

# Drawing a Line between Hope and Accountability: Midwives' Response to a "Psychosocial Antenatal Care" Pilot Project in Gauteng, South Africa

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## Abstract

Psychosocial care during pregnancy is embedded in women-centred care, and the improvement of quality care based on compassion has become a top priority for healthcare providers. Compassion is a deep feeling of connecting to human beings' suffering, a moral response that leads to patient care with comfort. Such caring is skilful and worthy, respects the dignity of individuals and is intertwined with professional competency. The purpose of the pilot project was to raise the midwives' awareness of the importance of psychosocial care during pregnancy, to assess the use of the psychosocial assessment tool, to fill the gap between routine physical antenatal care and psychosocial care, and to enhance the use of psychosocial services. An exploratory and descriptive study design was applied. The study population consisted of 34 midwives who participated in the implementation of the assessment tool in the 12 participating health facilities in Gauteng, South Africa. The data collection was conducted in two phases. Phase 1 consisted of a self-administered questionnaire to establish competency when using the assessment tool. Phase 2 consisted of focus group discussions. The four main themes that emerged were the importance of psychosocial risk assessments, experiences of the implementation of the assessment tool, challenges and barriers, and identified risk factors. The results reflected the midwives' ability and willingness to implement the tool as part of their accountability, despite the challenges experienced. Moreover, the midwives hoped that the tool will be incorporated as part of routine antenatal care.



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## Introduction and Background

Under the South African Nursing Act (South Africa 2005) and the South African Nursing Regulation 2598 (SANC 1991), the scope of practice for registered midwives includes advocating to obstetricians and hospital management on behalf of women and their infants to provide an optimal environment for physical, emotional and psychosocial health during the antenatal, intrapartum and postnatal periods. Furthermore, section 14.3(a) of the scope of practice (SANC 1991) stipulates that midwives have to develop an integrated comprehensive midwifery care plan for the promotion of activities of daily living, self-care, treatment and rehabilitation of healthcare users, also taking cognisance of the natural, biological and psychosocial sciences. Midwives in South Africa are trained to be first-line staff in the care of pregnant women in public facilities from various socio-economic structures and ethnicities that account for 84 per cent of the population (Froneman, Van Wyk, and Mogale 2019, 1069).

The World Health Organization (WHO 2016b), when updating its guidelines for antenatal care, highlighted the need for a new approach in the provision of antenatal care. A set of reviews was undertaken by the WHO to reflect on what was missing from the current antenatal programme. A concern emerged regarding the traditional approach to providing antenatal care services as it generally focuses on “clinical services, the prevention of potential complications, the assessment of physical risks or ill health and largely ignores the psychosocial aspects of pregnancy”.

Antenatal care refers to a form of health service provided to a woman from the time conception is confirmed until the beginning of labour, aimed to ensure a safe gestation and childbirth and has been described as one of the effective forms of preventive care (Cronjé, Cilliers, and Pretorius 2011, 45). Antenatal care is considered a unique intervention offered routinely to pregnant women, with the overall objective of the efficient management of pregnancy, provision of health education, and screening of symptomatic and asymptomatic pregnant women to detect and prevent both maternal and neonatal adverse events to, in turn, improve pregnancy outcomes (Hofmeyer and Mentrop 2015, 902). The recommendations for antenatal care by the WHO (2016b) highlight positive pregnancy experiences as the maintenance of physical and sociocultural normality and the emotional psychosocial and social needs of pregnant women.

Psychosocial intervention during pregnancy is reported to be an area that is neglected despite research indicating that antenatal depression is a strong risk factor for postpartum depression (Dennis, Ross, and Grigoriadis, 2010, 4). As stated by Stanton et al. (2002, 753), the last decade has seen the introduction of scientifically sound research on the normative emotional state of pregnancy and the way in which women respond to various physical, emotional and social changes.

An evaluation of routine antenatal psychosocial assessments in a regional private maternity setting in Australia revealed acceptance by both midwives and women (Kalra, Reilly, and Austin 2018, 2). The validation of a short psychosocial risks screening tool, the KINDEX (Spanish version), during pregnancy by Spyridou, Schauer and Ruf-Leuschner (2014, 16), concluded that the tool was valid in the hands of healthcare personnel to identify women with multiple psychosocial risk factors and could serve as a base instrument for referral of at-risk women for appropriate psychosocial intervention. Furthermore, psychosocial care requires the proactive collaboration of a multidisciplinary group of professionals.

Bibring (as cited by Dragonas and Christodoulou 1998, 128) 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 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.

This is further supported by Stanton et al. (2002, 754), stating that women vary substantially in their responses to pregnancy owing to a range of factors that includes socio-economic resources, the occupational status, the availability of social support and a range of roles which can make it a stressful event for some women.

A study by Dennis, Ross and Grigoriadis (2010, 4) revealed that there is growing evidence that perinatal psychological and environmental stressors are detrimental to pregnancy success and infant outcomes. Stress as a component of psychosocial risks is often defined as “events, situations, emotions and interactions that are perceived as negatively affecting the well-being of an individual, or that causes responses that are perceived as harmful”. Furthermore, the lack of psychosocial support is a strong risk factor for depression during both the pregnancy and the postpartum period (Dennis, Ross, and Grigoriadis 2010, 4). Madhavanprabhakaran, D’Souza and Nairy (2015, 1, 6) in a study on the prevalence of pregnancy anxiety and associated factors, highlighted that pregnancy-specific anxiety might occur simply as the woman worries about her pregnancy, physical changes and delivery, underlying psychosocial risk factors, the health of her infant and future parenting. The findings further suggested the necessity of implementing interventions to reduce pregnancy-specific anxiety and thereby to positively influence birth outcomes.

As a measure to promote psychosocial risk assessments, a new approach to psychosocial risk assessments during pregnancy (called the Advanced Nursing Education Workforce (ANEW) programme) was initiated in Australia to provide an alternative way to psychological risk screening in pregnancy (Gunn et al. 2006, 52). The training programme in advanced communication skills and the assessment of common psychosocial issues regarding childbirth was offered to midwives and doctors at the

Mercy Hospital for Women in Australia. The aim was to improve the identification and support of the women's psychosocial needs in pregnancy. The programme resulted in the improved competence of healthcare professionals when identifying and caring for women with psychosocial problems.

A study conducted by Mathibe-Neke, Rothberg and Langley (2014, 8) on the perceptions of midwives regarding psychosocial risk assessments revealed that midwives displayed an awareness of psychosocial risks as they encounter them daily. Furthermore, they regarded psychosocial assessments as an important aspect when caring for women during pregnancy, however, they felt not adequately equipped to do so for various reasons. As stated by Rollans et al. (2013, 940), there are increasing moves internationally to standardise the psychosocial risk assessment and depression screening of all pregnant women. The pilot project closes the gap between psychosocial care and routine antenatal physiological care and offers a holistic approach to pregnancy management.

## Aim and Purpose of the Project

The general purpose of the pilot project was to raise the midwives' awareness of the importance of psychosocial care during pregnancy as part of their accountability, to assess the use of the assessment tool by midwives in selected facilities, to fill the gap between routine physical antenatal care and psychosocial care, and to enhance the use of psychosocial services. The pilot project was based on the conclusions and recommendations of a study conducted in 2012 for a doctoral degree. The initial pilot study was conducted in three facilities as an outcome of the doctoral study and as a way of validating the psychosocial assessment tool. The tool was developed from the data obtained from different data sources.

The front cover of the assessment tool reflects guidelines to complete the form and the particulars of the woman. The second page outlines the psychosocial risk factors to be assessed and the last page is a follow-up or referral resources plan that could be identified based on the woman's needs. There was a further need to administer the tool on a larger population, hence the Gauteng province was identified as the context.

## Objectives of the Study

The objectives of the study were to

- determine and describe the midwives' experiences of the implementation of the psychosocial assessment tool; and
- establish the views of the midwives regarding the incorporation of the tool as part of routine antenatal care.

## Population

The study population consisted of 34 midwives who participated in the implementation of the assessment tool in the 12 participating health facilities in Gauteng. A total of 22 facilities were invited and only 12 facilities volunteered to participate. A total of 34 midwives participated in the follow-up evaluation of the implementation of the assessment tool.

## Methodology

An exploratory, descriptive study as described by Polit and Beck (2017, 585) was applied. A tool to assess psychosocial risks during pregnancy was administered by the midwives in randomly selected community health centres that provided antenatal care in Gauteng, South Africa, between November 2018 and April 2019. Each facility had to administer the assessment tool for six months. All pregnant women attending antenatal services at the facilities were assessed by using the tool (see Figure 1).

An ideal assessment process was for the midwife to:

- introduce herself and the woman;
- provide an explanation to the woman regarding the overall purpose of the antenatal care visit;
- assure privacy and confidentiality;
- provide a rationale for asking psychosocial questions;
- introduce the psychosocial questions at the beginning of the assessment;
- respond to questions asked by the woman; and
- debrief the woman after the sensitive questions (Rollans et al. 2013, 937).

A follow-up evaluation on the use of the tool was through a self-administered questionnaire and focus group discussions with the midwives. Permission to pilot and evaluate the tool was obtained from the Gauteng Provincial Health Research Council. All the participants voluntarily signed a consent form.

Psychosocial Risk Factor	Response			Comment
	Earlier	Later	Not at all	
If you had to change the timing for this pregnancy, would you want it to happen earlier, later or not at all?	Earlier	Later	Not at all	
Is the baby's father happy about the pregnancy?	Yes	No father	Not sure	
Are you married to the baby's father?	Yes	Traditional	No	
Are you currently living with the baby's father?	Yes	Sometimes	No	
Do you have any problems in your relationship?	Yes		No	
Are you employed?	Yes		No	
Who supports you financially?	Partner	Friend	Family	
Do you have a car or access to transport in case of emergencies?	Yes		No	
Do you have access to a telephone?	Yes		No	
Do you have a family member who supports you during this pregnancy?	Yes		No	
Do you or your partner smoke?	Yes		No	
In the past few months, have you or your family used drugs or alcohol?	Yes	Sometimes	No	
Have you suffered from any form of abuse during this pregnancy?	Yes		No	
Do you have any fears or anxiety about this pregnancy?	Yes	Unsure	No	
Do you have any problem that prevents you from attending antenatal clinic?	Yes		No	
How do you rate your current stress level?	High	Low	Medium	
Do you feel unsafe where you live?	Yes		No	
Have you ever had emotional problems, consulted a psychiatrist or therapist?	Yes		No	
Do you have problems at work or school?	Yes		No	
Do you want to keep this pregnancy?	Yes	Not sure	No	

<p><b>Psychosocial risk assessment during antenatal care:</b></p> <p><b>A Guideline for midwives in Gauteng Province</b></p> <p><b>NB:</b> Mark the appropriate response. To be completed for all pregnant women as part of assessment during antenatal care. Review during each follow up visit. The "comment" column should be used to elaborate on responses if a need arises. (Please consider the sensitivity and confidentiality of this information)</p> <p><b>NAME:</b> .....</p> <p><b>CONTACT NO:</b> .....</p> <p>Date completed: .....</p> <p><b>Signatures:</b></p> <p>Midwife: .....</p> <p>Pregnant woman: .....</p>	<p><b>Follow-up plan:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Supportive counseling by provider</li><li><input type="checkbox"/> Prenatal education</li><li><input type="checkbox"/> Smoking cessation resources</li><li><input type="checkbox"/> Addiction treatment programmes</li><li><input type="checkbox"/> Social Worker</li><li><input type="checkbox"/> Psychologist / psychiatrist</li><li><input type="checkbox"/> Therapist / marital / family</li><li><input type="checkbox"/> Womens' helpline / shelter</li><li><input type="checkbox"/> Other</li></ul> <p><b>COMMENTS:</b></p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
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Figure 1: Psychosocial risk assessment tool

## Data Collection and Analysis

The data collection for the evaluation started during October 2018 and was completed during April 2019. A private room was provided by the managers at each facility. The data were collected at a time convenient to the midwives, mostly during their tea or lunch breaks as refreshments were offered. The data collection was conducted in two phases. Phase 1 consisted of a self-administered questionnaire (see Table 1) to establish the acceptance of and competency when using the tool. The Likert scale questionnaire was developed by the researcher with the assistance of a statistician. The average time to complete the questionnaire was 10 minutes. The self-administered questionnaires were distributed and completed by each participant before beginning with the focus group discussions.

**Table 1:** The midwives' evaluation tool

Dear Midwife We would like to establish your understanding of, comfort with, commitment to, and interest in, using the psychosocial risk assessment tool. Please indicate your degree of agreement with the following statements:				
<b>(SA = strongly agree; A = agree; D = disagree; SD = strongly disagree)</b>				
a. I understand the way in which to use the antenatal psychosocial assessment tool.	A	SA	D	SD
b. I am comfortable with performing an antenatal psychosocial assessment.	A	SA	D	SD
c. I commit to and support the use of the antenatal psychosocial assessment tool.	A	SA	D	SD
d. More psychosocial problems were identified by using this tool.	A	SA	D	SD
e. The number of referrals increased owing to the use of this tool.	A	SA	D	SD
f. This assessment improved the well-being of pregnant women.	A	SA	D	SD
g. The quality of communication between you and the pregnant women improved with the use of this tool.	A	SA	D	SD
h. In your opinion, were the women happy to be assessed using this tool?	A	SA	D	SD
i. Barriers were encountered during the implementation of the psychosocial assessment and psychosocial care.	A	SA	D	SD
j. The assessment should form part of the routine antenatal care.	A	SA	D	SD
Do you have any further comments regarding the antenatal psychosocial assessment tool or its use?				
Thank you for your valuable responses.				



The quantitative data were analysed using the Statistical Package for the Social Sciences version 25 (Burns, Gray, and Grove 2015, 324).

Data collection for phase 2 was through focus group discussions which aimed to get more clarity on the implementation of the tool in open discussions that were audio recorded. The group discussions were conducted in a private room in which the midwives were working at a time convenient to them.

The researcher used an interview guide with predetermined questions to keep the discussion focused. The predetermined questions were supported by probing if necessary. A briefing was provided to the participants regarding the principles of a focus group discussion. Field notes were also taken to back up recorded responses. The average time taken for the group discussions was 45 minutes. The analysis of the data from focus group discussions occurred concurrently with the data collection data saturation. A qualitative data analysis process through organising the data, coding, interpretation of data and formulating themes as discussed by Creswell and Poth (2018, 181) was applied.

### **Validity, Reliability and Trustworthiness**

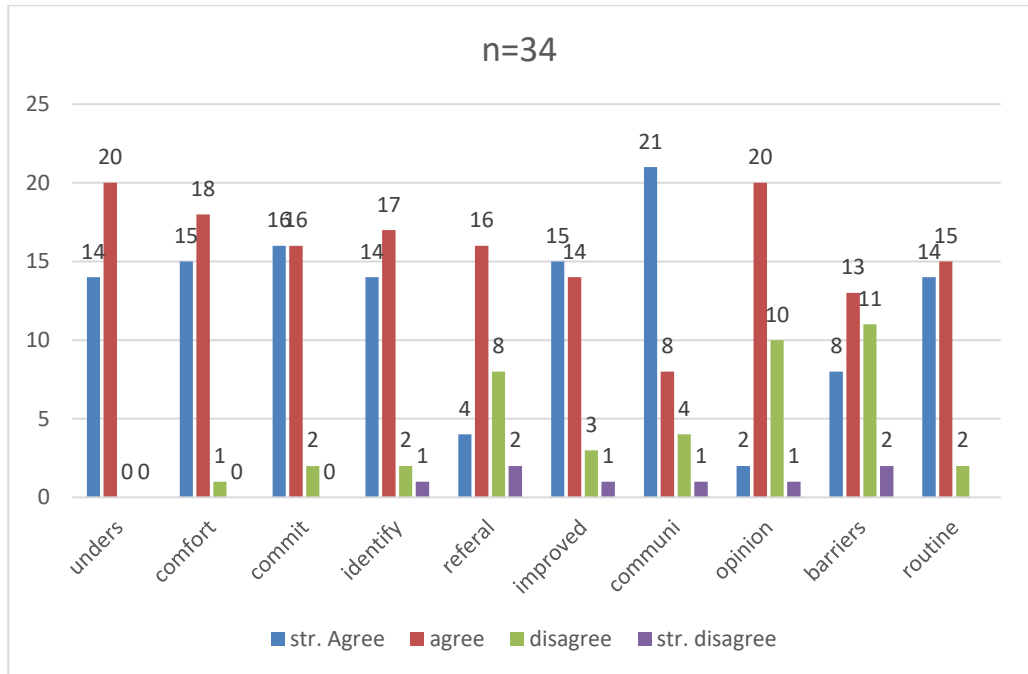
The assessment tool was pretested in 2012 in three clinical facilities and posed no challenges for the respondents. The tool's face validity was confirmed by three researchers and a statistician. A Cronbach's alpha of 0.741 indicated that the quality of the assessment tool was acceptable, as advocated by Polit and Beck (2017, 547). The trustworthiness of the qualitative data was ensured by adhering to Lincoln and Guba's principles. For the purposes of dependability, the field workers were researchers; data collection occurred over seven months with triangulation of the data collection methods. Member checks ensured the credibility of data. The principal researcher kept field notes and a self-reflection diary to control potential bias. Two researchers read the interview transcripts repeatedly and compared their coding results to reach consensus.

### **Ethical Consideration**

The project was funded by a grant (Women in Research Project). Ethical clearance was obtained from the Department of Health Studies Ethics Committee at the University of South Africa (ethical clearance no. REC-012714-039). Permission to pilot the project was further obtained from the Gauteng Department of Health and the participating clinical facilities. Facility participation was based on an informed decision as also supported by written consent.

## **Results**

The results presented are the midwives' responses to the self-administered evaluation tool and the focus group discussions themes. A total of 34 completed questionnaires were received. See Figure 2 for the midwives' responses to the use of the psychosocial risk assessment tool. The 10 variables that were evaluated are reflected in Table 1.



**Figure 2:** The understanding and use of the psychosocial risk assessment tool by the midwives

All the participants indicated that they understood the use of the assessment tool, with 41 per cent strongly agreeing. All the participants were comfortable with administering the tool. Two participants (5.9%) stated that they are not committed to using the tool, which is a non-significant response, as most respondents reported to be committed to the use of the tool. Only three participants (8.8%) disagreed that psychosocial risk factors could be identified by the use of the assessment, whereas 92 per cent agreed.

The assessment tool was reported to be clear and easy to use, but time-consuming. Most respondents (86.6%) agreed that the referrals for psychosocial support increased. The communication between the midwives and the pregnant women was enhanced as reflected by 61.8 per cent who strongly agreed.

### Thematic Analysis of Focus Group Discussions

A total of 10 focus group discussions were conducted in each of the 10 facilities. The other two facilities could not participate because they did not meet the minimum number for a focus group discussion as there were only two midwives. Focus group discussions enabled the researcher to develop a deeper understanding of the specific features that hindered the implementation of the assessment tool; for some the solution was beyond the requirements of the pilot project, for example, the shortage of midwives. The four main themes that emerged from the data were the importance of psychosocial

assessment, experience of the implementation of the assessment tool, challenges and barriers, and risk factors identified (Table 2).

**Table 2:** Main themes and subthemes

<b>Main categories</b>	<b>Subcategories</b>
Importance of a psychosocial risk assessment	Women presenting with psychosocial risks Intervene and refer accordingly Help to identify women with psychosocial risks
Experiences of the implementation of the assessment tool	Clear and adequate for assessment Triggered assessment Offered guidance Allowed engagement with women Enhanced referrals Ignorance from women Time-consuming
Challenges and barriers	Reluctance from midwives Powerlessness Work overload Shortage of staff Reluctance of women to be assessed Language barrier
Risk factors identified	Unplanned and unwanted pregnancies Lack of partner support Domestic assaults Intimate partner violence Adolescent pregnancies Unemployment Poverty Lack of transport

### **Importance of a Psychosocial Risk Assessment**

The importance of a psychosocial risk assessment was highlighted as many pregnant women presented with psychosocial risk factors. The assessment further enabled the midwives to interact with the women accordingly.

The tool allowed us to be able to ask questions that are not in the green card. (FcG5P1)

It also helped in identifying patients with problems such as transport and finances to advise them to apply for a grant or call an ambulance. (FcG5P2)

Those patients who come with burdens like she just want someone to can talk to and when the tool comes and you start talking with her you realise that she has more problems than the pregnancy she is carrying and its more deep and you need to go deeper and refer or do something about it. (FcG3P2)

This tool really gave us a lot of insight to be able to understand their situation at home. (FcG1P1)

### **Experiences of Using the Psychosocial Assessment Tool**

Most participants agreed that the use of the assessment tool enhanced the identification of psychosocial risk factors and improved communication between the midwife and the woman.

I think its straightforward, it's not a difficult tool to use. (FcG9P2)

The positive one was that I could engage with the patient without just treating the patient because of the pregnancy. (FcG4P1)

The tool is user friendly because we are able to communicate one on one with the patient. (FcG10P1)

Some women displayed ignorance of psychosocial risks:

My experience is that most of the patients has social problems but they don't see it as a problem for example a 38 year old who is gravida 5 and not married, not working. For her it's ok to depend on grants. (FcG9P1)

There are women who are having a problem who are not even aware of their problems and there are others who have problems but do not know who to tell. (FcG8P1)

In a study on psychosocial assessments, Rollans et al. (2013, 935) observed that the midwives used a range of skills when undertaking psychosocial assessment including being empathic and sensitive, which helped the women to open up and be patient with the intervention and in this way enhanced the psychosocial assessment.

Some midwives felt the assessment took too much of their time by stating that

It was time-consuming as we are always under pressure. (FcG6P2)

One participant concluded the discussion by sharing a positive experience as follows:

I find the tool valuable to use for continuity of care and not just for piloting. (FcG10P1)

### **Challenges and Barriers**

Features of the research sites that hindered the ability to implement the assessment tool were regarded as challenges and barriers. All the participating sites reported barriers,

however, the midwives' attitude also played a significant role in the success or failure to implement the tool as some were reluctant or refused to implement the assessment tool.

One barrier was that midwives were reluctant to administer the tool. Very reluctant, some they were not prepared and wanted the researchers to fill it because of shortage . . . there was conflict amongst us. I had to put more pressure and say it's a requirement. (FcG10P1)

The midwives felt that their professional autonomy and dignity were often violated through restricted practices by the management, the working environment was not conducive to a positive working experience, and they experienced job dissatisfaction and increased stress and frustration levels, as also found by Froneman, Van Wyk, and Mogale (2019, 1069).

We sometimes feel powerless as we feel we could do more, to give more to women as they tell you their problems, you feel you can do more. (FcG3P2)

A qualitative study on missed nursing care by Kalisch (2006, 308) supported that psychosocial care is often a missed opportunity as highlighted by the following participant's response: "I really don't have time to do a thorough assessment of the patient's psychosocial needs, you can just see that the patient is distressed, but there is really no time to get involved." However, the participants further emphasised that providing support to the patient and family was important to them as an element of care they deeply valued.

Staff shortage and work overload were significant in impeding psychosocial care.

We suffer burnout. (FcG4ALL)

Time does not allow as you look at the queue and think I cannot spend thirty minutes with one woman as I need to finish the queue. (FcG2P1)

With reference to the women who were reluctant to be assessed psychosocially, a participant shared the following:

They are very hesitant as they feel you are invading their space, I have never met anyone who will open up and ask what you mean. (FcG8P2)

The latter reflects a lack of trust of the midwife by the woman, which was probably due to the interaction during the first visit.

A feeling of embarrassment during the assessment was also reported by Walburg, Friederich and Callahan (2014, 130) which resulted in the women being hesitant to subject themselves to psychosocial assessment. They also felt that their privacy is being violated, as also supported by Gheibizadeh et al. (2016, 469).

Waiting time was a concern for the women:

It takes too much time, a lot of them get irritated, a lot of them refused saying I don't want to participate, I want to go home I have been sitting in the queue. (FcG4P1)

The issue of women's waiting time has been a concern as also confirmed by Gheibizadeh et al. (2016, 469) stating that from the women's point of view a long waiting time is unbearable and is inconsistent with equitable antenatal care. However, a midwife in this study shared the following:

It was different with individuals . . . others will open up freely, but once you make them comfortable and they understand that you are doing this in good spirit, it was easy for them to engage. (FcG5P3)

Walburg, Friederich and Callahan (2014, 135) concluded their study by suggesting that ensuring a respectful attitude from the midwives, and also having procedures explained could reduce feelings of modesty in healthcare recipients.

My experience is that when you take the history, they already trust you then when you come to the tool they know you and can open up . . . others were saying 'Sister, finally, there is someone willing to listen to me'. (FcG3P3)

Some studies reported that the women found the psychosocial assessment helpful when dealing with their needs (Cunningham et al. 2017; Katz et al. 2008, 9; Kohlhoff et al. 2016, 5; Spyridou, Schauer, and Ruf-Leushner 2014, 2).

Language barriers also played a significant role as the midwives in all facilities were offering antenatal care to foreign nationals, who ranged between 20% and 70% of all the pregnant women, depending on the population residing in the vicinity of the facility.

We have patients from Maputo who speaks strictly Portuguese. (FcG2P5)

Those who come from Malawi and Zambia do not know how to communicate. (FcG10P2)

Maybe if the tool was simplified in the woman's language. (FcG6P2)

### **Psychosocial Risk Factors Identified**

The common psychosocial risk factors identified were unplanned and unwanted pregnancies, unemployment, homelessness, lack of partner support, domestic violence characterised by assaults and intimate partner violence, poverty evidenced by a lack of food, and transport in the case of emergencies.

There are a lot of them that had problems, mostly lack of support from family or partner, yaa it was more about that you know, more of poverty on the other hand, whereby you

find that she is pregnant but there is no one working at home. She does not even know what is going to happen once she gives birth to this child. (FcG3P2)

According to Chitra and Gnanadurai (2015, 124), psychosocial stressors experienced during pregnancy encompass life experiences including changes in personal life, job status, family make-up and the possibility of domestic violence that might need adaptive coping mechanisms for the pregnant woman. Pregnant women who lack psychosocial support may experience stress, anxiety and depression that could affect foetal well-being and lead to postpartum depression.

Concerning unemployment, the following was shared by a participant:

You work the whole week without someone asking for a sick note, that's when you realise that most are not working. (FcG9P2)

Intimate partner violence is a major public health problem and the most frequent form of violence against women which often extends into childbirth (Shumba, Mathibe-Neke and Dolamo 2017, 11; Spyridou, Schauer and Ruf-Leuschner 2014, 2; Tura and Licoze 2019, 1). Tura and Licoze (2019, 9) further highlighted that women who experience intimate partner violence are unlikely to attend antenatal care.

This woman reported that after pregnancy, the husband started to be abusive, she was often beaten by this guy, she said it was for no apparent reason. There was a bruise that was somewhere at the back. FcG1P1

A woman who came for expanded programme on immunization who was kicked by the boyfriend, rolling on the ground in the antenatal clinic. FcG2P1

Another woman came for antenatal booking with facial injuries and reported to have been assaulted by husband, however she refused midwives to intervene. FcG2P4

Adolescent pregnancy is also a concern. The prevalence of adolescent pregnancies was supported by the following:

We still have the 15, 16 and 17 year olds who still have birth certificates, no identity documents, still receiving social grants but pregnant. (FcG9P2)

Govender, Naidoo and Taylor (2019, 73, 85) highlighted the fact that adolescent pregnancy is a complex public health problem worldwide and recommended research to determine the influence of partner support in the management of teenage pregnancy. The presence of psychosocial risk factors is also reported to produce higher perceived stress in women from low socio-economic status and adolescent or young mothers below 20 years (Spyridou, Schauer, and Ruf-Leushner 2014, 2).

There are some you want to refer to the hospital, and she will say I don't have transport money. (FcG2P4)

Because we have South African Social Security Agency (SASSA) to give them food packages, the one with malnutrition who says they go to bed without food, they don't have referral documents to assist them with whatever. (FcG7P3)

As stated by Hossain and Hoque (2015, 122), poverty emerges as one of the foremost obstacles in the use of antenatal care, suggesting that poverty eradication measures should be in place and pursued effectively. A lack of food leads to malnourishment during pregnancy which does not only compromise the pregnancy, but also affects the maternal biological system and children's physical and mental health years after birth as highlighted by Bravo and Noya (2014, 533).

In some instances, the women refused a referral to psychosocial resources:

There was one woman I picked up who needed financial support, she was living alone with no support at all, I referred her to the social workers, but she did not go. (FcG4P1)

Zhao et al. (2012, 7) in a study on the use of antenatal care reflected on poor use as being associated with a low socio-economic status, level of education, age and pregnancy history. Mbuagbaw and Gofin (2011, 1430) concur by highlighting that education, wealth, residence and parity affect a woman's chance of receiving optimal antenatal care. Consequently, poor acceptance of antenatal care relates to pervasive poverty, the subordinate role of women, and low literacy levels in most developing countries (Fawole, Okunlola and Adekunle 2008, 1052).

## Discussion of Results

The implementation of psychosocial care served as a major purpose of this study. The findings from this pilot project suggest that pregnant women experience psychosocial problems. The findings indicate that midwives are willing to incorporate the psychosocial assessment tool into routine antenatal care as part of their accountability, with a hope that prevailing challenges and barriers will be dealt with accordingly.

### **Importance of Psychosocial Risk Assessments**

The midwives worked in the maternity units where they were mostly the sole healthcare providers. Implementing and sustaining the assessment process were extremely challenging as the process demanded more time from them to engage with each woman. Despite the prevailing challenges, the midwives justified the importance of assessing women psychosocially. The midwives considered their accountability to assess women psychosocially over the routine physical care offered, furthermore hoping for support from management to achieve this role.

Numerous studies, for example, by Kaaya et al. (2010, 10), Pereira et al. (2009, 2732), Kalra, Reilly, and Austin (2018), Sahile et al. (2017, 59), and Kohlhoff et al. (2016, 4) support the recommendation to consider integrating psychosocial screening into routine antenatal care. However, Rollans et al. (2013, 940) and Novick et al. (2013, 2) highlight



the importance of training and supporting midwives to undertake psychosocial care, given the challenges they face in their daily practice. Furthermore, the relevant resources and structured referral pathways for psychosocial support should be in place to facilitate the appropriate referral of women with psychosocial challenges (Kalra, Reilly, and Austin 2018).

### **Experiences of Using the Assessment Tool**

More than half of the respondents indicated barriers to the implementation of the assessment tool; however, they supported that it should be administered as part of routine antenatal care. In a study by Austin et al. (2013, 22), 64 per cent of healthcare professionals who use the Antenatal Psychosocial Health Assessment (ALPHA) tool, reported that they found it easy to use.

Mbuagbaw and Gofin (2011, 1427) are of the opinion that the provision of antenatal care services depends mostly on organisational issues and that the determinants of the use of these services are complex and multifactorial. An oppressive work environment characterised by a high workload, disrespect and lack of support was shared by the participants. This is also supported in the literature by Valizadeh et al. (2018, 520) who conducted a study on threats to nurses' dignity and intent to leave the profession. Poat, McElligott and Fleming (2003, 397) further highlighted that midwives are still controlled by obstetricians and managers in some instances and that those who attempt to start autonomous practices are often intimidated. An added factor was that some women did not consider their situations psychosocially challenging even if identified by midwives during their discussions.

### **Challenges and Barriers**

Some midwives were reluctant to participate in the project citing work overload owing to the shortage of staff. The midwives reported being profoundly affected and traumatised as they listened to women tell their stories of sexual assault and domestic violence, and feeling powerless not being able to improve the women's difficult life circumstances. This concurs with a study on midwives' emotional well-being in conducting Structured Antenatal Psychosocial Assessments (SAPSA) by Mollart, Newing and Foureur (2009, 87) who further highlighted that these overwhelming feelings may lead to midwives experiencing disruptions in their interpersonal relationships, sleeping problems, fatigue and burnout.

Some of the pregnant women were reluctant to be assessed psychosocially probably because they are used to long waiting time periods and felt that this additional intervention prolonged the consultation time.

### **Risk Factors Identified**

The psychosocial risk factors identified in this study are similar to those in other studies and other populations. Although they were of social origin, they could have a negative

impact on the women's mental well-being. Pereira et al. (2009, 2732) conducted a study on the prevalence of risk factors among women attending a public health clinic in Brazil by reporting that social challenges included unplanned pregnancy, financial difficulties, unemployment and gender-based violence, which are associated with an increased prevalence of antenatal depression. Mathibe-Neke (2012, 99) in a study on psychosocial risk assessment, revealed that the response from 300 pregnant women indicated that 184 (61.3%) were experiencing stressful life events during their current pregnancy. Among those who experienced stressful life events, 72 (24%) experienced two events and 44 (14%), experienced three or more. This provides evidence of the importance of assessing women psychosocially as most pregnant women present with psychosocial challenges.

A study by Johnson et al. (2019, 319, 321) on the fear of childbirth at an urban community health centre reported that 45.4 per cent of the women reported stress due to fear of childbirth, and that an irrational fear of childbirth can affect the entire pregnancy, complicate labour, and lead to difficulties in the mother-infant relationship and postpartum depression as a long-term effect.

Pregnant women's mental and social health should, therefore, be a primary concern for all midwives as suggested by the WHO (2016a), and as further supported by the literature (Austin et al. 2013, 23; Sahile et al. 2017, 63). Johnson et al. (2018) reported various incidences of depression and anxiety disorders in pregnant women, which may be exacerbated by the physiological and psychosocial adjustment to pregnancy.

## Conclusion

Midwifery practice is based on a holistic model that encompasses both physical and psychosocial aspects of pregnancy. This pilot study marks only the first stage in the process of acknowledging psychosocial care during childbirth. There is a great deal to be done and the process might be frustrating, but the venture is one of the most worthwhile and rewarding aspects of healthcare. An ideal model of participatory antenatal care is suggested to enhance psychosocial care during pregnancy as a way to also acknowledge evidence-based practice, with reference to psychosocial risk factors identified in this and other studies. This study informs the educational preparation of midwives for the comprehensive management of pregnancy.

## Recommendations

### Administration

- Management should reflect on staff establishment versus patient ratio to ease the work overload and to allow for holistic assessments of pregnant women.

- Guidance on the home languages of the healthcare recipients should be provided (the assessment tool should be translated into Shona and Portuguese). Sign language should also be considered.
- Debriefing sessions for midwives should be conducted to allow them to de-stress based on the encounters they have with the psychosocial risks that women present with.

### **Midwifery Practice**

- An innovative interactive approach should be implemented that is characterised by “women-centred care and group antenatal care” and that allows women to get care in a supportive and respectful setting which integrates antenatal care, health information and group support.
- The “participatory antenatal care model” should be introduced with reference to due consideration of logistical demands of the model, specifically time and resources, which will provide hope to midwives in realising their accountability when providing women with psychosocial care.

### **Midwifery Education**

A teaching programme on “psychosocial antenatal care” aimed at capacitating midwives should be developed.

### **Research**

Research is needed to explore the psychosocial experience of pregnant women and to determine the way in which women manage the changes that typically occur psychosocially during the nine-month period.

### **Limitations**

Challenges that posed as limitations were the withdrawal from participation by 10 facilities in one district, the reluctance from some of the midwives to implement the tool, the reluctance from women to be assessed, midwives offering the assessment tool to women to self-administer, and once-off assessments without continuity and no follow-up care except for women presenting with psychosocial issues that needed urgent attention, for example, intimate partner violence.

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