Editorial

# Antenatal Care : Quality, Utilization and Influencing Factors

## Antenatal care : Current concept :

Antenatal Care (ANC) is defined as the care provided by the skilled health care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy[1]. The components of ANC are: risk identification, prevention and management of pregnancy-related or concurrent diseases, health education and health promotion. ANC reduces maternal and perinatal morbidity and mortality through detection and management of pregnancy-related and concurrent diseases as well as identifying individuals at increased risk of complications during pregnancy, child birth and post-partum[1].

WHO envisages of a world where "every pregnant women and newborn receives quality care throughout pregnancy, child birth and post-partum period." WHO releases comprehensive recommendations on routine ANC with positive pregnancy experience as the key consideration. A positive pregnancy experience[1] is defined as :

- Maintaining physical and sociocultural normality
- Maintaining a healthy pregnancy for both mother and baby
- Having an effective transition to positive labour and birth
- Achieving positive motherhood.

## Indian scenario :

In India, antenatal, intra-natal and postnatal cares are provided by both public as well as private facilities and providers. The observation of utilization of private health facilities for antenatal care by rural pregnant women in a district of Karnataka as presented by a recent study has made it imperative to take a stock of the current situation in India. It was mentioned that availability of ultrasonography and other investigations and specialists during delivery were the important factors behind choosing a private health facility over government one[2].

According to National Family Health Survey (NFHS)-2019-21, Institutional delivery in public facilities has increased to 61.9% (Rural 65.3%, Urban 52.6%), compared to 52.1% during NFHS- 2015-16[3-4]. As per NFHS-5 (2019-21), around 90% women of India had institutional delivery of which 70% took place in public health facilities. There is huge inter-state variation where 83.2% in Chandigarh but 53.9% women in Punjab delivered in public institutions. In Karnataka the figure was 64.8%. However, at the time of data collection, Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) and Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) were in the initial phase of being rolling out, hence these may be an underestimation of the current scenario[5-6]. Further, it was also reported in NFHS-5 (2019-21) that, 70.0% of pregnant women registered within first trimester, 58.1% had at least four ANC visits, whereas 44.1% consumed iron and folic acid for 100 days[3]. All of these figures were improved compared to those of NFHS-4 (2015-16). As per NFHS-4, 53.5% ANC were provided by public sector only, while 28.4% took place in private facilities[4]. Ultrasonography was done in 61.4% pregnant women,

although more proportion of women from higher wealth quintiles had ultrasound tests[4].

The government of India launched the National Rural Health Mission (NRHM) in 2005, which was expanded into the National Health Mission (NHM) in 2013, after incorporating National Urban Health Mission (NUHM). Various maternal and child health related schemes and services are being operationalized under the umbrella of NHM. Some noteworthy strategies adopted under NHM to improve maternal health care to address the inequity of essential obstetric care including antenatal care (ANC) are as follows:

***Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA):***[6]

Under PMSMA, which was launched in June, 2016; all pregnant women in the country are provided on a fixed day, free of cost assured and quality Antenatal Care and to screen high risk pregnancies by specialists/ physicians. It also envisaged for delivering a minimum package of antenatal care services (including investigations and drugs) would be provided to the beneficiaries on the 9th day of every month at identified public health facilities (PHCs/ CHCs, DHs/ urban health facilities etc.) in both urban and rural areas in addition to the routine ANC at the health facility/ outreach.Health care providers from private sector are also engaged as volunteers to providespecialist care in Government facilities. Under this scheme, one Ultrasound (US) scan during the 2nd/ 3rd trimester of pregnancy along with other related laboratory investigation are recommended for all pregnant women.

***JananiShishuSurakshaKaryakram (JSSK):***[7]

Provision was made under *Janani Shishu Suraksha Karyakram* for availability of ultrasound scan and other laboratory tests which were not available at a public health facility; in a public-private partnership mode and related expenditures are covered by the Government.

***SurakshitMatritvaAashwasan (SUMAN):***[7-8]

A newer initiative namely-SUMAN-Surakshit Matritva Aashwasan", launched on 10thOctober, 2019 aims to provide assured, free-of-cost and quality healthcare with dignity and respect towards the beneficiary and to obliterate denial of services forevery woman and newborn visiting the public health facility aggregating existing services like JSSK, PMSMA etc. It envisaged to end all preventable Maternal and newborn deaths.

***State of the art Maternal and Child HealthWings (MCH wings):***[7]

MCH wings have been sanctioned at District Hospitals/District Women's Hospitals and otherhigh case load facilities at Sub-District level, asintegrated facilities for providing quality obstetricand neonatal care.

***Village Health, Sanitation and Nutrition Days (VHSND):***[7]

The VHSND is an outreach activity aimed at providing of maternal and child care including nutrition in convergence with the IntegratedChild Development Services (ICDS)near the residences of the beneficiaries.

***Maternal and Child Health Card (MCPC):***[7]

The MCP Card is being used by all States as atool for monitoring and improving the quality of MCH and Nutrition interventions.

***Web-enabled Mother and Child Tracking System (MCTS):***[7]

This is being implemented to help the health workers in planning forservice delivery and identification of beneficiarydue for Antennal Check-up (ANC), Postnatalcheck-up (PNC) and Immunization services.It helps in identification of high-risk pregnantwomen and tracking of health conditions andassistance during the delivery of pregnant women.

***Leveraging the Network of ASHAs:***[7]

Accredited Social Health Activists (ASHAs) have been engaged to facilitate access to health care services by the community, particularly pregnant women[5].

Within the purview of national health programmes, there are initiatives that widen the choice of a pregnant woman to select a private facility under certain circumstances. However, whether and to what extent such schemes contributed to increase the utilisation of private facilities for ANC is not well documented.

## Differential Utilization and the Issue of Quality of Care :

Although, WHO has identified key parameters for quality ANC in 2016 under sub-domain of nutritional intervention, maternal and fetal assessment, preventive measures, intervention for common physiological symptoms and health system intervention for quality of care, the comprehensive assessment of quality of ANC has not been reported so far[1]. Basic services (iron and folic acid supplementation, tetanus immunization etc) and clinical (registration before weeks, at least four ANC visits, assessment of blood pressure, edema, anemia, weight, height and abdominal examination including fetal heart sound etc) parameters were used so far in Indian studies to assess the quality of ANC[9-12]. In such a study based on data collected in NFHS-2015-16, it was noted that around half of the Indian pregnant women received all components of care. However, there is gross variation across the states as well as social gradient[9].

A review of 85 studies conducted across the globe could not synthesize clear demarcation between quality of ANC between public and private providers. They concluded that women selected care from such providers or settings where they found it is a positive experience fitting with their beliefs and values, was easy for them to access, affordable, and showed respectful behaviour[13].

The World Health Organization (WHO) recommended one Ultrasound (US) scan before 24 weeks gestation to estimate Gestational Age (GA), improve detection of foetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience[1]. If an early US scan was not performed, then stakeholders may consider performing a scan later in pregnancy to identify the

number of fetuses, fetal presentation, and placental location. However, this may not be available in each tier of public health facilities. Availability of ultrasound scan may be one reason to attract pregnant women to avail private facility for ANC.The JSSK and PMSMA broadened the opportunity to avail high end tests from accredited private institutions[7]. A positive association between health insurance coverage and full ANC utilisation has been found in a study based on the data of NFHS-4[9]. Only 20% women were covered by health insurance or health schemes and majority of these were beneficiaries of central or state government health insurance schemes[9]. Majority of the private insurance as well as the recently launched National Health Protection Scheme under the aegis of 'Ayushman Bharat' (AB-PMJAY) do not cover ANC services[5]. A study conducted in Karnataka reported that incentives by the Government facilitated the utilisation of public health facilities whereas lack of general cleanliness and poor infrastructure at public facilities were regarded as barriers[10]. Furthermore, factors such as accessibility, waiting time, unacceptability of providers were also reported as the reasons behind poor utilisation of ANC services[11]. Health professionals found to be spending more time in consultation in private facilities than public, which may considered favorable for private facilities[12]. It was also reiterated in another study where the authors concluded that the dominant utilization of private sector services by richer households signify possible variations in quality of care and health care services between public and private sectors, including better infection control practices[14]. In addition, public health facilities may not be well-equipped with Emergency Obstetric Care (EMOC) management and may not be able to provide C-section birth services on a need-basis[14]. On the contrary, an assessment of 201 private sector healthcare facilities in Maharashtra, Jharkhand, and Uttar Pradesh based on 16 item checklist developed by FOGSI for Manyata programme, which mainly encompasses intra-partum care and immediate newborn care, including infection control; revealed that overall quality of maternity care in private healthcare facilities is poor, especially for clinical standards related to management of complications of labour[15]. Delivery load was a significant determinant of quality of care[15].

Overall, a detailed account of the differences in antenatal care utilisations across all types of service providers as well as its loco-regional variation needs to be further explored. Without such evidence it is too early to comment, as a generalized note, on whether really women prefer to avail private facility over public ones.

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