Available online at www.scholarsresearchlibrary.com

Scholars Research Library

Archives of Applied Science Research, 2011, 3 (2):75-82

(http://scholarsresearchlibrary.com/archive.html)

ISSN 0975-508X
CODEN (USA) AASRC9

A study on the acceptance and practice of focused antenatal care by healthcare providers in The South-West Zone of Nigeria.

Ademola M AMOSU[1]; Adenike M DEGUN[2]; Adebo M THOMAS[3]; Motunrayo F OLANREWAJU[4], Abraham O BABALOLA[5] , Precious E OMEONU[4]
[4] Omolayo O OLA[4] ; Oyewole O Oyerinde[4] and Susan NWOGWUGWU[5]

[1] Department of Nursing Science, Lead City University, Ibadan, Nigeria
[2]Obafemi Awolowo University Teaching Hospital, Ile-Ife, Nigeria
[3]Department of Anatomy, Bowen, University, Iwo, Nigeria
[4]Department of Public and Allied Heealth, Babcock University, Ilisan-Remo, Nigeria
[5]Department of Nursing Science, Babcock University, Ilisan-Remo, Nigeria

---

ABSTRACT

This is a study on the acceptance and practices of focused antenatal care by healthcare providers in five public hospitals the south-west zone of Nigeria. Its goal is to provide a comprehensive and integrated system of reproductive health care that offers an integrated set of services and within a four visit model. This research focused primarily on the knowledge of the health care providers including nurses and doctors, on the new World Health Organisation (WHO) initiative, and aimed to determine how the health workers can enhance its practice. Of the six hundred validated semi-structured questionnaires administered in this cross-sectional study 500 were found usable for data analysis. Analysis was carried out using descriptive statistics. The result showed that 42% of the respondents considered frequent routine as the norm and that women should be classified by risk category, 52% identified ignorance as one of the factors affecting focused antenatal care. Furthermore, 66% accepted that focused antenatal care is not enforced by their healthcare facility as a result of lack of policy concerning the practice of focused antenatal care. Only 6% of the respondents disagreed that early detection and prevention of diseases are a major component of focused antenatal care. It was observed that establishing link between the community and the facility in order to increase utilization of the services offered by the new WHO package can enhance its practice. In addition, proper supervision by a skilled, trained healthcare provider will also be effective in enhancing its practice. The package is accepted by the health care workers but not practiced.

Keywords: *Focussed antenatal care World Health Organisation, healthcare providers, healthcare facilities, WHO package.*

INTRODUCTION

Antenatal care is the care a woman receives throughout her pregnancy in order to ensure that women and newborns survive pregnancy and childbirth. 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.

The World Health Report, 2005 calls for "Realizing the Potential of Antenatal Care". While antenatal care (ANC) interventions, in and of themselves, cannot be expected to have a major impact on maternal mortality, their purpose is to improve maternal and perinatal health, 'this being an end in itself and necessary for improving the health and survival of infants'. In addition, the potential of ANC as a line of action to increase the rate of births attended by skilled health staff, and its value as entry point for other health programmes such as malaria, tuberculosis, nutrition and Human Immunodeficiency Virus (HIV)/Acquired Immune deficiency Syndrome (AIDS) is now better understood and applied.

Maternal mortality, the death of a woman while pregnant or within 42 days of termination of pregnancy, remains disturbingly high in sub-Saharan Africa. It is estimated that 270,000 maternal deaths occurred in the region in 2005 [1]. The UN millennium Development goal (MDG) on maternal health aims to reduce the number of women who die in pregnancy and childbirth by three-quarters between 1990 and 2015 [2]. To achieve this goal, it is estimated that an annual decline in maternal mortality of 5.5% is needed; however between 1990 and 2005 the annual decline was only 0.5% in the sub-Saharan region, compared to 4.2% for the middle income countries of Asia [1], [3].

Maternal mortality occurs from risks attributable to pregnancy and child birth as well as from poor availability and quality of health services [4]. The most common causes of maternal mortality in sub-Saharan Africa include haemorrhage (34%), sepsis/infections (10%), hypertensive disorders (9%), HIV/AIDS (6%), and other direct causes (5%); other indirect causes contributed approximately 17% [5].

Experiences from different countries have shown that reducing maternal mortality may depend in part on the availability and use of a professional attendant at labour and delivery and a referral mechanism for obstetric care for managing complications, or the use of basic essential obstetric care facilities for all deliveries [6]. In many developing countries however, the majority of births occur at home, frequently without the help of a skilled assistant (midwife, nurse trained as midwife or a doctor) [7].

The effect of antenatal care on maternal mortality is unclear [8], [10]. However, there is broad agreement that antenatal care interventions can lead to improved maternal and newborn health, which can also impact on the survival and health of the infant [11]. Additionally, the ANC visit, which many women in sub-Saharan Africa attend, is an opportunity to reach pregnant women with messages and interventions. A global evaluation of antenatal care has resulted in the recommendation to deliver antenatal services in 4 focused visits (Focussed antenatal care; FANC), one within the first trimester and 3 after quickening, and this schedule is now endorsed by WHO [12],[13]. Proven effective antenatal interventions include serologic screening for syphilis, provision of malaria prevention, anti-tetanus immunization, and prevention of mother-to-child transmission of HIV [14], [15]. To fully benefit from these interventions, it is important that women start visiting the antenatal clinic (ANC) early in pregnancy.

The traditional approach to antenatal care, which is based on European models developed in the early 1900’s, assumed that multiple visits were better in the care for pregnant women. Frequent routine visits were the norm, and women were classified by risk category to determine their chances of complications and the level of care they needed [16].

The traditional antenatal care promotes and maintains the physical, mental, and social health of mother and baby by providing education to the pregnant mother and her family on nutrition, rest, and personal hygiene. It detects and treats high risk conditions arising during pregnancy whether medical, surgical or obstetrical. It also ensures delivery of a full term healthy baby with minimal stress or injury to the mother and her baby.

In traditional antenatal care, visits were often irregular with long waiting time, little feedback to (or real communication with) mother and little or no communication with obstetrical or labour units [17].

Focused antenatal care approach recognises two key realities: first, that frequent antenatal visits do not necessarily improve pregnancy outcomes and secondly, that while many women with risk factors may never develop complications, those women without often do [16].

The World Health Organisation (WHO) initiated focused antenatal care in order to improve the care given to pregnant women. Initially, frequent routine visits were the norm and women were classified by risk category to determine their chances of complications. The level of care disregards these categories and focuses on an updated approach to antenatal care over number of visits [18]. Each focused antenatal care visit includes interventions that are appropriate to the woman's stage of pregnancy, and which address her overall health and preparation for birth and care of the new born. This goal directed interventions are important because pregnancy is one of the most important periods in the life of a woman, a family and the society at large.

Antenatal care services were provided daily in all intervention clinics. However, the introduction of focused antenatal care was not accompanied with a reorganisation of antenatal care services [17]. Service delivery continues to follow the assembly line format where clients have to go through several access points during a single visit including: reception for cards to be numbered and recorded, weighing, health education, consulting room (for history taking, consultation and physical examination). Depending on the outcome of consultation and number of visits, clients may be sent to the laboratory or for counselling or pharmacy to collect medications like iron, folic acid.

The sequencing of services varies across clinics, but on average, clients make a minimum of five contacts on a single visit. Focused antenatal care however, expects that a woman will receive individualised care primarily from one provider, consistently over the four visits. It was introduced in a context in which many critical antenatal care services were not being widely offered, such as monitoring the progress of a pregnancy, identifying complications, referring mothers for specialised care at an appropriate time, and promoting postpartum family planning. The function of antenatal care in preventing problems for mothers and newborns depends on an operational continuum of care with accessible, high quality care before and during pregnancy, childbirth and the postnatal period. It also depends on the support available to help pregnant women reach services, particularly when complications occur. An important element in this continuum of care is effective antenatal care. The goal of focused antenatal care is to prepare for birth and parenthood as well as prevent, detect, alleviate, or manage the three types of health problems during pregnancy that affect mother and newborns such as: complications of pregnancy itself, pre-existing conditions that worsen during pregnancy and effects of unhealthy lifestyles.

Antenatal care also provides women and their families with appropriate information and advice for a healthy pregnancy, safe childbirth and postnatal recovery, including care of the newborn,

promotion of early exclusive breastfeeding and assistance with deciding on future pregnancies in order to improve pregnancy outcomes.

The elements of the new model comprise the early detection and management of disease/abnormality, counselling on health promotion, counselling on birth preparedness, readiness to take care of possible complications and the development of an individual birth plan. Counselling and health education have therefore become a major strategy to improve maternal health and, in particular, to increase the proportion of skilled delivery.

Several antenatal care visits with often irregular long waiting time, little feedback or no communication has been a major factor affecting antenatal care by pregnant women. Also, staff turnover, inadequate logistics, and planning have negatively affected clinic capacity to implement and sustain the antenatal services as well as quality of service provision.

With these limiting factors, antenatal care delivery by the health care providers is not efficient to detect any complications that may arise during pregnancy. Acceptance among health care providers, the content and coverage of services are not well understood.

The importance of caregiver's views has been acknowledged because it is a crucial component of any attempt to change institutional protocols. The main characteristics of focused antenatal care are reduction in the number of visits with an evidence-based set of contents, the provision of accurate information to women to identify warning signs, and encourage preventive behaviour [12]. Its goal is to provide a comprehensive and integrated system of reproductive health care that offers an integrated set of services and within a four visit model [16].

This study aims at assessing acceptance and practise of focused antenatal care by the health care providers in the study locations.

MATERIALS AND METHODS

The study population consisted of medical doctors and nurses working in five public hospitals in the south-west zone of Nigeria.

In other to have a homogeneous population, the simple random sampling technique was employed in selecting respondents across the health facilities. A self-developed questionnaire which was validated by experts in health sciences for face, content and construct validity and with reliability of 0.79 was considered adequate. Research assistants were recruited and trained for them to help in the administration of the questionnaires. After sorting out the questionnaires, 500 copies were found acceptable for analysis was carried out using descriptive statistics.

RESULTS AND DISCUSSION

Demographic Data

Out of the 500 respondents, 150(30.0%) were less than 30 years old, 150(30.0%) between 31-35 years, 120(24.0%) between 36-40 years, 50(10.0%) between 41-45 years, and 30(6.0%) above 46 years. Female respondents were 330 (66.0%) while the males were 170 (34%). There were 200 (40%) medical doctors and 300 (60%) nurses in the study sample. As for professional experience,110 (22%) had been practicing for over 10 years, 170(34%) between 5- 10 years, 140 (28%) between 1-5 years while 80 (16%) had been in practice for less than 1 year.

Distribution of respondents with regards to their knowledge on focused antenatal care:
Four hundred (80%) of the respondents were not aware of focused antenatal care, 60 (12%) obtained the information from the internet, 140 (28%) by attending seminars, while 80 (16%) could not remember how they received the information. Four hundred and seventy (94%) of the respondents agreed that the goal of focused antenatal care is to prepare the pregnant mothers for delivery and possible complications, twenty (4%) said it is to ensure adequate exercise while 10 (2%) felt it is to encourage the practice of traditional birth attendance. Four hundred and seventy (94%) agreed that focused antenatal care allows pregnant women to receive adequate care. Eighty-four percent of the respondents disagreed that counselling and health education do not influence negative lifestyle during pregnancy. With regards to number of visits, 70% agreed that a maximum of four visits are encouraged in focused antenatal care. When asked if establishing link between the community and the health facility will increase utilisation of services, 92% of the respondents agreed, while 90% also agreed that an essential element of a focused approach to antenatal care is the identification and surveillance of the pregnant women and their babies. Also, when asked if the major components of focused antenatal care include the early detection and prevention of diseases, only 6% of the respondents agreed. As regards classifying the pregnant women into categories, 22% of the respondents supported classification by weeks of gestation, 42% by risk of developing complications while 36% said it should be by the medical conditions which may affect the mother and her foetus.

Further, Tables 1 and 2 show the frequency distributions of respondents with regards to acceptance of and the practice of focused antenatal care respectively.

Research Question 1:
How can health workers enhance the practice of antenatal care initiative?
The result obtained showed that 460 (92%) of the respondents agreed that focused antenatal care practice can be enhanced by establishing link between the community, and the health facility in order to increase utilization of the services offered by the new W.H.O package. Also, all the respondents agreed that focused antenatal care will be effective if properly supervised by a skilled healthcare provider.

The Maternal, Child and Women's Health Unit of the Kwazulu-Natal Department of Health in collaboration with the Population Council's USAID-funded frontiers in Reproductive health Program, in an attempt to improve the quality of antenatal care in South Africa observed that by the end of the survey, four of the six intervention clinics had at least one staff member who had covered all the training modules.

This implies that with the awareness created by the facility through the health professionals to the community, the practice of focused antenatal care is encouraged and enhanced. In addition, it means that focused antenatal care can be enhanced by employing a skilled healthcare provider to supervise the activities of the unskilled healthcare providers during antenatal care.

Research Question 2:
What are the attitudes of healthcare providers towards focused antenatal care?
As indicated in the result, 42% respondents considered frequent routine as the norm and that women should be classified by risk category. It has been observed,[17], that visits were often irregular with long waiting time, little feedback to mothers and little or no communication with obstetrical or labour units This is a component of the traditional antenatal care resulting from lack of knowledge and practice.

Research Question 3:
What are the factors influencing focused antenatal care?
Fifty-two percent of the respondents identified ignorance as one of the factors affecting focused antenatal care. Furthermore, 330 (66%) accepted that focused antenatal care is not enforced by their healthcare facility as a result of lack of policy concerning its practice. In Kenya, the frontiers programme found out that inadequate staff training and shortages of equipment and supplies inhibit the full provision of services.

Research Question 4:
What are the components of focused antenatal care?
Only thirty (6%) of the respondents agreed that early detection and prevention of diseases are major components of focused antenatal care. According to the frontiers program in Kenya, it was observed that the new model did increase the quality of specific components of care, such as detection of diseases and counselling on family planning use postpartum.

The implication is that the health providers were not aware of the components of focused antenatal care.

Table 1: **Frequency distribution of respondents with regards to acceptance of focused antenatal care.**

	RESPONDENTS N= 500	
	FREQUENCY	PERCENTAGE %
Acceptance of focused antenatal care is influenced by:		
• Ignorance	260	52.0
• Poor socio-economic status of the healthcare provider	160	32.0
• Adequate training on focused antenatal care	80	16.0
Focused antenatal care is enforced in my healthcare facility.		
• Yes	170	34.0
• No	330	66.0
What is the level of quality of care that is offered to pregnant women under focused antenatal care package?		
• High quality	410	82.0
• Low quality	70	14.0
• Insufficient care	20	4.0
Can your healthcare system sustainably deliver a focused antenatal care?		
• Yes	350	70.0
• No	150	30.0

Table 2: **Frequency distribution of respondents in relation to practice of focused antenatal care**

	FREQUENCY	PERCENTAGE %
Inadequate resources do not affect the practice of focused antenatal care		
• True	410	82.0
• False	90	18.0
Advice and support to the woman and her family will enhance the practice of focused antenatal care		
• True	450	90.0
• False	50	10.0
Culture is not important while rendering antenatal care		
• Yes	100	20.0
• No	400	80.0
Religious practices are not considered during antenatal care		
• True	170	34.0
• False	330	66.0
Lack of funding for the implementation of focused antenatal care can affect practice		
• Yes	380	76.0
• No	120	24.0
Focused antenatal care will be effective if properly supervised by skilled healthcare provider		
• Yes	500	100.0
• No	0	0.00

CONCLUSION

It was observed that the antenatal care initiative by WHO is acceptable to the healthcare providers in the five public hospitals, where the study was carried out. Factors identified as militating against focused antenatal care are poor funding, culture, religious practices, ignorance and inadequate training of health care providers on the advantages of focused antenatal care.

REFERENCES

[1] World Health Organization, UNICEF/ UNFPA, The World Bank: Maternal mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva, Switzerland **2007**.
[2] United Nations: Resolution adopted by the General Assembly 55/2 United Nations Millennium Declaration, (**2000**). New York, USA: United Nation.
[3] C Ronsmans ,WJ Graham : *Lancet* (**2006**). 368:1189-1200.
[4] LP Freedman, RJ Waldman, H de Pinho, ME Wirth, AM Chowdhury, A Rosenfield: *Lancet*, (2005), 365:997-1000.
[5] KS Khan, D Wojdyla, L Say, AM Gulmezoglu, PF Van Look: *Lancet*, **(2000),** 367:1066-1074.
[6] MA Koblinsky,O Campbell, J Heichelheim: *Bull World Health Organ*, **(1999)**, 77:399-406.
[7] C AbouZahr, T Wardlaw: *Bull World Health Organ*, **(2001)**, 79:561-568.
[8] C Bullough, N Meda, K Makowiecka, C Ronsmans, EL Achadi, J Hussein: *BJOG*, **(2005),** 112:1180-1188.
[9] G Carroli, C Rooney, J Villar: *Paediatr Perinat Epidemiol*, **(2001)**, 15(Suppl 1):1-42.
[10] M McDonagh: *Health Policy Plan*, **(1996),** 11:1-15.
[11] World Health Organization, UNICEF: *Antenatal care in developing countries. Promises, achievements, and missed opportunities.* Geneva, Switzerland: World Health Organization; **(2003).**
[12] J Villar, H Ba'aqeel, G Piaggio, P Lumbiganon, J Miguel Belizan, U Farnot, Y Al-Mazrou, G Carroli, A Pinol, A Donner, *Lancet***, (2001)**, 357:1551-1564.
[13] G Carroli, J Villar, G Piaggio, D Khan-Neelofur, M Gulmezoglu, M Mugford, P Lumbiganon, U Farnot, P Bersgjo: *Lancet*, **(2001),** 357:1565-1570.
[14] P Bergsjo, J Villar: *Acta Obstet Gynecol Scand*, **(1997)**, 76:15-25.
[15] J Villar, P Bergsjo: *Acta Obstet Gynecol Scand*, **(1997),** 76:1-14.
[16] JHPIEGO/Maternal and neonatal health: Prevention and control of malaria during pregnancy. Reference Manual for health care providers. **(2003)** In Edited by: Blouse A, Chase R, Elabd S, Gomez P
[17] J Villar and P Bergsjo: WHO. Antenatal Care Randomized trial: *Manual for the implementation of the new model*. **(2004)**, WHO Geneva.
[18] JHPIEGO/Maternal and Neonatal Health Program:Behaviour Change Intervention for Safe Motherhood Common Problems, Unique Solutions. The MNH Program Experience. JHPIEGO: **(2004),** Baltimore MD.