Enhancing focused antenatal care in Ghana: An exploration into perceptions of practicing midwives

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1. Introduction and background

Globally, and typically in Africa, the period of parturition is characterised by moments of joy and pride for women, their families and society. The birth of a healthy newborn is welcomed and the mother is expected to remain safe throughout delivery, the post-partum period and beyond. The majority of pregnancies will proceed without complications; however in sub-Saharan Africa, the death of a woman while pregnant or within 42 days of termination of pregnancy are not declining sufficiently to reach Millennium Development (MDG) Goals 4 and 5 (Amosu et al., 2011).

The Government of Ghana adopted the World Health Organization’s (WHO) focused antenatal care (FANC) approach in 2002 in an attempt to address the comparatively high maternal mortality rate and to improve access, quality and continuity of antenatal care (ANC) to pregnant women. The outcome of antenatal care (ANC) on maternal mortality is uncertain. However, ANC interventions have been found to enhance maternal and newborn health, which can also impact the survival and health of the mother and infant (Bullough et al., 2005; WHO, United Nations International Children’s Emergency Fund [UNICEF], 2003). ANC is a key entry point for a pregnant woman to receive a broad range of health promotion and preventive health services; it is the care, supervision, and attention given to an expectant mother and foetus during pregnancy up to delivery. It provides a chance for pregnant women to make appropriate and informed choices and decisions, contribute to optimum pregnancy outcome and improved care of the newborn. The traditional method of ANC includes routine activities like weighing, history taking, urine analysis, measuring of foetal growth, physical
examination, palpation, early detection and management of minor complaints. During the traditional ANC methods, the pregnant woman visits the hospital up to 28 weeks of gestation, and then fortnightly up to 36 weeks and weekly visits thereafter. Furthermore, the traditional ANC assumes that more frequent ANC is better and thus quantity of care is emphasized rather than the essential elements of care. In the traditional ANC, care is provided by different midwives, nurses and doctors and women were classified by risk category to determine their chances of complications and the level of care they need.

In contrast, the FANC approach was originally intended to reduce waiting time during antenatal visits and subsequently increase the time for direct contact to share information on pregnancy-related issues (WHO, 2001). FANC is individualized, client-centred, comprehensive antenatal care that emphasizes disease detection rather than risk assessment. It is an evidence-based intervention which focuses on individual women’s needs and concerns and what is appropriate for the gestational period at that time of their pregnancy. The concept of FANC services is a model of preventive health care targeted at primary, secondary and tertiary prevention of diseases and pathological conditions during pregnancy and delivery. It is a model of care that is characterized by a series of health examinations done by health personnel to detect conditions in pregnancy which may threaten the pregnancy and its outcome. FANC emphasizes quality of visits and individualized care rather than quantity of visits. The FANC package includes continuous care provided by the same midwife and focuses on the involvement of the client’s partner or support person in the process of care and preparation for delivery. FANC focuses on the client and unborn baby’s needs. This needs include examining of the pregnant mother, involvement of the partner, treating clients as unique individuals (individualized care) with respect, preparing the client for delivery, educating her on what to expect and how to prepare the layout needed for delivery (birth preparedness). Women are also prepared for possible complications (complication readiness). Components such as individualized care, complication readiness, birth preparedness and detection and prevention of diseases help midwives to proactively detect diseases early and prevent complications; these components are strongly emphasised in the FANC approach (Nyarko et al., 2006).

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 additional ANC, 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.

1.2. Factors affecting the implementation of FANC

Client and care related factors such as clients’ knowledge, attitude, educational background, income levels, cost of service and accessibility of services influence the care and utilisation of antenatal services (Simkhada, Van Teijlingen, Porter, & Simkhada, 2003; Ye, Yoshida, Harun-Or-Rashid, & Sakamoto, 2010). Client related factors influencing women’s choice of place of delivery, were related to issues such as sub-optimal quality of care including communication, attitudes and cooperation within the health care system; cultural influences from decision makers, and their own perceptions of danger signs (bleeding, edema, headaches, diminished fetal movement) and traditional views on pregnancy and delivery (Seljeskog, Sundby, & Chimango, 2006). These client related factors were found to be the major barriers to utilising FANC services. In Nigeria, pregnant women who participated in a study acknowledged ignorance as one of the factors affecting accessing FANC.

In addition health system issues such as the lack of policy support and supervision were major factors influencing the delivering of FANC (Amosu et al., 2011). In Ghana where FANC was implemented to improve ANC, it is also not without challenges. In a study conducted by Nyarko et al. (2006) it was indicated that some components of delivering FANC were lacking in several clinics, most importantly procedures and facilities for disease detection, such as rapid testing for malaria, syphilis and HIV. Existing opportunities for referral were not completely utilized and client’s awareness of the process of FANC delivery was poor and was often confused with free delivery policies (Nyarko et al., 2006). Outreach actions, such as follow-up visits and information sharing, to ensure client compliance, infra-structure strengthening to ensure availability of space, equipment and essential drugs, supplies and equipment to providing FANC services were often found to be inadequate (Birungi, Stephanie, & Hughes, 2008).

In Ghana the acceptability and feasibility of introducing the FANC approach, was well accepted and appreciated. Components such as individualized care, privacy during service delivery and an emphasis on birth planning were received very positively (Nyarko et al., 2006). Midwives in Ghana were satisfied with the new approach as the quality of care for pregnant women and the unborn child improved pregnancy outcomes (Nyarko et al., 2006). However, the maternal mortality rate in the country is estimated at 350 per 100,000 live births (WHO, 2011) in spite of the high antenatal attendance of pregnant women in various health facilities. Sepsis, haemorrhage, hypertensive disorders of pregnancy, unsafe abortion, complications of obstructed labour, malaria, anaemia, malnutrition and opportunistic infections associated with HIV/AIDS are some of the leading causes of maternal mortality in Ghana (Ministry of Health, 2007; Asamoah, Moussa, Stafström, & Musinguzi, 2011). Most of above-mentioned conditions can be prevented or detected early, and managed by midwives during the antenatal period.

Since the implementation of FANC in 2002 very little research has been conducted and documented on the perceptions of midwives on the benefits and challenges of delivering FANC. The specific objectives of this study were to explore the perceptions of midwives on FANC at a large urban hospital in Tema, Ghana.

2. Methodology

An interpretive descriptive design (Thorne, 2008) was implemented. The study setting was an out-patient ANC unit at a large urban hospital in Tema, Ghana. FANC services have been delivered
at this hospital since 2002. The target population included all midwives who rendered care at this hospital (N = 40). Ethical approval was received from the Institutional Review Board of Noguchi Memorial Institute for Medical Research which is part of the University of Ghana and additional approval was sought from the hospital authorities. A visit was made to the study site to familiarize potential participants with the study and to access their interest in participating. Ten (10) midwives who were practicing FANC were purposively sampled. Midwives who had previously provided traditional ANC, FANC within the last six months and consented to participate, were included. Midwives who chose not to participate and who had not previously delivered FANC were excluded. The researcher explained the purpose, objectives, and the benefits of the study to the midwives and informed that the interviews would be audio-recorded and transcribed. Consent forms were signed to indicate agreement to participate. Semi-structured individual interviews were conducted by the principal investigator over a two month period, to collect data. All interviews were conducted in English, audio-recorded and transcribed verbatim for concurrent analysis. Pseudonyms were assigned to each participant to ensure confidentiality. Transcribed data were reviewed several times to obtain a general view of the data before coding. Data were manually coded using two methods described by Saldana (2009). This involved initial coding which was followed by an open coding approach. Initial coding included taking the data apart and examining it for similarities and differences. This helped to organize the data into themes. During the initial coding, memos were used to highlight areas for clarification. Areas for clarification were identified and attended to in the following interviews. A coding scheme was developed to ensure that data with similar properties was grouped together. Guba’s model of trustworthiness (Lincoln & Guba, 1985) was implemented. To ensure credibility the principal investigator ensured prolonged engagement by conducting an early familiarization with the hospital culture before collecting the first data and extended engagement with each participant that allowed for cross-checking the information. Confirmability was ensured by keeping an audit trail of all decisions made and by conducting the analysis by two independent coders to ensure that they came to the same conclusions. Dependability was ensured by displaying selective examples of data to support arguments and drawing of conclusion in the data were done.

3. Findings

Five themes emerged from the data analysis. It included midwives’ conceptualization of FANC and their perception of FANC processes/flow, quality of care, factor inhibiting the implementation of FANC, and strategies to enhance FANC interventions.

3.1. The midwives conceptualization of FANC

The scope of practice of the midwife expanded within the FANC approach. FANC was perceived as a service provided to pregnant women from pregnancy to delivery and six weeks into the postnatal period. This approach placed the midwife in a position of responsibility to be more proactive rather than reactive. The strength of FANC is the strong relationship between the service provider, in this case the midwife and client which promotes trust, openness, confidentiality and respect for uniqueness of each individual. FANC redefined the work of the midwife in terms of structure, organisation and focus and therefore it was perceived as superior to the delivery of the traditional ANC. The midwives conceptualised FANC largely as individualised care provided on a one-on-one basis to clients and as preferred services superior to traditional antenatal care as confirmed by Asantewaa, a Principal Midwifery Superintendent who had practiced FANC for nearly eight years:

“Focused antenatal is an individualized method of attending to pregnant women and its importance is that the woman is relaxed. In whatever question you ask, because you are the only two, she will tell you everything about herself, about her problems. Being a midwife and knowing the importance of focused antenatal, you will get the opportunity of telling and guiding her well in pregnancy.”

Awo, a young midwife who had been practicing FANC for 2 years conceptualised FANC as follow:

“Focused Antenatal Care is a kind of antenatal care where the midwife sees a client from the start of the pregnancy until she finishes or until she is in labour. So the midwife does everything for the client.”

Abrefi perceived FANC to be more productive and enhancing for both the midwife and the pregnant client. She stated that:

“In the traditional antenatal care that we were giving, we were not giving out our best but I can confidently say that if all of us are practicing the focused antenatal care well, maternal mortality rate will be reduced. Because with this, we are able to detect the complication that we are talking about that may endanger the life of the pregnant woman.”

In summary, the participating midwives conceptualised the delivering of FANC to build rapport and trust with the clients. In a trusting relationship the hope is that clients will feel more comfortable to share problem and discuss sensitive issues. The opportunity for “telling and guiding” implied a more productive and enhancing visit for both the midwife and the client and the potential to compliance with the services. Better ANC attendance will in the long term contribute to a decrease in maternal mortality.

3.2. Midwives perception of FANC process/flow

FANC services involve the delivery of routine processes for women that attend ANC. The clients are required to register and are assigned to a specific midwife. Fafa reflected:

“The new cases that come, we normally take detailed history and register them. We test them for their HIV status in the cubicle, we also ask them to go and do other investigations that are not done in the cubicle, at the lab.”

Asantewaa was of the view that the new as well as the deferred cases were all taking through the same procedure of registration and care. She stated that:

“We pay particular attention to all the clients especially the new, and those who have deferred from other clinics. With the referrals apart, from the history, we probe further to get more information as to the reasons why they left their previous clinic. After that they are assigned to a particular midwife.”

The importance of preparing appropriate teaching methods and mode of delivery to facilitate clients’ ability to understand, were emphasized. Composition of songs on scheduled topics was used to promote acceptance and easy recall of information. Giving health talks was a daily activity. Education was given in addition to routine assessments to prevent and detect prevalent diseases. Clients with STIs and HIV were often counselled by the FANC midwives before and after laboratory tests have confirmed the status of the client.

3.3. Midwives’ perception of quality care in FANC

Participants explained that the indicators of quality of care in FANC were reflected in confidentiality of the service, work flow,
detection of complications, rapport between the midwife and the client, client satisfaction, job satisfaction and effectiveness of monitoring and supervision.

Abrefi, an experienced midwife remarked:

“I think it is just something one can just boast of. FANC is really giving [better] quality of care than the traditional ANC you see. The services in FANC, both antenatal and postnatal and even the labour ward, is noted for giving quality of care because of the way things are handled now. You see we go to the extent of exchanging numbers for further management.”

Awo who is new to delivering FANC believed that the quality of care is better:

“I would say the quality of service in both cases is good, but FANC has a higher quality than the traditional one, in that with FANC, it is the same midwife that does everything like BP, urine, palpation and so on. If there is a change in the BP, she is able to detect it early to prevent complications.”

The structure of FANC services allowed individualised care and contributed to client satisfaction. The participants shared the view that clients did not complain about waiting times mainly because they were satisfied with the way FANC was organised. The participants noted that both midwives and clients were satisfied with how FANC is delivered. Participants were of the view that they needed more frequent supervisory visits to the units by nurse managers. Regular visits by managers will improve the midwives’ motivation and quality of services despite the volume of workload. They needed to feel supported and to have open communication to share the challenges they experienced from day to day.

3.4. Midwives’ perception of factors inhibiting implementation of FANC

Participants revealed that factors such as lack of sufficient resources, incentives, workload, waiting time and inadequate personnel were hindering the implementation of FANC. They noted that although FANC was beneficial in terms of the quality of the service, the midwives were often over worked, and resources to deliver the service were inadequate. The clients wait for longer hours and the number of personnel providing services is not enough. Obrago was of the view that:

“There are no transports for nurses; the authorities should make transportation available for us. We need transport so that we can come early and give effective focused antenatal service, then… I think the big people should think seriously about it because it will bring more productivity. …yes, err… that’s all I can say for now.”

Baaba felt increasing staff numbers to deliver FANC will help to reduce the workload and improve the service. She said that:

“I think nationwide we are short of midwives… they should train a lot of professional midwives and add to the existing ones, who are giving professional care. …[if] they train more midwives and can put two to each room, the workload will be a little relieved.”

Asantewaa noted that workshops and in-service training will help to upgrade the knowledge of the care provider:

“…all midwives practicing FANC should be sent to workshops regularly to update their knowledge about the concept. They can also organize an in service training for them.”

Some midwives indicated that they got all the assistance and logistics they needed to deliver FANC, other responses indicated that some FANC units were in need of assistance and logistics.

3.5. Midwives perception of strategies to enhance FANC interventions

The researcher wanted to know which support will help to achieve the purpose of FANC. Training of midwives, partner involvement, development of infrastructure and legislation were some of the issues that were mentioned. Abrefi felt they should have adequate facilities and suggested training of more staff:

“So one, the government should provide enough facilities, and then two, they should train enough midwives so that there will be enough midwives to work, now, workshop on this prevention of mother to child transmission (PMCT), I don’t know whether it has stopped or [if] it is ongoing, but there should be a lot of workshops to enhance the work. I suggested to my senior colleagues that they should train the young ones, because pretty soon the old ones will be facing out.”

Abrefi added that:

“Facilities as I can say in my institution here though it is not the best I don’t have much to complain about, but nationwide when I go to some of my friends even some people sit under the shed to do antenatal clinic and it is better to practice focused antenatal under this circumstance. In focused antenatal privacy is ensured which cannot be achieved under a shed. The ministry should be able to provide finance infrastructure.”

The involvement of spouses needs more attention. Nana asserted that she always involves the spouses on health education and this is her submission:

“At times their husbands comes with them so we take the advantage, we counsel them, so we make the husbands to know what they have to do to support their wives during labour and then delivery. The involvement of the spouses boost the client’s moral and they stick to advice because the husband assist and support them throughout the pregnancy.”

Participants felt that it is important to involve the husbands/partner in health education and advise them on how to support their wives.

4. Discussion

Different aspect of midwives perception of FANC were highlighted in the findings. The participating midwives conceptualised FANC mainly as an individualised care that was implemented to enhance quality of care for a pregnant woman and her unborn child. The participating midwives recognised that early detection, prevention of pregnancy and birth related complication was critical to improve maternal health. The structure and flow of service in the FANC approach promoted the building of a good relationship between the midwife and her client since confidentiality and privacy were assured; the women are seen by the same midwife during all the visits. However, inadequate resources, increased workload and long waiting time negatively affected how FANC services were implemented or were perceived by the participating midwives. Training of midwives in FANC, infrastructural development and relevant legislation were perceived as essential to the smooth implementation of FANC. The distinctive indicator in the various descriptions was that FANC ensured one-on-one care and eliminated fragmentation of services. These findings were similar to that of Nyarko et al. (2006) who concluded that it was often factors that were not in control of the practicing midwives, which influence the acceptability and feasibility of delivering the services.

The midwives mentioned that the components of FANC included detection and prevention of diseases, danger signs and complication readiness, health education and birth preparedness. The detection
of complications is mainly based on the clients’ report of symptoms and early diagnosis using laboratory investigations (WHO/UNICEF, 2003). Not all pregnancy related conditions are detected by clinical manifestations and investigations and the study participants shared the need to be able to order laboratory tests.

The monitoring of service quality requires standards that serve as a guide for evaluation. Various frameworks for evaluating quality exist; and the participants suggested regular audits. Nyarko et al. (2006) measured quality of delivery based on implementation of the components of the FANC approach. The midwives in this study noted that confidentiality of the service, work flow; detection of complications, rapport between midwife and client, client satisfaction; job satisfaction and effectiveness of monitoring and supervision were indications of good quality care in FANC (Nyarko et al., 2006).

In the current study, issues related to resources, incentives, workload, waiting time and shortage of personal were some of the factors that inhibited the implementation of FANC. Although FANC was beneficial in terms of the quality of service, the midwives were often over worked, resources were inadequate, the clients waited for longer hours and the number of personnel providing services were not sufficient to handle the number of clients. The support, provided for the service needs attention, for example supply of adequate resources and in service training. Similar to a study conducted by Yengo (2009) on nurses’ perception of FANC services in a district health facility in Dar Es Salam, shortage of human resources was cited as a major obstacle to the successful implementation of FANC. Nyarko et al. (2006) noted that the Ghana Health Service (GHS) had human resources constraints and the high attrition rate of a limited number of trained staff was a contributing factor.

FANC was viewed as beneficial to clients as it ensured client satisfaction and improved antenatal attendance. Strategies such as training of midwives, partner involvement, development of infrastructure and legislation were suggested by midwives as means of improving the services. Nyarko et al. (2006) suggested in-service training as a short term solution but advocated for the inclusion of FANC in pre-service training curricula. Staff training, outreach to ensure client compliance, infrastructure strengthening to ensure availability of space, more equipment and supplies for providing services are requirements for sustainable provision of FANC (Birungi et al., 2008).

4.1. Implications and recommendations for clinical practice, research and policy

Ghana continues to face significant challenges across the spectrum of development sectors and services, especially due to wide disparities in regional and district poverty levels and a marked socio-economic divide between the North and the South of the country. In an attempt to improve the outcomes FANC services certain recommendations are made: more midwives need to be trained to decrease the shortage and to improve the delivery of FANC. Continuous quality management is essential to ensure a supportive environment to deliver FANC services. This should include the physical infrastructure, adequate supplies and support services. Continued and increased support from Ghana Health Service (GHS) will be of great importance.

Support needed, include improved policies to progress the sustainability of FANC services. Further research aimed at evaluating FANC services from both the provider and user perspective is important. The study had limitations. The research was conducted at a hospital in Tema and the findings cannot be generalized to other regions in Ghana. Only midwives were interviewed and input from pregnant women and other health care providers are not represented.

5. Conclusion

It is clear that the midwives in this study perceived FANC positive. FANC can contribute to the quality of ANC delivery and subsequent improvement in the health status of pregnant women in Ghana. Midwives cannot do this alone; it needs a multi-professional and client-centred approach. This demands constant professional development of the midwives and policy formulation to support effective implementation of FANC. There is a need for the health and nurse managers to motivate for more equipment to ensure adequacy of resources to deliver quality care. The prevailing challenges are many but in the face of these, the midwives are positive about the delivery of FANC.

This study informed stakeholders; the Ghana Health Service and Ministry of Health, on the need to design and implement policies geared towards improving and supporting practices related to the successful implementation of FANC. In addition, the findings contributed to existing knowledge and have the potential to guide future research in the field of ANC to improve maternal health and reduce maternal deaths.

Conflict of interest

None declared.

References


