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A Relative Assessment on Food Routines, Dietary Consumption and Nutritional Status of Pregnant Women

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Abstract – Pregnant women have been widely recognized as a vulnerable group from health point of view. They need more food than normal person for the proper nourishment of the growing fetus. A total of hundred pregnant women who were in their third trimester were selected for the study. Indian women have very high prevalence of anemia as well as malnutrition in the world. Hemoglobin (Hb) level in their blood is reported below the normal value i. e 11-14gm According to National Family health survey of India -3,prevalence of anemia among women of 15-49 years age group is found to be 55.3 %, in pregnant women it was 58% and in children less than three years of age it was 80 %. It is underlying cause for 20 - 40 % maternal death, thus anemia is the most frequently observed nutritional diseases in the world. In India, anemia is the second most common cause of maternal death, accounting for 20% total maternal deaths.

The food intake consisted of rice, nuts and pulses and vegetables, meaning that it was mainly plant-based food. Rice behaved as a strongly inferior good in economic terms, meaning that its consumption increased in spite of its price increase. Especially, rural, poor women with access to rice fields increased their rice intake and decreased their intake of non-rice staple foods. Reasons for the continued rice intake included that the women had been accustomed to eating rice since they were born and that cooking methods for non-rice staple foods were difficult. The intake of nuts and pulses and vegetables increased for most groups. Nuts and pulses were an important supplier of calcium and iron, and vegetables were an important supplier of vitamin A. Urban poor and rural poor, landless women experienced a decreased intake of most nutrients in the transition period but an increased intake.

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INTRODUCTION

Women is regarded as the nerve centre of the family and society maternal nutrition and health is consider as the most important regulator of human fetal growth (Ventura 2008). A healthy mother can produce a healthy child. Pregnancy is the period of dynamic change for a mother requiring a lot of care. During this period the fetus is nourished directly by the mother through placenta. A woman's normal nutritional requirement increases during pregnancy in order to meet the needs of the growing fetus and of maternal tissues associated with pregnancy (Lisa, 2009). In pregnancy anaemia has a significant effect on the health of the fetus and the mother.

According to Agarwal (1991) maternal anaemia resulted in 12 to 28% of fetal loss, 30% of prenatal and 7 to 10% of neonatal death. Anaemia in pregnancy is also associated with increased maternal morbidity and mortality. About two third of pregnant women in India are estimated to suffer from anaemia. The field of nutrition of pregnant women is sadly a much – neglected are of research.

Pregnant women form one of the most vulnerable segments of the population from nutritional point of view. Numerous studies in India and elsewhere have shown that in chronically undernourished women subsisting on unchanged dietary intake in pregnancy and lactation have an adverse effect on maternal nutritional status.

Maternal under\ nutrition is associated with low birth weight and all its attendant adverse consequences. Epidemiological studies from India documented the magnitude and adverse consequences of chronic energy deficiency (CED) on the mother child dyad and paved way for effective intervention programs to address under nutrition during pregnancy and lactation. Over 75 % of pregnant women in India are anemic and anemia remains to be a major factor responsible for maternal morbidity, mortality and low birth weight .Too early, too close, too many and too late pregnancies adversely affect nutrition and health

status of the mother child dyad. Yet another important indirect cause of under nutrition continues to be infections; under nutrition increases the susceptibility for infections; infections aggravate under nutrition. Though current decade has witnessed the progressive rise of over nutrition in women during reproductive age especially among the affluent segments of population both in urban and in rural areas. It has become imperative to assess the nutritional status of pregnant women and give them appropriate advice and care. Interventions to improve dietary intake and nutritional status India has included food supplementation for pregnant and lactating women.

NUTRITION POLICY AND PROGRAMMES

Food and nutrition problems are often difficult to solve because of the multitude of factors in their aetiology and maintenance. Undernutrition is a result of inadequate food intake and disease. A child who consumes a good diet but who frequently suffers from diarrhoea or fever most likely becomes undernourished. Thus, disease is the immediate causes of undernutrition (UNICEF, 1998). Poor diet and disease, in turn, are caused by food insecurity, as well as inadequate maternal and child health care. The distant causes are social structures and institutions, political systems and ideology, economic distribution, and potential resources (UNICEF, 1998).

The associations between health and national development are complex. The interaction is a two-way phenomenon, with health being both influenced by and influencing economic development. Unfortunately, improved health has for too long been considered solely a result of economic growth, a part of the product of growth, rather than one of its causes (Sorkin, 2001).

Food and nutrition policies in the poor societies have focused primarily on food production, the control of communicable diseases and education (WHO, 2000). Nutrition policies in Indonesia have developed stage by stage. In the long term, the most appropriate strategies to reduce nutrient deficiencies among pregnant women and children include improvement in dietary intake and fortification of foods with nutrients (Kodyat et al., 1996a). The latter is necessary despite an abundant supply of nutritious foods, because micronutrient deficiency, especially anaemia, remains common. Periodic iron tablet supplementation for pregnant women is the recommended short-term solution for the prevention of iron deficiency (MOH and WHO, 2000).

However, according to the International Conference on Nutrition's (ICN) World Declaration on Nutrition and the plan of action for nutrition, signed by the ministers of 159 countries, the first priority should be given to food-based strategies. This is because experience has shown that the most effective and least costly approaches to reducing micronutrient deficiency problems are to increase the availability and consumption of micronutrient-rich foods (Buyckx, 1993).

NUTRIENT NEEDS OF PREGNANT WOMEN

Human eating behaviour depends on both biological and cultural factors. Both perceptions and food taboos often influence food intake during pregnancy. Perceptions and food taboos are often influenced by traditions passed on from generation to generation.

A well-nourished woman, gaining 12.5 kg and giving birth to an infant weighing 3.5 kg, is estimated to require 80 000 kcal in addition to her non pregnancy energy balance. The 80 000 kcal are expected to cover the increased basal metabolic rate (36 000 kcal) and the synthesis of new tissue including foetal tissue, maternal fat deposits and increased blood volume (in total 44 000 kcal). Hence, the mother requires extra energy and extra intake of nutrients.

For some women, a reduction in physical activity covers part of this extra cost of pregnancy, but for many women this is not the case. Consequently, an increased intake of 300 kcal/day during the second and third trimesters is recommended for pregnant American women and 285 kcal/day for pregnant Indonesian women. In addition, protein intake is also critical, and overall, 0.9 kg of protein is deposited during pregnancy. The need is low at the beginning and increases as pregnancy progresses.

Dietary protein surpluses do not accumulate. However, women in well-to-do societies on usual diets frequently consume more protein than is actually required. Under these circumstances, the extra needs of pregnancy are actually met with no significant changes in dietary intake.

OBJECTIVES

- To assess the health status of rural pregnant women.
- To assess food consumption pattern and nutrient intake of pregnant mothers.
- To assess hemoglobin level of pregnant women through biochemical test.

SUGGESTIONS

Efforts must be made to educate women to enhance their level of economic status. Food fortification i. e. sugar or salt with iron and folic acid, Proper ANC services from first trimester Consumption of IFAT regularly. Execution of available Food supplementation program to meet RDA, Guidance about family planning measures for fertility control, Nutrition education regarding awareness, prevention and control of anemia, dietary sources of iron , use of iron knife etc. and factors favoring and inhibiting dietary iron,

Screening for HIV and other infections and their management primarily.

CONCLUSION

It was found that the nutrient intake of the respondent was significantly less as compared to RDA. The malnutrition problems among pregnant women are very complex. A judicious combination of various food groups required to ensure that nutrient demands of individuals are fully met. It was also found that the mean daily dietary intake of iron and folic acid of the anaemic pregnant women was significantly lower than those of the non-anaemic pregnant women. In spite of better education and highly monthly income, nutrition intake was lower than RDA. This might have been due to poor knowledge on nutrition and ignorance about healthy by these women. The women consumed inadequate food already before the crisis. Rice was the most important food item. When the price of rice increased, the consumption of rice increased and the consumption of expensive foods such as meat, milk decreased.

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