FOCUSED ANTENATAL CARE IN SUB-SAHARAN AFRICA

Antenatal care (ANC) is defined as the care provided to the woman during pregnancy, by a skilled attendant, supported by a functioning health system. Developed in Europe in the 1920s, it quickly spread round the world and was given in an unquestioning manner until the decades beginning around 1980. If the protocol was followed, the ANC consisted of procedures, tests and interventions which the women received over the course of 12 to 14 visits during the pregnancy.

Over the past three decades these routines have been subjected to critical analysis (1) and through clinical trials, either the individual routines or whole programmes have been studied (2,3). These trials and the systematic reviews that followed them showed that many ANC routines were not effective or beneficial. The evidence of benefit, or lack of it of the procedures, tests and interventions is now widely available (2-4). A few developing countries have taken part in some of the larger trials which have assessed whole programmes of ANC (5-7). These latter trials showed that appropriate care could be given to low risk women with four to six planned visits.

During this time it became apparent that there were complications that ANC did not predict and could not prevent (8). Women could attend all the visits and still end up with abruptio placenta, or severe postpartum haemorrhage from an atonic uterus. Such women and their babies were at great risk despite good antenatal care if emergency obstetric and neonatal care (EmONC) was not available.

The World Health Organisation, using information from their trial and a systematic review of other studies (9), developed a model of ANC for low risk women which can be delivered over four goal oriented visits(10). These four visits take place at 8-12 weeks, and around 26, 32 and 38 weeks of gestation. At each visit, the provider has goals which are determined by the potential to detect the common preventable conditions or complications in the mother and foetus, and the gestation of the pregnancy. The activities at each visit follow from the goals. For example, for the important goal of detecting pregnancy induced hypertension, the blood pressure will be measured at every visit. For detecting foetal malpresentation or malposition in late pregnancy, the activity would be careful uterine palpation at 38 weeks. A basic list of goals and activities appropriate for most sub-Saharan African (SSA) countries is provided in the model. In women with complications, extra interventions and visits would be recommended by the providers according to the circumstances.

The four visit model has given rise to some controversy. At a recent scientific meeting of the East, Central and Southern African Association of Obstetricians and Gynaecologists (ECSAOGS) in Dar-es-Salaam in November 2005, the model was said by some specialists to be minimalist. However the four visit model is not a rigid protocol which every country must follow without deviation. Extra routines and visits can be added to the model to suit any setting as long as this is scientifically justified and it improves quality of care. It is the quality of care that is important, rather than the number of visits.

The four basic elements of focused antenatal care are: increased coverage, goal oriented routines of proven effectiveness, quality of care and satisfaction of the women with the care they receive. In sub-Saharan Africa coverage of ANC, described as the proportion of women who have had one visit is 69% (11). Nearly one third of women (31%) never receive ANC and there are many late bookers among the 69% who do so. No matter how good the ANC programme is, it will not help those who do not book or do so late. ANC also manifests the inverse care law; among those who do not book, there will be a higher proportion of high risk mothers. Therefore one area of focus is to bring in the disadvantaged women into ANC, and to encourage them to book much earlier than at present. Multiple approaches, mainly through community interaction are required to achieve this, but one obvious intervention is to make health facilities more attractive and user friendly, which many are not.

The goal oriented routines must be derived from the good outcomes that must be achieved or the bad outcomes that should be prevented. In SSA
the top five causes of maternal deaths are haemorrhage, eclampsia, puerperal sepsis, post abortal sepsis and obstructed labour. The top five causes of neonatal deaths are birth asphyxia, prematurity, light for gestational age birthweight, neonatal sepsis and neonatal jaundice. The order may vary from country to country but the contents of the lists do not change. By working backwards from the causes of maternal and neonatal deaths to the antenatal antecedents, an ANC programme can be created which includes the effective interventions that are needed, and at what time in pregnancy they should be delivered.

It is not enough for women to have a certain number of visits at the correct times in pregnancy; the quality of care they receive is very important. Quality of care means that the services are delivered to the clients with a personal, clinical and technical level of care which meets specified standards. This means these standards have to be formulated and disseminated. The facilities should meet these standards in resources and the staff should have the competencies and the right attitude to deliver high quality care. Studies have shown that the quality of ANC can be very poor, even for common conditions such as anaemia (12,13) and hypertension (14), conditions for which the management protocols are very clear. There are various ways of monitoring the quality of care, but at district level simple process audit with feedback can be carried out with routinely collected data supported by periodic surveys. Monitoring the availability of supplies and whether procedures are being carried out correctly should be incorporated into the district routines (15).

Lastly focused ANC should attempt to improve the satisfaction that women get from the service. Dissatisfaction with the services is a recurring complaint by women and has been reported in several countries (16-18). Any changes to the ANC programme must be introduced after discussion with the stakeholders especially in areas where women were used to routines of the traditional model. There is evidence from some studies that women’s needs for reassurance should be considered when changes are made to programmes (6,19,20).

Having described the four main elements of focused ANC, it can now be described as ‘appropriate care of high quality given to as many women as possible during the antenatal period to reduce or eliminate preventable complications in the mother and newborn’. This should be the definition of antenatal care. However we should keep the term ‘focused antenatal care’ for the time being to describe optimal care, and to distinguish it from what continues to happen in many places.

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