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Psychosocial Antenatal Care: A Midwifery Context

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Abstract

The rationale of any national screening programme is to recognise the benefits for public health, to assess a predominantly healthy population including pregnant women and to detect risk factors for morbidity in order to provide timely care interventions. The focus of antenatal care screening is to identify wider determinants of health that may have an impact on a pregnant woman's well-being that includes the physical, psychological, social and religious factors. Psychosocial risks, among others, include poor socioeconomic conditions such as poverty, lack of social support, general health inequalities, domestic violence and a history of either personal or familial mental illness, all of which have the capacity to influence a pregnant woman's decision to utilise health care services. This chapter highlights the antenatal care process, the importance of psychosocial care during pregnancy, maternal risks during pregnancy, the impact of pregnancy on maternal well-being, the possible psychosocial risk factors during pregnancy, psychosocial assessment, psychosocial care as a missing piece of the antenatal care puzzle, the presentation of the results of a study on psychosocial risk assessment and support and further outlining various antenatal care approaches that could be adopted to offer pregnant women holistic care.

Keywords: antenatal care screening, pregnancy, psychosocial care, psychosocial support, women

1. Introduction

This chapter presents a discussion pertaining to psychosocial care for women during pregnancy. Pregnancy as a developmental phase involves both physiological and psychological adaptations that are acceptable to a certain extent, but if excessive, may lead to pathological changes. Psychosocial stressors experienced during pregnancy encompass life experiences that include changes in personal life, job status, family makeup, housing and the possibility of domestic

violence [1]. While risks cannot be totally eliminated once pregnancy is established, they can be reduced through effective, accessible and affordable maternity health care. Numerous studies reveal significant depressive symptoms in pregnant women that are associated with sociodemographic and economic status and that depression during pregnancy may negatively influence psychosocial adjustment [2, 3]. Research findings also recommend an integrated approach to antenatal care that focuses on both the physiological and psychosocial dimensions.

2. Antenatal care as a process

Antenatal care has been described as one of the effective forms of preventative care. It involves screening symptomatic and asymptomatic pregnant women, with the aim of detecting and thereby preventing both maternal and neonatal adverse events. The introduction of antenatal care in 1910 in the Royal Adelaide Hospital in Australia has played an important role in preventing high maternal and perinatal mortality rates. Antenatal care should ideally be geared towards the promotion of health and the prevention of physical and psychosocial problems [16].

The psychopathology of pregnancy needs to be understood in terms of the adjustment that all women have to make when they conceive, as pregnancy is also an adaptive process. A pregnant woman should carry the baby safely through to delivery and adjust to the sacrifices that motherhood demands. The challenges that face her, include the acceptance of the pregnancy by the family; development of an attachment to the baby and preparation for birth; and adjustment to the changes in her physical appearance, and to development and maintenance of a positive relationship with the father of the baby. Many women respond to this complex process with grief and anger, especially when the pregnancy is unplanned and unaccepted. Unmanaged grief or anger might ultimately lead to maternal depression [17].

Pregnancy can be enhanced through a coordinated antenatal care programme, which includes both medical and psychosocial care. As such, pregnant women's mental health should be a primary concern for all midwives due to a reported high prevalence of depressive and anxiety disorders in women. Hollander and Langer [18, 19] reported a 21% incidence of depression and 34% anxiety disorders in women, which may be exacerbated by pregnancy. Pregnancy-specific anxiety may occur as the woman worries about her pregnancy, physical changes and delivery.

Antenatal preparation should be offered to all women during pregnancy as a national policy. Screening during pregnancy is crucial, with the aim of detecting and preventing both maternal and neonatal adverse events and instituting early intervention. During screening, midwives should actively listen to the concerns and needs of pregnant women to be able to assess them comprehensively.

The findings of a cross-cultural survey by Namagembe [20] on the extent of physical and emotional abuse on African American, White American and Hispanic women during pregnancy indicated that one in four women gave a history of battering and physical abuse. The implication for this was that many women's community subsystems of safety and physical environment are not in harmony and that battering and physical abuse during pregnancy might lead to a significant delay in obtaining antenatal care by 6.5 weeks as compared to non-abused women.

During childbirth, women may look upon their midwives as their advocates despite the existing medically inclined maternity care context. The challenge faced by midwives is the provision of comprehensive and holistic maternity care. This challenge can be achieved through the maintenance of a woman-centred, individualised and caring approach, which needs a caring and responsive midwife. Midwifery care should involve the physical, emotional, social, spiritual and psychological elements for it to be regarded as comprehensive [14].

3. The importance of psychosocial care during pregnancy

Psychosocial morbidity is not given enough recognition, it is not thought to be self-limiting as it is the care that is attributed to normal emotionality of pregnancy, and it is less frequently identified, especially if there is no continuity of care by the same midwife or clinician. Pereira et al. [4] reported that antenatal depression affects 4–16% of women, domestic violence during pregnancy rates at 16% and postnatal depression affects 15–20% of postpartum women.

Historically and contemporarily [4], much of what constitutes antenatal care throughout the world remains strongly rooted in the medical model within which it developed. Widespread, institutionalised routine antenatal care began around 80 years ago, focusing on mass screening with the aim of reducing maternal and perinatal morbidity and mortality under medical supervision [5]. What is of concern within the context of antenatal care are the beliefs and assumptions that continue to underpin the structure and content of antenatal care.

Traditionally, antenatal care consists of a prescribed set of acts with a focus on the clinical physiological monitoring and screening of pregnant women. This approach was based on the notion by Oakley (1984) that pregnancy is a state of pathology rather than a normal physiological and developmental stage [5]. As further stated by Chitra and Gnanadurai [1], “antenatal care is usually offered in a form of routine physical assessment and care with limited or no psychosocial assessment and care”.

Inadequate psychosocial risk assessment may lead to lack of psychosocial support afforded to the pregnant women. Pregnant women who lack psychosocial support may experience stress during their pregnancy and childbirth. These changes may increase the woman’s vulnerability to depression, which may in turn have adverse effects on both maternal and foetal well-being [6]. Unrelieved stress can also increase vulnerability to physical and emotional problems, for example, insomnia, fatigue, development of ulcers and heart problems [7].

Supportive care during childbirth may have long-term positive effects and may protect some women from a long-lasting negative birth experience. The latter was found in a longitudinal cohort study on “why some women change their opinions about childbirth over time” [8]. Mixed feelings were elicited from women regarding their attitude towards childbirth, changing from positive to less-positive opinions based on, for instance, dissatisfaction with intrapartum care and lack of support for psychosocial problems such as single marital status or the presence of depressive symptoms. Changing from negative to less-negative feelings was associated with less worry about birth in early pregnancy and a more positive experience of support by the midwife.

According to O'Keane and Marsh [9], psychosocial support not only lowers prematurity and low birth weight rates but also inspires healthier behaviours and lifestyle among pregnant women and discourages behaviours like smoking, substance abuse and poor nutritional intake, which can have other detrimental effects on the mother and baby. Psychosocial support calls for a multi-level approach, consisting of strengthening partners and families and enhancing system capacity by ensuring the availability of resources. Interventions need to bolster the support provided within the woman's existing social network in order to maintain the woman's cultural beliefs and values.

Dodd et al. [10] tested a hypothesis on the relationship between psychosocial stress, social support, self-efficacy and circulating pro- and anti-inflammatory cytokines in women throughout pregnancy. Pregnant women within the study completed the Denver Maternal Health Assessment. The conclusion was that high social support was associated with low stress scores. Elevated stress scores positively correlated with higher levels of pro-inflammatory cytokine interleukin-6 (IL-6) and tumour necrosis factor- α (TNF- α).

A longitudinal community-based study conducted by Gelder et al. [11] through the use of the Edinburgh Postnatal Depression Scale (EPDS) revealed that women who lacked social support showed more symptoms of depressed mood. The maternal depressive mood had a negative impact on breastfeeding, the experiences of motherhood and the relationship with partners.

Appropriate psychosocial assessment is important for designing relevant intervention strategies and for public health policy formulation [12]. Ethically, psychosocial risk assessment should be linked to a plan of care through the provision of appropriate psychosocial support. The plan of care should ensure that the maternal referral arrangements are in place at the participating facilities. The plan of care should be coordinated with all appropriate disciplines.

Irrespective of how maternity care providers perceive antenatal care, the important issue to be taken into consideration is the woman. From a psychosocial point of view, for midwives using a midwifery model, antenatal care is a time of building a relationship with each woman and her family. It is a time when a partnership is developed and negotiated; expectations, roles and responsibilities are identified; options are discussed and choices are made by women and supported by midwives.

While not neglecting physical safety, antenatal care should be emotionally, socially, culturally and religiously acceptable to the woman. Physical care alone is not sufficient for the woman, as her needs and expectations are unique. The effectiveness of antenatal care as a central focus is still being discussed by midwives, obstetricians, medical anthropologists, sociologists and women's organisations. Handley [13] cited Oakley (1984) in her book "Captured Womb" and wrote extensively on pregnancy, antenatal care and childbirth. She argues the importance of antenatal care but also believes that antenatal care is something that is done in an attempt to control the behaviour of women's bodies, an intervention offered to women that does not benefit all women, but probably a few who do not know what to expect from an antenatal care service.

Purdy (2001) as cited by Woodward [14] defines medicalisation as the process that transpires when health practitioners treat natural bodily functions as if they were diseased. Purdy further stated that it is essential that conventional medicine re-evaluates its health care model towards the needs of patients and not its own.

Conventional medicine must also accept other health care practices such as midwifery-led maternity care as a valid source of healthcare, especially to address psychosocial risk factors. Women's health problems, including pregnancy, should cease to be medicalised.

Parry [15] in a study exploring whether Canadian women's choice of midwifery care identifies a resistance to the medicalisation of pregnancy and childbirth came to the conclusion that women have a desire for personal control of their pregnancy as reflected in this comment:

"I just wanted to be in control of what was going on with my body, It scares me that they will push you when you are in your most vulnerable state, because it is more convenient for their schedule". Participants further related how midwifery care met their needs for control over their bodies, their pregnancies and their experiences with childbirth, notwithstanding a sentiment that medical interventions also have a place in pregnancy and childbirth.

An ideal option for effective antenatal care is the incorporation of psychosocial care as a component of antenatal care, acknowledging the women's own experiences of pregnancy [2]. Midwifery, which means "to be with women", is based upon a philosophy of care in which the management of pregnancy is shared between the midwife and the woman, with a focus on informed choice, shared responsibility, mutual decision making and women articulating their health needs.

4. Maternal risks during pregnancy

According to Baldo [7], maternal risk is defined as the probability of experiencing various levels of injuries or even dying as a result of pregnancy or childbirth. Physiological and psychosocial risk screening should therefore be conducted during the first and subsequent visits of antenatal care as part of a comprehensive assessment during antenatal care.

The opinions of Handwerker (1994), Lupton (1999) and Saxell (2000) as cited by Refs. [1, 21] were that risk assessment during childbirth is made more complex by the differences in the perceptions of risks between midwives and pregnant women, as risk from a midwife's perspective is based on her specialised knowledge and training, epidemiology, personal values and experience, whereas a woman's understanding of risk is far more contextual, individualised and embedded in her social environment and everyday life experience.

Historically, the definition of maternal risk emphasises mainly medical factors and includes few psychological and socioeconomic factors. To add to this, the interest of midwives seems to be directed towards foetal well-being and the newborn child, ignoring the psychosocial needs of the mother. Furthermore, when a woman reports for delivery, her family member's concern is mostly on the well-being of the newborn rather than on the maternal well-being.

Psychosocial factors are an important area to assess during pregnancy. Various studies, for example, those of [12, 22–24] demonstrate that stress, depression, alcohol abuse and lack of social support during pregnancy are commonly associated with low birth weight and perinatal morbidity and mortality. Furthermore, in this era of HIV/AIDS, psychosocial problems are common among affected populations. These issues may have an indirect influence by affecting antenatal care attendance, the woman's coping capacity and the physiology of pregnancy.

Most of the risk assessment systems in midwifery care focuses on physical characteristics such as age, parity and education; however, these assessment systems are not exclusively suggestive of a risk for maternal morbidity and mortality as they mostly exclude psychosocial factors. A review of several studies by Hamid et al. [25] on the perceptions of antenatal care by women suggests that there are several psychosocial risk factors that need to be taken into consideration in order to ensure a safe pregnancy and delivery. Psychosocial interventions have proved to be beneficial in providing comprehensive antenatal care.

Furthermore, a systematic review of 16 studies on antenatal screening for postnatal depression by Hamid et al. [25], which involved 23,000 participants, revealed that the proportion of women who are at risk for postnatal depression was between 10 and 67%. The authors further commented that the preliminary evidence suggested that the introduction of screening tools to aid early detection and diagnosis of depression has helped to raise awareness among health care providers regarding social and psychological maternal risk factors.

5. Possible psychosocial risk factors during pregnancy

Psychosocial risks are described as the demands or challenges that are psychological or social in origin, having the potential to directly or indirectly alter homeostasis during pregnancy and childbirth [21]. They relate to a combination of the affective states and cognitive factors of anxiety, depression, self-esteem mastery and perceived stress as measured by the scale of Gunn et al. [30].

According to Glazier et al. [28], a psychosocial problem may occur in response to an exposure to a stressful life event, for example, unemployment. The psychosocial response will, however, be determined by the effect it has on an individual, for example, loss of self-esteem and feelings of worthlessness.

Fawole et al. [29] have identified the following as some of the psychosocial risk factors that a woman may have experienced or may experience during pregnancy: woman battering; family violence or intimate partner abuse; sexual abuse and harassment; discrimination; gender inequality; past history of depressive disorders; absent/abusive or non-supportive spouse; marital difficulties; pregnancy occurring below 18 years of age, which antedates social development; unintended, unplanned or unwanted pregnancy; maternal or paternal unemployment; adverse life events, for example, loss of spouse; socio-economic factors, for example, poverty; barriers to accessing health care services, for example, distance travelled and transport unavailability; medical disorders, for example, hypertension and HIV/AIDS and poor quality of interaction with health care providers that may lead to non-compliance to planned interventions and defaulting treatment.

6. The impact of pregnancy on maternal well-being

6.1. The physiological effect of pregnancy

Pregnancy may have an enormous psychological and physiological effect on a woman's body and mind. This is due to suppression of the hypothalamic-pituitary-adrenal axis, which leads

to dramatic changes in oestrogen and progesterone levels. Changes in these hormone levels may alter a pregnant woman's coping mechanisms. The physical discomfort of pregnancy, accompanied by anticipation of childbirth and the responsibility of parenthood, often causes anxiety and emotional changes [27].

6.2. Stress alters physiology

There is a growing body of data suggesting that psychosocial factors such as high stress and low social support negatively affect the success of pregnancy. The findings of a survey by Shamim ul Moula [26] to address relationships between psychosocial variables and serum inflammatory markers during pregnancy support the notion that prenatal stress alters maternal physiology and immune function in a manner that is consistent with an increased risk of pregnancy complications such as preterm delivery and pregnancy-induced hypertension. The conclusion based on the findings of the above survey was a need for the development of strategies for supporting maternal mental health.

6.3. The impact of psychosocial stress on maternal and foetal well-being

It is clear that birth and infant development are affected by prenatal events that could lead to maternal stress. Maternal psychosocial stress has been recently identified as a factor in early foetal development. There is growing evidence that perinatal psychological and environmental stressors are detrimental to pregnancy success and infant outcomes. Stress is often defined as events, situations, emotions and interactions that are perceived as negatively affecting the well-being of an individual or that cause responses that are perceived as harmful [10].

A direct relationship is said to exist between maternal psychological stress and low birth weight, prematurity and intra-uterine growth retention. This is related to the release of catecholamines that results in placental hypo-perfusion and consequent restriction of oxygen and inhibition of nutrients to the foetus, leading to foetal growth impairment [27].

6.4. The relationship between antenatal depression and postnatal depression

There is considerable evidence that postnatal depression is a public health care challenge as it can become chronic, can damage the relationship between the woman and her partner and might have adverse consequences for the emotional and cognitive development of the newborn. Regular assessment of mood during pregnancy should be routine for all women to establish the risk for depression, as postnatal depression can recur. Antenatal mood assessment is one of the most robust predictors of postnatal depression, as 50% of postnatal depression is reported to have begun during pregnancy [27].

There is evidence from research that women with antenatal psychosocial risk factors are more likely to have a postnatal mood disorder, and as such, antenatal assessment can be beneficial for these women. The early identification and management of psychosocial risk factors have been shown to be beneficial in various studies. For example, in the study by Ref. [29], regarding the review of existing tools that are used to assess psychosocial morbidity in pregnant women, and a study by Gunn et al. [30] on anxiety and depression during pregnancy, outcomes were improved by minimising the occurrence of postpartum depression.

Recommendations from a survey by Namagembe [20] were that a search for battering and abuse should be carried out during the antenatal assessment of pregnant women and midwives should have knowledge of the appropriate interventions and be familiar with the resources for referral. The increased cost and complications that may arise as a result of any delays should be a concern for maternal-child health professionals. Routine antenatal and postnatal screening for psychosocial distress has been supported by investigators as a preventive measure for postnatal depression [28].

7. Psychosocial assessment

Psychosocial assessment is defined by Chitra and Gnanadurai [1] as an evaluation of an individual's mental health, social status and functional capacity. The individual's physical status, appearance and modes of behaviour are observed for factors that may indicate or contribute to emotional distress or mental illness. Observation includes posture, facial expressions, manner of dress, speech and thought patterns, degree of motor activity and level of consciousness. The individual is questioned concerning patterns of daily living, including work schedule and social and leisure activities. Data should include the individual's response to and methods of coping with stress, relationships, cultural orientation, unemployment or change of employment, change of residence, marriage, divorce or death of a loved one [30].

The above-listed risk factors can directly or indirectly affect the outcome of pregnancy in a negative way [7]. A meta-analysis of perinatal depression identified depression as a major complication of pregnancy affecting 14.5% of pregnant women [19].

8. Psychosocial care as a missing piece of the antenatal care puzzle

Traditionally and in many contemporary contexts, including in South Africa, antenatal care consists of a prescribed set of acts based around the clinical monitoring and screening of all pregnant women. This establishment of routine care was based on the notion that pregnancy is a state of pathology rather than normal physiology. There is evidence of a focus on technological dominance and a focus on the detection of obstetric and medical conditions occurring during pregnancy. This is based on a review of seven guidelines for antenatal care from the USA, Canada, Australia and Germany and mostly reflects expert opinion rather than scientific evidence [21].

For example, antenatal care in South Africa is provided at the primary, secondary and tertiary levels of care in both the public and private health care systems. Basic antenatal care services include physical examination, weight measurement, urinalysis, blood pressure monitoring, blood investigations and health information and are supposedly provided at all levels of antenatal care as routine practice.

The ongoing debate on antenatal care regarding its frequency, content, continuity, quality and effectiveness in reducing maternal and neonatal morbidity and mortality led to a new evidence-based protocol on the frequency of antenatal care. This is the result of randomised

trials carried out in the United Kingdom and Zimbabwe and of the World Health Organisation trials in Thailand, Argentina, Cuba and Saudi Arabia during 1996 [31].

The new schedule, as recommended by WHO [30], consists of four visits during pregnancy, the first one being early in pregnancy, with subsequent visits at 26, 32 and 36 weeks. This schedule is designed for the pregnant woman at low risk. These fewer antenatal visits led to poorer psychosocial outcomes and drew attention to greater maternal satisfaction with the routine care that was previously provided. The question is whether there would be an opportunity for the midwives to address psychosocial care within this regime.

Baldo [7] in a review of the antenatal care debate quoted McIlwaine (1980) highlighting that he was amazed that pregnant women came for antenatal care and waited in the clinic for 2 hours, only to be seen for 2 minutes by someone laying his or her hands on them, and then leave. The reason for this is the traditional focus on the biophysiology of pregnancy. The author recommended that antenatal care appointments should be structured, focused and advocated for longer first appointments to allow comprehensive assessment in order to address both physiological and psychosocial risk factors.

The Changing Childbirth report explicitly confirmed that women should be the focus of antenatal care to enable a woman to make informed decisions based on her needs, having discussed her matters with the midwife involved. Key aspects of care valued by women are reported to be respect, competence, communication, support and convenience [32].

The above are supported by the researcher's findings from a phenomenological study on the expectations of antenatal care by pregnant women. Most women were happy with the physical health care but were dissatisfied with interpersonal aspects, for example, involvement, guidance and communication from the health care providers [33].

As a midwifery lecturer, the researcher often accompanied students for clinical facilitation. On guiding students on psychosocial care of women in the antenatal care clinic, women frequently verbalised social and emotional concerns. The researcher's further experience is that if psychosocial assessment is indeed conducted on a pregnant woman, it usually elicits the woman's current active and significant psychosocial challenges.

The following are common remarks that were expressed by women during their antenatal visits while the researcher was engaged in student accompaniment.

A woman carrying her first pregnancy at age 25, gravida 1 para 0, from one of Gauteng's provincial hospital's antenatal clinic remarked:

"No one ever asked me this. Why don't everyone do like this? I think I am lucky today, I had so much to ask or discuss previously but there was just no one to listen to me. I moved from a black hospital to a one for whites thinking things will be better but it's the same. We come here, they quickly check the baby, and within 30 minutes you are gone with so much to share, as if the baby is the only one important". She then asked for the lecturer's and the student's contact numbers for further consultation.

A pregnant woman, 42 years old, was asked if the pregnancy was planned at this vulnerable age as her first child was 20 years old. Her response was that she had lost a husband 5 years ago and had recently remarried. She was coping but her challenge was that the first child was

rejecting both the new husband and the pregnancy. This was a reflection of another need for psychosocial support that could have been achieved through a proper psychosocial assessment by a midwife and appropriate referral offered.

9. Why should psychosocial risks be screened during antenatal care?

The concept of psychosocial stressors during pregnancy encompasses life experiences, including among others, changes in personal life, job status, family makeup, housing and domestic violence [1]. All these require adaptive coping mechanisms on the part of the pregnant woman, which can be achieved through the support of the midwife.

Risk screening, according to Refs. [1, 7], involves using a list of risk factors and some form of scoring system to classify pregnant women into specific risk categories, typically high risk or low risk, using cutoff points or thresholds. The focus of risk screening is to detect early symptoms and to predict the likelihood of complications. The intention of risk assessment is to predict problems before they occur and, as such, take appropriate action by providing optimal maternal care.

Bibring (1959) as cited by Stahl and Hundley [16] was among the first psychoanalytic writers to claim that “pregnancy is a psychobiological crisis affecting all expectant mothers, no matter what their state of psychic health is. As [with] every normal crisis that constitutes a turning point in life, it precipitates an acute disequilibrium...may lead to a new level of psychological maturity and integration. The outcome of this crisis might have a profound effect not only on the woman herself but also on the mother-child relationship”.

A cross-sectional study to identify a relationship between life stress, perceived social support and symptoms of depression and anxiety was conducted by Waldenstrom [34]. Based on her findings, it was recommended that psychosocial assessment of pregnant women and their partners may facilitate interventions to augment support networks and as such reduce the risk of psychosocial stress.

The New Antenatal Care Model proposed by WHO [35] recommends a set of activities during each visit for those women who are identified to be at low risk by screening for conditions likely to increase adverse outcomes of pregnancy, providing therapeutic intervention known to be beneficial and educating women about safe birth. However, the model does not emphasise psychosocial issues but proposes that some time should be set aside during each visit to discuss the pregnancy and related issues. Emphasis was put on the importance of communication.

As a measure to promote psychosocial risk assessment, a new approach to psychosocial risk assessment during pregnancy (ANEW) was implemented in Australia during 2000, in a form of a project to provide an alternative way to psychological risk screening in pregnancy. A training programme in advanced communication skills and common psychosocial aspects of childbirth was offered to midwives and doctors at the Mercy Hospital for women, with the aim of improving the identification and support of women with psychosocial needs in pregnancy [36]. The outcome of the programme was that it improved the ability of the health care professionals to identify and care for women with psychosocial needs.

A randomised controlled trial examining the effectiveness of the Antenatal Psychosocial Health Assessment (ALPHA) form in detecting psychosocial risk factors in pregnant women revealed that 72.7% of the women in the ALPHA group showed interest in discussing psychosocial issues. The experimental group was twice as likely to declare psychosocial problems as the control group (based on odds ratio 1.8, 95% confidence interval and 1.1–3.0, $p = 0.02$).

Two-thirds of health care providers in the ALPHA group found the form easy to use, and 86% said they would use it if it were recommended as standard practice. The conclusion of the trial showed that the assessment of psychosocial well-being during antenatal care was acceptable to both women and health care professionals [4, 31] in a project on antenatal psychosocial risk assessment in Australia, stating that antenatal depression, domestic violence and postnatal depression occurred more frequently than gestational diabetes, placenta praevia, pre-eclampsia and other obstetric and medical conditions, but most midwifery care settings still do not routinely screen for psychosocial problems.

As stated in Ref. [5] and other literature, for example, Hall (2001) as cited in Ref. [5], the procedures that are commonly undertaken to monitor pregnancy are aimed at reducing morbidity and mortality, but have been found to often cause physical, social and emotional harm. The physiological care that is routinely offered during antenatal care clearly illustrates that the scope of antenatal care is primarily derived from a medical perspective. The implication is that routine antenatal care fails to meet reasonable expectations and the needs of women.

Midwives are urged to overcome the perception in literature and media that health care providers are unkind, rude, unsympathetic and uncaring, as negative emotions such as anger may arise when a woman receives insensitive care. Delwo [37] concluded her study of Swedish women's satisfaction with medical and emotional aspects of antenatal care by urging midwives working in antenatal care to support pregnant women and their partners in a professional and friendly way in order to increase their satisfaction with care. They also advised that identifying and responding to women who are dissatisfied with their antenatal care could help to improve their satisfaction.

10. A study on psychosocial risk assessment and support during pregnancy conducted in Gauteng Province, South Africa

The aim of this study was to develop guidelines for the enhancement of psychosocial risk assessment of pregnant women, with a focus on the provision of psychosocial support.

It was hoped that the results of the study would provide evidence that could motivate interventions aimed at closing the gap between the routine assessment of physiological risk factors and the assessment of psychosocial risk factors during antenatal care. This would provide a basis for midwives to implement an appropriate action should any psychosocial risk be identified. Once formally tested, such guidelines could be incorporated into national guidelines for best practice.

10.1. Ethical considerations

Ethical clearance was obtained from the University of the Witwatersrand Human Research Ethics Committee, protocol number M081013. Participation was voluntary. Anonymity and

confidentiality were maintained throughout the research process. The ethical principles of autonomy, beneficence, non-maleficence and justice were observed accordingly.

10.2. Research context and methods

A mixed-method research was used for this study. A sequential explanatory design was employed, whereby quantitative data were first collected and analysed, followed by qualitative data collection and analysis in two consecutive phases [38]. The investigation was conducted within the following contexts:

10.3. Sampling and data collection

Sampling was purposive for all data sources, which were midwifery education and training regulations from the South African Nursing Council; midwifery education and training records of the three nursing colleges providing basic nurse education in Gauteng Province in South Africa; records of antenatal care for women attending government antenatal facilities in Gauteng Province were reviewed to establish the inclusion of psychosocial care; the administration of questionnaires to pregnant women attending antenatal care in Gauteng Province clinics; focus group discussions with both midwives and pregnant women at the antenatal care clinics; a survey to establish the extent of psychosocial assessment and psychosocial care by midwives during pregnancy, through a self-administered questionnaire; and in-depth interviews conducted with midwifery experts from various settings at which midwifery was offered, for example, universities, nursing colleges and midwifery obstetric units (MOUs).

10.4. Data analysis

10.4.1. Quantitative data analysis

Quantitative data were analysed using Stata Release 10 statistical software. Data analysis generally included summary statistics (mean, standard deviation for continuous variables, frequencies and percentages for discrete variables) and Cronbach's alpha for internal consistency. Confidence intervals of 95% were used to report for discrete variable.

10.4.2. Qualitative data analysis

Qualitative data analysis occurred concurrently with data collection. To enhance the depth of qualitative analysis, multiple approaches to data analysis were used (e.g., constant comparison, thematic analysis and framework analysis) comparing themes and categories as a form of across-case analysis technique [38]. The stages that were involved in reducing data were examining, categorising and tabulating data [39].

Data analysis was systematic, sequential, verifiable and continuous in order to minimise potential bias. A "Framework Analysis" was mostly used in qualitative data analysis.

10.5. An overview of study findings and discussion

10.5.1. Quantitative results

The findings confirmed that women experience stressful life events during pregnancy as illustrated in **Table 1**.

The response from 300 participants was that 184 (61.3%) were experiencing stressful life events during the current pregnancy, whereas 116 (38.6%) did not experience any stressful life events. Among those who experienced stressful life events, 72 (24%) experienced two events and 44 (14%) experienced three or more stressful life events. This provides evidence of the importance of assessing women psychosocially as almost all women present with psychosocial problems.

The SANC Regulations, the curriculum and learning guides display a broad approach to psychosocial care as the focus is on holistic care. Written tests, examinations and clinical tools implemented at the colleges address psychosocial care to a minimal level. The Gauteng antenatal care guideline policy, the Guidelines for Maternity Care in South Africa (2015) and the midwifery competency register do not reflect psychosocial content in their guidelines or psychosocial criteria to be met during antenatal care. The antenatal card does not reflect guidelines on psychosocial care, as midwives recorded what they perceived as relevant to be assessed psychosocially.

| Pregnancy stressful life events | Women's responses n (%) | |
|---|--------------------------------------|---------|
| | Yes | No |
| 1.1. Have you experienced death of a spouse or family member? | 82(27) | 218(73) |
| 1.2. Have you gone through a divorce or marital separation? | 26(9) | 274(91) |
| 1.3. Were you retrenched or fired from work? | 37(12) | 264(88) |
| 1.4. Have you been a victim of rape or sexual assault? | 15(5) | 286(95) |
| 1.5. Have you ever experienced any pregnancy loss? | 60(20) | 242(80) |
| 2. Was the pregnancy planned? | 140(46) | 162(54) |
| 3. Have you been sick during this pregnancy? | 141(47) | 160(53) |
| If yes, what was the illness? | Note response to the questions below | |
| 4. Have you ever attempted suicide? | 15(5) | 285(95) |
| 5. Have you ever been diagnosed with a mental health condition? | 14(5) | 286(95) |
| 6. Have you been hospitalised for a mental health problem? | 16(5) | 284(95) |
| 7. Did you attend any mental health counselling session? | 27(9) | 274(91) |

Table 1. Stressful life events experienced by respondents during the current.

10.5.2. Qualitative findings

The findings from the focus group discussions within this study also indicated that psychosocial assessment and care were important during pregnancy. The respondents further highlighted the importance of an appropriate guideline and a record for psychosocial assessment and care as reflected within the following responses:

Respondent 1: *“If you look now the state of affairs of our antenatal card it just says social...(emphasizing), and you can ask anything... there is nowhere psychosocial issues are recorded”.*

Respondent 2: *“Yes, something like TICK, TICK, will help maybe something like a checklist to ask relevant questions, with a checklist I think we would be made aware of the things that we normally don't ask”.*

“Yes, (All participants) the checklist will remind us to go deeper, you know beyond the surface, to go deeper than the care that we normally give because it's useless to pretend as if everything is fine whereas the patient has a big problem that can lead to complications, but once we have something that will guide us to ask something, even if you don't ask all the questions, but you know maybe you can highlight, and maybe you pick up something, that will be very helpful”.

Respondent 3: *“There must be a tool because on the green card is just a small line, where we ask for example, it is not written clear, just says “social”... therefore if there was a guideline regarding what should be done it will be appropriate for the pregnant women”.*

The concern about the need for training and support for midwives and other health professionals undertaking care to pregnant women [40] led to the development of a psychosocial risk assessment tool that was also based on the findings of the study. Furthermore, there are few studies worldwide reporting the development, evaluation and implementation of screening tools for psychosocial risk factors in pregnant women and subsequent intervention and prevention programs [45]. The assessment tool developed from the findings of this study is currently being piloted in 21 Community Health Centers in Gauteng Province as a 3-year project (2017–2019). The aim of the pilot study is to evaluate the tool, modify it and incorporate it as part of routine antenatal care. The long-term plan is to have a policy developed that integrates psychosocial risk assessment and support with routine physical care.

Based on the increasing international move to standardise as routine the psychosocial assessment and depression screening of all pregnant women and offer relevant support [40–42], different options need to be considered in order to enhance psychosocial care. Some of the interventions that are applied in certain countries globally are reflected in **Table 2**.

10.6. Group antenatal care

Based on the shortage of midwives or clinicians reported in this and other studies, and coupled with a limitation in psychosocial care, group antenatal care might be another option.

Group antenatal care originated a decade ago in Minnesota, USA, during the early 1970s. It was introduced in Denmark in 1998, followed by Sweden in 2000. It is offered concurrently with traditional antenatal care. Antenatal visits are carried out in groups of 6–8. There is evidence that this approach increases networking between pregnant women, women are

| Type of intervention | Description |
|--|---|
| Group antenatal care (Centering Pregnancy, USA) | Consist of a group facilitated by the clinician that lasts approximately 90–120 minutes. This allows a discussion of a wide range of pregnancy-related issues that include psychosocial issues [43]. |
| Hawaiian-style “Talkstory” | The talk-story is integrated into the woman’s antenatal and postnatal assessment and care and involves an exchange of thoughts between the woman and midwife. It is based on the woman’s values, beliefs and experiences, acknowledging custom and culture. |
| A psychosocial risk assessment model (PRAM) Australia | Offers a conceptual framework, measures and methods suitable for a brief psychosocial assessment of pregnant and postpartum women [44]. |
| ALPHA tool (Canada) | 35 items used to detect 15 risk factors for postnatal adverse psychosocial outcomes [31]. |
| KINDEX (University of Konstanz, Germany) | Assess 11 risk arears during pregnancy, the presence of psychosocial factors and the experience of adversities by women [45]. Has been applied in European countries. |
| Antenatal risk questionnaire (ANQR) | Composed of 12 items retrieved from the original 23 pregnancy risks [46]. |

Table 2. Interventions to enhance psychosocial care.

able to validate and sort information within the group and it also allows a midwife to devote more time to pregnant women by saving about 3 hours per woman [47]. Groups may address common psychosocial problems, and those who need further individual consultation can be offered the same, which will probably not be often, with routine individualised care.

The Schindler-Rising model of “centering pregnancy”, one of the recommended models for antenatal care, is presented in **Figure 1**.

A “Centering pregnancy” model is an innovative model for prenatal care. It focuses on “woman-centered care” by integrating antenatal care, health information and group support. It acknowledges a woman as an expert regarding her needs. The approach is practised, for example, in Canada, where women are involved in their basic assessment by weighing one another, checking ones’ own urine sample, and intragroup checking of blood pressure. Each woman also records results in her own antenatal card [47]

Figure 1. “Centering pregnancy”.

A “centering pregnancy” model is an innovative model for prenatal care. It focuses on “woman-centred care” by integrating antenatal care, health information and group support. It acknowledges a woman as an expert regarding her needs. The approach is practised, for example, in Canada, where women are involved in their basic assessment by weighing one another, checking one’s own urine sample, and intragroup checking of blood pressure. Each woman also records results in her own antenatal card [47].

Although the “centering pregnancy” model might free midwives or clinicians from routine investigations and as such allow them more time to address issues like psychosocial care, it carries a limitation in a sense that women should be literate, and the process should still be supervised by a midwife or a clinician until women are familiar with all aspects.

10.7. The Hawaiian-style “talkstory”

A Hawaiian-style “talkstory” originated from a needs-assessment project undertaken in Hawaii during 2000, where women indicated that their psychosocial needs were largely unmet.

A Hawaiian-style “talkstory” could offer an ideal approach in offering culturally focused antenatal care as it is a culturally based interactive communication approach, aimed at addressing the pregnant woman’s psychosocial needs. It could be mostly effective during the initial antenatal care booking as the woman is taking the lead in sharing her childbirth experiences. **Figure 2** explains the talkstory process as a guideline for midwives who might be interested in its implementation.

“talkstory process”

The “talkstory” process involves a pregnant woman taking the lead in sharing her experiences and expectations with a midwife or a clinician in her care, as a form of assessment. The woman is given an opportunity to articulate what she feels is important for her pregnancy and if there are problems. Her suggestions as to how to overcome the problems are sought. The interpretation of data obtained during the discussion is determined between the woman and the midwife.

Figure 2. The “talkstory” process.

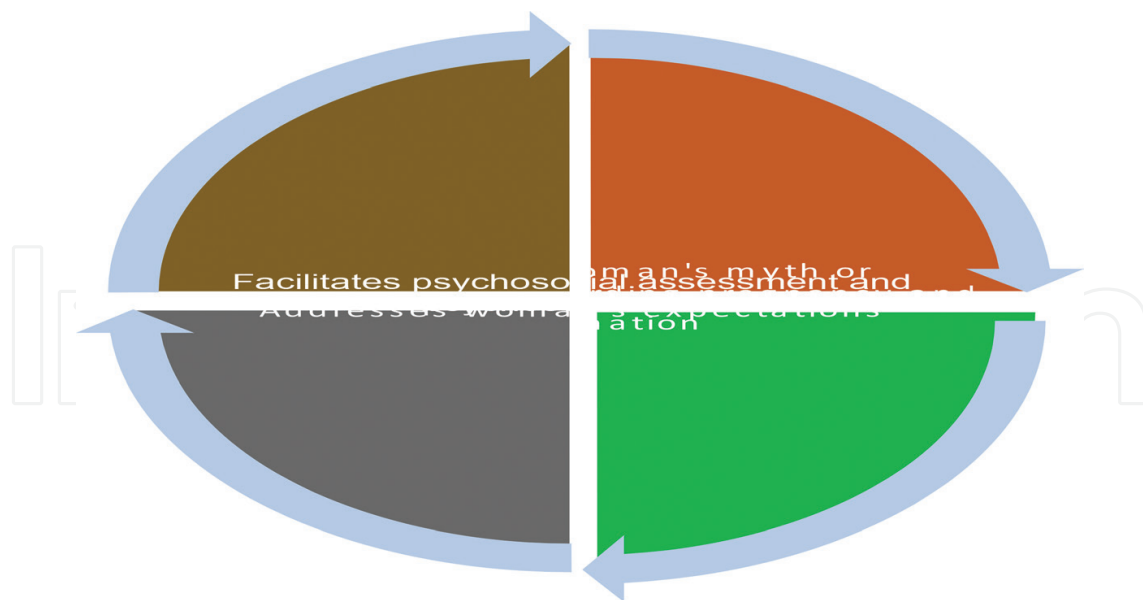


Figure 3. Outcomes achieved through the “talkstory process”.

10.8. The success of the “talkstory” approach

The “talkstory” approach, as illustrated in **Figure 3**, served as an ideal way of assessing women psychosocially. It offers an opportunity to provide the woman with relevant health information and to validate myths or misconceptions about childbirth that the woman might be having, while also addressing her expectations. This is a type of psychosocial assessment and care that is women-centred, through placing an emphasis on a woman’s own beliefs, offering her autonomy and a right to informed choice [48].

A “talkstory” is an ideal approach during the initial contact of the woman and the midwife or a clinician, and as such it might promote communication between the two; it needs some time and requires a midwife or clinician who is skilled in listening and who has an ability to convey compassion, acceptance and encouragement to the woman. This approach might be a challenge in institutions experiencing the shortage of staff.

The implementation of psychosocial care incorporates adherence to the following principles: human rights and equality, justice and confidentiality. Measures to be put in place as part of psychosocial support are availability of referral resources (social, mental, economic and judicial); the assessor should be well informed about the options of referral and to consider the possibility of the accompaniment of the woman throughout the process as a form of continuity of care and as stated by the United Nations Entity for Gender Equality and the Empowerment of Women.

11. Conclusion

The issue of psychosocial risk assessment and support seems to be a concern both nationally and internationally. The process of adapting to pregnancy and the resulting life changes are often difficult, even if the pregnancy is planned as pregnancy involves intense emotional, spiritual, psychological and social factors that need a midwife’s caring awareness and responsiveness.

A pregnant woman should be assisted to recognise and incorporate these changes into her self-image, her social network and her lifestyle. When the pregnancy is unplanned, the psychosocial changes may be more profound and lead to uncertainty, anxiety and depression [19].

There is a growing need for understanding the place and significance of maternal psychology and other psychosocial factors in the management of pregnant women by midwives or clinicians. Strategies for supporting maternal and foetal mental health need to be developed, as the importance of a good-quality pregnancy extends beyond antenatal care. Psychosocial risk assessment during pregnancy is further considered as the first strategy to support maternal well-being as this will allow the pregnant woman to cope with her pregnancy [26].

In theory, risk assessment is a logical tool for rationalising service delivery to ensure that those in greater need receive special attention and care. However, it is becoming increasingly clear that with incorrect and inadequate psychosocial risk assessment, scarce resources may be diverted away from pregnant women who are in real need. However, in the absence of evidence of an effective risk screening process, risk assessment cannot be relied on as a basis for matching needs and care in maternity services [7]. Ideally, psychosocial risk assessment should be included within the overall risk assessment or could be administered as a separate tool in the form of a checklist.

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