



Refusal of antenatal care and the applicable conceptual models

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Highlights:

- The 'five-prong purpose' model describes the functions of antenatal care.
- Addressing challenges identified with the five 'A's model prevents refusal of antenatal care.
- Refusal of antenatal care leads to adverse pregnancy outcomes and socio-economic challenges.
- A fetus acquires ethical rights after birth and refusal of antenatal care endangers the neonate.
- Good clinical governance will improve utilization of antenatal care.

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Five A's model of assessing care

Five-prong purpose of antenatal care

1. Introduction

Antenatal or prenatal care is a well-intentioned health-care programme for utilization by all pregnant women to improve the outcomes of their pregnancies. Unfortunately, a number of factors militate against the programme and occasionally lead to incomplete utilization of the services, and sometimes result in blatant refusal of care. This editorial discusses the refusal of antenatal care and proffers applicable models. The consequences of antenatal care (ANC) refusal and preventive measures are also discussed.

2. Purpose of Antenatal Care

The purpose of ANC may be broadly categorized using the 'five-prong purpose' model of antenatal care. The five prongs are represented by the acronym **tidss**: (i) **t**reatment of disorders in the mother and/or the fetus; (ii) **i**nformation about the present and future pregnancy, as well as about intrapartum, postpartum and early childhood care; (iii) **d**iagnosis of disorders in the mother and/or the fetus; (iv) **s**creening for [1,2], and prediction of, disorders in the mother and fetus; and (v) **p**rovision of prenatal nutritional **s**upplements. These functions are aimed at preventing perinatal and maternal morbidity and mortality. This is crucial given that medical conditions that are

recognizable during the ANC period are the leading causes of maternal deaths in many parts of the world. For instance, in the UK, pre-existing conditions such as cardiac disease worsened by pregnancy are the commonest cause of maternal mortality [3]. In South Africa, non-pregnancy-related infections such as HIV are the commonest cause of maternal mortality [4].

3. Causes and Measures to Prevent Refusal of Antenatal Care

The success of a medical screening test, in summary, depends on the provision of diagnosis, treatment and follow-up care [1]. However, ANC includes services other than screening. Factors militating against ANC and occasionally leading to incomplete uptake or refusal of the services can be clearly discussed using the five 'A's model of assessing care, which relates to the **a**vailability, **a**wareness, **a**ccessibility, **a**ffordability and **a**ceptability of the ANC services. The interplay of these factors determines whether a pregnant woman will accept or refuse ANC.

3.1. Availability and Awareness

ANC services are available in most settings and many women are aware of them. In low- and middle-income countries, the awareness is lacking in certain settings due to lack of female education [5], while the ready availability is compromised by misappropriation of limited resources.

3.2. Accessibility and Affordability

Another bane of ANC is challenges associated with accessibility and affordability. Women who live far away from the ANC clinic and those who are unable to pay for services are deterred from accessing the care. Physical disability and language barriers may also limit access [6]. Home-based ANC may be a panacea to most of the challenges associated with access, but it will be expensive and possibly have limited coverage in some settings.

3.3. Acceptability

Furthermore, the contents of ANC, as well as the conduct and knowledge of the health-care professionals providing the services, may improve or mar the acceptability of ANC. The attitudes and professionalism of health-care professionals will influence the experiences of those attending an antenatal clinic. Therefore, a positive experience for those attendees [7] is important for improving the acceptability of the services. The details of the services provided, such as the timing and frequency of visits, and whether or not the services are patient-centred, may also determine whether a woman will accept or refuse ANC. What should be the target, therefore, is a goal-directed ANC schedule (such schedules have high yield for effort) in the form of a “modified” traditional pyramid of care, an inverted pyramid of care [8], or what has been termed “basic antenatal care (BANC) plus” [9], depending on the patient’s risk category and the available resources. Risk categorization should commence in the preconception period. ANC, therefore, should be linked with preconception care [10], but this will be achievable only in the case of planned pregnancies. Unfortunately, many pregnancies are unplanned and thus opportunities are missed. However, commencement of ANC at 10 weeks of gestation [11] allows early risk categorization and planning of subsequent care. A one-stop clinic for assessment of risk (OSCAR) and subsequent provision of the required treatment will reduce the frequency of ANC visits, and this is preferable. The reality in many settings is that referral to another level of health-care may be necessary, based on the patient’s risk and the availability of resources, and this is less preferable to many ANC attendees. Most importantly, provision of adequate information during the first ANC visit (or preferably in the preconception clinic) about services provided, including the waiting time for services, may improve the acceptability of services for clients, increase their confidence in the health-care system, and thereby decrease drop-out and refusal rates. Scheduled ANC classes also provide the avenue for addressing and resolving health-care concerns (for example arising from the woman’s belief system) and socio-cultural issues, and may improve acceptance and utilization of the services. Importantly, an effective method of communication such as the RESPECT model [12] should be implemented to improve the acceptability of ANC. The RESPECT model is a patient-centred method of communication that includes Rapport, Empathy, Support, Partnership, Explanation, Cultural competence and Trust [12]. Above all, public health education on the importance of ANC and inclusion of the same in the academic curriculum of all primary schools will improve awareness and acceptability among future parents.

4. Ethics and Consequences of Refusal of Antenatal Care

While the refusal or incomplete uptake of ANC services by a mentally competent mother may be regarded as an exercise of the patient’s right to autonomy, it undoubtedly compromises the health of the fetus, who will acquire ethical rights as a neonate at birth. If a patient declares her intention to refuse ANC, she should be counselled and the details of the discussion documented. Appropriate documentation by the health-care professional and the pregnant woman ensures a clear understanding of the information discussed and may improve beneficence [13]. Again, lack of ANC results in adverse outcomes for the mother and her baby. The consequences may be debilitating [14] and long-lasting and

compromise functionality, including social relationships, as well as mount undue pressure on private and public resources. A typical example is a genital injury such as vesicovaginal fistula from unsupervised pregnancy and labour compromising the marital relationship and resulting in divorce [15].

5. Conclusion

In any setting, the gaps identified with the five ‘A’s model of assessing care will assist in developing strategies to prevent refusal of ANC services. Good clinical governance, including monitoring and evaluation as well as due consideration of the opinions of professionals directly involved in women’s healthcare, will improve the utilization of available resources to provide safe, sustainable and acceptable ANC.

Contributors

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Conflict of Interest

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