

Original Research Article

Perception, Attitude and Satisfaction of Women with Focused Antenatal Care in Ondo State, Nigeria

ABSTRACT

Aims: The overall objective of the study was to evaluate women perception, attitude and satisfaction with Ante Natal Care in Ondo State using the new Focused ANC model and this information will improve the quality ANC provided for women.

Study design: Both a quantitative and qualitative design was used.

Place and Duration of Study: The study was conducted in two hospitals, the State Specialist Hospital, Akure and Arakale Maternity Hospital also located in Akure South Local Government Area of Ondo State Nigeria between September and October 2011.

Methodology: Data gathering was self-report using a structured questionnaire and a focus group technique. Purposive and convenience sampling techniques were used in the study. The participants for the quantitative aspect were a total of 200 pregnant women and a subgroup of the quantitative sample was used for the focus groups interview and the sample size was determined by saturation of data. Data was analysed using the Statistical Package for Social Sciences (SPSS) and content analysis using open coding according to Tesch's approach.

Results: The findings from the study revealed that the majority of the women 104 (55.9%) were aged 25 – 34 years and 110 (56.7%) had between 4-6 children. The majority (81%) of respondents agreed that FANC is good and will encourage compliance while 71.1% respondents feels there was no need to reduce visits.

Conclusion: The process of stimulating changes in ANC requires consultation with and inclusion of key actors, notably the pre-service training institutions and professional bodies, to ensure institutionalization and standardization of focused ANC training, so that FANC is presented as a comprehensive and integrated service.

Keywords: *[attitude, focused antenatal, perception, satisfaction]*

1. INTRODUCTION

Maternal mortality has continued to be a major health problem in the Africa and Nigeria has one of the highest maternal mortality rates in the world, 704 deaths per 100,000 live births compared to less than 10 deaths per 100,000, births in developed countries [1]. Deaths associated with pregnancy, delivery and first six weeks after delivery total approximately 600,000 women worldwide. Nearly half of these deaths occur in Africa, which constitutes only 12.0% of the total world population [1].

Maternal mortality in Nigeria is one of the highest globally. Every 10 minutes, one woman dies on account of complications of pregnancy or childbirth in Nigeria, giving a total of 53,000 per year. This

means that about 800 women die in every 100,000 live births. Many people do not readily appreciate this disaster because the deaths do not occur together in one place. They occur silently in the many different communities of Nigeria [1] [2]. Antenatal care aims to promote better health, maternal education, screening and management of illnesses/complications during pregnancy to ensure the delivery of a healthy baby to a healthy mother [3].

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Villar [4], reported that the World Health Organisation (WHO) has issued guidance on a new model of antenatal care (ANC) called Goal- oriented or Focused Antenatal Care (FANC) for implementation in developing countries. The new model reduces the number of required antenatal visits to four, and provides focused services shown to improve maternal outcomes. FANC eliminates the traditional risk assessments and instead emphasizes helping woman to maintain normal pregnancies by identifying existing health conditions, detecting emerging complications, promoting health, preparing for a healthy birth, and educating clients on post-partum care including nutrition, breastfeeding and family planning. Trials conducted in Argentina, Cuba, Saudi Arabia, and Thailand proved that FANC was safe and was a more sustainable, comprehensive and effective ANC model.

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The antenatal care policy practiced in many developing countries, including Nigeria, has been fashioned along the lines developed in the western countries in the early decades of the last century, that is, involving repeated ritualistic visits without distinction between high- and low-risk pregnancies [5]. These programmes are often poorly implemented, with irregular clinical visits, long waiting times and a poor feedback to the mothers [6].

Poverty and financial constraints have been identified as the major reasons for the poor utilization of antenatal care services in Nigeria, especially in the rural areas. Delay in service purchase is another reason, especially in centers where there is acute understaffing and a large number of clients [7].

The WHO focused ANC package was introduced and adapted in Nigeria in 2002 with targeted assessments of pregnant women to ensure a normal child bearing cycle, individualized care to help maintain the normal progress of pregnancies [2]. For women whose pregnancies are progressing normally, WHO recommends four ANC visits but despite the benefit of FANC over traditional ANC many Federal and State facilities have not implemented it [8].

In 2004, the policy of free maternity care services was introduced by the government in response to United Nations Millennium Development Goals (MDGs) 4 and 5, which led to an astronomical rise in the use of antenatal resources. The free maternal care in Ondo State led to patronage by clients from neighboring states. This number became overwhelming for the care providers causing long queues which have been unbearable for care providers and clients.

In 2008, FANC was introduced in Ondo State to meet the demand and still provide quality care. Ondo State of Nigeria comprises largely of rural areas with high poverty and illiteracy rates and access to healthcare is poor. Preliminary figures in the State Specialists Hospital showed unacceptably high maternal mortality and perinatal mortality rates. Antenatal care services were minimally utilized. In March 2009, the state Life Saving Skills (LSS) Trainers did on-the-job-training on Focused Antenatal Care for obstetric staff in the Hospital. This led to the implementation of the new model in the State Specialist Hospital to guide and planned implementation in other health facilities in the State.

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The WHO focused ANC package was introduced and adapted in Nigeria in 2002. This package seeks to promote the health and survival of mothers and babies through:

- Targeted assessments of pregnant women to ensure a normal child bearing cycle and newborn period, and to facilitate the early detection of complications, chronic conditions, and other potential problems that could affect the pregnancy; and
- Individualized care to help maintain the normal progress of pregnancies, including preventive measures, supportive care, health messages and counseling of women and families for effective self-care, and birth preparedness and planning for complications [2].

For women whose pregnancies are progressing normally, WHO recommends four ANC visits, ideally at less than 16 weeks, at 26 weeks, 32 weeks and 36 weeks. Each visit should have care that is appropriate to the overall condition and stage of pregnancy and should include: identification of pre-existing health conditions, early detection of complications arising during pregnancy, health promotion and disease prevention, and birth preparedness and complication planning [8].

Despite the benefit of FANC over traditional ANC many Federal and State facilities have not implemented it. This may be due to the need to modify existing policies, guidelines and programmes related to maternal Health which should be implemented Nationwide. Interview with women in the state revealed that some women in traditional setup want FANC while those in FANC prefer more

visits. The aim of this study was to determine the perceived quality of the new WHO-ANC model in health facilities in Ondo State over the traditional ANC among women and providers. The researcher explored the perception of pregnant women on the quality of care in FANC in selected clinics in Ondo State in comparison with the traditional ANC. Findings from the study can promote better policy development and utilization of FANC health facilities by pregnant women for institutional deliveries.

2. THEORETICAL FRAMEWORK

The Conceptual Model Theory [9] was the theoretical framework for the study. The Conceptual Model was used in analyzing health policy development and programme implementation to develop a more feasible approach to improving the provision of FANC services to pregnant women in Ondo State. The Walt and Gilson policy analysis triangle points to the importance of interactions between actors, contextual features, processes, and policy. The model for Health policy analysis:

- Identifies and examines factors that affected the implementation of a policy.
- Identifies and examines factors that will affect implementation of a new or revised policy or programme.
- Examines circumstances that will influence its outcome.
- Takes into consideration the content, actors and process of implementing the change and;
- Examines the context within which changes are introduced.

Health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, also to understand past policy failures and successes and to plan for future policy implementation. [9] reported that a number of scholars have argued that policy analysis was central to health reforms. However, there has been much less attention given to how to ensure policy analysis and what research designs, theories or methods best inform policy analysis. He reported that a software tool was designed and updated to help researchers and policy-makers analyse the political dimensions of public policies while guidelines for undertaking stakeholder analysis have also been designed as a part of health policy analysis. Different theoretical frameworks of the policy process have equally been developed.

Walt and Gilson [9] developed a policy analysis framework specifically for health, although its relevance extends beyond this sector. They noted that health policy research focused largely on the content of policy, neglecting actors, context and processes. Their policy triangle framework is grounded in a political economy perspective, and considers how all four of these elements interact to shape policy-making. The framework has influenced health policy research in a diverse array of countries, and has been used to analyse a large number of health issues, including mental health, health sector reform, tuberculosis, reproductive health and antenatal syphilis control.

By application to the study, new policies often generate unexpected and unwanted impacts. For example, although the removal of user fees in south Africa led to increased utilization by poorer groups, it also contributed to worsening health worker morale with negative consequences for health worker attitudes and behaviours towards patients (such as turning patients away or stigmatizing some patient groups). Thus, Nurses' knowledge of FANC as actors and implementers can use their power of persuasive communication to encourage other actors and stakeholders, including public and public sector bureaucrats, to understand and respond to policy change.

3. MATERIAL AND METHODS

A comparative study designed was used to examine the women's perception of care and acceptability of FANC at the clinic level between an intervention site (clinic offering FANC) and a comparison site (not offering FANC) in Ondo State, Nigeria. The two hospitals selected for the study were located in Akure South Local Government Area and easily accessible to the women due to their locations.

The target population for the study consisted of pregnant women utilizing services in the selected health facilities. Both a quantitative and qualitative design was used. Data gathering was self-report using a structured questionnaire and a focus group technique. The focus group interview was conducted using a focus group schedule. Purposive and convenience sampling techniques were used in the study. The participants for the quantitative aspect were a total of 200 pregnant women that attended the clinics and the selection of the study population was within two weeks.

The selection of the region for study was also purposive, done in consultation with the Reproductive and Child Health Unit of the Ondo State Ministry of Health, and was based on the type and patient load. The data was gathered using structured questionnaires on client's perception and awareness on quality of care received and content of FANC. On each clinic day, the WHO Classifying form was used to determine eligibility and participant were informed about the study, after which consent was obtained. Multistage sampling method was used with the attendance register. The sample was determined using a formula developed by Frounkfort – Nachmias .

The instrument used for quantitative data gathering was structured questionnaire designed from literature review with open and closed ended questions and Likert Scale Format was used to elicit information on women perception of quality of care in FANC. The questionnaire was self-administered based on the ability of the women to read or write. It has five sections. Section A: elicit information on demographic data, Section B: were questions on knowledge of FANC, Section C was questions on attitude of women to the new schedule of four visits; Section D was based on quality care on FANC while Section E was on client acceptance/satisfaction of the service. Two hundred and thirty (230) questionnaires were distributed and retrieved out of which two hundred (200) were correctly filled.

For validity and reliability, prepared questionnaire was given to the project supervisor for vetting while experts in the field were allowed to review the instrument to ensure face and content validity. The tool was pilot tested using a group of ten women similar to the study population at Mother and Child Hospital, Akure, the result was used to modify the questionnaire before the actual study. Content validity of the instrument covered all essential areas and was shown to experts for comments and further review. The final tool was translated by the interviewer to local dialect for better understanding of those who may not understand English and to ensure the reliability of the instrument, Test- retest method was used. Data was analysed using the Statistical Package for Social Sciences (SPSS). Summary statistics that are presented as means and standard deviation was used. Student T-test was used for comparison of mean values between the two groups.

The sample used for the focus groups interview was a subgroup of the quantitative sample. Interested participants were briefed about the study and their rights. Participation was voluntary. The rationale

for choosing the same population is that after completion of the quantitative data gathering, they had the opportunity to explain in-depth what they understood or did not understand about the pregnancy leaflet. The sampling method was convenient sampling. The sample size was determined by saturation of data [10].

Content analysis using open coding according to Tesch's approach was done since the study data is verbal in nature [11]. To determine when data is saturated, data analysis was done concurrently with data gathering. Trustworthiness was established according to the strategies promoted by [10].

For ethical consideration, letter of introduction from the department of nursing was submitted to the various health institutions and departments in order to obtain permission. Official permission was obtained from the authorities of the hospitals and clinics used for the study. The proposal was submitted to the institutional Chief Medical Directors (CMDs), the Chairman of Medical Advisory Committee (C.M.A.C) for scrutiny. Only women consenting to be in the study were included. Issues discussed with respondents and data collected was treated in absolute confidence.

4. RESULTS AND DISCUSSION

As shown in Table 1, the ages of respondents were between 15 and 54 years. The majority (55.9%) of the respondents are between ages of 25 – 34 years, followed by those of ages between 35 and 40 years (24.7%). The marital status of the participants indicated that the majority (76.5%) are married while 15.3% are single. Most 75.8% of the participants are Christians and the educational qualification distribution pattern of the participants indicated that the majority 72.4% had Diploma. Most (56.7%) of the respondents have had 4-6 pregnancy while 23.7% had between 7-9 children.

212 **Table 1: Respondents Demographic Data at Intervention and Control Clinics**

		Intervention	%	Control	%	Total	%
Age	15 – 24	18	19.1	16	17.4	34	18.3
	25 – 34	51	54.3	53	57.6	104	55.9
	35 – 44	23	24.5	23	25.0	46	24.7
	45 – 54	02	2.1	-	-	2	2.2
Marital Status	Single	17	16.5	15	16.1	32	16.3
	Married	79	76.6	71	76.3	150	76.5
	Separated	05	4.9	5	5.4	10	5.1
	Divorced	02	2.0	2	2.2	4	2.1
	Widowed	-	-	-	-	-	-
Religion	Christianity	71	77.2	73	74.5	144	75.7
	Islam	19	20.6	25	25.5	44	23.2
	Others	02	2.2	-	-	2	1.1
Education	O'Level	33	35.23	35	37.2	68	36.2
	Diploma	31	3	37	39.4	68	36.2
	First degree	25	26.64	10	20.2	44	28.4
	Postgraduate	4	.2	2	2.1	6	3.2
	Others-----	1	1	1	1.1	2	1.0
No of Children	1 – 3	19	20.4	17	17.3	36	19.6
	4 – 6	55	59.1	55	55.5	110	56.7
	7 – 9	19	20.5	27	27.2	46	23.7

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215 **Client's awareness and perception of FANC**

216 When the participants were asked about their awareness of FANC and the result shows that the
 217 awareness of women attending ante natal clinic is generally low with 31.2% of women having the
 218 understanding that the WHO FANC is not to ease the nurses (care provider's work) but to offer quality
 219 service, while the remaining 68.8% indicated that the FANC is to ease nurses work and not to offer
 220 quality service (Table 2).

Table 2: Client's awareness and perception of FANC

	Intervention	%	Control	%	Total	%
Aware of FANC	82	77.4	33	35.1	115	57.5
Not Aware of FANC	24	22.6	61	64.9	85	42.5
Total	106	100	94	100	200	100

When asked about their opinion on the definition of ANC, most (92%) of the participants knew that ANC is the care given to women throughout pregnancy. The majority 959%) also agreed that it is 13 or more visits while 72% of the participants believed that it helps to identify problems early in pregnancy (Fig.1).

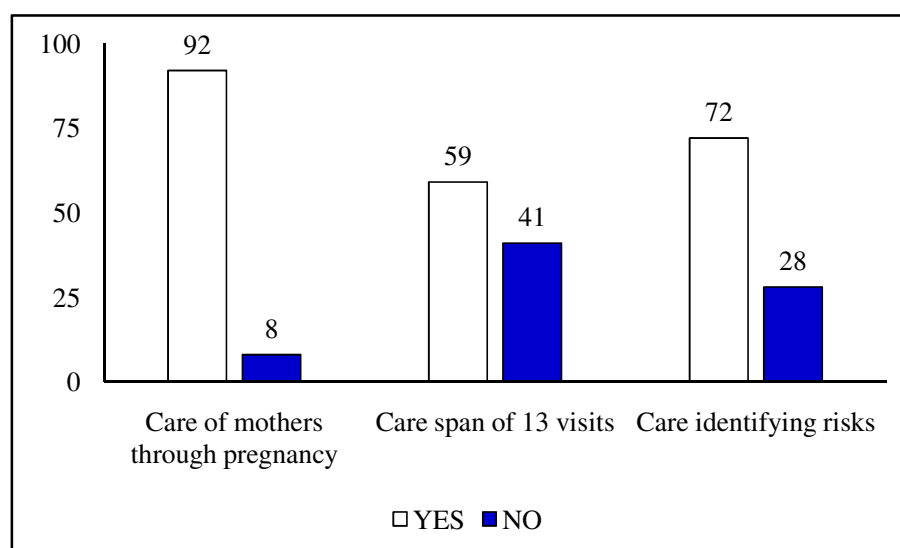


Fig. 1: Participants' definition of ANC

With regards to the definition of FANC, most 69% of the participants believed that FANC is to ease the work of nurses while 66% mentioned that the purpose of the 4 visits was to ease nurses' work. The majority 91% believed that FANC is free ANC, whereas 63% perceived it as quality care in just 4 visits (Fig. 2).

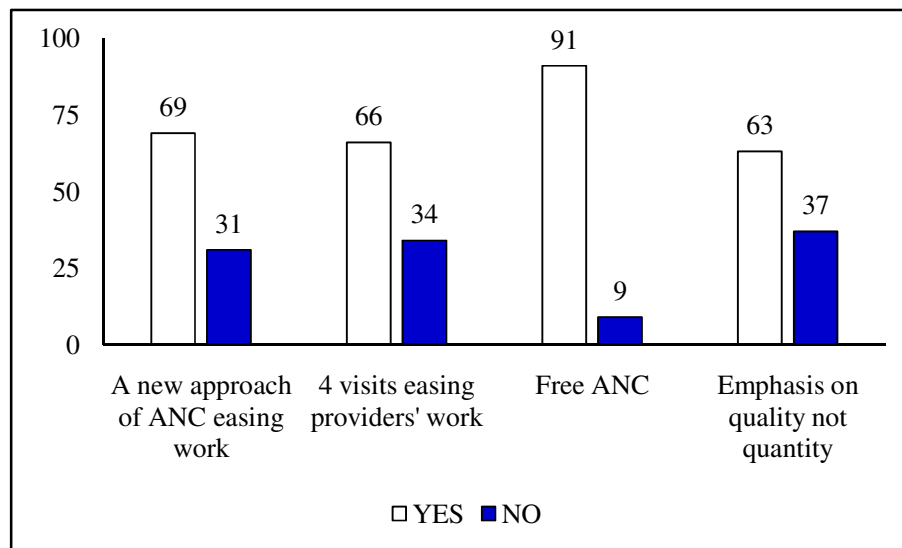


Fig. 2: Respondents' definition of FANC

When asked about the components of FANC, a large proportion (72%) of the participants received anti-malaria, also, 83% had counseling on Family planning and birth preparedness, while 78% were counseled on HIV/AIDS, 58% had TB screening done and 82% have received counseling on the danger signs of pregnancy (Fig. 3).

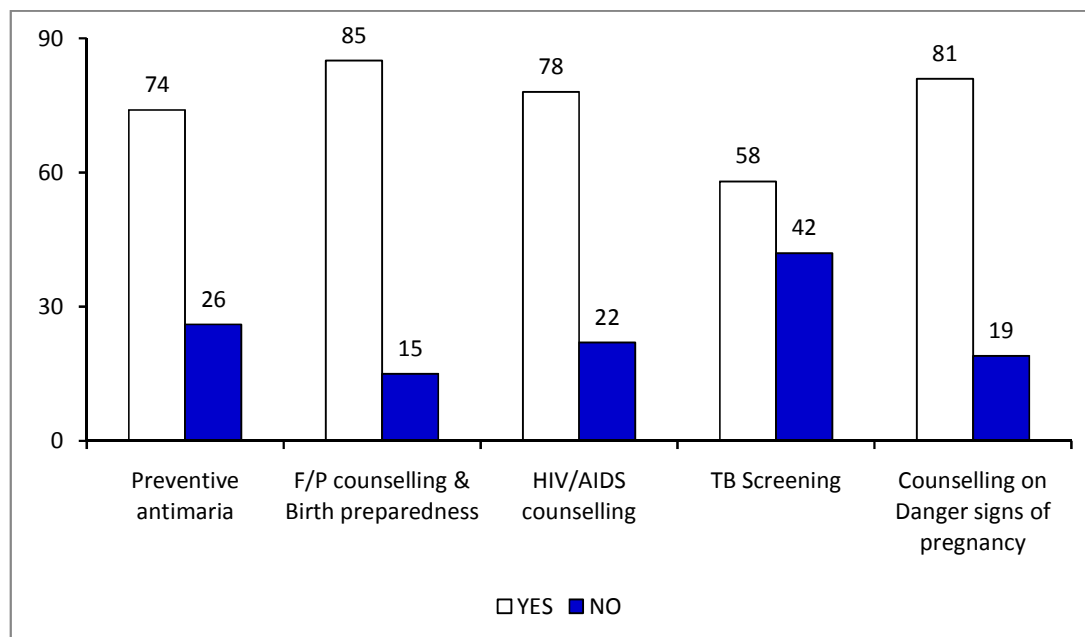


Fig. 3: Respondents' use of components of FANC

Perception of the participants regarding the quality of ANC services revealed that many (59.6%) of the participants were not tested for Syphilis while 54% indicated that there was no hotline telephone numbers for emergencies however 73.9% identified effective privacy during consultation with provider (Table 3).

Table 3: Respondents perceived quality of ANC services

		Frequency	Percentage
Syphilis test	Yes	72	40.4
	No	106	59.6
Specific care (TB screening)	Yes	82	43.6
Hotline for emergencies	No	106	56.4
General care (Privacy)	Yes	136	73.9
	No	48	26.1

As shown in Table 4, the majority (81%) of respondents agreed that FANC is good and will encourage compliance while 71.1% respondents feels there was no need to reduce visits and that most mothers in-law 61.8% does not support four visits nevertheless 64.6% believed that FANC can result in quality care

Table 4: Respondents' attitudes towards FANC

S/No	Statements	Agreed		Disagreed		Total
		N	%	N	%	%
1.	FANC is good and encourages compliance	162	81	38	19	100
2.	Reducing visits is not necessary	128	71.1	52	28.9	100
3.	Mother-in-laws did not support 4 visits	94	61.8	59	38.2	100
4.	FANC may lead to complications	98	53.8	84	46.2	100
5.	FANC reduces waiting time	64	87.6	106	62.4	100
6.	FANC results in quality care	128	64.6	56	30.4	100

On the perception of respondents on waiting time satisfaction, a large proportion (65%) was not satisfied with the waiting time while only 13% indicated that they are satisfied (Fig. 4). When asked

about their satisfaction with regards to problem discussion, most (72%) of the respondents indicated that they are satisfied and only 9% were dissatisfied (Fig. 4). With respect to quality of examination and treatment received, the majority (64%) of the respondents is not satisfied with the quality of examination and treatment received while 32% are fairly satisfied (Fig. 4). With regards to respondents level of satisfaction with next appointment, a large proportion (81%) are satisfied with the date for their next appointment, 24% are fairly satisfied and only 5% are not satisfied (Fig. 4).

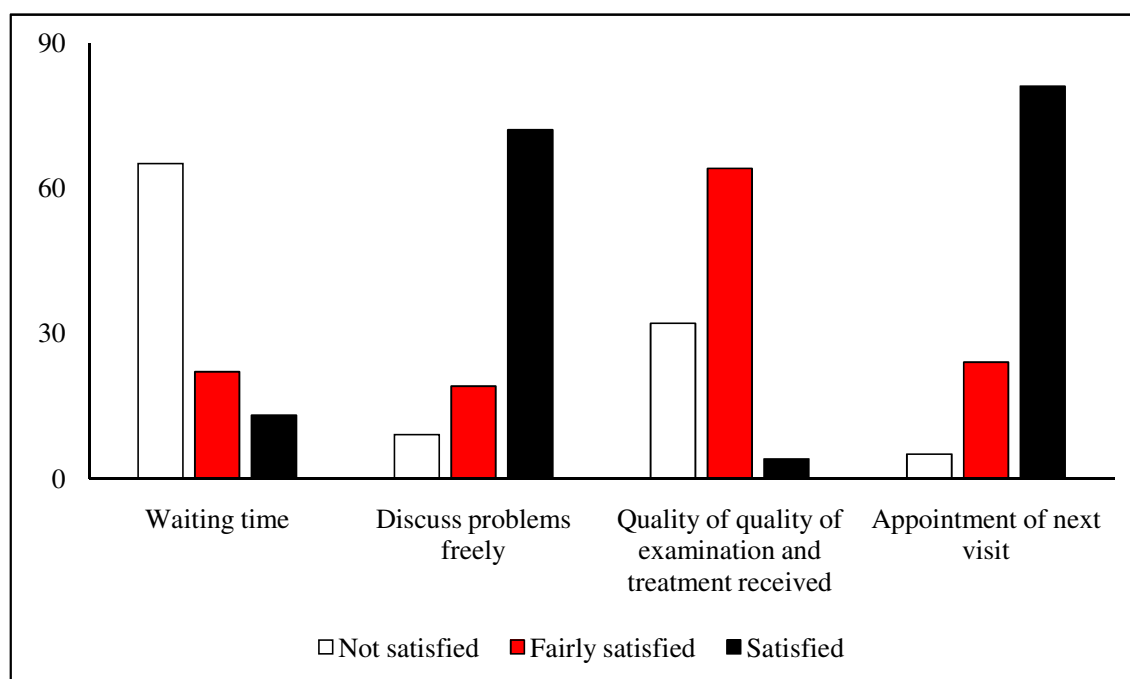


Fig. 4: Respondents' levels of satisfaction with waiting time, ability to discuss their problems freely, quality of examination and treatment received and appointment of next visit

The findings of the qualitative study are described according to the main theme and categories generated from the focus group data responses Table 5.

Table 5: Themes and sub themes generated from the samples

Main themes	Categories
Knowledge	Information about FANC
	Information about normal ANC

ANC/FANC visits	Number of ANC visit times during previous pregnancy Number of ANC visit times during present pregnancy Benefits/disadvantages of FANC reduced visits
Suggestions	How to improve service delivery Impression of relatives/ in laws about FANC What can the government do to improve FANC

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295 **Theme 1: Knowledge**

296 With regards to questions regarding participant understanding of the traditional ANC and the FANC,
 297 the majority (5 of 10) described ANC as care given to pregnant women, 2 of 10 perceive it as the way
 298 to know how pregnant women cares for themselves while the remaining 3 participants described it as
 299 care for baby and mother. The followings are some of the participant's responses:

300

301 *"ANC is the care given to pregnant women, from the day she discovers that she is*
 302 *pregnant till she delivers her baby".*

303 *"It is to check yourself and the baby, care of pregnant women and their babies, to teach pregnant*
 304 *women what to do while pregnant and what to do when after delivery".*

305

306 None of the participants understood FANC. This shows that many pregnant women are not aware of
 307 FANC at all, even in the implementing facility.

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309 **Theme 2: ANC/FANC visits:**

310 Participants were asked about the number of ANC visits during their previous pregnancy and almost
 311 half (4 of 10) of the participants indicated only 5 – 6 times visits during their last pregnancies out of
 312 about 13 visits, although they are using the same previous facility.

313 With regards to the number of visits in current pregnancy, all the participants the ten mentioned
 314 different number of visits ranging from 2 – 3 times, depending on their gestational age. They were told
 315 that the system that had reduced the number of visits and it is called FANC.

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When the participants were asked the benefits or the disadvantages of the FANC reduced visits, almost all (8 of 10) of the women highlighted various benefits while the remaining two participants indicated that the reduced visits is not a good idea. Some of the benefits mentioned are as follows:

“Yes, it is better because you don’t need to go to clinic every time because pregnancy is not a disease”.

“It is better because it does not waste time as before, we have been to our offices and shops before coming and we are sure we would return early”.

“I am not very comfortable with the reduced visits, because you won’t know if something is going wrong on time but I like the fact that I can come for ANC in the afternoon, no rushing and no time wasting”.

Theme 3: Suggestions

With regards to how the current service delivery can be improved, more than half (7 of 10) wanted improvement in the facility, like more furniture, equipment, nurses and the remaining (3 of 10) think there is no awareness about FANC and advocates for increase awareness in the community. Some of their responses are as follows:

“Provide more chairs for pregnant women to sit, we need more nurses and more equipment for nurses/providers to work with”.

“Educate more women on FANC, the reduced visits as many people don’t know about it”.

Question regarding how do your relatives/ in laws see FANC, that is, the reduced visits and the care participants are receiving, all (10 of 10) the participants answers in the affirmative, the answers to this question shows that in-laws and relatives of these pregnant women have no objection to FANC, so they are not hindrances to FANC.

When the participants were asked for their opinions on what the government can do to improve FANC services, a large proportion (8 of 10) of the women praised Government for what they are doing but

still want more nurses, more equipment and wants government to allow more hospitals in the State to practice FANC. The following are some of their responses:

“Government has done well but should employ more providers and pay attractive salaries, so they can work better”.

“Allow more hospitals to practice FANC, so that all pregnant women can enjoy satisfaction with care”.

Findings from the study revealed that a substantial number of pregnant women 104 (55.9%) are between ages 25 – 34 years. It is generally assumed that use of ANC is lowest in the youngest and oldest age because many young pregnant women will be unmarried and unable or unwilling to use maternal health services of many older pregnant women will have in grand cultural biases against formal health as revealed by number of children 36 (19.6%) and 46 (23.71%). This is a pointer for the need to provide awareness on the benefits of family planning.

The result on clients awareness of FANC shows that the awareness of the women attending Ante-natal clinic is low with 58 (29.5%) of women having the understanding that WHO FANC is not to ease the nurses (care providers) work rather than to offer quality services to the women attending the clinic. Also according to the focused group discussion (FGD), none of the participants understood the meaning of FANC. This shows that many pregnant women are not aware of FANC, even in the implementing facility. There is need for more awareness on FANC among the women attending ante-natal clinic, so as to change from the traditional ANC to the new one (FANC), which is aimed at improving maternal health. The antenatal period clearly presents opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. For example, if the antenatal period is used to inform women and families about danger signs and symptoms and about the risks of labour and delivery, it may provide the route for ensuring that pregnant women do, in practice, deliver with the assistance of a skilled health care provider [3] [12].

The result of clients attitude towards the introduction of FANC reveals that 128 (71.1%) of the women attending the Ante-natal clinic are not in support of the reduced number of visits. This result shows that larger percentage of the women still prefer the routine Ante-natal clinic of many visits before

delivery due to believe that reduced visits may lead to complication and possibly because of the influences from relatives. FANC recognizes two key realities, firstly, frequent visits do not necessarily improve pregnancy outcomes, and in developing countries they are often logistically and financially impossible for women. Secondly, many women who have risk factors never develop complications, while women without risk factors often do. So, when antenatal care is planned using a risk approach, scarce healthcare resources may be devoted to unnecessary care for “high-risk” women who never develop complications, and “low-risk” women may be unprepared to recognize or respond to signs of complications.

Ante natal care is focused visits with the skilled provider, aimed at ensuring the healthiest possible outcome for every mother and baby. It emphasizes quality over quantity of visits. On the whole, antenatal care programs in developing countries have been modeled on those in developed countries. These programs, however, have been poorly implemented and largely ineffective. In response, the World Health Organization (WHO) designed and tested a focused antenatal care package that includes only counseling, examinations, and tests that serve an immediate purpose and have a proven health benefit. The WHO recommends reducing the number of antenatal care visits to four, and this has not been found to pose a risk to the health of mother or baby [8].

On the perceived quality of care offer by FANC by the participants, the result shows that not all the women attending the Ante-natal care have access to some specific care such as the rapid syphilis test which is essential for the detection of symptomatic STIs. The response is 72 (40.4%) which is low and ought not to be. Also the percentage on the recommendation for emergencies is 41 (43.6%). There is need for proper care of pregnant women attending FANC in case of any emergency, adequate contact should be put in place. According to Caroli and Villar [12], effective FANC will prevent maternal mortality and consequent serious morbidity. On the whole the general quality of care is encouraging with 136 (73.9%) of the women answering yes (Table 3). There is now broad agreement that the FANC interventions should be on improving maternal health, this being both an end in itself and necessary for improving the health and survival of infants. With this improved understanding has come a refocusing of maternal health programmes towards ensuring that women have access to care during the critical period around labour and delivery – which is when most deaths occur – coupled with referral for the management of obstetric emergencies. Thus, safe motherhood

programmes tend to prioritize the need for skilled care during delivery, including emergency obstetric care, rather than ensuring that all women receive antenatal care [3] [12] [13].

5. CONCLUSION AND RECOMMENDATIONS

In conclusion, sustainability of the focused ANC package will also require explicit policy direction and coordinated RH program implementation and support. The process of stimulating changes in ANC service delivery will require further consultation with and inclusion of key actors, notably the pre-service training institutions and professional bodies, to ensure institutionalization and standardization of focused ANC training and supervision. The new WHO antenatal care model provides detailed instructions on how to conduct the four-visit schedule of the basic component of the new WHO model. It includes a classifying form for easy assessment of a woman's eligibility for the basic component, and provides a checklist of activities that are to be performed throughout the four-visit schedule [4]. FANC has been introduced in Nigeria as well as in Ondo State and should be continued given its acceptability and effect on the quality of care received by women. This study provides many insights into ways in which expansion of this approach to ANC could be strengthened, both to further improve the quantity, quality and relevance of services received by pregnant women, and to enhance the likelihood that such a comprehensive and integrated service can be sustained as a routine best practice.

Community mobilization is still essential to create more awareness about FANC timing and the need to co-opt other critical actors, especially male partners, in preparation for birth and complications. A national educational campaign may help in this regard.

Although a focused ANC is acceptable to both clients and providers, for the approach has received tremendous support from the government and health development partners, to ensure its sustainability, it is vital to train providers so as to improve their competency. Also, there is the need to ensure that supervisors are able to support and enable providers to deliver integrated, comprehensive FANC services and to ensure effective client flow so as to reduce client-waiting time.

In addition, it is also important to communicate the new regimen of services and their timing to the general public so that FANC attendance is encouraged and according to the required visit schedule.

Also important is the need for community mobilization to create awareness about the new services being offered during FANC, such as birth planning and preparedness for complications, timing of ANC visits and the need to co-opt other critical actors, especially male partners, in preparation for birth and readiness for possible complications.

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