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Prenatal Practices and Pregnancy Outcomes Among Primigravida Mothers in Ilocos Sur

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ABSTRACT

The study determined the prenatal practices and pregnancy outcomes among primigravida mothers in Ilocos Sur. It looked into the significant relationship between the respondents' socio-demographic profile and prenatal practices. Significant relationship between pregnancy outcomes and prenatal practices of primigravida mothers was also determined. The study made use of a descriptive correlational type of research. A questionnaire-checklist formulated by the researchers was the main tool used to gather data. It involved 120 primigravida mothers from selected municipalities of Ilocos Sur, who were chosen through purposive sampling. Frequency, percentage and simple linear correlation analysis were the statistical tools used to treat the data. Majority of the respondents were 21-25 years old, single, college graduates, plain housewives, from rural areas, with a monthly family income of PhpS,000 and below, availed of the services of the midwives for prenatal check up, at the rural health unit, once during the first trimester, twice during the second and third trimester, availed of tetanus toxoid immunization, assessment of fetal growth, fundic height measurement, iodine and iron supplementation, physical examination , laboratory examinations, and health education. Most of the respondents did not develop any complications, delivered a full term baby in the hospital through normal spontaneous delivery. Significant relationship existed between civil status and pre-natal practices along preference for health care provider; age and health education classes, occupation and physical assessment and health education classes; income and physical assessment; provision of iodine supplementation and health education: place of residence and tetanus toxoid immunization. A significant relationship also existed between provision of iodine and pregnancy outcome: hemorrhage and type of delivery; hemorrhage and health education classes; anemia and health education classes; preterm birth and abdominal palpation and health education classes. It is, then, recommended that primigravida must be

encouraged to follow the desired number of prenatal visits. Health workers in the RHU should conduct home visits to remind them of the next visits.

Keywords: pregnancy, primigravida, mothers, prenatal practices, Ilocos Sur

INTRODUCTION

Prenatal care refers to the medical care recommended for women before and during pregnancy. The aim of good pre-natal care is to detect any potential problems early enough to prevent them from occurring, if possible and to direct the women to appropriate specialist, hospitals, and rural health unit, if necessary. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriage as well as birth defects, low birth weight, and other preventable infant problems in the developed world (Cabuena, 2009).

Cabuena (2009) also states that prenatal care is one of the international health services offered to every pregnant woman. It ensures healthy safe pregnancy and delivery of the baby through continued assessment, physical examination, laboratory testing, and counseling on the different aspects of childbearing. Health care providers have known from numerous studies that prenatal care is important because potential problems that may endanger the mother or the fetus may be discovered and treated prior to birth. In many cases, potential problems can be prevented altogether. This envisions the birth of a healthy infant and assures normal growth of the baby and, thereby, decreases the burden of highly expensive services. This goal can be attained if an expectant mother complies with the pre-natal services rendered by their rural health unit. It is important that the pregnant mother may not begin pre-natal care early but receives continuous care throughout her pregnancy. However, knowledge on prenatal care significantly affects the compliance and utilization of the health service.

According to the Natural Center for Health Statistics in the United States (2002), 83.7 percent of live births were among women receiving early pre- natal care; 12.7 percent live births were among women who began prenatal care in the second trimester; and 3.6 percent live births were among women receiving late or no prenatal care. About one of 28 infants (3.6% live births) was born to women receiving late or no prenatal care in the United States.

Records from the Department of Health Philippine Annual Statistics in Prenatal Care (2002) shows that out of a population of 2,702,629 of pregnant women, 1,683,106 (60.5%) had three or more prenatal care. In Ilocos Sur, among the 19,362 pregnant women, 13,363 (69%) received three or more prenatal care.

To the policy makers, the results of the study would serve as an insight for the modification of plans and policies for future development of maternal care.

For the health workers, the knowledge gained from this study could serve as a driving force to provide an in-depth prenatal care, thus, improving the health status of mother and the baby.

Mothers would obtain insights from the result of this study, improve their knowledge on prenatal care, and be more responsible to take an active role in promoting health as a way of life.

To future researchers, result of the study would serve as a catalyst to more complex or profound studies related to prenatal care.

The study primarily aimed to determine the prenatal care practices and pregnancy outcome among primigravida mothers in selected municipalities of Ilocos Sur during the Calendar Year 2012. Specifically, it looked into the following: socio-demographic profile of the respondents such as age, civil status, educational attainment, occupation, monthly family income, and place of residence; prenatal practices of the respondents in terms of preference of health facility and health care provider, frequency of prenatal visit, and availment of health services; outcome of pregnancy among the primigravida mothers in Ilocos Sur; relationship between the socio-demographic profile of the respondents and their prenatal practices; and relationship between the outcomes of pregnancy and prenatal practices.

This study made use of the theory of Watson stating that there are two major assumptions that underlie human care which are valued in nursing. These are care and love constitute the primal and universal psychic energy; and care and love are requisite for the survival and nourishment of humanity (Kosier, et al., 1999) Caring promotes health more than curing. Watson really emphasizes the importance of caring.

According to Octaviano and Balita (2001) Henderson's theory emphasizes the following: patients require assistance to achieve health and independence or in some cases a peaceful death; health is viewed as the quality of life and considered to be basic for human to function; nurses function independently from doctors who promote the treatment plan prescribed by the doctors.

As stated by Crombleholm (2009), prenatal care is essential for ensuring the overall health of newborns and the mothers is a major strategy for helping reduce complications of pregnancy such as the number of low birth weight babies born yearly.

An overall healthy lifestyle includes a positive attitude about sexuality, womanhood, and childbearing. Once a woman becomes sexually active, preparation for successful pregnancy includes practicing safer sex, regular pelvic examinations, and prompt treatment of any transmitted infections to prevent complications (Katsufrakis, et al., 2008).

Bernstein, et al., (2007) state that women who maintain healthy lifestyle come for the first prenatal visit prepared to follow health promotion strategies. For many women, this is the first time they have been to a health care facility. It may also be the first time they have had an appointment that focuses more on health promotion than on the diagnosis of a disease. A woman may have a specific reason for coming to a first prenatal visit (e.g. to confirm the diagnosis of pregnancy). A prenatal visit encompasses more than this. It is also the time for additional health promotion, pregnancy education, and development of positive pattern of healthy behaviors for the family to use in the future. What and how much is needed vary depending on the lifestyle, age, and parity of a woman and her degree of family support.

Cootauco, et al., as cited by Pilliteri (2007) state that lack of prenatal care is associated with the birth of preterm infants and various complications for a woman such as hypertension in pregnancy. The purposes of prenatal care are to: establish a baseline of present health, determine the gestational age of the fetus, monitor fetal development and maternal wellbeing; identify women at risk for complications, minimize the risk of possible complications by anticipating and preventing problems before they occur, and provide time for education about pregnancy, lactation, and the newborn care. If a woman has good health in pregnancy, it helps to ensure good pregnancy outcome, so care includes both perceptual and pregnancy time frames.

Once a woman is or suspects that she may be pregnant, her next step is to choose a primary health care provider to care for her throughout the pregnancy until birth. Various options are available, including a pre-natal clinic, her health maintenance organization or preferred provider, a certified nurse- midwife, an obstetrician or a family practitioner. Regardless of the type of health care provider chosen, prenatal care needs to be initiated early and continued throughout pregnancy (Pilliteri, 2010).

Postpartum bleeding is a completely normal part of the postpartum period and most part, goes away on its own. However, bleeding during postpartum period can sometimes indicate underlying complications like bright red discharge for more than seven days after birth, discharge that smells bad, fever and chills, and abnormally heavy bleeding. The most common cause of this postpartum bleeding is when the uterus does not contract after birth. This allows the uterus to continue bleeding and can result to massive blood loss. Other causes are failure to pass all the placenta, forced removal of the placenta, and trauma to the uterus, cervix, or vagina during delivery (www.epigee.org/fetal/post bleeding.html).

METHODOLOGY

The study made use of the descriptive -correlational method of research. The respondents of the study were the primigravida mothers from Vigan City, Caoayan, Santa, and Candon City, Ilocos Sur who were willing to participate in the study. A questionnaire-checklist formulated by the researchers based on the prenatal services of the DOH served as the main tool in gathering the data needed for the study. After the executive officials of the aforementioned municipalities gave them permission to conduct the study, the researchers selected RHUs to look into their records to identify the primigravida mothers who served as the respondents. After identifying the respondents the researchers visited them and administered the questionnaire. The data were statistically treated with frequency, percentage, and simple linear correlation analysis.

RESULTS AND DISCUSSION

Socio-demographic Profile of the Respondents

Table 1. Socio-demographic profile of the respondents.

Variables	f	%
Age		
41-45	3	2.5
36-40	5	4.1
31-35	8	6.5
26-30	22	18.04
21-25	46	37.72
16-20	38	31.14
TOTAL	122	100
Civil Status		
Single	69	56.55
Married	53	43.45
TOTAL	122	100
Educational Attainment		
Masters degree	2	1.63
College graduate	40	32.79
College undergraduate	30	24.60
High School graduate	38	31.15
High School undergraduate	8	6.56
Elementary graduate	4	3.27
TOTAL	122	100
Occupation		
Professional	20	16.4
Skilled	9	7.4
Unskilled	44	36.06
Others(no job)	49	40.14
TOTAL	122	100
Monthly Family Income		
Php 20,000 and above	5	4.09
Php 15,001-20,000	10	8.19
Php 10,001-15,000	19	15.57
Php 5,001-10,000	28	22.95
Php 5,000 and below	60	49.20
TOTAL	122	100
Place of Residence		
Rural	99	81.15
Urban	23	18.85
TOTAL	122	100

Table 1 shows that almost half (46 or 37.72%) of the respondents are within the age bracket of 21-25 years old. The least number (3 0r 2.5%) are 41-45 years old. Majority (69 or 56.55%) of the respondents are single while the rest (53 or 43.45%)

are married. It is great to note that greater proportions (40 or 32.79%) of the respondents are college graduates while the least number (2 or 1.63%) are able to finish their masters degree.

Out of the 122 respondents, 49 (40.14%) have no job while the least (9 or 7.40%) are skilled workers. Majority (60 or 49.20%) of the respondents have a monthly income of PhpS000 and below. There are only five (4.09%) whose income is Php20,000 and above. Most (99 or 81.15) of the respondents live in the rural areas; 23 (18.85%) reside in the urban areas.

Prenatal Practices of the Respondents

RHU Health **Providers.** Table 2 shows that 63 (51.64%) of the respondents were attended by a midwife during prenatal care at the RHU; 23 (18.85%) were attended by the doctors; and only three (2.46%) were attended by a nurse.

Table 2. Pre-natal practices of the respondents in terms of their preference of health care facility and health care providers.

Variables	f	%
1. RHU Health providers		
Doctor	23	18.85
Nurse	3	2.46
Midwife	63	51.64
Sub total	89	72.95
2. Hospital health providers		
Doctor	13	10.66
Nurse	3	2.46
Midwife	4	3.27
Sub total	20	16.4
3. Traditional Birth Attendants		
Hilot	13	10.66
Sub total		
Grand total	122	100

Hospital Health **Providers.** Some (13 or 10.66%) of the respondents claimed that they were provided prenatal services by a doctor in the hospital; four (3.27%) by a midwife; and only three (2.46%) claimed that they received prenatal services from a nurse.

Traditional Birth Attendants. It is worth mentioning that out of the 122 respondents only 13 (10.66%) availed of the services of traditional birth attendants.

Frequency of Prenatal Visits

Table 3 shows that the majority (68 or 55.7%) of the respondents had their prenatal visit once on their 25-36 weeks; 38 (31.1%) had it twice on their 13-24 wks and 43 (35.2%) during the first 12 weeks.

Table 3. Prenatal practices of the respondents in terms of frequency of prenatal visits.

Age of Gestation	Once		Twice		3x		4x		6x		7x		8x	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%
25-36 wks	68	55.7	20	16.4	9	7.4	-	-	-	-	3	2.5	2	1.6
13-24 wks	21	17.2	38	31.1	16	13.1	3	2.5	-	-	1	.8	1	.8
1-12 wks	14	11.S	43	35.2	25	20.5	7	5.7	3	2.5	7	5.7	12	9.8

Table 4 signifies the prenatal practices of the respondents in terms of availment of services.

On Tetanus Toxoid (TT) **Immunization**

On TT1. Most (121 or 99.25%) of the mother-respondents claimed they were able to receive their TT1 vaccine, but only one (0.8%) was not able to receive it.

On TT2. Almost all (119 or 97.5%) the respondents received the TT2 immunization while three (2.5%) failed to receive the said vaccine.

On Assessment of fetal growth. Majority (96 or 78.7%) of the respondents had undergone assessment of fetal growth while the remaining 26 (21.3%) did not have it.

On Fundic Height Measurement. Majority (104 or 85.2%) of the respondents claimed that the health practitioner measured the height of their fundus, while 18 (14.8%) of them was not able to receive above mention pre-natal service.

Table 4. Prenatal practices of the respondents in terms of availment of services.

Variables	f	%
1. Tetanus Toxoid Immunization		
a. TTI		
Yes	121	99.2
No	1	0.8
TOTAL	122	100
b. TT2		
Yes	119	97.5
No	3	2.5
TOTAL	122	100
2. Assessment of fetal growth		
Yes	96	78.7
No	26	21.3
TOTAL	122	100
3.Fundic Height Measurement		
Yes	104	85.2
No	18	14.8
TOTAL	122	100
4.Iodine Supplement		
Yes	75	61.5
No	47	38.5
TOTAL	122	100
S.Iron Supplementation		
Yes	120	98.4
No	2	1.6
TOTAL	122	100
6.Physical Examination		
a. abdominal palpation		
Yes	119	97.5
No	3	2.5
TOTAL	122	100
b. internal examination		
Yes	119	97.5
No	3	2.5
TOTAL	122	100
c. BP monitoring		
Yes	121	99.2
No	1	0.8
TOTAL	122	100
d. weight monitoring		
Yes	120	98.4
No	2	1.6
TOTAL	122	100
7.Laboratory Exam		
Yes	114	93.4
No	8	6.6
TOTAL	122	100

Table 4 continued

Variables	f	%
8.Health Education		
a. Nutrition		
Yes	99	81.2
No	23	18.8
TOTAL	122	100
b. Hvpiene and Cleanliness		
Yes	93	76.2
No	25	23.8
TOTAL	122	100
c. Physical activity		
Yes	88	72.1
No	34	27.9
TOTAL	122	100
d. Exercise		
Yes	89	73
No	33	27
TOTAL	122	100
e. Safety during pregnancy		
Yes	98	80.3
No	24	19.7
TOTAL	122	100
f. Clothing		
Yes	84	68.9
No	38	31.1
TOTAL	122	100
g. Rest and Relaxation		
Yes	87	71.3
No	35	28.7
TOTAL	122	100
h. Dental Health		
Yes	78	63.9
No	44	36.1
TOTAL	122	100
i. Presentation of infection		
Yes	85	69.7
No	37	30.3
TOTAL	122	100
j. Medications		
Yes	82	67.2
No	40	32.8
TOTAL	122	100
k. Discomforts of pregnancv		
Yes	91	74.6
No	31	25.4
TOTAL	122	100

Table 4 continued

Variables	f	%
l. Danger Signs of pregnancy		
Yes	85	69.7
No	37	30.3
TOTAL	122	100
m. Side effects of smoking/alcohol drinking		
Yes	71	58.2
No	51	41.8
TOTAL	122	100
n. Preparation for Labor & Delivery		
Yes	95	77.9
No	27	22.1
TOTAL	122	100
o. Preparation *for* Newborn Care		
Yes	100	82
No	22	18
TOTAL	122	100
p. Breastfeeding		
Yes	114	93.4
No	8	6.6
TOTAL	122	100
q. Family Planning		
Yes	96	78.7
No	26	21.3
TOTAL	122	100

On Iodine Supplementation. More than half (75 or 61.5%) of the respondents received iodine supplementation during pregnancy while 47 (38.5 %) was not able to receive the said micronutrient.

On **Iron** Supplementation. It is worth to note that almost all (120 or 98.4%) of the respondents had taken in iron supplementation. The least (2 or 1.6%) did not take iron supplementation during their period of conception.

On **Physical Examination.** An equal number of 119 (97.5%) each had undergone abdominal palpation and internal examination. Majority (121 or 99.2%) of them submitted themselves for BP taking; while 120 (98.4%) had their weight taken.

On Laboratory Examinations. It is great to note that almost all (114 or 93.4%) of the respondents underwent laboratory examinations. Only a few (8 or 6.6%) did not undergo laboratory examination.

On Health Education. It is worth mentioning that most (99 or 81,2%) of the respondents attended health education classes on nutrition; 93 (76.2%) on hygiene

and cleanliness; 88 (72.1%) on physical activity, 89 (73%) on exercise; 98 (80.3%) on safety during pregnancy, 84 (68.9) on clothing; 87 (7.3%) on relaxation; 78 (63.9%) on mental health, eight (69.7%) on prevention of infection; 82 (67.2%) on medications; 91 (74.6%) on discomforts of pregnancy; 85 (69.7%) on danger signs of pregnancy; 71 (58.2%) on side effects of smoking/alcohol drinking, 95 (77.9%) on preparation for labor and delivery, 100 (82%) on preparation of newborn care, 114 (53.4%) on breastfeeding; and 96 (78.7%) on family planning.

Outcomes of Pregnancy

Table 5. Outcomes of Pregnancy on the Part of the Mother and the Neonates

Variables	f	%
1. Mother		
Preeclampsia	9	7.4
Infection	3	2.5
Anemia	8	6.6
None	102	83.6
Total	122	100
Type of delivery		
a. caesarian section	39	32
b. normal spontaneous delivery	83	68
TOTAL	122	100
2. Neonate		
Term	104	85.3
Premature	11	9.0
Infection	6	4.9
Birth of trauma	1	0.8
TOTAL	122	100

Outcome to the mother. Table 5 shows that out of 122 respondents only nine (7.4%) suffered from preeclampsia and eight (6.6%) suffered from anemia. The least (3 or 2.5%) had an infection. One hundred two (83.6%) of the respondents claimed that they did not experience any complications during pregnancy and delivery. On type of delivery, majority of the respondents (83 or 68%) delivered by normal spontaneous delivery while 39 (32%) of them delivered through caesarian section.

Outcome to the neonate. It is worth mentioning that of the respondents' neonate (104 or 85.3%} were delivered full term; only one (0.8%) suffered from birth trauma.

Significant Relationship Between Socio-demographic Profile of the Respondents and their Pre-natal Practices

As reflected in Table 6, there is an inverse relationship between civil status and prenatal practices along preference for health care facility and health care providers (r=-0.287). This implies that single mothers tend to go to the hospital for prenatal care.

Table 6. Correlation coefficient showing the relationship between the socio-demographic profile of the respondents and pre-natal practices along preference for health care facility and health care providers.

	Age	CS	Educational Activity	Occupation	Income	Place of Residence
RHU Health Care Providers	0.023	-0.027	-0..084	0.021	-0.006	0.225
Hospital Health Care Providers	0.076	-.287**	0.035	0.079	0.079	0.061
Traditional Birth Attendant	0.166	-0.056	0.153	0.164	0.164	0.098

** Highly significant at .OS level

The other socio demographic variables such as age, educational attainment, occupation, monthly family income, and place of residence do not influence the prenatal practices of primigravida mothers along their preference for health care facility and health care providers.

Table 7 indicates the relationships between the socio demographic profile and prenatal practices along frequency of prenatal visits and availment of health services.

Table 7. Significant relationship between socio- demographic profile and prenatal practices along frequency of prenatal visits and availment of health services.

	Age	CS	Educ.	Occu.	Income	Residence
Frequency of Visit	0.116	-0.057	0.182	0.291°	-0.038	0.053
Tetanus toxoid	-0.157	-0.065	-0.097	0.07	0.084	.251°°
Assessment of fetal growth	0.115	-0.041	0.294..	0.363°	0.264..	0.093
Iodine supplementation	0.152	-0.066	0.319°°	0.286°°	0.263°°	0.018
Iron supplementation	0.073	-0.098	0.104	0.151	0.117	-0.048
Abdominal palpation	0.018	-0.119	-0.027	0.029	0.004	-0.057
Internal Examination	-0.16	-0.123	0.029	0.026	-0.05	-0.057
BP taking	0.1	-0.226°	0.153	0.114	0.088	-0.037
Weight taking	0.072	-0.101	0.04	0.165	0.127	-0.051
Laboratory Examination	-0.113	0.024	0.264°°	0.315°	0.125	-0.101
Health Education						
Nut	0.033	0.061	0. 286°°	0.236°	0.104	-0.026
Hygiene	0.025	-0.197	0.09	0.236°	0.106	0.001
Physical Assessment	0.033	-0.103	0.101	0.192	0.247	0.123
Exercise	0.135	-0.210°	0.136	0.203	0.254°	0.142
Safety during preparing	0.112	-0.201°	0.18	0.273°°	0.216°	-0.098
Clothing	0.04	-0.043	0.131	0.249°	0.276°	0.052
Rest Relaxation	0.14	-0.168	0.074	0.318°°	0.247°	0.106
Dental health	-0.109	-0.192	0.06	0.217	0.248°	0.148
Prevention of Infection	0.062	-0.078	0.127	0.316°°	0.301°	0.153
Medications	.198°	-0.082	.238°	0.159	0.271°	0.15
Discomforts of pregnancy	0.043	-0.279°	0.032	0.164	0.146	0.163
Danger Sign of pregnancy	-0.009	-0.12	0.118	0.243°	0.17	-0.051
Side effects smoking	-0.013	-0.192	0.125	0.259°	0.265°	0.189
Preparation of Laboratory	0.168	-0.092	0.185	0.282°°	0.273°°	0.036
Preparation of Newborn care	0.149	-0.039	0.082	0.164	0.169	0.134
Breast feeding	0.117	0.086	0.153	.0	0.085	-0.035
Family planning	-0.02	0.058	0.185	0.139	0.238°	-0.027

•• Highly Significant at .05 level
• Significant at .OS level

On Age. It is evident in Table 7 that age is significantly related to the prenatal practices along availment of health education on medication (r=0.198). This means that younger primi tend to attend health education classes regarding the advantages and disadvantages of taking in unprescribed medication during pregnancy.

On Civil Status. An inverse significant relationship existed between civil status and the following prenatal practices on the availment of health services along

Bp taking (r=-0.226); health education along exercise (r=-0.210); safety during pregnancy (r=-0.210); and discomfort of pregnancy (r=-0.279).

This implies that married primi mothers tend to avail prenatal care services especially on BP taking. This is so because they wanted to prevent some complications of pregnancy brought about by an increase in the blood pressure.

On Educational Attainment. There is highly significant relationship between educational attainment and prenatal practice along availment of health services on assessment of fetal growth (r=0.294)", iodine supplementation (r=0.319); laboratory examination (r=0.264); and health education along nutrition (r=0.286) and significant relationship between educational attainment and medications (r=0.238).

This means that those primi mothers who attained higher level of education tend to submit themselves for the assessment of the growth of the fetus. This could be attributed to the fact that educated individuals are more conscious on the outcome of their pregnancy. In like manner, they take in iodine supplementation during pregnancy because they are aware of the importance of iodine in the mental development of their child as a product of their learnings while pursuing a higher education.

Similarly, those with higher education tend to submit themselves for laboratory examination. This is so because they want to remain as healthy as possible and they do not like that their pregnancy may interfere with their work. Moreover, since they have job they may have the means to pay for any laboratory examination.

Furthermore, these primi attend health education classes especially on nutrition, which implies that these mothers are conscious on their nutritional status and that of their children.

On Income. There is a significant relationship between income and prenatal practices like assessment of fetal growth (r=0.264); provision of iodine supplementation (r=0.263); health education along physical assessment (r=0.247); exercise (r=0.254); safety during pregnancy (r=0.216); rest and relaxation (r=0.247); dental hygiene (r=0.248); prevention of infection (r=0.301); medication (r=0.271); side effects of smoking (r=0.265); preparation of labor and delivery (r=0.273); and family planning (r=0.238)

This implies that primigravida mothers with higher income tend to avail of prenatal services especially on the assessment of fetal growth and the taking in of iodine.

On Place of Residence. It can be noted also in Table 7 that only on the health service on the provision of tetanus toxoid immunization (r=0.251) yielded a significant relationship to the place of residence.

This means that those living in the urban area tend to submit themselves for tetanus toxoid immunization. This could be attributed to the fact that most of the health facilities are located in the urban areas which could mean lesser expenses for their transportation in going to a health facility.

Relationship Between Outcome of Pregnancy and Prenatal Practices along Preference of Health Facility and Health Care Providers

Table 8. Relationship between the outcome of pregnancy and prenatal practices along preference of health care facility and health care providers.

Pre-natal Care Providers' Qualification	Hemor-rhage	Preeclamp-sia	Infection	Anemia	Type of Deliver	Term Birth	Pre-term Birth	Infects	Sil Birth	Birth
1.RHU Health Providers	A	-1,000**	-.500	A	.588	A	1,000**	.000	A	.803
2.Hospital Health Providers	A	.250	.333	.143	-.021	A	.303	-.042	A	.954
3.Traditional Birth Attendant	A	.620	.522	.316	-.097	A	A	a	A	a

It can be noted in Table *8* that there is a significant relationship between RHU health care providers and preeclampsia (r= -1.000).This implies that those primigravida who prefer to go to the RHU for prenatal tend to develop preeclampsia than those who prefer to go to the hospital. This could be attributed to the fact that hospitals are more equipped with facilities.

Likewise preference for health care facility and health care providers is related to the incidence of pre-term baby.

On Maternal Outcome

Table 8 also indicates a significant correlation between provision of iron supplementation and occurrence of hemorrhage (r=0.518) and type of delivery (r=1.000); occurrence of hemorrhage and health education along medications (r=0.629) and discomforts of pregnancy (r=0.615). Likewise, the occurrence of anemia is significantly related to health education along side effects of smoking (r=1.000) and preparation for labor and delivery (r=1.000).

This means that those receiving iron supplementation tend to have a greater chance not to suffer from hemorrhage. Those who attended health education classes on side effects of smoking tend to have higher resistance to the development of anemia.

On Neonatal Outcome

There is a significant relationship between the occurrence of preterm birth and the following: abdominal palpation (r=.671); attendance to health education classes particularly on discomforts of pregnancy (r=.667); preparation for labor and delivery (r=.1000); and breastfeeding (r=1.000).

This implies that those who submit themselves for abdominal palpation may probably deliver a full term baby. Similarly, those who attend health education in preparation for labor and delivery and breastfeeding may tend to deliver a full term baby.

Infection as a complication to the neonate is significantly related to attending health education classes along discomforts of pregnancy (r=1.000) and danger signs of pregnancy (r=1.000).

This means that mothers attending health education classes on discomforts of pregnancy tend to deliver a baby without infection.

CONCLUSIONS

In the light of the findings above, the researchers conclude that majority of the respondents are 21-25 yrs. old, single, college graduates; plain housewives; from rural areas, with a family monthly income of Php 5,000 and below, availed of the services of the midwives for prenatal check up at the rural health unit once during

the first trimester, twice during the second and third trimester, availed of tetanus toxoid immunization, assessment of fetal growth, fundic height measurement, iodine and iron supplementation, physical examination , laboratory examination and health education. Most of the respondents did not develop any complications and delivered a full term baby in the hospital through normal spontaneous delivery. Significant relationship existed between civil status and prenatal practices along preference for health care provider, age and health education classes, occupation and physical assessment and provision of iodine supplementation and health education, place of residence and tetanus toxoid immunization. Significant relationship existed between provision of iodine and pregnancy outcome, hemorrhage and type of delivery; hemorrhage and health education classes, occurrence of anemia and health education classes, preterm birth and abdominal palpation and health education classes.

RECOMMENDATIONS

The researchers recommend that primigravida mothers must be encouraged to follow the desired number of prenatal care visits. Health Workers in the RHU should conduct home visits to remind them of their next visit. Since there are still some who availed of the services of traditional birth attendants (TBA), the DOH through the RHU should prepare a training program for the TBAs to equip them with the necessary knowledge and skills to provide prenatal care. Provision of iron and iodine as part of prenatal care services among RHUs must be maintained if supply is not available, pregnant mothers should be encouraged to buy.

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