pakistan.**Results:** Information was obtained by filling a data collection form by women76% of the women were multigravida while 24% were primagravida To 61% of the women, doctors provide complete information while to 39% of the women doctors did not provide complete information.56% of the women prefer doctors for information during pregnancy while 14% prefer pharmacist, 9% nurses and 21% others.61% of the women provided by information about drugs by doctor, 12% by pharmacist, 2% by nurses and 25% by mother/sister..56% of the women were allowed to visit health care professional during pregnancy while 44% were not allowed. **Conclusion:** *W*hen antenatal education programs are based on adult education principles and employ innovative strategies, women experience increased satisfaction with their birth and new parenting experience.

Keywords: Pregnancy, Services Hospital Lahore, Primagravida, Multigravida, antenatal education.

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INTRODUCTION

In Pregnancy, there are major psychological, as well as physiological

changes in woman's body,as carries fertilized egg inside her body, implanted in the lining of uteruse. Pregnancy is intrinsically imperfect, with high rates of complications for mothers and babies.A minorities of pregnancies is entirely uncomplicated,Medical disorder are frequent contributors to morbidity for mothers and babies, and have become the major sourse of maternity mortality.For these reasons , Medicine plays a central role in the care of pregnant women.Provision of resources to maternity services must recongnise the changing demographics and clinical characterictics of pregnant women. A written birth plan encourages women to clarify desires and expectations and communicate with their providers like Pharmacist to make a realistic plan for care during labour. Variouse complementary and alternative medicines, that includes particularly herbal therapy, chiropractic, acupuncture/ acupressure, massage, homoeopathy, and aromatherapy are commonly recommended and used in the maternity setting. A healthy diet during pregnancy is essential for normal growth and development of the foetus.

It affects physical as well as mental growth,so a proper diet plan is very important. Pregnant women may obtain nutrition information from a number of sources but evidence regarding the adequacy and extent of this information is sparse. Although healthcare practitioners perceived nutrition education to be important, barriers to providing education to clients included lack of time, lack of resources and lack of relevant training

Exercise during pregnancy have benefits in multiple ways, including improved cardiovascular health, less weight gain, more appropriate blood glucose levels, and decreased risk of gestational diabetes. In addition, exercise during pregnancy is associated with delivering closer to the estimated due date and having fewer complications at delivery. Maternal exercise also improves the functioning of the fetal.

Nutrition as well as drug selection is very pregnant women take prescription or nonprescription. In general, drugs should not be used during pregnancy unless absolutely necessary because many can harm the fetus. About 2 to 3% of all birth defects result from drugs that are taken to treat a disorder or symptom. Sometimes drugs are essential for the health of the pregnant woman and the fetus. In such cases, a woman should talk with her doctor or other health care practitioner about the risks and benefits of taking the drug. Before taking any drug a pregnant woman should consult her health care practitioner. A health care practitioner may recommend that a woman take certain vitamins and minerals during pregnancy.[1]

In 1979 the FDA introduced a ranking system (A, B, C, D, and X) for the purpose of classifying drug products according to the risks posed to the fetus and the benefits posed to the pregnant woman (and fetus). The descriptions of categories A and B (and to some extent, C) are based on increasing risk, while the descriptions of categories D and X (and to some extent, C) are based on a comparison of possible risk and benefit. The FDA has established five categories to indicate the potential of a drug to cause birth defects if used during pregnancy. The pregnancy categories are: in Category A; Adequate and well-controlled studies have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of risk in later trimesters).Example drugs are folic acid magnesium sulfate. in Category B; Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women. Example drugs: metformin, hydrochlorothiazide, cyclobenzaprine, In Category C; Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. Example drugs: tramadol, gabapentin. In Category D; there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. Example drugs: Lisinopril, alprazolam. In Category X; Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits. Example drugs: atorvastatin, simvastatin.

In Pakistan, access to maternal and newborn health care centers differs greatly depending upon the socio-economic groups. In urban areas mothers have accessibility to these centers but in rural areas the availability and accessibility affected by lack of education, affordability, awareness and distant locations. Pharmacist can play an important role in selection of medicines in pregnancy and can better educate the

person as he is experts in medicines by knowing drug's action. He can better understand risk to benefit ratio and its use in pregnancy.[2]

AIMS AND OBJECTIVES:

- To study and identify the different available sources of drug information to women in pregnancy.
- To study the access of pregnant women to the medical information and health care systems.
- To study the role of the health care providers in provision of relevant medical information to pregnant women.
- To study the FDA pregnancy categorization of drugs to be used in pregnancy.

MATERIAL AND METHOD

It was a reterospective as well as prospective study. Data collection form was designed which contained many questions regarding pregnant women's view about Provision of medical information to pregnant women; Their Access to health care system and the role of Health providers.

Sample size: 100

Place Of Study: Gynae OPD's of various public and private sector hospitals in Lahore.

Study Duration: 1 month.

Data collection tools: Data collection tool was interview based questions comprising 5 items in totality.firstly inquire about demographic data of patient,secondly was about patient satisfaction with the treatment,thirdly to assess the reason for dissatisfaction,fourthly the questionair was filled with the observation and reassessment,last was about clinician demographic data.

Inclusion Criteria: Pregnant women of outdoor of gynae department.patients which are admitted in wards and private rooms.

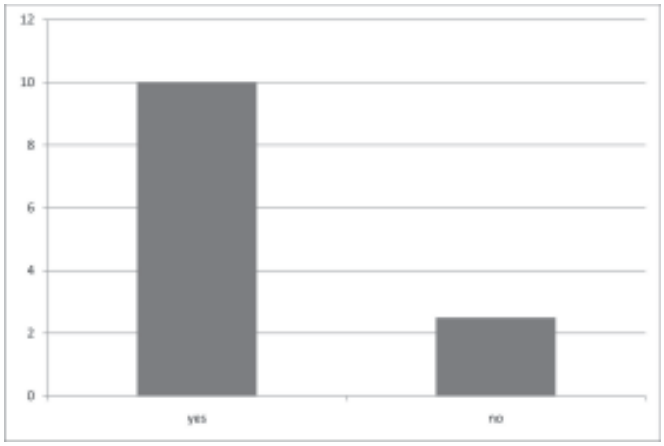
Exclusion Criteria: Males and Children,Non-Pregnant women.

The topic Provision of medical information to Pregnant

TABLES AND FIGURE
Are you using any drug during pregnancy?

Drug use	Frequency	%
Yes	10	10
No	90	90

N=100

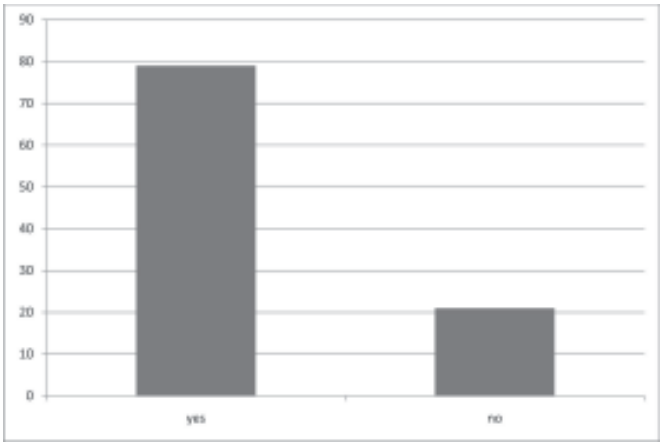


90% of the women were not using medcines in pregnancy only 10% were using medicines.

TABLES AND FIGURE
Use of any supplement during pregnancy?

Supplement	Frequency	%
Yes	79	79
No	21	21

N=100



79% of women use supplement during pregnancy while 21% not use any supplement during pregnancy.

woment: Access vs role of health providers was assigned. The project was completed in selected Sample size was 100, Data collection form was prepared, which comprised of questions regarding pregnant women's view about Provision of medical information to pregnant women. Data collection form were filled by face to face interaction with consultation of health care providers. Results were calculated and presented in the form of tables and graphs.

RESULTS

According to the study 70% of the women were House wife while 30% were working women. 76% of the women were multigravida while 24% were primagravida.68% of women belong to urban areas while 32% belongs to rural areas. 70% of the women have normal delivery while 30% have C-section. Only 11% of women have abnormal child while 89% of the women have normal child. No one believes that abnormality was due to medicines. 90% of the women were not using medicines in pregnancy only 10% were using medicines. Only 2% of the women experiences ADR in pregnancy due medicines while in 98% use of medicines were safe. To 61% of the women, doctors provide complete information while to 39% of the women doctors did not provide complete information.79% of women use supplement during pregnancy while 21% not use any supplement during pregnancy. 54% of the women were agree that Pregnant women should not take natural remedies without the advice of health care provider while 38% were disagree and 8% were uncertain.68% were agree that Natural remedies are safer than medicines while 20% were disagree and 12% were uncertain. 56% of the women prefer doctors for information during pregnancy while 14% prefer pharmacist, 9% nurses and 21% others.70% 0f the women have information about tetanus vaccine only 30% not have any information about tetanus vaccine.61% of the women provided by information about drugs by doctor, 12% by pharmacist, 2% by nurses and 25% by mother/sister.37% of the women have health care locality within range of 1km, 25% within 2km and 38% within 4km.18% of the women visit a health care professional 2 times, 8% visit 3 times, 41% visits 4 times and 33% visit everymonth during pregnancy.56% of the women were allowed to visit health care professional during pregnancy while 44% were not allowed. 63% of the women visit with their husband to doctor while 23% with their mother-in-law and 14% with others. 75% of the women feel comfortable while sharing with doctor or other health care providers regarding pregnancy while 25% not feel comfortable.80% of the women have balanced dietary intake while 20% have non-balanced dietary intake during pregnancy. 28% of the women have delivery at home while 72% at hospital. 65% of the women have delivery by doctors, o% by nurses and 35% by others.50% of the women were satisfied with the health care system while 50% were not satisfied.

DISCUSSION

Pregnancy is intrinsically imperfect, with high rates of complications for mothers and babies. Many women, particularly those living in poverty or already with many dependent children, may view pregnancy with ambivalence or negative feelings.Issues or memories surrounding poor parenting or abuse women have suffered may reassert themselves and cause distress.Relationships are often under pressure - domestic violence increases during pregnancy. Women have a lifetime risk of depression of about 1 in 4 and it is most prevalent during their reproductive years. Much of the focus on medication use during pregnancy and breastfeeding has been on psychotropic agent the use of pain medicines during pregnancy should be carefully considered. We urge pregnant women to always discuss all medicines with their health care professionals before using them.Severe and persistent pain that is not effectively treated during pregnancy can result in depression, anxiety, and high blood pressure in the mother.[1] Medicines including nonsteroidal anti-inflammatory drugs (NSAIDs), opioids, and

acetaminophen can help treat severe and persistent pain. However, it is important to carefully weigh the benefits and risks of using prescription and OTC pain medicines during pregnant.

Complications of pregnancy may include high blood pressure of pregnancy, gestational diabetes, iron-deficiency anemia, and severe nausea and vomiting among others Term pregnancy is 37 to 41 weeks, with early term being 37 and 38 weeks, full term 39 and 40 weeks, and late term 41 weeks. After 41 weeks, it is known as post term. Babies born before 37 weeks are preterm and are at higher risk of health problems such as cerebral palsy Delivery before 39 weeks by labor induction or caesarean section is not recommended unless required for other medical reasons**.** Sometimes during pregnancy a symptom that is considered a discomfort can be considered a complication when it is more severe. For example, nausea can be a discomfort (morning sickness), but if, in combination with significant vomiting, it causes water-electrolyte imbalance it is a complication (hyperemesis gravidarum). The implications for practice of this review are very clear. The fact that they are so does not, of course, mean that they are easy to implement, especially in a health-care economy where little midwife time is available for one-to-one discussion with women, and midwives receive limited training in leading groups for adult learners. The review makes it clear that pregnant women like to receive emotionally demanding or intellectually complex information from a health-care professional in person. A study was held at at services hospital Lahore to get information about the pregnancy and health care facilities obtained by the women in Pakistan. Information was obtained by filling a data collection form by women. They want to be able to ask questions, seek clarification, and relate information to their own circumstances. They like to learn about labor, birth, and motherhood in peer groups made up of a small number of pregnant women, with a facilitator who is able to identify how much information to give, has skills to present it in a way that is easy to remember, promotes discussion, gives plenty of opportunities for practicing skills, and encourages them to get to know and support each other. Large groups, in which it is difficult to ask questions, and facilitators who present themselves as "experts" and who do not interact with women render education in the antenatal period ineffective. Pregnant women enjoy learning from each other and respect and value the input of other women who have recently been through the experiences they are about to face themselves. None of this is the least surprising and has been well known within the literature on adult education and antenatal education for many years .

CONCLUSION

Antenatal classes present an ideal opportunity to help women learn how to communicate effectively with hospital staff. By so doing, women can make their own choices rather than merely conforming to hospital policies, protocols, and professional preferences. Giving information in a way that allows women to choose for themselves requires educators and midwives to have reflective skills to understand where women's needs are different from those the maternity care system believes it is catering for, and to show courage in educating women to challenge a system of which they themselves are part.

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"Any time you deny the acknowledgment of GOD, you are undermining the entire basis for which our country exists."
(Roy Moore)

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RECOMMENDATIONS

- Avoid smokers and smoking areas whenever possible.
- Processed food items, such as hot dogs.
- Foods containing sodium nitrate, such as cured

meats like ham or bacon. These substances may be carcinogenic (cancer-causing).

- Cut down or eliminate food and drinks that contain caffeine such as coffee, tea, colas and other soft drinks, cocoa and chocolate.
- Discuss your concerns about alcohol and pregnancy with your healthcare provider.
- Eat no more than 12 ounces of cooked fish a week.
- Be sure to take frequent stretch breaks and look away from the computer screen whenever possible.

· If you (mother) are Rh negative and your baby's blood is Rh positive there is an Rh incompatibility. Because some of the baby's red blood cells leak into your system, your body will produce antibodies to fight the Rh factor as if it were a harmful substance. These antibodies will remain in your body and may affect your next baby. If you are Rh negative, you will be given an injection of Rhogam at about 28 weeks of pregnancy, and within 72 hours after a birth, miscarriage, abortion or amniocentesis. The Rhogam will prevent your body from making these harmful antibodies. If your baby is Rh negative, you will not need Rhogam after delivery. Talk with your health care provider for more information.

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