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Prevalence and Associated Risk Factors of Pregnancy Induced Hypertension Among Pregnant Women at Burao General Hospital, 2024

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Abstract

This research, conducted as a cross-sectional study at Burao General Hospital in 2024, aimed to determine the prevalence and associated risk factors of pregnancy-induced hypertension (PIH). The study, which utilized a sample of 77 randomly selected pregnant women, found that a significant portion of participants, 27.3%, had been diagnosed with PIH, while the majority (72.7%) had normal blood pressure. The analysis, performed using SPSS version 21, identified several key risk factors strongly associated with PIH. The study found a statistically significant link between PIH and whether a woman had received antenatal care (ANC) follow-up before data collection, a personal history of chronic hypertension, and a family history of chronic hypertension. The p-values for these associations were 0.040, 0.000, and 0.001, respectively, indicating a high degree of statistical significance. These findings highlight a concerning prevalence of PIH in the study population and underscore the importance of targeted interventions. To improve maternal and fetal outcomes, the researchers recommend increasing initiatives for both pregnant women and healthcare providers regarding the risks and early signs of PIH. Additionally, they stress the need for regular ANC visits and lifestyle modifications to manage risk. For women identified as high-risk, the study recommends developing specific intervention strategies, such as tailored treatment plans, frequent monitoring, and specialized support services. These measures are crucial to mitigating the risks associated with PIH and improving overall maternal health.

Keywords: Associated Factors, Pregnancy-Induced, Hypertension, Burao

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Introduction

Pregnancy is a physiological phenomenon for most women. Sometimes pregnancy won't be normal due to various reasons or risk factors. Mothers need to take care of their health during pregnancy to continue healthy pregnancy (Grenier et al., 2021; Brink et al., 2022). Due to physiological changes, there are many health issues women undergo during pregnancy (Rockliffe et al., 2021; Motosko et al., 2017). Pregnancy-induced hypertension (PIH) is one of the most leading issues and the cause of maternal and fetus mortality (1). PIH is clinically defined as new onset of hypertension (HTN), that is, systolic blood pressure (BP) ≥ 140 mm Hg and/or diastolic BP ≥ 90 mm Hg or an absolute rise of BP of at least 140/90 mm Hg, if the previous BP is not known or a rise in systolic pressure of at least 30 mm Hg or a rise in diastolic pressure of at least 15 mm Hg over the previously known BP, at ≥ 20 weeks of gestation in the absence of proteinuria (2). The clinical diagnosis of PIH is based on specific blood pressure thresholds and other key indicators that differentiate it from other hypertensive disorders of pregnancy.

Severe preeclampsia in pregnancy is defined as systolic blood pressure ≥ 160 mmHg or diastolic blood pressure ≥ 110 mmHg, or both. The Society of Obstetric and gynecologists of Canada (SOGC) expert consensus suggests that a single reading at this level be confirmed the severe pregnancy induced hypertension within 15 minutes. To diagnose PIH, especially when the pregnant woman is seen for the first time after 20 weeks of gestation, or when there is no record of BP measurement before 20 weeks of pregnancy, is not always easy. However, the criteria that facilitate the diagnosis of PIH and its differentiation from other hypertensive disorders of pregnancy include elevated BP, which was previously normal, absence of protein in the urine, and absence of manifestation of preeclampsia– eclampsia. Furthermore, in the differential diagnosis, spot urine polymerase chain reaction; full blood count; urea, creatinine, electrolytes; ultrasound assessment of fetal growth and amniotic fluid volume; and umbilical artery Doppler assessment are generally included in the battery of test that needs to be done. Pregnancy-induced hypertension (PIH) was defined as new hypertension that appears at 20 weeks or more gestational age of pregnancy with or without proteinuria, which includes gestational hypertension, pre-eclampsia, and eclampsia (3); (Berhe et al., 2020). Once diagnosed, PIH requires careful management, as it can escalate into life-threatening conditions that demand immediate medical attention.

The American Congruence Obstetrics and Gynecology (ACOG) Committee recommends that severe hypertension that persists for 15 minutes or more in the setting of preeclampsia or eclampsia is a hypertensive emergency that requires immediate intervention (Eclampsia is a severe form of pregnancy induced hypertension and women with eclampsia have seizures resulting from the condition. Eclampsia occurs in about one in 1,600 pregnancies and develops near the end of pregnancy, in most cases (4). While these severe complications can occur, PIH is typically identified through a set of more common, yet equally critical, symptoms. HELLP syndrome is a complication of severe preeclampsia or eclampsia. HELLP syndrome is a group of physical changes including the breakdown of red blood cells, changes in the liver and low platelets (cells found in the blood that are needed to help the blood to clot in order to control bleeding (5). Usually, there are three primary characteristics of pregnancy induced hypertension condition are high blood pressure (a blood pressure reading higher than 140/90 mm Hg or a significant increase in one or both pressures), protein in the urine, edema (6). These characteristics highlight why Pregnancy Induced Hypertension (PIH) is not just a clinical condition but a significant global health issue.

Pregnancy Induced Hypertension (PIH) is a global problem and the most common medical problem requiring special attention in the intrapartum period (7, 8). Pregnancy induced hypertension (PIH) is a leading cause of maternal and perinatal mortality and can also lead to long- term health problems like chronic hypertension, kidney failure, or nervous system disorders (6); (Muti et al., 2015; Ngene & Moodley, 2024; Stephansson & Sandström, 2024). As studies showed eclampsia is a leading cause of maternal and perinatal mortality in Nigeria. Preventive and interventional measures have been shown to reduce maternal mortality and morbidity with no significant beneficial

effect on neonatal outcomes (9). A survey in Ethiopia on Emergency Obstetrics and Neonatal Care (EmONC) assessment; approximately 1% of all deliveries and 5% of all pregnant women with complications were documented as having severe pre-eclampsia or eclampsia. However, nearly 16% of direct maternal deaths were due to pre-eclampsia/eclampsia. Overall, 10% of maternal deaths (direct and indirect) occurred among women whose pregnancies were complicated by pre-eclampsia/eclampsia (10). Given these severe global consequences, a comprehensive understanding of the different types of hypertensive disorders of pregnancy is essential for effective diagnosis and management. Hypertension disorder of pregnancy encompasses a spectrum of conditions including pre-existing hypertension, gestational hypertension, preeclampsia/eclampsia, and superimposed hypertension (Horgan et al., 2025; Hinkosa et al., 2020).

Methodology

This part of the outlines its contains for encompassing various key aspects such as the study area, study period, research design, target population, selection criteria, determination of sample size, sampling procedures, variables under consideration, operational definitions, data collection procedures, quality control measures, data analysis methods, and ethical considerations .

Study Area , Study Period , Study Design

The study was conducted in Burao General Hospital. Burao General Hospital is a governmental hospital that was established in 1948. It is largest hospital in Togdher region and it contains eight wards. Ward 1 male medical, ward 2 male, surgical ward, ward 3 female surgical ward, ward 4 military ward, ward 5 maternity ward 6 female medical ward, ward 7 pediatric ward and ward 8 which stabilization center and it has TB department, ICU Department , pharmacy, and medical laboratory area. The study period was conducted from 01-20 June, 2024. An Institutional based cross-sectional study was conducted.

Source Of Population, Study Population Selection Criteria

1. Source Of Population

All pregnant mothers who were attend at Burao general hospital.

2. Study population

All pregnant women who w er e attend Burao general hospital particularly maternity ward was selected randomly.

3. Selection criteria

a. Inclusion criteria

A Pregnant mothers who was visited Burao General Hospital during the data collection period andThe research design and method should be clearly defined. were willing to participate in *this study*.

b. Exclusion criteria

Pregnant mothers who were unable to respond to the interview due to severe illness, hearing impairment.

Sample size determination

The was a single population proportion formula that was used to calculate the sample size considering the following assumptions: prevalence of pregnancy induced hypertension in Tikur Abessa Hospital in Addis Ababa Ethiopia was 5.3 % (11). Therefor our sample size was 77 participants.

$$n = \frac{z^2 p(1-p)}{d^2}$$

n = desired sample size

Z = 1.96 the factor from normal

distribution. P = 5.3 % (0.053)

q = 1-p (0.947)

D = absolute sampling

error 0.025 $n = \frac{(1.96)^2 \times$

0.053 x 0.947

$(0.5)^2$

$n = \frac{3.841 \times 0.050}{$

0.0025

n = 77

Sampling technique

Systemic random sampling method was used to select study.

Variables

1. Dependent variable:

- Prevalence of pregnancy induced hypertension.

2. Independent variables

- ✓ Socio demographic level
- Obstetric and medical condition of the pregnant women
- ✓ Personal risk factors of the pregnant women

Operational definitions

Pregnancy induced hypertension (PIH): is hypertension that occurs after 20 weeks of gestation in women with previously normal blood pressure and also its effects approximately 6-10 % pregnancies mothers (2).

Data collection procedure/technique

An interview questionnaire was used for data collection in the study, and we measured blood pressure (BP).

Data Quality Assurance And Data Processing Analysis

The collected data was reviewed and checked for completeness by investigators. The supervisors were made close following up and assistance during the process of data collection prior to data collection time. Data was entered cleaned and checked using *SPSS version 23*. Descriptive analysis (frequency distribution, proportion and mean) was performed to summarize the characteristics of the study subjects, knowledge and prevention of preeclampsia. Data was analyzed and results was presented in tables, graphs and texts.

Ethical consideration

All the respondents participating in the research was require to consent to take part in the study after they become fully aware of the purpose and their role in the study was through the letter from the Ministry of Health in Somaliland. The researcher reassured the respondents of use and confidentiality of the information given.

Results and Discussion

Sociodemographic Factor

1. *As shown in the table below*, six factors were used to collect socio-demographic information relevant to the study. Respondents were asked about their age. Out of 77 respondents, 35 (45.5%) were between 15-24 years old, 30 (39.5%) were between 25-34 years old, and 12 (15.6%) were between 35-48 years old. The majority of the respondents were young, with nearly half being between 15-24 years old. Out of 77 respondents, 59 (79.65%) were married, 2 (2.6%) were divorced, 2 (2.6%) were widowed, and 14 (18.2%) were separated. Marital status data show that a significant proportion of the respondents were married.
2. Regarding educational levels, 23 (29.9%) respondents were illiterate, 28 (36.4%) had primary/intermediate education, 16 (20.8%) had secondary education, and 10 (13.0%) had a diploma or higher. Educational levels varied, with a notable percentage of women having only primary or intermediate education. The occupational levels of the mothers were as follows: 54 (70.1%) were housewives, 8 (10.1%) were government employees, 9 (11.7%) were privately employed, and 6 (7.8%) were merchants. Most respondents were housewives.
3. Regarding residence, 34 (44.2%) of the mothers lived in rural areas, while 43 (55.8%) lived in urban areas. The income levels of the mothers were as follows: 33 (42.9%) earned less than \$100, 24 (31.2%) earned between \$101-200, 12 (15.6%) earned between \$201-300, 4 (5.2%) earned between \$301- 400, and 4 (5.2%) earned more than \$400. Income data reveal that a substantial portion of the respondents were from low-income households.

Table 1. Socio Demographic Factors

Variables	Category	Frequency	Percentage
Age of the mother	15-24 years	35	45.5
	25-34 years	30	39.5
	35-48 years	12	12.6
	Total	7	100
Marital status	Married	59	76.6
	Divorced	2	2.6
	Windowed	2	2.6
	Separated	14	18.2
Educational	Total	98	100
	Illiterate	23	29.9
	Primary /intermediate	28	36.4
	Secondary	16	20.8
	Diploma and above	10	13.0

Occupation	Total	77	100
	House wife	54	70.1
	Government employee	8	10.4
	Private employee	9	11.7
	Merchant	6	7.8
Residence	Total	77	100
	Rural	34	44.2
	Urban	43	55.8
Monthly in come	Total	77	100
	Less than \$100	33	42.9
	\$ 101-200	24	31.2
	\$ 201-300	12	15.6
	\$ 301-400	4	5.2
	Above \$ 400	4	5.2
Total		77	100

Questions related to obstetric and medical condition of the women

Table 2 below shows questions related to the obstetric and medical conditions of the women.

1. When asked if they had ANC (Antenatal Care) follow-up before data collection, 56 (72.7%) respondents said yes, while 21 (27.3%) said they had not visited ANC. A significant majority of the respondents had ANC follow-up, which is crucial for monitoring and managing potential complications during pregnancy. Of those who attended ANC, 19 (24.7%) visited once each month, 17 (22.1%) visited three times each month, 13 (16.9%) visited twice each month, and 8 (14.4%) visited four times each month. The varying frequency of ANC visits indicates different levels of healthcare engagement. Regarding current gravidity status (total number of pregnancies), 27 (35.5%) respondents had 3-4 children, 20 (26.0%) had 5-6 children, 19 (24.7%) had more than 6 children, 10 (13.0%) had 2-3 children, and 10 (13.0%) had 1 child.
2. When asked about the number of pregnancies resulting in live birth, 26 (33.8%) respondents had 1-2 children, 22 (28.6%) had 3-4 children, 14.8% had 5-6 children, and 8 (10.4%) had more than 6 children. In response to whether they had a history of chronic hypertension, 32 (41.6%) respondents said yes, while 45 (58.4%) said no.
3. When asked about a family history of pregnancy-induced hypertension, 32 (41.3%) respondents said yes, while 45 (58.4%) said no. Regarding a history of diabetes mellitus, most participants, 67 (87.5%), said no, while 10 (12.9%) said yes

Table 2. Questions related to obstetric and medical condition of the women

Variable	Category	Frequenc y	Percentage
Do you have ANC following up before data collection	Yes	56	72.7
	No	21	27.3
	Total	77	100
If yes how many times do you visit MCH?	One times each month	19	24.7
	Two times each month	13	16.9
	Three times each	17	22.1

	month		
	Four times each	8	14.4
	month		
	Total	77	100
Current gravidity status [total	1.1	10	13.0
number of pregnancies	2-3	10	13.0
	3-4	27	35.1
	6-5	20	26
	Above 6	19	24.7
	Total	77	100
Number of pregnancies	1.0	10	13.0
resulting in live birth	1-2	26	33.8
	3-4	22	28.6
	5-6	11	14.8
	Above 6	8	10.4
	Total	77	100
Do you have history of	Yes	11	14.3
chronic hypertension?	No	66	85.7
	Total	77	100
Do you have family history of	Yes	32	41.6
chronic hypertension?	No	45	58.4
	Total	77	100
Do you have family history of	Yes	32	41.3
pregnancy induced	No	45	58.4
hypertension	Total	77	100
Do you have history of	Yes	10	12.9
diabetic mellitus?	No	67	87.5
	Total	77	100

Questions related to personal risk factors of the women.

Table 3 below shows questions related to the Questions Related to Personal Risk Factors of the Women.

1. Smoking: When asked if they had smoked any cigarettes, all 77 respondents (100%) said no.
2. Caffeine Consumption: In response to whether they had consumed any caffeine, 58 respondents (75.2%) said no, while 19 (24.7%) said yes.
3. Salt Consumption: When asked if they ate foods high in salt, 46 respondents (59.7%) said yes, while 31 (40.3%) said no.
4. Physical Exercise: Regarding scheduled physical exercise during the current pregnancy (such as walking, swimming, running, low-impact aerobics), 62 respondents (80.5%) said yes, while 15 (19.5%) said no.
5. Dietary Diversity: When asked about having a diversified diet during the current pregnancy, specifically per week consumption of various food groups, 37 respondents (48.1%) said cereals, 14 (18.2%) said milk and milk products, 14 (18.2%) said protein sources like legumes and meats, and 8 (10.4%) said fruits and vegetables.
6. Sleep Duration: When asked about their sleep duration per night, 46 respondents (59.7%) said they slept 4-6 hours, 19 (24.7%) said they slept 1-3 hours, and 12 (15.5%) said they slept 7-9 hours.

7. Daytime Naps: In response to whether they took naps during the day, 48 respondents (62.3%) said yes, while 29 (37.7%) said no.

Table 3. Questions related to personal risk factors of the women.

Variable	Category	Frequency	Percentage
Have you smoked any cigarettes	No	77	100
	Total	77	100
Have you had any caffeine?	Yes	19	24.7
	No	58	75.3
	Total	77	100
Do you eat foods that are high in salt?	Yes	46	59.7
	No	31	40.3
	Total	77	100
Are you doing scheduled physical exercise regularly during current pregnancy? Like walking, swimming, running, low impact aerobics.	Yes	62	80.5
	No	15	19.5
	Total	77	100
Have you had diversified diet during current pregnancy per a week of the following foods or food groups?	Fruits and vegetables	8	10.4
	Protein sources like legumes and meats	14	18.2
	Cereals	37	48.1
	Milk and milk products	14	18.2
	Fat and oils	4	4.5
	Total	77	100
How many hours did you sleep per night?	1-3 hours	19	24.7
	4-6 hours	46	59.7
	7-9 hours	12	15.6
	Total	77	100
Did you have a nap at day time?	Yes	48	62.3
	No	29	37.7
Total		77	100

Prevalence Pregnancy-induced Hypertension among Pregnant Women

The figure illustrates the prevalence of pregnancy-induced hypertension (PIH) among the surveyed pregnant women at Burao General Hospital in 2024. It shows that 27.3% of the women were diagnosed with pregnancy-induced hypertension, while 72.7% of the women maintained normal blood pressure levels.

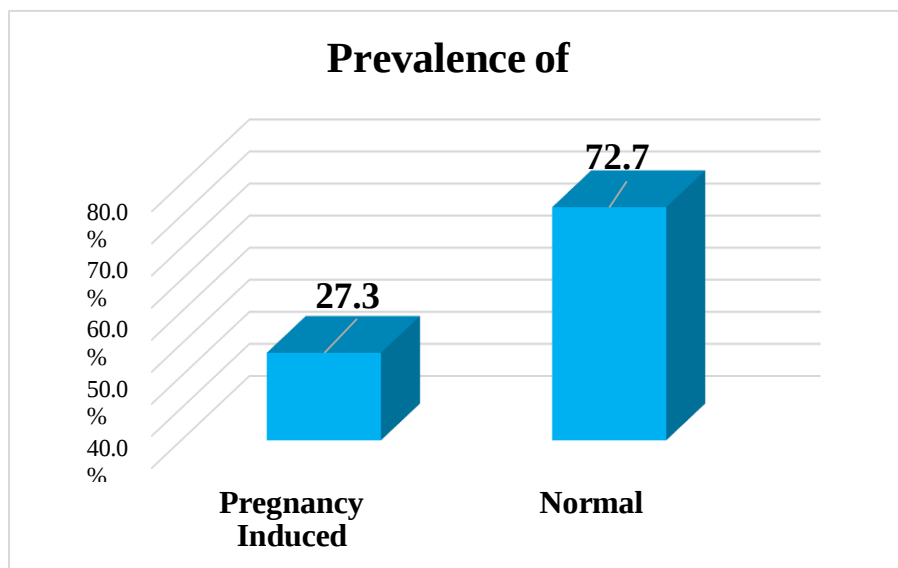


Figure 2. Prevalence pregnancy-induced hypertension

Factors Associated with Pregnancy-Induced Hypertension

The analysis indicates that having ANC follow-up before the data collection period (p-value 0.040), a history of chronic hypertension (p-value 0.000), and a family history of chronic hypertension (p-value 0.001) was significantly associated with pregnancy-induced hypertension among pregnant women. The statistically significant p-values suggest that these factors are closely linked to the development of PIH.

Table 4. Factors Associated with Pregnancy-Induced Hypertension Among Pregnant Women (Cross tabulated)

Variables	Categories	Does she have pregnancy induced hypertension		P-Value
		Yes	No	
Do you have ANC follow up before data collection period?	Yes	12(15.6%)	44(57.1%)	0.040
	No	9(11.7%)	12(15.6%)	
	Total	21(27.3%)	56(72.7%)	
Do you have history of chronic hypertension?	Yes	10(13%)	1(1.3%)	0.000
	No	11(14.3%)	55(71.4%)	
	Total	21(27.3%)	56(72.7%)	
Do you have family history of chronic hypertension?	Yes	15(19.5)	17(22.1%)	0.001
	No	39(50.6%)	6(7.8%)	
	Total	21(27.3%)	56(72.7%)	

Conclusion

1. The study conducted at Burao General Hospital in 2024 revealed a high prevalence of pregnancy-induced hypertension (PIH) among the surveyed pregnant women.
2. Significant factors associated with PIH included antenatal care (ANC) follow-up before the data collection period, a history of chronic hypertension, and a family history of chronic hypertension.

Conflicts of Interest

The author declares that there is no conflict of interest.

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