

## IMPROVING FOCUSED ANTENATAL CARE AND COUNSELLING PRACTICES AMONG HEALTH FACILITIES IN THE EFFUTU MUNICIPALITY

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**ABSTRACT:** *Counselling practices during focused antenatal care are considered an effective strategy to improve pregnancy outcome. Using the Explanatory design of mixed method approach, 369 women who have ever attended antenatal care and gave birth in the health facilities, opinion leaders in the communities and practicing midwives within the Effutu Municipality were sampled randomly and purposively. Two research questions were formulated and were analysed using Mean, Standard Deviation and Spearman's Correlation Coefficient. The study revealed that the general perception of women in the municipality was that counselling during FANC was not effective and that reasons for counselling implementation gaps were: poor communication, negative midwives' attitudes, lack of knowledge and experience of midwives in counselling, poor time management and uncooperative client behaviour. The study recommended that Midwives, the ministry of health and the Ghana health service should improve accessibility to antenatal services and the municipal health directorate and the midwife should improve midwives' knowledge and skills in antenatal counselling and focused antenatal services as a whole. Finally, a model was developed to improve counselling during focused antenatal care.*

**KEYWORDS:** Counselling practices, Counsellor, Focused antenatal care, Midwives

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## INTRODUCTION

### Background

In Ghana, maternal health care has improved over the past 20 years but at a very slow pace. Between 1990 and 2005, maternal mortality ratios reduced from 740 per 100,000 live births to 503 per 100,000 live births, and then to 451 per 100,000 live births in 2008. If the current trends continue, maternal mortality will be reduced to only 340 per 100,000 by 2015, instead of the MDG target of 185 per 100,000 by 2015. The improvement, however, is not the same for all regions. There are disparities in maternal mortality ratio (MMR) across the 10 regions in Ghana (Ghana Demographic and Health Survey (GDHS), 2008). Maternal mortality ratio reflects the rate of death of women from pregnancy to puerperium and it is the most important indicator used for evaluating the effectiveness of safe motherhood services (GDHS, 2008).

A woman's health and behavior in pregnancy not only affect her but also affect her baby. Maternal health and newborn health are closely linked. More than three million newborn babies die every year, and an additional 2.6 million babies are stillborn (Cousens, Blencowe, Stanton, Chou, Ahmed, Steinhardt, Creanga, Tunçalp, Balsara, Gupta, Say & Lawn, 2011). Antenatal care (ANC) is a key strategy to improve maternal and infant health. Along with family planning, skilled delivery, post-partum care and emergency obstetric care, it is a key element

of the package of services aimed at improving maternal and newborn health (WHO, UNICEF, UNFPA, 2012).

Focused antenatal care means that providers focus on assessment and actions needed to make decisions, and provide care for each woman's individual situation. It is an updated approach to antenatal care that emphasizes quality over quantity of visits (Kinze & Gomez, 2004). This approach of antenatal care recognizes three key realities: First, antenatal care visits are a unique opportunity for early diagnosis and treatment of problems in the mother and preventions of problems in the newborn. Second, the majority of pregnancies progress without complication. Third, all women are considered at risk of complications because most complications cannot be predicted by any type of risk categorization. Therefore, all women should receive essential care and monitored for complications that are focused on individual needs (Maine, 1991).

In the monograph of Pecku (1991), counselling is a very important aspect of focused antenatal care. Effective counselling will assist the pregnant woman and the household in effective decision-making; this will influence the outcome of the pregnancy. While effective antenatal counselling alone will not prevent global maternal and newborn mortality, the quality of counselling during focused antenatal care plays a vital role in ensuring the healthiest possible outcome for mother and baby.

### **Statement of the Problem**

In Ghana, it has always been the priority of the government to reduce maternal and under-five mortality. Thus the government continues to decide on how to make maternal health services more accessible to all categories of women. In addition to the introduction of focused antenatal care, the government has few years ago replaced the exemption for antenatal care and delivery by the implementation of National Health Insurance Scheme (NHIS). The Safe Motherhood Programme in the country is aimed at improving women's health in general and especially reducing maternal morbidity and mortality as well as contributing to the reduction of infant morbidity and mortality (Nyarko, Birungi, Armar-Klemesu, Arhinful, Deganus, Odoi-Agyarko, & Brew, 2006).

In the Effutu Municipality, resources are in place for an effective implementation of focused antenatal care. The Municipality has been making progress in terms of antenatal coverage and supervised delivery coverage, however in terms of maternal and perinatal outcomes; the Municipality is performing poorly (Effutu Municipal Health Directorate, 2013). Maternal mortality ratio has increased from 92 per 100,000 live births in 2011 to 161 per 100,000 live births by the end of 2012. Stillbirth rate is also high (Effutu Municipal Reproductive and Child Health, 2013). In addition to this, the women seem always not aware of emergencies and the part they should play to ensure positive outcome of pregnancy. Post-partum family planning and good nutrition remain a dream to some of them. The fundamental question is: Were they counselled on birth planning, family planning, good nutrition, and prevention of diseases such as malaria during antenatal care? The study therefore explores the challenges associated with counselling services during focused antenatal care and makes some recommendations to improve counselling services during focused antenatal care in the Effutu municipality.

## **Purpose of the study**

The study aimed at reviewing the current counselling practices during antenatal care in Effutu Municipality and proposed a framework for making counselling during focused antenatal care an effective strategy to ensure successful pregnancy outcome.

## **Objectives**

Its specific objectives were the following:

1. Ascertain the effectiveness of counselling practices during focused antenatal care in the Effutu Municipality;
2. Propose framework for improving counselling services during focused antenatal care in Effutu Municipality.

## **Research Questions**

1. How effective are counselling practices during focused antenatal care in health facilities in the Effutu Municipality?
2. What can be done to improve counselling services during focused antenatal care and ensure adequate preparation toward better pregnancy outcome?

## **Significance of the study**

This study will help address the issues of poor implementation of focused antenatal care in Effutu municipality. The Municipal Health Management Team and other stakeholders, such as the municipal assembly, the traditional council and the health training institutions will be better informed about the counselling and quality issues that affect users and prospective users of focused antenatal services in the municipality and develop strategies of making quality services more available, receptive and acceptable to every pregnant woman in order to reduce maternal mortality and morbidity.

## **RELATED LITERATURE**

### **Focused ANC in Ghana**

The daily behaviours and activities of a prospective mother who has conceived must be monitored and directed by experts and professional health care providers, to advice and help the prospective mothers through proper medication and good practices until they deliver. The Government of Ghana has adopted the WHO focused ANC package in a move to improve access, quality and continuity of ANC services to pregnant women. As part of these efforts, the Government has exempted fees for ANC clients. Focused ANC, which relies on evidence-based interventions provided to women during pregnancy by skilled healthcare providers such as midwives, doctors, and nurses with midwifery and life-saving skills. Focused ANC includes assessment of maternal and fetal well-being, preventive measures, preparation of a birth plan including complication readiness, and health messages and counselling (LINKAGES, 2000). Focused antenatal care means that providers focus on assessment and actions needed to make decisions, and provide care for each woman's individual situation.

### **Counselling as a key component of Focused Antenatal Care**

Counselling in focused antenatal care is an interactive process between the skilled attendant/health worker and a woman and her families, during which information is exchanged and support is provided so that the woman and her family can make decisions, design a plan and take action to improve their health (Akummey, 2003). The skilled health provider must be aware that not all topics require counselling; some are points of communication and discussion - others require a more in-depth process to determine how women will take better care of themselves with support from their families. Limited time and resources mean it is not always possible to counsel all women in all aspects of care during pregnancy. The skilled health provider must identify with each woman which points should be prioritized and how to best respond to the individual needs of each woman. It is important to find a balance between general communication and the need to provide specific counselling and support to individual women (Pecku, 1991).

### **Benefits of Effective Counselling in Focused Antenatal Care to a Health Worker**

Effective counselling during focused antenatal care is extremely beneficial to the service provider. It helps him / her to better understand the needs of the women and the community to whom services are provided and support them in to take better care of themselves and their babies during pregnancy, birth and the postnatal period (Akummey, 2003). This support will also be extended to the women families to take actions to improve maternal and newborn health which specifically meet their needs. Every culture has its own rituals, taboos, and proscriptions surrounding pregnancy and childbirth. These beliefs and practices are deeply held and define what a culture regards as acceptable or unacceptable conduct on the part of the pregnant woman, her partner and family, and others who are caring for her. Cultural awareness, competency, and openness are essential in a care relationship with a woman during this important time in her life. By taking into consideration all of the information known about a woman: current health, medical history, daily habits and lifestyle, cultural beliefs and customs, and other unique circumstances, the skilled provider can individualize components of the care plan for each woman. The woman's health and survival, basic human rights, and comfort are given clear priority. The woman's personal desires and preferences are also respected. Communication, participation, and partnership in seeking and making decisions about care help to ensure a fuller and safer antenatal, delivery and post natal experience for the woman, her newborn, and her family (Cormier & Harold, 1999).

Effective counselling will also contribute to increased confidence and satisfaction of women, families and the community in the health facility services and personnel. This will increase coverage and promote several interactions between women and service providers. Repeated contacts between the women and the health service providers offer many opportunities for providing evidence based interventions likely to affect maternal, fetal, and neonatal health and survival. Several interactions will give the opportunity to women to understand the messages of: Place of delivery, skilled attendant at delivery, assistance at delivery, arrangement for housekeeper, money and transport arrangement and understanding of normal labour and complications in pregnancy signs. In addition they will be able to prevent malaria, adhere to infant feeding guideline accept post-partum family planning and prevent diseases (Pecku, 1991; Cormier & Harold, 1999; Akummey, 2003).

## **Factors affecting counselling and ANC**

A study conducted to examine the implementation challenges of maternal health care services in the Tamale Metropolis of Ghana revealed inadequate in-service training, limited knowledge of health policies by midwives, increased workload, risks of infection, low motivation, inadequate labour wards, problems with transportation, and difficulties in following the procurement act, among others as some of the challenges confronting the successful implementation of the MDGs targeting maternal and child health in the Tamale Metropolis (Banchani & Tenkorang, 2014).

Lack of adequate infrastructure, shortage of supplies, drugs and basic equipment can compromise the quality of counselling provided during focused antenatal care. Inadequate human resource is a major challenge to implementation of effective counselling during focused antenatal care. Deployment of staff to rural areas can be a real difficulty, particularly where there are no economic incentives to deploy and retain staff in less favourable conditions. Staff may not have the required knowledge and skills to provide effective counselling during FANC or may not receive the support they need. The attitudes and behaviours of health care providers in FANC clinics compound this problem by failing to respect the privacy, confidentiality, and traditional beliefs of the women. This may negatively influence the use of ANC as well as Maternal Neonatal and Child Health services at large (Ellis, 2003).

Focused antenatal care means that providers focus on assessment and actions needed to make decisions, and provide care for each woman's individual situation. Focused ANC includes assessment of maternal and fetal well-being, preventive measures, preparation of a birth plan including complication readiness, and health messages and counselling (LINKAGES, 2000).

Lack of knowledge and skills of midwives in antenatal counselling, increased workload, low motivation, poor attitudes and behaviours of midwives and lack of adequate infrastructure, shortage of supplies, drugs and basic equipment can compromise the quality of counselling provided during focused antenatal care (Ellis, 2003).

## **METHODOLOGY**

### **Research Design**

Explanatory design of mixed method approach was employed to enable measuring of relationships among variables through the quantitative procedures, while qualitative procedures were followed to explain challenges and their impact on ANC in the study area. In other words, a sequence of quantitative followed by qualitative methods was employed (Creswell & Plano Clark, 2011).

### **Population**

The study inclusion criteria was: having been pregnant, attended antenatal care at a recognized health facility and had delivered in the Effutu Municipality; or had been admitted to any of the hospitals in the Effutu Municipality as an emergency referral in the postpartum period and the willingness to participate in the study (called clients).

### Sample Size and Sampling Procedure

Data for the study came from 369 respondents using the simple random sampling (lottery) method as well as the purposive sampling method. The sample size is summarized in Table 1.

**Table 1: Sample size**

Category	Number	Percent
Pregnant women	341	92.4
Midwives	8	2.2
Women opinion leaders	20	5.4
<b>Total</b>	<b>369</b>	<b>100</b>

*Source: Field Data, 2014*

### Piloting the instruments

The instruments were piloted to enable the researcher identify potential roadblocks before full implementation and also to address issues of validity and reliability of the research instruments. The sets of questionnaires were administered to 20 pregnant women; two midwives and three women opinion leaders were interviewed in the Agona West Municipality for the pilot testing. Cronbach's Alpha test was conducted on the pilot data collected and a Cronbach's Alpha coefficient of 0.75 was attained before the main data collection was carried out.

### Data Analysis

Data were statistically analysed with the SPSS. Most of the findings were reported in tables with some narrations (quotations) from the participants. In sum, the method of analysis used for the respective research questions are indicated as follows:

(RQ 1) How effective are counselling practices during focused antenatal care in health facilities in the Effutu Municipality?: Mean, Standard Deviation and Spearman's  $\rho$  Correlation Coefficient. (Coolican, 1999).

(RQ 2) What can be done to improve counselling services during focused antenatal care and ensure adequate preparation toward better pregnancy outcome?: Percentages preceded Attribute coding, Structural coding, Pattern coding and Focused coding (Saldana, 2009; & Creswell, & Plano Clark, 2011).

## RESULTS AND DISCUSSION

*Research Question 1:* How effective are counselling practices during focused antenatal care in health facilities in the Effutu municipality?

Two sub-objectives (attendance to counselling and effectiveness of counselling) were set out.

### Attendance to Counselling

To ascertain the attendance of pregnant women to ANC counselling the researcher compiled information on how often the clients received counselling on the selected ANC indicators for this study. Table 2 presents mean and standard deviation scores for the indicators.



**Table 2: Means and Standard deviations for ANC indicators (N=300)**

ANC indicators	Mean	Std. Deviation
Counsel on malaria prevention	1.07	.261
Counsel on family planning methods	1.21	.406
Counsel on nutrition	1.03	.171
Place likely to deliver	3.45	1.915
Counsel on normal labour pain	1.21	.406
Counsel on danger signs	1.10	.296
Counsel on BPCR	7.04	3.307

Source: Field Data, 2014.

Table 2 shows that among the selected indicators for this study Birth preparedness and complication readiness (BPCR) had a mean of 7.04 with a standard deviation of 3.31. It gives indication that on the average, every pregnant woman has approximately seven counselling sections on BPCR. The reason for this could be that counsellors attached more importance to BPCR.

Birth preparedness and complication readiness is an important part of FANC as it leads to birth plan. Many women valued their birth plan as a communication tool for conveying their wishes to others. They felt a heightened sense of control because they had choices. They viewed their role as one of active participation because they engaged in collaborative decision making with the midwives. These women believed that their realistic and flexible birth plans contributed to their satisfaction and a positive birth experience (Doherty, 2013).

On the other hand counselling on nutrition recorded the lowest attendance with the mean 1.03 and a standard deviation of 0.17. This finding is contrary to Banchani and Tenkorang, (2014) who showed that 64.4% of women had nutrition knowledge during pregnancy at Guto Gida Woreda.

### Knowledge of pregnant women on counselling topics

To ascertain the effectiveness of counselling practices during focused antenatal care in the Effutu municipality. Spearman's correlational analysis was run to establish association between numbers of times women attended antenatal counselling and the various targets earmarked for effective focused antenatal care.

**Table 3: Spearman's Correlations among Counselling ANC indicators (N=300)**

		ANC Visits	Parity	Edu. Level
Counsel on malaria prevention	Correlation	-.249(**)	.122(*)	-.118(*)
	Sig. (2-tailed)	.000	.035	.041
Counsel on Family Planning	Correlation	-.030	-.129(*)	.134(*)
	Sig. (2-tailed)	.609	.026	.020
Counsel on Nutrition	Correlation	-.298(**)	.146(*)	-.103
	Sig. (2-tailed)	.000	.012	.074
Counsel on Delivery place	Correlation	.197(**)	-.137(*)	.171(**)
	Sig. (2-tailed)	.001	.018	.003
Counsel on normal labour pain	Correlation	-.223(**)	-.062	.090

	Sig. (2-tailed)	.000	.281	.120
Counsel on danger signs.	Correlation	-.253(**)	.082	-.089
	Sig. (2-tailed)	.000	.156	.125
Counsel on BPCR	Correlation	.295(**)	-.039	.024
	Sig. (2-tailed)	.000	.497	.675

Source: *Field Data, 2014.*

Note. \*\* Correlation is significant at the 0.01 level (2-tailed); \* Correlation is significant at the 0.05 level (2-tailed).

The data in Table 3 shows that there was significant positive correlation between ANC attendance and both counsel on delivery place, and counsel on BPCR. Specifically, it shows that there was a low positive significant correlation between attendance and counsel on BPCR,  $r = .295$ ,  $p$  (two-tailed)  $<.01$ . Birth Preparedness and Complication Readiness (BPCR), is supposed to educate pregnant women on common and usual complications associated with pregnancy and child-birth, and also educate them on home-based first aid remedies. Birth Preparedness and Complication Readiness was shown to be positively correlated to ANC attendance. According to the GDHS (2008) more than two-thirds of women (68%) who attended ANC counselling were informed of BPCR.

Again, in a study conducted in rural Burkina Faso to assess the link between counselling and birth preparedness and complication readiness, one independent factor was found to be associated with reception of birth preparedness and complication readiness advice which was the number of antenatal visits attended (Soubeiga & Sia, 2013).

Furthermore, Table 3 shows that there was a low positive significant correlation between ANC attendance and counsel on delivery place,  $r = .197$ ,  $p$  (two-tailed)  $<.01$ . This gives indication that as women increased their ANC attendance, they were enlightened to make well-informed decisions on their place of delivery. Plan to identify a means of transport to the place of childbirth was related to greater awareness of birth preparedness and complication readiness (Ekabua, et al 2011).

*Research Question 2:* What can be done to improve counselling services during focused antenatal care and ensure adequate preparation toward better pregnancy outcome?

Participants were interviewed and expressed diverse strategies which have been organised under thematic areas and presented in Table 4 and Table 5 for pregnant women and opinion leaders; and midwives respectively.

### **Suggestion for improvement from pregnant women and women opinion leaders**

Pregnant women (clients) are key stakeholder and partakers in ANC counselling therefore their suggestions towards improvement of ANC counselling cannot be taken for granted. Their suggestions as well as that of opinion leaders obtained from the interview are presented in Table 4.



**Table 4: Suggestions to improve ANC by Mothers and Women Opinion Leaders**

<b>Suggestion</b>	<b>Number</b>	<b>Percentage (%)</b>
Initiate midwives visit	10	50
Introduction of ANC hotline	19	95
Improve Midwife capabilities	18	9
Improve midwife motivation	5	25
Improve counsellor/counselee respect	7	35

*Source: Field Data, 2014.*

Table 4 shows that, a majority of 19 (95%) of pregnant women and opinion leaders suggested that a telecommunication system for better communication between counsellors and clients must be put in place. Some pregnant women believed that the provision of hotline service will enable them make emergency (SOS) calls in times of doubts for explanation and clarification to supplement the periodic counselling sessions. Others were of the view that the database of clients' phone numbers and telephone system should be made available to midwives. Thus counsellors (midwives) can make follow up calls to pregnant women who absent themselves from counselling session. One pregnant woman from Ansaful, 'AF' narrated that:

*"I experienced some funny symptoms at the beginning of my second trimester and I wished I could explain it to my midwife but it was on a weekend and I did not have her phone number to contact her".*

Besides hotline services, 18 (90%) of pregnant women and opinion leaders suggested that midwives capabilities should be boosted in order to improve ANC counselling in the municipality. While some mentioned bettering of their counselling skills, others were of the view that midwives knowledge and expertise in the midwifery profession should be upgraded frequently to improve their efficacy levels.

Furthermore, according to Table 4, suggestion was made for improvement in the counsellor/counselee respect by some seven participants constituting 35%. This suggestion, although mentioned by a few of the participants, it is in a way reinforcing the core conditions of relationship between the counsellor and the counselee. Rogers (1983) theorised that the counsellor must be congruent, must experience unconditional positive regard for the client (counselee), and must be empathetic toward the client. He opined that without respect for counselee they would hardly open up to be themselves for effective counselling to take place.

### **Suggestions for improvement by midwives**

Midwives play the counsellor role in the ANC counselling. The midwife participants suggested ideas and strategies which will help improve ANC counselling. Suggestions made were categorized into themes as shown in Table 5.

**Table 5: Suggestions to improve ANC (Midwives =8)**

<b>Suggestion</b>	<b>Number</b>	<b>Percentage (%)</b>
More clients education	7	87.5
Increase motivation	4	50
Better conditions of service	6	75
Introduction of ANC hotline	8	100

*Source: Field Data, 2014.*

Table 5 shows the categorized themes as more clients, midwife motivation, better conditions of service and introduction of hotline telecommunication system to improve ANC counselling. It further shows that out of the eight midwives interviewed, all of them suggested that counselling can be much better when clients have 24 hours access to counsellors through the telephoning system. In addition, some midwives were of the view that follow-up calls to absentee pregnant women can help as a reminder and also inquire whether they are experiencing challenges.

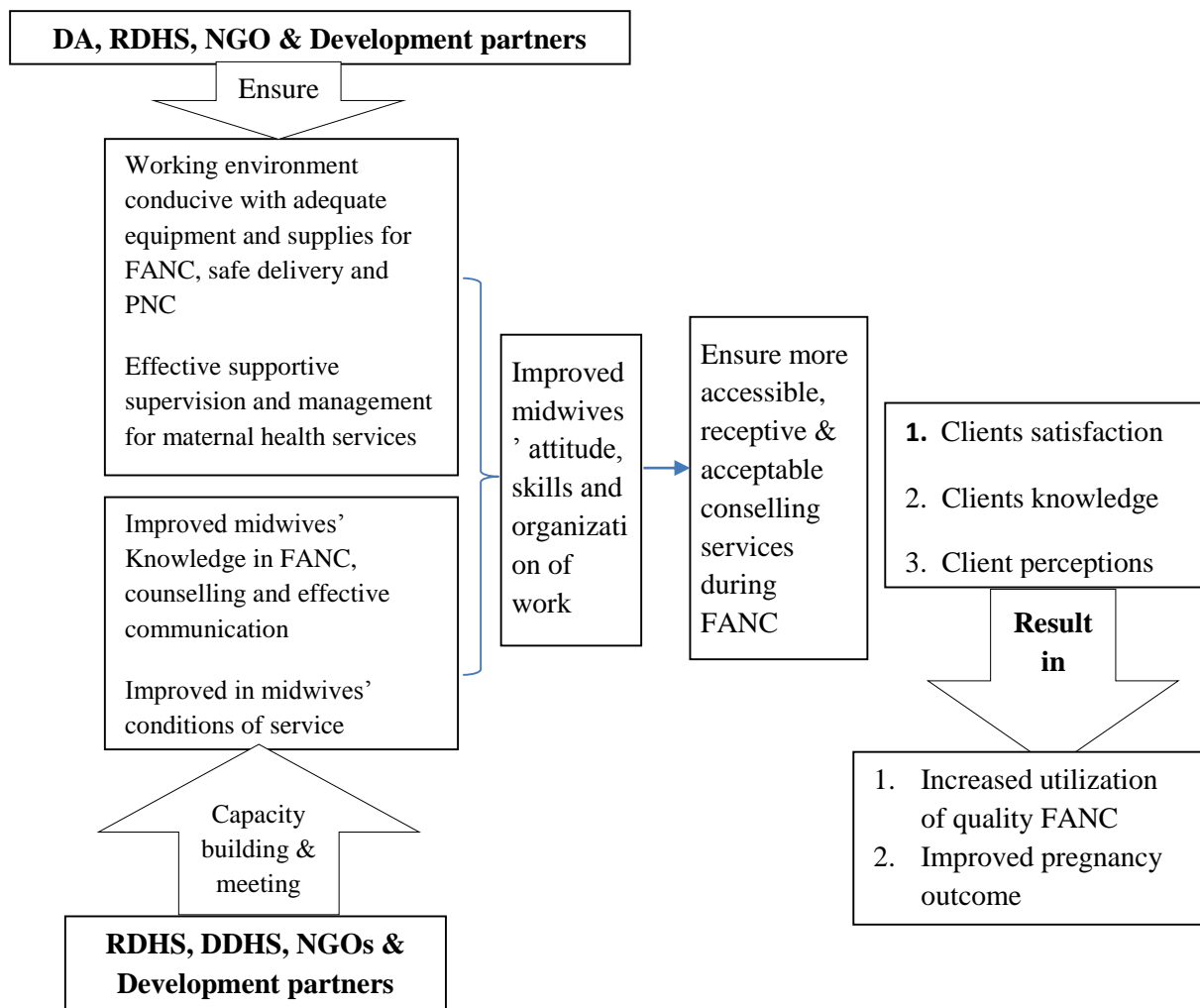
Table 5 further indicates that seven (87.5%) of midwives suggested more public education on the importance of ANC counselling so that women become knowledgeable of ANC even before they get pregnant. A midwife Auntie 'AR' noted that:

*'The behaviour of some pregnant women tells that they don't even know the essence of ANC, so they think we are worrying them'.*

Finally, the midwives suggested motivation (4; 50%) and better conditions (6; 75%) of service as factors for improvement of counselling services during FANC. Studies have shown that worker performance is optimized when it is supported by a variety of elements, including: (1) clear job expectations; (2) timely performance feedback; (3) adequate environment and tools; (4) internal motivation and/or external incentives; (5) knowledge and skills; (6) capacity to do the job. With these premises at hand, organizations have recently developed and utilized the Performance Improvement (PI) approach to improve provider performance and project interventions in the developing world (Luoma & Voltero, 2002). The participants believed that the municipal health administration should improve their conditions of service and their performance levels will increase accordingly.

A model was developed to improve counselling during focused antenatal care. Figure 1 depicts the model.

**Figure 1: Model to improve counselling during Focused antenatal care Model to improve Counselling during Focused Antenatal Care**



Source: Researcher designed diagram, 2014.

## CONCLUSION

Counselling provided by midwives during focused antenatal care is ineffective as only two targeted indicators: counselling on BPCR and counsel on delivery place had positive correlation with ANC attendance. The general perception on counselling during FANC as far as the pregnant women and opinion leaders in the municipality were concerned was poor and there was the need to improve counselling during FANC. From the study it is clear that reasons for counselling implementation gaps were: poor communication, midwives' attitudes, inadequate knowledge and experience of midwives in counselling, poor time management and uncooperative client behaviour. In addition transport issues, heavy work load and lack of motivation were also mentioned as reasons for implementation gaps in counselling during FANC within the Effutu municipality.

## RECOMMENDATIONS

The following recommendations were made:

1. The midwife should improve “Midwife-Client” relationship
2. Midwives, the ministry of health (MOH) and the Ghana health service (GHS) should improve accessibility to antenatal services and the municipal health directorate (MHD) and
3. The midwife should improve midwives’ knowledge and skills in antenatal counselling and focused antenatal services as a whole.

### Limitations

Among the limitations of the study were indifferent attitudes of some respondents. Some of the respondents did not return their questionnaire within the stipulated one week period and were trying to solicit responses from colleagues, behaviour which might affect the data validity. Again the researcher faced constraints in scheduling and meeting respondents for interviews and focused group discussions (FGD) as most of them were not so time conscious. The over delayed questionnaires were discarded. In addition the researcher exercised optimum patience in dealing with the participants for the interviews and FGD.

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