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A Review on the Evolution of Planned Health Education on the Knowledge and Practices of the Pregnant Mothers Attending Antenatal

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ABSTRACT

The maternal health status of Indian women was noted to be lower as compared to other developed countries. Promotion of maternal and child health has been one of the most important components of the Family Welfare Programme of the Government of India. For sustainable growth and development of country, there is a need to improve MCH Care in the country. Antenatal care service is an important goal concerning in the health status of the pregnant women during their reproductive period and its health beneficial accounting for nearly one quarter of all pregnant worldwide. Early booking has an advantage for proper pregnancy information sharing and pregnancy monitoring. Unfortunately, adverse pregnancy outcome can occur even in women without identifiable risk factors

Keywords: Antenatal Care, ANC, pregnancy, FANC.

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1. INTRODUCTION:

Antenatal Care (ANC) is an umbrella term used to describe the medical procedures and care that are carried out during pregnancy. The goal-oriented antenatal care approach was recommended by researchers in 2001 and adopted by the World Health Organization (WHO) in 2002. Ethiopia has accepted and adopted Focused Antenatal Care (FANC) as part of monitoring women's health and offering preventive services[1].Focused antenatal care approach recognizes two key realities: first, frequent antenatal visits do not necessarily improve **pregnancy** outcomes and secondly, many women with risk factors may never develop complications. While ANC interventions, maternal mortality and the death of a woman while pregnant or within 42 days of termination of pregnancy, remains disturbingly high in sub-Saharan Africa[2]

Proper ANC is one of the important ways in reducing maternal and child morbidity and mortality. Unfortunately, many women in developing countries do not receive such care. Ante-natal care (ANC) services indirectly saves the lives of mothers and babies by promoting and establishing good health before childbirth and the early postnatal period. It often presents the first contact opportunities for a pregnant woman to connect with health services, thus offering an entry point for integrated care, promoting healthy home practices, influencing care-seeking behaviors and linking women with pregnancy complications to a referral system; thus impacting positively on maternal and fetal health.[3] The very low maternal/infant morbidity and mortality rates reported for developed countries compared with the extremely high figures in developing countries have been attributed to the higher utilization of modern obstetric services by the former. Studies in developing countries have shown that the use of health-care services is related to the availability, quality and cost of services, as well as to the social structure, health beliefs and personal characteristics of the users.

Pregnancy and childbirth is a normal physiological phenomenon. Moreover; many cases terminate with the complications such as abortion, maternal or fetal disability and even maternal death or fetal loss or both.[4] Global evidences shows that all pregnancies are at risk and complications during pregnancy, childbirth, and the postnatal period are difficult to predict. [3] Pregnancy and childbirth process are still overlooked as a natural phenomenon; consequently, maternal mortality and disability are unexpectedly high in Nepal. And 281 maternal deaths occur/100,000 live births with estimated 32,000 mothers dying every year in Nepal. Despite the structural network of safe-motherhood service delivery in Nepal, more than 70% of deliveries take place at home without the

assistance of health workers, And less than a quarter of deliveries occur with the assistance of skilled birth attendants (doctors, nurses, and auxiliary nurse midwives).

1.1. Care providers' perception of FANC and services

Providers' attitude and perceptions play an important role in how women are cared for in the FANC model. Communication is an important part of delivering FANC services; midwives build trust through effective communication that in the long term contributes to better pregnancy outcomes. In a study conducted by Sanders, Somerset, Jewell, and Sharp (1999) midwives emphasized that face to face contact and reassurance of their health status was the main reason women wished to attend the clinic regularly. Midwives indicated that women, who had fewer antenatal attendances, needed supplementary information on how to make additional appointments, contact a midwife if necessary and how to identify signs of pregnancy-related complications. Sanders et al. (1999) concluded that the midwives uniformly felt the traditional ANC model is too inflexible to meet the needs of women. In the traditional ANC, midwives often do not have the authority to order specialised screening for HIV, syphilis and Hepatitis B testing (Todd et al., 2008). Midwives supported the ability to order testing for above mentioned diseases as possible in FANC. Todd et al. (2008) recommended improved training, empowerment of midwives and the ability to order rapid testing. In a study conducted in four developing countries (Langer et al., 2002), midwives rated the overall aspect of care such as number of ANC visits, waiting time, types of information received and the quality of information provided in the FANC model as very good in comparison to services delivered in the traditional ANC model.

Every year, worldwide, approximately 8 million women suffer from pregnancy-related complications and over half a million die. Majority of these deaths could be prevented through proven, effective, and affordable actions [5]. Poor maternal health, leading to maternal death and severe acute maternal morbidity, remains a major problem, especially in sub-Saharan Africa where the maternal mortality ratio (MMR) is declining steadily, where one of every 16 women dies of pregnancy related causes during her lifetime, compared with only 1 in 2,800 women in developed regions [6].

Thus, most maternal deaths result not from 'disease' per se, but from pregnancy-related complications, which are now widely recognized as a leading cause of death and disability among women of reproductive age in developing countries. The common causes of maternal deaths are hemorrhage, postpartum infection, hypertensive disorders, obstructed labor and abortion complications. These life-threatening complications are treatable thus most of these deaths are avoidable if women with the complications have timely access to appropriate emergency obstetric care.

Generally, at the first antenatal visit to a healthcare facility, a pregnant woman is issued with an antenatal care card. This card is the principal record of the pregnancy and is filled in whenever the woman goes for an ANC visit. After the first visit, the woman is considered to be booked for subsequent ANC visits to identify the complications like preterm delivery and manage these complications in timely manner.[6] The first visit is important because that is when a woman receives a complete assessment of gestational age and the risk factors. A full and relevant medical history is taken from the pregnant woman including current pregnancy, previous pregnancies, previous history of preterm birth, complications and outcomes, medical problems, including psychiatric problems and previous operations, familial and genetic disorders, allergies, use of medications, use of alcohol, tobacco and other substances and family and social circumstances. A physical examination is done which is divided into three categories including a general examination, which includes weight, height, heart rate, the color of mucus membranes, blood pressure, check for edema, and palpitations of lymph nodes. In addition, a systematic examination, includes examination of teeth, gums, breasts, thyroid, and heart and lung functions. Finally, pregnancy related examination includes inspection and palpitation of the pregnant uterus, with measurement of the symphysis-fundal height in centimeters. After that, pregnant women undergo essential screening investigations, which include syphilis serology, rhesus (D) blood group, hemoglobin (Hb) level, human immunodeficiency virus and protein and glucose levels in urine. All pregnant women are given supplements of ferrous sulphate tablets to prevent anemia, calcium tablets to prevent complications from pre-eclampsia, folic acid, and tetanus toxoid to prevent neonatal tetanus. Recently, it is the recommendation of Word Health Organization that pregnant women should have their first contact in the first 12 weeks' gestation, with subsequent contacts taking place at 20, 26, 30, 34, 36, 38- and 40-weeks' gestation.[7] Hence, a minimum of eight contacts is recommended to reduce perinatal mortality and improve women's experience of care. In addition, ANC along with family planning, skilled delivery care, and emergency obstetric care, is a key element of the package of services aimed at improving maternal and newborn health.

1.2 Quality of care

Women were reported to initiate ANC late owing to the perceived bad quality of service at the healthcare facility[8]. The women's criticisms were related mainly to lack of services, citing reasons such as being sent home without receiving services owing to insufficient staff, and having to purchase drugs, cards or diagnostic tests, although the service was supposed to be free.

However, many of the pregnant women do not attend ANC in the first trimester. This means that many pregnant women fail to book for the recommended four ANC visits and are not benefiting from the services offered during this period. Many of them end up with complications leading to high maternal and infant mortality rates. In an effort to determine the factors contributing to underutilization of ANC services by pregnant women, intrapersonal, institutional, and health systems as well as social demographic factors have been identified to be associated with poor ANC attendance. In addition, there is also strong evidence suggesting that parity, gravidity, knowledge about ANC, intention to get pregnant, and substance use as well as social services and cultural beliefs are some of the factors likely to be associated with late booking and utilization of prenatal care services[8,9]. From the foregoing, there are many sociocultural factors that may be associated with late ANC booking. One of these factors likely to be critical in health promotional activities is educational attainment. Yet, studies focused on examining if education is associated with poor ANC attendance have remained limited. In this study, we aimed to find out if educational attainment is associated with ANC utilization, given the potential impact educational attainment could have on maternal and child survival.

The new approach to ANC emphasises the quality of care rather than the quantity. For normal pregnancies WHO recommends only four antenatal visits. The major goal of

FANC is to help women maintain normal pregnancies through:

- Identification of pre-existing health conditions.
- Early detection of complications arising during the pregnancy.
- Health promotion and disease prevention.
- Birth preparedness and complication readiness planning (WHO, 2017)

Antenatal care is one of the four pillar initiatives of the Safe Motherhood. It provides reassurance, education support for the women on screening programs and detects the problems that make the pregnancy high risk[9]. There are many socioeconomic and cultural factors which act as barriers to use of antenatal care. Although it cannot be claimed that antenatal care is the only solution for the high maternal and prenatal death, it can help to reach the Millennium Development Goals for the maternal and child mortality[10].World Health Organization recommended four antenatal visits for the low risk pregnancy. There is still debate regarding the optimal number of visits for the antenatal care. Early commencement of antenatal care by pregnant women as well as regular visits has the potential to affect maternal and foetal outcome positively. However antenatal care services are available in developing countries but utilization of these existing services is poor.

Each of the ANC visits consists of a well-defined set of activities related to three equally important general areas, namely screening for conditions likely to increase adverse outcomes, providing therapeutic interventions known to be beneficial, and educating pregnant women about planning for a safe birth, emergencies during pregnancy, and how to deal with them.[8]

There were many studies done which found that educated women have better pregnancy outcomes compared with uneducated women and that education during the antenatal period can reduce pregnancy and delivery complications.[11]

Antenatal care (ANC) is the care a woman receives throughout her pregnancy in order to ensure that both the mother and child remain healthy. A healthy diet and lifestyle during pregnancy is important for the development of a healthy baby and may have long-term beneficial effects on the health of the child. Almost 90% of maternal deaths occur in developing countries and over half a million women die each year due to pregnancy and childbirth related causes.

Women have been fulfilling their reproductive responsibility of propagating human race, many have died and many more faced death in the process of delivering babies, but this can be prevented by taking appropriated antenatal care, clean and safe delivery and essential obstetric care. Antenatal care is the first phase to be encountered once a woman has conceived. As recommended by WHO, regular antenatal (AN) care is essential during pregnancy. It suggested that a pregnant women should get at least minimum 4 antenatal visits. At each visit, regular blood pressure examination should be done and observation of any swelling of feet and face is also essential. She should have two tetanus toxoid injections at one month interval and be supplied with daily folic and iron tablets. During pregnancy period, she should consume a variety of food more often.[12]

2. CONCLUSION

Sustainability of the focused ANC package will also require explicit policy direction and coordinated RH program implementation and support. The process of stimulating changes in ANC service delivery will require further consultation with and inclusion of key actors, notably the pre-service training institutions and professional bodies, to ensure institutionalization and standardization of focused ANC training and supervision. Related to this is the need to update the curricula and training materials to be able to present focused ANC as a comprehensive and integrated service, rather than an aggregation of services that a provider may or may not be able to offer. Community mobilization when the new package is introduced is still required to create awareness about IBP, timing of ANC and the need to co-opt other critical actors, especially male partners, in preparation for birth and complications. A national educational campaign may help in this regard.

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