Prospects and problems of adoption of focused antenatal care (FANC) by pregnant mothers attending antenatal clinics in Anambra State, Southeast Nigeria

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Abstract

Antenatal care (ANC) remains a key tool for controlling triple problems of maternal morbidity, maternal mortality and infant mortality in any social group. This review paper with focus on Anambra State, Southeast Nigeria addressed three principal objectives. First, it examined the prevailing state of ANC services in the state. Secondly, the paper carefully explored the distinctive features of traditional antenatal care (TANC) model and those of focused antenatal care (FANC) model. Thirdly, it examined the processes of setting up, and the problems and prospects of adoption of focused antenatal care by pregnant mothers attending antenatal clinics in the state. As a review paper, the authors relied solely on secondary sources to outline the principles, component activities and task sequence expected of all public health facilities for the implementation of FANC model in Anambra State, Southeast Nigeria. The paper concluded that there are very bright prospects and tremendous benefits accruable from acceptance, adoption and implementation of FANC model to both health workers and pregnant mothers attending antenatal clinics in the state. Such benefits include that FANC approach, as an evident-based and goal oriented intervention help women to maintain normal pregnancies through targeted assessment and individualized care. It addresses predominant health issues that affect mothers, neonates and new born. Above all, the reduced visits by pregnant women to the health care settings under FANC provide reduction in financial implications. The saved money can be channeled to other use such as for specialized investigation. Also, less visit to the health care personnel enable them to be available for other purposes especially in the context of resource constrains facing the state
Keywords: *focused antenatal care, pregnant mothers, antenatal clinics, Southeast Nigeria*

Introduction

High rate of maternal morbidity and mortality constitute major threats to **t**he quest by applicable health authorities to improve maternal health status within specified population groups and nation states, especially in less developed regions of the world like Nigeria. Such maternal morbidity issues include any complications, disability, or deformation resulting from pregnancy, delivery and/or within six weeks after birth. According to Adesokan (2011), maternal morbidity refers to any physical or psychological symptom or condition resulting from pregnancy related causes that has adverse effect on women's health. On his part, Boulvain (2008) defined maternal morbidity as any departure, subjective or objective from state of physiological or psychological wellbeing during pregnancy, childbirth and the postpartum period up to forty two (42) days or one year. Irrespective of how maternal morbidity is conceptualized by different scholars, it is important to note that its magnitude could be controlled in any society if quality antenatal care services are put in place during pregnancy.

On the other hand, maternal mortality which implies the death of any woman while pregnant, during delivery and within six weeks after delivery or postpartum period is also a crucial issue that affects women of child bearing age. Med - Condition.Net (2012) defined maternal mortality as deaths of mothers resulting from complications of pregnancy and childbirth in a given population. The World Health Organization (WHO, 2018), clarified that maternal mortality refer to the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy: or from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes. WHO (2018) further stated that every day approximately 830 women die from preventable causes related to pregnancy and childbirth. Young adolescents face higher risk of complication and death as a result of pregnancy than other women. The maternal mortality ratio of Nigeria in 2015 was 814 deaths per 100,000 live births; and in 2017 the ratio rose to 830 deaths per 100,000 live births (UNICEF, 2015, 2016 & WHO 2018). It is noteworthy that good health practices among pregnant women, and particularly adequate, timely and quality antenatal care during pregnancy could significantly reduce maternal morbidity and mortality and significantly improve maternal health.

The concept of maternal health encapsulates overall state of health of women during the periods of pregnancy, child birth and the post partum cycle. It encompasses the health care dimensions of family planning, pre-conception, pre-natal and post-natal care, all of which are given in order to reduce maternal morbidity and mortality (WHO, 2005). In pre-conception case, it entails the education, health promotion, screening and other interventions among women of reproductive ages to reduce risk factors that might affect future pregnancies. In pre-natal care, it is mainly to detect any potential complications of pregnancy early enough to prevent if possible and to direct women to the appropriate medical specialist attention. On the other hand, post- natal care involves recovery from child birth, adequate check-up, concerns about new born care, nutrition, breast feeding and family planning (WHO, 2005). High quality maternal health cannot be achieved in any clime, including Anambra state, southeast Nigeria without adequate antenatal care (ANC) strategies and arrangements.

The concept of Antenatal Care (ANC) is a general term used to describe the medical procedures and preventive care women receive throughout their pregnancy. It is important in helping to ensure a healthy pregnancy state and safe childbirth (Magadi, Madise & Diamond, 2010). According to World Health Organization (WHO, 2016), antenatal care is a type of care delivered by skilled health care professionals to pregnant women in order to ensure the best health condition and positive outcomes for mother and baby during pregnancy. It is thus one of the basic components of maternal care on which the life of mothers and fetus depend.

The benefits of antenatal care cannot be overemphasized. It remains a vital health care tool to reduce the risk of still births, prevent labour and pregnancy complications, maternal morbidity and mortality. As a specialized pattern of care, it is organized for pregnant women to enable them to attain and maintain a state of good health throughout pregnancy and to improve their chances of having safe delivery of healthy infants. A good and timely ANC is a sine guenon for a healthy pregnancy experience, healthy mother and child.

In recent times, Anambra state, Southeast Nigeria instituted very effective antenatal care (ANC) interventions that could minimize maternal morbidity and mortality. These include the long established traditional antenatal (TANC) and the relatively new focused antenatal (FANC) strategies. Notwithstanding this development, many pregnant women still die of preventable complications on account of ignorance or lack of broad knowledge about current and effective antenatal care strategies and interventions (Umeora, Sunday-Adeoye and Ugwu, 2008). Consequently, high maternal deaths remain a matter of utmost concern to public health in Anambra state as is the case with other states and parts of the Nigerian nation.

The two models of antenatal care (ANC) services that have emerged over the years, namely traditional antenatal care (TANC) and focused antenatal care (FANC) have their unique features, advantages and disadvantages which aggregately underscore their different levels of support by both World Health Organization (WHO) and the federal ministry of health in Nigeria. This review paper examines the prospects and problems confronting the adoption of focused antenatal care option by pregnant mothers attending antenatal clinics in Anambra State, Southeast Nigeria

The Traditional Antenatal Care (TANC) Model

The traditional ANC service model was introduced in early 1900s; traditional ANC assumes the frequent visits and classifying pregnant women into low and high risk (by predicting the complications ahead of time) is the best way to care for the mother and fetus (Safe motherhood, 2000). It was introduced by social reformers in the United State, and in 1978 the World Health Organization (WHO) integrated the risk based approach to ANC still with aim of improving the quality and outcome of care (Oshinyemi, Aluko and Oluwatosin 2018). During the risk based approach, pregnant women are expected to make frequent visits to the health care facility; they are then classified into low and high risk with the aim of identification of those at risk of developing complications from their previous history such as medical obstetrics and gynecology and social history (Kearns, Hust,Caghia, Langer, 2014)

However, World Health Organization maternal health and the Save Motherhood Program (1994) initiated the "Mother-Baby package, implementing safe motherhood in countries and save motherhood initiative as family planning, antenatal care (ANC), clean/safe delivery and essential obstetric case. This package was not expected to operate on its own, but was to be integrated into the existing health system and the existing model of ANC was the risk based approach under the traditional model of ANC (WHO, 1994, Kearns et al, 2014). The weakness of the high risk approach include its uncertainty at predicting pregnant women at risk because all women can be regarded as being at risk of different complications which may not be identified during the frequent antenatal visits, therefore improved quality of care is essential to all women in order to achieve better outcomes in maternal and child health (WHO, 1994, kearn et al, 2014).

The traditional model of ANC visits were once a month till 32 weeks gestation, twice a month till 36 weeks gestation and weekly till delivery, hence a pregnant woman is expected to make up to 14-16 ANC visits to the clinic before delivery (Kearns et al, 2014). Emphasis is placed on the number (quantity of visits rather that the quality of the visit), routine risk indicators such as maternal height and weight were used to identify those at risk of developing complications during delivery. There seems to be difference in outcome of care between the frequent traditional antenatal visit and the focused antenatal visit (Kearn, et al, 2014) currently, the trend is shifting toward reducing the number of ANC visit, while at the same time established clearly defined objectives to be achieved at each visit and improving quality of care rendered at each visit (Women Health care, 2014).

Focused Antenatal Care (FANC) Model

Focused Antenatal Care (FANC) is a type of ANC services that help women to maintain normal pregnancies through targeted assessment and individualized care. FANC represent a goal oriented ANC approach which was recommended by researchers in 2001 and adopted by World Health Organization in 2002 (Brown, Sohani, Khan, Lilford & Muklwana, 2008). According to the Maternal Neonatal Health (2004), FANC approach is based on evident-based intervention that addresses the most predominant health issues that affect both mothers and new born.

The major aim of FANC is to help women maintain normal pregnancies through targeted assessment and individualized care (United States Agency for Interventional Development (USAID), 2007). In FANC, skilled health care providers are guided by each woman individualized situation rather than making the traditional frequent antenatal care visits as a routine activity for all pregnant women and categorizing women based on routine risk indicators (Simkhada, Teijlingen, Porter and Simkhada, 2008).

Under Focused Antenatal Care (FANC) arrangement, the World Health Organization (WHO), the National Policy and Ministry of Health guidelines recommended a minimum number of four Focused Antenatal Care (FANC) visits, ideally at 16 weeks, 24-28 weeks, 32 weeks and 36 weeks for pregnant women whose pregnancies are progressing normally (Quma, VanEijk,Hamel & Sikuku, 2010). Each of such visits has specific items of client assessment, education and care to ensure early detection and prompt management of complications (Millennium Development Goals, 2015).

Focused Antenatal Care (FANC) is evidence based, client centered and goal directed care provided by skilled health care providers with emphasis on quality rather than frequent of visits (Bhutta, Chopra, Axelson, Boerma, Bryce, Bustreo and Cavagnero, 2010). The approach of FANC submits that every pregnant mother is at risk of complications and that all pregnant women should therefore receive the same basic care and monitoring for complications (WHO, 2002, Blutta 2010, Etuk, Awodeyi and Ekponne 2017).

According to Magadi, Madise and Diamond (2011) essential interventions in FANC include identification and management of obstetric complications such as pre-eclampsia / post-eclampsia, tetanus toxoid immunization , intermittent preventive treatment (IPT) for malaria in pregnancy, Anaemia in pregnancy ,family planning, malnutrition in pregnancy, identification and management of infectious and other Sexually Transmitted Infections (STIs) example HIV voluntary counseling and testing and among others.

According to Aniebue and Aniebue (2010), FANC aims are to give holistic individualized care to each woman to help maintain the normal progress of her pregnancy through timely guidance and advice on birth preparedness, nutrition education, immunization, personal hygiene, family planning, counseling on danger symptoms and others.. FANC services include gathering information about the pregnancy, physical examination, diagnostic tests, evaluating any risk factors and making an individualized care plan (Ghaffar, Pougpauich, Chapan,Pahca muree,2012)

FANC is one of the effective health interventions that prevent maternal and neonatal mortality especially in countries where the general health condition and outcome is low. FANC services promote the use of skilled attendance of birth and healthy behaviors such as proper breastfeeding, early postnatal care and planning for optimal pregnancy spacing. In order to achieve the full potential of ANC for the mother and the child, it is advisable for every expectant mother to attend a minimum of four ANC visits which provide an opportunity to seek effective intervention called Focused antenatal care (WHO, 2017).

.During the FANC service, If no abnormalities are identified the care plan will focus on counseling, birth preparedness and complication readiness. If the pregnant mother needs specialized care then the plan will be to refer her to a higher health facility. Adequate knowledge and timely FANC provides an opportunity to prevent the direct cause of maternal and neonatal deaths which are linked to obstetric conditions (Dabebe, Deress & Negash, 2017).

Comparing Traditional Antenatal Care (TANC) and Focused Antenatal Care (FANC)

A multi-country randomized trial was conducted in 2001 by researchers (reformers) to assess the effectiveness of the FANC and to compare it with the traditional ANC model. Findings revealed that health care providers better tolerated the FANC model, women in both models were generally satisfied with services, and FANC financial implications were relatively the same or lesser than the traditional ANC (WHO 2001, Kearns et al, 2014). Another review of randomized controlled trial by WHO (2001) compared interventions with a lower number of FANC visits to the traditional ANC model. Again findings revealed similar results (Carroli, Villar, Piaggio, Khan, Neel Ofur, Gulmezoghu, Mugafid, Lumbiganonh, Famut, Bersgsjo 2001 and Kearns et al, 2014).

The implication of the above results was that Focused antenatal care (FANC) constitutes a better option to the TANC model. The later requires regular clinical assessment and frequent visit to the ANC clinics which consumes more time and larger resources. The TANC model also face the challenge of accurately classifying pregnant women into high or low risk groups based on pre-identified criteria, and the possibility of the low risk group developing complications at delivery (Kearns at al 2014 and Assegid et al, 2017).

These studies led to WHO's conclusion that the model with reduced antenatal visits should be implemented or adopted in both developed and developing countries without negatively affecting health outcomes of pregnant women or their infants. Consequently, the Focused antenatal care (FANC) was adopted in 2002 by the World Health Organization (WHO) in an attempt to overcome challenges faced by the traditional antenatal care (ANC) model.

The FANC model focuses on quality of antenatal care rather than the frequent or quantity of visits. Its emphasis is laid on providing an individualized care, rather than categorizing groups of women into high risk or low risk. The FANC model of care makes pregnancy a family responsibility, the husband and the women are fully informed of the potential complications, birth preparedness, postnatal care and planning future child spacing ad child birth.

In FANC model, women who present with pre-existing risk factors or medical conditions as well as women who are identified as having complications throughout their care are enrolled in a specialized care model that includes additional assessments, visits and evaluation (WHO 2001).

The FANC model separates pregnant women into two groups; those likely to need only routine antenatal care (i.e. 75% of the total population of the pregnant women) and those with specific health conditions or risk factors that necessitates special care (i.e. 25% of pregnant women). For the first group, a standard programme of four ANC visits is recommended (with additional visits should conditions emerge which require special care). The WHO guidelines are also specific as regards the timing and contents of antenatal care visits according to gestation age. The guidelines stipulate that "only examinations and tests that serve an immediate purpose and that have proven to be beneficial should be performed" (About- Zahir, Lidia, Wardlaw, 2003).

Assegid et al (2017) stated that a study conducted in Zaire in 1984 on 3614 pregnant women showed that majority (71%) of the women who developed obstructed labour were previously categorized as 'not at risk' while 90% of women who were identified as at risk did not develop obstructed labour, this shows evidence that most pregnancy problems are unpredictable. Maternal Neonatal Health (MNH 2004) viewed that focused antenatal care approach is based on evidence-based interventions that address the most predominant health issues that affect both the mothers and newborns. The major aim of FANC is to help women maintain normal pregnancies through targeted assessment and individualized care. It recognizes that every pregnant woman is at risk of complications and should receive the same basic care and monitoring for complications but inadequate knowledge about FANC has affected its popularity and practices among pregnant women.

Implementing FANC Model in Anambra State, Southeast Nigeria: Overview of Component Activities and Task Sequence Expected of all Public Health Facilities

The FANC model first categorizes pregnant women into two groups: those eligible to receive routine ANC called the basic component and those who need special care based on their specific health conditions or risk factors. Pre-set criteria are used to determine that eligibility of women for basic component (representing 75% of all women attending antenatal care), and the women who need special care will represent, an average approximately 25% of all pregnant women attending antenatal care (WHO 2002, USAID, 2007).

The classifying form for FANC as designed by the WHO is used at the first ANC for the clinic to decide which women will follow the basic component or specialized care. The format of the form can be adapted to the format to be used in each clinic setting (WHO, 2002). The form contains 18 check list, composed of closed ended questions that requires a 'yes' or 'no' responses. The form covers the patient's obstetric history, current pregnancy and general medical conditions as presented below;

Table 1: Prototype Patient Classifying Form for FANC

S/N	SUBJECTS FOR ASSESSMENT	YES	NO
1.	**Obstetric History** History of three or more consecutive spontaneous abortions -Previous neonatal loss or still birth -Birth weight of last baby < 2500g or 2kg -Birth weight of last baby > 4500g or 4kg -Last pregnancy: hospital admission for hypertension or pre-eclampsia -Previous surgery on reproductive tract		
2.	**Current Pregnancy** -Age less than 18 years -Age more than 40 years -Diagnosed or suspected multiple pregnancies -Iso-immunization: Rhesus negative in current or previous pregnancy - Pelvic mass -Diastolic blood pressure 90mmHg or more at booking		
3.	**General Medical Conditions** -Cardiac disease -Renal disease -Insulin-dependent diabetes mellitus -Known substance abuse (including heavy alcohol drinking and tobacco consumption). -Any other severe medical condition or disease.		

Source: World Health Organization, 2002

World Health Organization's Clinical Guideline for the Basic Component or Compulsory Four Visits of FANC (WHO, 2002)

The First FANC Visit should occur before 16 weeks gestation but some pregnant women may present later than that, activities are directed at using the pre-set criteria to categorize women into those eligible for the basic component of the ANC and those who require specialized care (WHO, 2002, Lincetto et al, 2006). The objectives of the first FANC visit are to:

- Obtain a detailed medical and obstetric history and carry out physical examination and observation of vital signs.
- Assess hemoglobin level to determine the presence of anaemia, perform urinalysis to identify abnormalities
- Perform abdominal examination, and correlate the last menstrual period date with the fundal height measurement to determine the gestational age of the fetus.
- Initiate the individualized birth plan
- Health education on balance diet, routine antenatal medication such as iron and folic acid supplementation and the use of long lasting insecticidal bed nets (LLINS) and intermittent preventive treatment (IPT) of malaria in pregnancy, using sulfadoxine-pyrimethamine (SP).
- Provide HIV counseling and prevention of mother to child transmission of HIV (PMTCT) service. Offer immunization services such as administration of tetanus toxoid.

The Second FANC Visit should occur between 24-28 weeks gestation. The objectives of the second visit are follow-up on the first visit, monitor the progress of pregnancy and address any complaints of the woman, individualized care plan is reviewed and modified appropriately.

The Third FANC Visit should start between 30-32 weeks gestation. In addition to what is expected of the second visit, the objectives of the third visit are to:

-Identified presence of multiple pregnancies necessitating referral system.

-Detect for the presence of protein in urine

-Determine the need for referral based on risk assessment.

-Health education on exclusive breast feeding, birth preparedness, signs of labour, postnatal care and family planning.

The Fourth FANC Visit should start between 36-40 weeks gestation, in addition to the objectives of the third visit, the activities in the fourth visit are to:

-Confirm fetal presentation and position during the abdominal examination

-Review the individualized birth plan.

For effectiveness of the basic component of the focused antenatal care, the World Health Organization (WHO)'s clinical guidelines for each of the visits should be properly adhere to by the skilled health care provider and the pregnant mothers. This component with a minimum number of four FANC visits is recommended for pregnant women whose pregnancies are progressing normal (Ouma, Vaneijk, WHO, 2002, Hamel & Sikuku, 2010, LinceHol et al 2006).

General Principles that Guide Operations of FANC across Societies

According to WHO, (2002), USAID (2007) and Assegid et al (2017), for best results, the Focused Antenatal Care (FANC) model operates under the following principles:

- Principle of women friendliness; FANC should be rendered in a cordial environment, health care providers should be accommodating, clinic hours should be friendly and convenient enough to accommodate the need of clients and their schedule of work. Health service providers should make all pregnant women feel welcome at the clinic; it has been shown that the number of women seeking antenatal care increases proportionally with increase hours of operation (USAID, 2007). Antenatal interventions or investigations should be carefully planned with the woman to increase their satisfaction with care while at the same time making room for improved outcome of care (Assigid et al, 2017).

- Identification of care; all information known about the woman from the detailed health history (medical, surgical, obstetrics and social history) should be used to individualized plan and care with the woman(WHO, 2002, Assegid et al, 2017)

- Targeted assessment and management; targeted assessment of pregnant women under the FANC model assist in early identification and treatment of already established disease and early detection of complications and other potential complications, it is also used in categorizing pregnant women into groups of those that require specialized care. Early management of those conditions that are identified can lead to improved maternal and fetal outcome (WHO, 2002, Oshinyemi, Aluko & Abimbola, 2018).

- Family participation; the health care provider respect the opinion of the spouse in decision-making process, the entire family watches out for signs of complications and participations in birth preparedness, complication readiness and emergency planning. Family participation ensures compliance on the part of woman and a fuller and safer reproductive health experience for the woman, her newborn and her family (Fagbomigbe, et al, 2013).

- Culturally acceptable and appropriate; all activities in the FANC model must be culturally acceptable and appropriate as every culture has specific myths and beliefs, taboos and practices surrounding pregnancy and childbirth thus information should be centered around the necessity of certain health care interventions (WHO, 2002, USAID 2007, Assegid et al, 2017).

- Health promotion; FANC should include health promotion activities by disseminating information, health education, and counseling on balance diet, personal and environmental hygiene , birth preparedness, emergency readiness and delivery. Also the steps in newborn care, importance of breastfeeding and immunization should be emphasized (Aniebue and Aniebue, 2010)

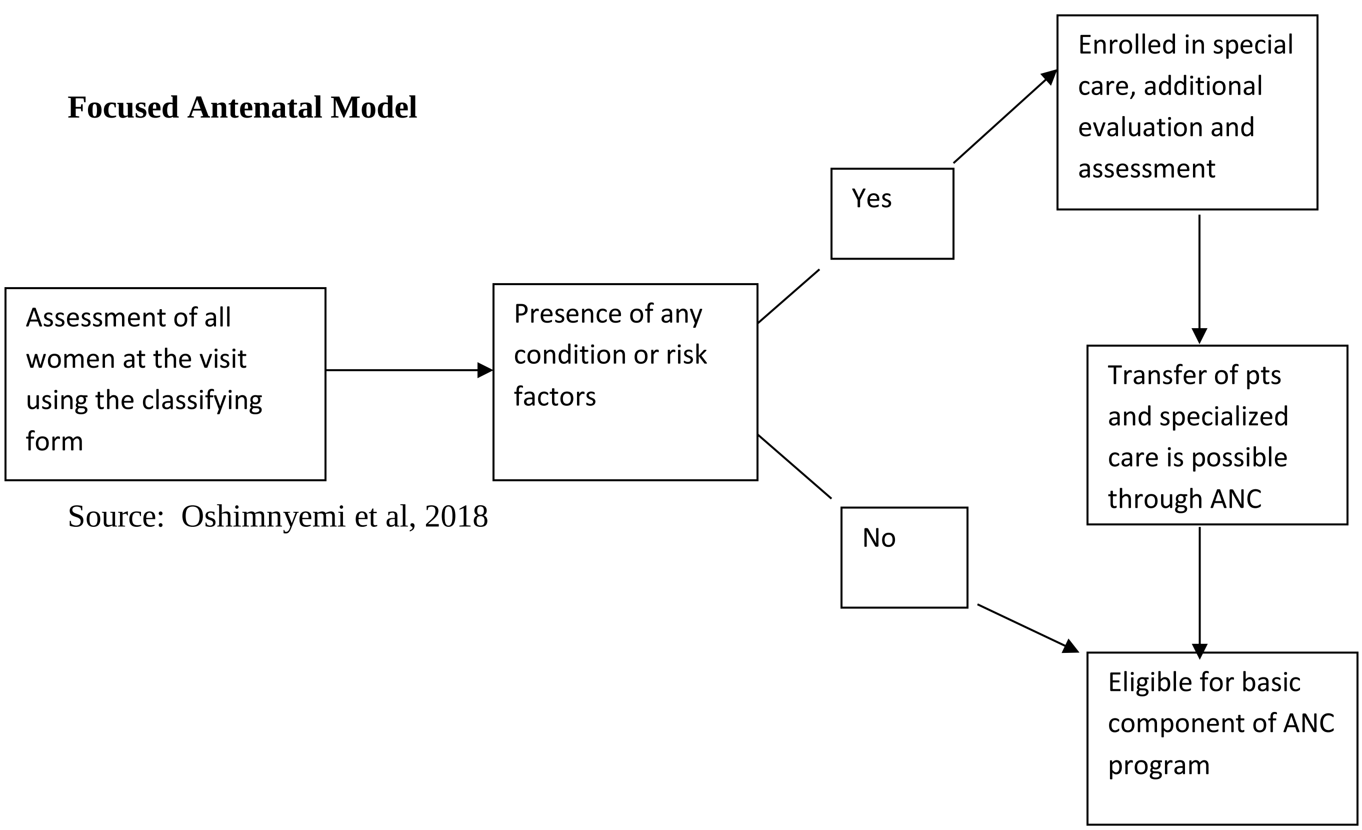
- Community commitment; Many of the component of FANC can be provided at the community level; therefore linkage with the formal health care system is imperative to ensure adequate training and supervision of community health workers and implement functional referral systems(WHO, 2002, Ghaffar et al, 2012)

- Integration of care, Focused antenatal care should include other activities such as (PMTCT)sexual transmitted infection and HIV testing/counseling, malaria detection and prevention, micronutrient provision, birth planning, emergency planning and family counseling(WHO, 2002, Magadi et al, 2011)

- Referral; The FANC model should be adequately plan for referral and transportation to the appropriate health facility, a simple referral form should be created; this can be used to easily identify women with special health conditions or those at risk of developing complications and utilized to refer women to a higher level of care (USAID,2007,Assegid et al,2017).

- Appropriate examination/tests; only examinations and tests that serve as an immediate purpose and have been proven to be beneficial should be performed (WHO, 2002, USAID, 2007, Oshinyemi et al, 2018)

Focused Antenatal Model



Source: Oshimnyemi et al, 2018

Prospects/ Benefits of the Adoption of Focused Antenatal Care Model by Pregnant Mothers attending Antenatal Clinics in Anambra State, Southeast Nigeria

There are very bright prospects and benefits accruable from adoption of Focused Antenatal Care Model by Pregnant Mothers attending Antenatal Clinics in Anambra State, Southeast Nigeria. Since Focused antenatal care aims at achieving positive pregnancy outcome in pregnant women; therefore the immediate outcome in Anambra state if religiously implemented and accepted is to ensure improved maternal and neonatal health across the entire state.

Secondly, the reduced visits by pregnant women to the health care settings provides reduction in financial implication thereby saved money can be channeled to other use such as for specialized investigation. Also less visit to the health care personnel enable them to be available for other purpose especially in the circumstances of resource constrained environment of the state

Specifically, adopting the focused antenatal model is expected to produce the following outcomes documented by USAID, (2007) and Assegid et al (2017) but which gains are all applicable to Anambra State, if carefully and comprehensively implemented:

-Targeted assessment of pregnant women; it is used in categorizing pregnant women into groups of those that require specialized care and those eligible for basic component of ANC program.

-Prompt identification and treatment of disease; such as malaria, anaemia, eclampsia, providing HIV counseling and (PMTCT), malnutrition in pregnancy among others.

- Early management of those conditions that are identified in pregnant women can lead to improve maternal and fetal outcome (USAID, 2007; Oshinyemi et al, 2018).

-Early detection of complications and other potential problems that can affect the outcome of pregnancy. This may result to enroll them in specialized care for additional evaluation and assessment thus may lead to transfer of clients through antenatal clinics to a higher Health facility for appropriate treatment and attention (Assegid et al, 2017).

-Providing prophylaxis and treatment for malaria, anemia, urinary tract infections, tetanus and sexually transmitted infections (STIs) including HIV, during pregnancy period.

-Providing individualized approach to care of pregnant women. FANC emphases are laid on providing individualized plan and care accordingly rather than categorizing groups of pregnant women into low risk or high risk. The FANC model assumes that all pregnant women are at risk of developing complications therefore; care is focused on early identification of complication as they arise, and targeted and individualized care and the use of evidence based practice in developing care (USAID, 2007, Assegid et al, 2017).

-FANC provides health promotion activities which focused on birth preparedness, complication readiness, adequate nutrition, benefits of immunization to both the mother and the child, personal hygiene and postnatal care among others.

-Providing counseling on warning or danger signs necessitating urgent attention such like pre-eclampsia, eclampsia, eodema of the legs, hypertensions, diabetes and others(USAID, 2007, Assegid et al, 2017).

The importance of Focused antenatal care cannot be over emphasized, but inadequate knowledge of pregnant women about Focused antenatal care services is affecting the accessibility and practices in the societies.

Problems/ Challenges which Focused Antenatal Care Encounter in Anambra State

The full and successful implementation of focused antenatal care (FANC) is yet to be achieved in Anambra State, Southeast Nigeria due to reasons or operational difficulties which are also applicable to other developing economies.

According to Ekabua et al (2011), political factor and lack of political will on policy change and implementation of favourable policies on the issue of maternal and neonatal morbidity and mortality drastically hinders the implementation of FANC services. They further stated that the diversion of state fund for infrastructural development to personal usage negatively affected the outcome of maternal and child health services. Ekott et al (2017) opined that resistance to change from the present traditional model of ANC of frequent visits to the reduced FANC visits by health care workers and clients affected FANC implementation. This action may arise by inadequate knowledge to influence their negative attitudes towards FANC.

Kearns et al (2014) and Ajayi et al (2013) stated that inadequacy of human and material resources adversely affects the implementation of FANC services. Health care providers like doctors, midwives, nurses and other health personnel are few in number to man the various antenatal clinics. Also the migration of trained health care workers to industrialized nations negatively affects the FANC implementation in rural areas (Kearns et al, 2014).

The current economic climate and commercialization of health services (antenatal care services) may impede the effective implementation of FANC in certain settings in developing countries like Nigeria (Ekut and Gitonga et al, 2017). Also low education and inadequate knowledge about Focused antenatal care among the health care providers and the clients in certain settings impede the effective implementation of FANC services (Umeora, 2008 & Ojong, 2016) They stated that increase education and awareness creation among pregnant woman tends to realize the goal of FANC and improve its services.

Ibor (2011) had it that prevailing cultural norms, traditional beliefs, illiteracy and myths about pregnancy and childbirth attendant/traditional healers; instead of the professional health workers as pregnancy is perceived as a natural health process are also an impediment for implementation of Focused antenatal care in developing countries like Nigeria. The attitude and behavior of health care providers in antenatal clinics, lack of respect for privacy and confidentiality, traditional belief of some women often negatively affect the use of ANC as well as maternal and child health services at large (USAID, 2007, Assigid et al, 2017).

Against the background of the aforementioned barriers to FANC, Lincetto et al (2006) opined that social, economic and cultural barriers and presence of weak health referral system to support case management of complications of pregnancy, invariably reduces the overall impact of FANC. Also poor communication among formal health care providers, traditional birth attendants (TBA) and community health workers may be the cause of low utilization of antenatal care services in the communities that make up Anambra state.

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