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PREGNANT WOMEN'S ACCEPTANCE AND PREFERENCE FOR FOCUSED ANTENATAL CARE IN IBADAN

OLUWATOSIN OA and ALUKO JO

ABSTRACT

In 2001 the World Health Organization (WHO) proposed the Focused Antenatal Care (FANC) to enhance health of mothers and neonates. This study assessed the level of awareness, acceptance and preference of FANC among pregnant women in a mission hospital. Design of study was crosssectional survey. One hundred and sixty pregnant women attending the booking clinic of a Catholic Mission Hospital, Ibadan were recruited over a four week period. Data was collected by means of a structured questionnaire. Descriptive analysis of frequency and crosstabulations and spearman's correlation were utilized. The participants were between 16 and 44 years of age, with a mean (SD) of 28.4 (5.1) years. One hundred and twenty eight (82.6%) were married and 46 (29.7%) had tertiary education. Only 22(14%) had heard of FANC while three (1.9%) considered that FANC was better than the traditional model. Sixty-three participants (40.6%) would prefer the ANC with adequate effective four (4) clinic visits.

INTRODUCTION

The WHO Focused Antenatal Care (FANC) was initiated for implementation in developing countries with the aim of improving maternal and perinatal health, in 2001¹. Trials conducted in Argentina, Cuba and Saudi Arabia showed that it was a safe, more sustainable, comprehensive and effective ANC model. In view of these evidences many Sub Saharan African countries indicated adoption of this model of ANC. However the feasibility of implementation as well as the changes in policy and programme required was not

very clear¹. FANC is an updated approach which emphasized quality over quantity of service. With FANC, women with normal pregnancies are recommended to have four ante natal visits. The first visit at less than 12 but not greater than 16 weeks of pregnancy, second visit at 24-28 weeks, third visit at 32 weeks and the last visit at 36th week². It was indicated that 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, disease prevention, birth preparedness and complication-readiness planning³. The benefits of FANC have been shown to outweigh those of the traditional ANC as the FANC is structured to provide opportunities for early detection of diseases and timely treatment and opportunities for preventive services such as immunization with tetanus toxoid and prophylactic treatment of Malaria⁴.

KEYWORD: Focused Antenatal care, Preference, Awareness, Pregnant women; Mission hospital.

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The traditional ANC model was a European model developed in 1900 and adopted by developing nations without due consideration for the demands of their environment and resources. It expects that a woman attends 12-13 ANC visits before delivery, without due consideration for the financial implications for such visits as well as distance to health facility especially by rural population. The approach is also risk focused, as care is based on the potential for risk. However women who were classified to be at risk may sometimes not develop any complications hence wasting resources⁵.

Research reports^{6,7} have shown that women in developed countries do not comply to the required traditional ANC visits and several socio-demographic factors may be responsible for this. Transport expenses, distance to ANC and cost of ANC were indicated as factors consistently reported for infrequent ANC visits⁸. The reduction in the number of ANC visits however is one of the main characteristics of FANC⁹. Therefore the FANC should be more acceptable to clients as comprehensive focused care is given during the few visits. Several reports^{4, 10 - 12} have affirmed that effective ANC is vital to ensuring accomplishment of this goal. However late initiation and irregular attendance at ANC were reported factors that reduced effectiveness of ANC. These factors are common features in the developing countries where there is high maternal and neonatal mortality and morbidity rates^{7, 13, 14}. The traditional ANC approach considers frequent routine as the norm and also women were classified based on level of risk envisaged, to determine their potentials for developing complications as well as their level of care. The report further observed that most developing countries adopted this traditional model without modification to suite neither the peculiarities of their resources nor the

needs of their population⁵. This approach is also risk focused but it has been reported that most of the women do not eventually have any diseases⁵.

Over the years it has shown that the resources were not adequate. In addition, noncompliance with required ANC visits was consistently reported. USAID report showed that majority of women who access traditional ANC have about four visits and about 70% of pregnant women had at least one visit¹⁵. A Nigerian study⁴ reported that about three fifths (60.3%) of their study population utilized ANC services at least once in their most recent pregnancy. Similarly a study in Kenya⁸ indicated that 90% visited ANC at least once during pregnancy and the number of ANC visits ranged from one to 10 visits. These reports among others are evidence that pregnant women do not comply with the number of visits expected in the traditional ANC visits. This study was designed to assess the level of awareness, acceptance and preference of the WHO FANC among pregnant women at a sub urban mission hospital in Ibadan.

METHODS

This was a descriptive cross-sectional study that utilized a structured questionnaire to assess pregnant women's acceptance and preference for FANC. It was carried out at the booking clinic of a Catholic Mission Hospital in a sub urban area in Ibadan. The hospital is well equipped with human, structural and material resources for management of obstetrical and gynecological cases. It serves as a secondary health facility in a sub urban region of the city.

The study proposal was submitted to the hospital authority review committee and study commenced after obtaining written approval. Detailed information about the study was provided to clients at every

booking clinic. Based on the record of previous antenatal clinic attendance in the preceding year one hundred and sixty women willing to participate in the study were recruited over a four week period. A structured questionnaire was used to elicit information on socio-demographic data, obstetric/gynaecologic history, and pattern of present antenatal booking as well as participant's knowledge of FANC, acceptance and preference for FANC. Using the Software Package for Social Sciences (SPSS) for windows version 15, descriptive analysis of sociodemographic characteristics as well as cross tabulations of preference for effective and adequate ANC with four visits throughout pregnancy and educational status and gestational age at booking were carried out. .

RESULTS

Response, suitable for analysis was obtained from 155 (96.9%) of the 160 women that were recruited for the study. Mean (SD) age of respondents was 28.4 (5.1) years. Five (3.2%) participants were teenagers. The highest level of education was senior secondary education for sixty six (43.7%) of the participants, 128 (83.7%) were married while 106 (68.45%) were self employed. Table 1 shows details of socio demographic data of participants. Forty five (29%) were primigravidas, 39(25.2%) were gravida 2, 25(16.1%) were gravida 3, 18(11.6%) were gravida 4 while 23 (14.8%) were grand multigravida. Thirtyseven (23.9%) had experienced miscarriage while another 30(19.4%) had experienced death of a child.

Figure 1 shows that 22(14%) had heard about FANC. The source of information for 13(59.1%) was the mass media, three(13.6%) each was nurses/midwives and doctors respectively while one (0.5%) each indicated friends and printed media as source of information and one

participant did not indicate source of information.

The participants at the booking clinic indicated the number of clinics they thought they would need to attend before delivery. The number of clinics indicated was grouped and cross tabulated with gestational age at booking, table 2. One hundred and twenty eight (82.6%) hoped to attend all the indicated clinic visits while 17 (11%) would not.

One hundred and fifty one (97.4%) did not know the number of visits recommended by the WHO model of ANC. Four (2.6%) of the participant that indicated that they know the number of visits recommended gave wrong answers were not correct, two (1.3 %) indicated one visit while the other two indicated three, and five visits each.

In response to the question "whether the WHO model of ANC was better than the traditional model", 148 (95.4%) of respondents claimed that they did not know while three(1.9%) considered that it was better, two of these had tertiary education while one had secondary school education. Another three (1.9%) also claimed that it was not better than the traditional model; one each in this group had primary, secondary and tertiary education.

However in response to another question assessing participants preference for effective and adequate ANC with just four clinic visits throughout the pregnancy period, 63(40.6%) would prefer the four (4) clinic visits Figure 2 shows the distribution by educational status. Spearman's correlation of educational status and the response to preference for the four clinic visits that is effective and adequate showed a negative correlation(-.129) with significant value of 0.13. Figure 3 shows the preference by

Table1: Socio demographic characteristics of respondents

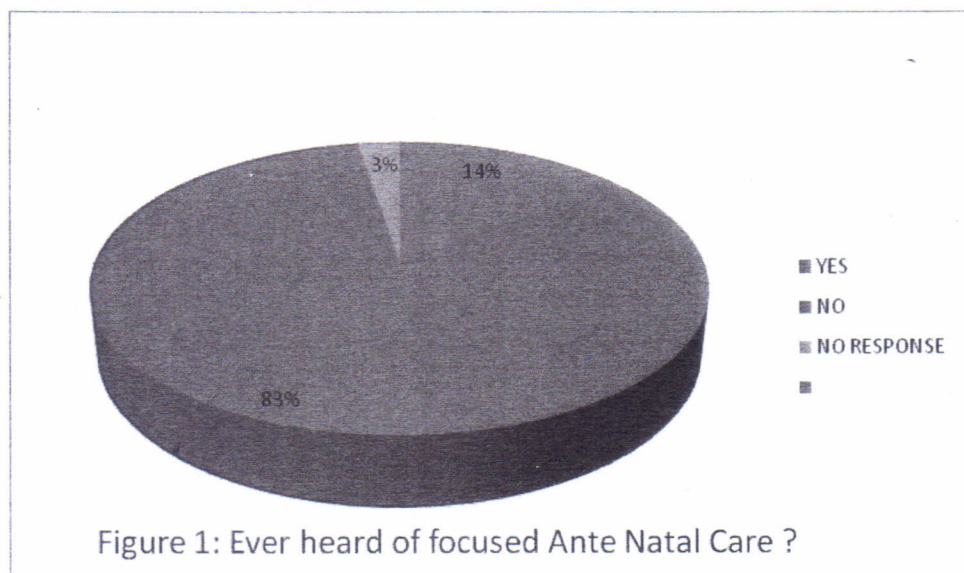
Character	Frequency	Percent
Age group		
16 – 19	5	3.3
20 - 24	29	19.3
25 - 28	43	28.7
29 - 34	52	34.7
35 - 44	21	14.0
Total	150	100.0
Marital Status		
Single	20	13.1
Married	128	83.7
Divorced	3	2.0
Widowed	2	1.3
Total	153	100.0
Educational Status		
No formal education	4	2.6
Primary	26	17.2
JSS1-3	9	6.0
SSS1-3	66	43.7
Tertiary	46	30.5
Total	151	100.0
Religion		
Christianity	69	45.4
Islam	83	54.6
Total	152	100.0
Occupation		
unemployed	5	3.2
student	16	10.4
housewife	4	2.6
self employed	106	68.8
civil servant	12	7.8
others	11	7.1
Total	154	100.0

Table 2: Participants' indication of expected number of visits at booking.

No of visits suggested	Gestational age at booking				
	4-12weeks	13-24weeks	25-32weeks	Total	%
< 4visits	5	16	11	32	21.5
4 visits	0	0	0	0	0
≥5	9	77	31	117	78.5
Total	14	93	42	149	100

Table 3: Reasons for preference and non-preference of effective and adequate antenatal care with just 4 clinic visits throughout pregnancy period

Reasons for preference	Frequency	Percent
If there is no problem at initial stage of pregnancy	12	25
Doctors/Nurses know what is good for us.	14	29.2
It is convenient, saves time, reduce costs & stress.	10	20.8
With good assistance from nurses when there is any complain	11	22.9
If pregnancy is 6 months before booking.	1	2.1
Total	48	100
Reasons for non-preference		
Adequate knowledge not possible in 4 visits.	6	10.7
I may have complaints	7	12.5
Treatment or care for pregnancy cannot be done in four visits	42	75
4 clinic visits is too much for me	1	1.8
Total	56	100



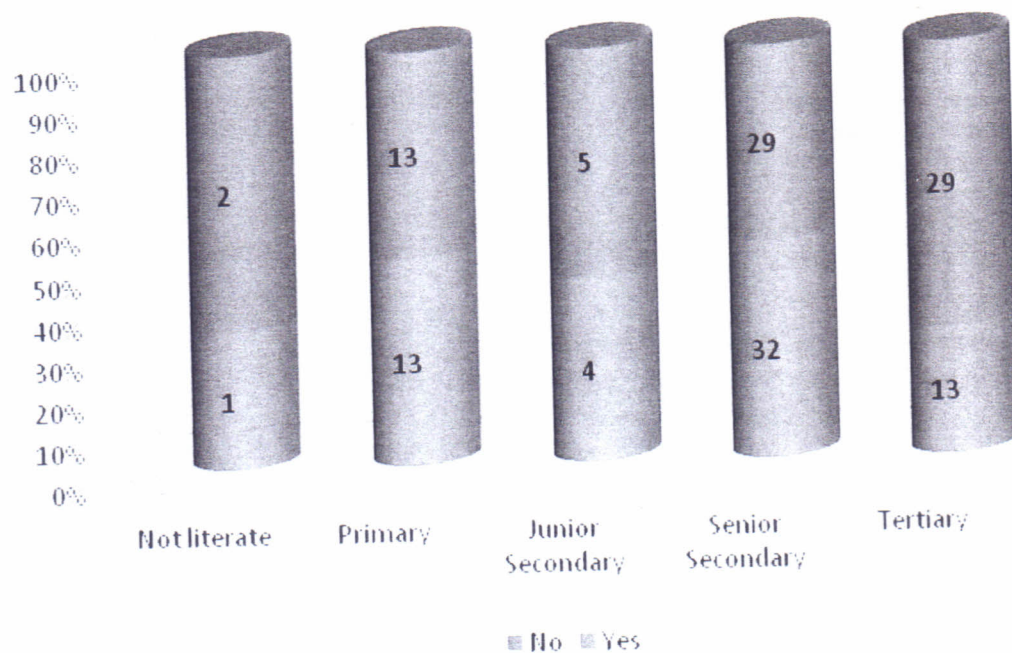


Figure 2: Preference for effective and adequate ANC with just four clinic visits throughout the pregnancy period by educational status.

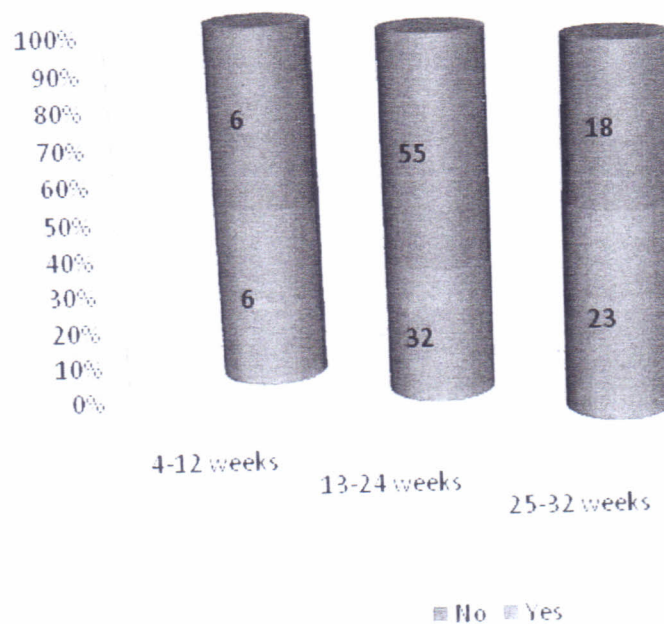


Figure 3: Preference for effective and adequate ANC with just four clinic visits throughout the pregnancy period by gestational age at booking.

gestational age at booking. Forty eight of the 63 participants gave reasons for their preference; table 3 shows details. Table 4 shows participants' reasons for non-preference.

DISCUSSION

This study shows that very few participants have heard about FANC, a finding that complements previous studies that showed that level of awareness of WHO focused ANC was very low in developing countries. A study¹⁶ among rural women in Nigeria showed that none of the participants were aware of FANC. Another report⁹ among health care professionals in South West Nigeria also showed low level of awareness as more than 80% of the study participants were not aware of FANC. This previous report may explain the current findings among pregnant women. If after a decade of initiation of FANC, health care workers and pregnant women are not informed or aware of the program, then there is a big gap between policy and implementation. These findings have implication for health policy and planning as well as maternal health. The objective of initiating FANC was to improve both maternal and neonatal health in developing countries. In these countries both maternal and neonatal morbidity and mortality are very high and also there were reports of irregular ANC attendance¹⁷. This finding however is contrary to reports from other African countries such as Ghana, South Africa and Kenya.

The source of information among the women about FANC varied between health care workers, the media, and friends. The level of awareness was very low to the extent that majority responded that they do not know whether FANC was better than the traditional ANC. Only three participants either way considered FANC better and not

better than the traditional ANC. However it may be deduced that the participants could not compare as they have not been exposed to one of the two. This may support the fact that there is dearth of information hence it may be erroneous to imply that participants do not prefer FANC when in actual fact the issue is that they do not have understanding of what it entails.

It is pertinent to note that the response of the participants tilted positively when asked specifically whether they would prefer "effective and adequate antenatal care with just four clinic visits throughout the pregnancy", many more would prefer this described ANC. More than one third of the respondents indicated preference while another one third indicated reasons for non-preference. In the current study reasons for preference were based on trust in the health professionals, 29.9% indicated that if this is what the professionals consider to be good then they prefer it while another 22.9% indicated that if the nurses will be available to answer their questions and see to their complaints. It is imperative that health care worker brace up to this expectation.

Few 20.8% implicated cost and convenience as indicated in a previous study¹⁸. In conformity with previous findings¹⁸ majority of the participants indicated non-preference for fear of inadequate information and inadequate time to familiarize with health care providers. Also they considered that such few visits will not give opportunity for early detection of disease. Similarly another study¹⁶ in a Nigerian rural population indicated that more than half of the participants in the study preferred the traditional ANC with multiple visits as they considered it more reassuring as it provides time away from their routine chores and opportunity to interact with other pregnant women and health care workers.

These findings show that a lot needs to be done to provide both health care workers

and pregnant women information about the FANC such that the concepts and the benefits will be evident. It has been observed that the components of FANC such as HIV testing, Malaria prevention and tetanus immunization were part of the services offered at the ANC clinics, but frequent ANC visits and long waiting period remain the norm of services¹⁴. It is pertinent to note that though the introduction of the FANC has great potentials to improve health of pregnant women as well as increase number of births attended by skilled personnel, there is need for additional investment in human resources as well as reorganization to ensure successful implementation.¹⁹.

In conclusion, Nigeria is lagging behind in the full implementation of FANC 10 years after initiation as indicated by research reports and casual observation. In view of these findings it is imperative to explore the content of midwives' and other health care workers' curriculum for training to establish the implementation of another vital aspect of the FANC proposal which is to include the concept into health care workers training curriculum¹.

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