ACCESS AND UTILISATION OF ANTENATAL CARE SERVICES IN A RURAL COMMUNITY OF ETHEKWINI DISTRICT IN KWAZULU-NATAL

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student Date

Approved for final submission

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Abstract

Introduction

Although the South African Government adopted a primary health care approach to health care service provision in order to ensure equitable access to and utilization of health care services to all communities, the country continues to face challenges regarding access and utilisation of health care services especially in the rural communities. Antenatal care which is mostly provided at primary health care level is regarded as the cornerstone for the success of the maternal and child health care programme. Therefore, poor access to and under-utilisation of health care services could potentially influence the success of this programme and pregnancy outcomes.

Aim of the study

The aim of the study was to determine whether pregnant women from KwaMkhizwana rural community had access to and were utilising antenatal care services.

Methodology

A qualitative, exploratory, descriptive and contextual study was conducted guided by Thaddeus and Maine's three delays model. Purposive sampling of the pregnant women and all categories of nurses who were employed in the three health care facilities in the area was done. Data was collected in two phases through in-depth semi-structured interviews with both the pregnant women and the nurses respectively between February and March 2016. The sample size was guided by data saturation. All data were analysed using the Tesch's method of data analysis.

Study findings

Six major themes and several sub-themes emerged from the interviews with both Phase 1 and Phase 2 participants. The major themes included: 1) access to health care and emergency services, 2) availability of human and material resources, 3)

social and cultural beliefs, 4) past pregnancy experiences, 5) communication and transparency regarding health care service delivery and 6) quality of antenatal care services.

Summary of findings

The pregnant women encountered several challenges which led to delays in seeking, reaching and receiving antenatal care. Most of the pregnant women participants related limited access to health care, with under-utilisation of antenatal services. They were unhappy about the antenatal care services they received in the three available health care facilities in the area, which made these facilities to be inaccessible and underutilised. The nurse participants recognised the challenges facing the pregnant women regarding the access and utilisation of antenatal care services, together with the challenges faced by the nurses while working in the three available health care facilities in the area.

Recommendations

The recommendations that were made included: to consider building a centrally located fixed primary health care clinic that would ensure equal access to health care services, strengthening the implementation of policies regarding the referral system and ambulance services, ensuring sustainable availability of human and material resources, developing strategies to ensure that the antenatal care services are delivered in line with the South African Department of Health policies and guidelines and strengthening community education. A further study on provision of antenatal care services in the area is also recommended.

Dedication

I dedicate this dissertation to The Lord my God for awarding me strength to complete the study and to all the orphans whose mothers died during pregnancy and delivery mostly from preventable causes and to my late mom and dad, Phyllis and Duncan Ngcobo, who both believed in my academic excellence. I know you would have been greatly excited to be here with me at the end of this journey. I will always be grateful for your love and encouragement.

Jeremiah 29: 11 "for I know the plans I have for you" declares the lord "the plans to prosper you and not to harm you, plans to give you hope and a future".

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Glossary of terms

Access

Access is described as the potential or the actual entry of an individual or population group into the health care system and 'having access' signifies potential to utilise a service when required (Gulliford *et al*. 2002: 186).

Access to antenatal care (ANC)

Access to ANC means entering or reaching antenatal services with the aim of receiving antenatal care.

Antenatal care (ANC)

Antenatal care is pregnancy-related care provided to women by health professionals, amongst which major interventions provided aims to maintain the health of women during the entire pregnancy and prevent neonatal deaths (Titaley, Dibley and Roberts 2010: 485).

Health care access

Health care access is defined as access to a service, a provider or an institution, whereby there is an opportunity for consumers of health care and communities to be able to use appropriate services with regards to their health needs (Levesque, Harris and Russell 2013: 18).

Health care facility

Health care facility is a facility at, and from which, a range of primary health care services is provided and that is normally open eight or more hours a day (KwaZulu-Natal Department of Health 2001).

Health posts

A health post is a building or premises which was originally built for other purposes but is being utilised to provide health care services as a means to bring health care services closer to the community.

Household

Household is a family or kinship unit (e.g. the conjugal family) and/or those who share a common residence, or those who share a joint function such as consumption, production, investment or ownership.

Midwife

Midwife means a licensed health care practitioner who is registered with the South African Nursing Council. She/he has a recognised education and training programme to nurture, assist and treat the client, who can be a woman, a neonate or a family, in the process of promoting a healthy pregnancy, labour and post-partum period (South African Nursing Council 2001). He or she will be referred to as a registered midwife (RM).

Primary Health Care

Primary Health Care (PHC) is essential health care based on practical, scientifically sound, and socially accepted methods and technology, universally accessible to all in the community through their full participation at an affordable cost, and geared toward self-reliance and self-determination (World Health Organisation and United Nations Children's Fund 1978: 15).

Primary health care services

Primary health care services are the first accessible level of health care included as part of the package of basic essential health services (KwaZulu-Natal Department of Health 2001).

Professional nurse

Professional nurse is a person registered with the South African Nursing Council (SANC) as a nurse under Article 16 of the Nursing Act, No 33 of 2005, as amended (Republic of South Africa 2005). The terms ‘registered nurse’ and ‘professional nurse’ are used interchangeably.

Utilisation

Utilisation is described as the ability to utilise a service when required following having access to it (Gulliford *et al*. 2002: 186).

List of acronyms

Acronym	Full term
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
BANC	Basic antenatal care
BP	Blood pressure
CEOs	Chief Executive Officers
CINAHL	Cumulative Index of Nursing & Allied Health Literature
DUT	Durban University of Technology
FANC	Focused antenatal care
FP	Family planning
HIV	Human immunodeficiency virus
HRH	Human resource for health
IMR	Infant mortality rate
INTREC	In-depth training and research centres of excellence
KZN	KwaZulu-Natal
MCWH	Maternal, child and women's health
MDGs	Millennium Development Goals
MMR	Maternal mortality rate
NCCEMD	National Committee on confidential enquiry into causes of maternal deaths
NSDA	Negotiated Service Delivery Agreement
PHC	Primary Health Care
PMTCT	Prevention of mother to child transmission
TDM	Three Delays Model
TB	Tuberculosis
WHO	World Health organisation

Chapter outline

Chapter no	Title	Contents
Chapter 1	Overview of the study	Introduction and background, purpose and objectives of the study and the need to describe access to and utilisation of ANC services
Chapter 2	Literature review	The views, assumptions and investigations made by various authors and researchers on access to and utilisation of ANC services and literature that explored different approaches to ANC with regard to access to and utilisation of ANC services from other countries other than South Africa .
Chapter 3	Research methodology	Describes and justifies the research design and method used for this study and application of the theoretical framework.
Chapter 4	Presentation of the results	The results of the study are presented, highlighting the themes and sub-themes that emerged from the interviews
Chapter 5	Discussion of the results	Presents the discussion of the study findings. The literature used in the previous chapters, and new relevant literature, are integrated to contextualise the meaning of the themes and sub-themes.
Chapter 6	Summary of findings, conclusions, limitations and recommendations of the study.	Discusses the summary of findings, conclusions, limitations and recommendations of this study.

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Until the year 2015 South Africa had not met the target achievability of the Millennium Development Goals (MDGs) number 5, which was to reduce the maternal mortality rate (MMR) by three-quarters between 1990 and 2015. It was indicated in the 2013 MDGs Country Report that it was unlikely that South Africa would achieve this indicator within the specified time (Department of Health 2013b: 73). According to this Country Report, the MDG 5's target achievability was 269 per 100 000 in 2010 and 38 per 100 000 live births by 2013. In order to reduce the MMR as required, the Primary Health Care (PHC) approach became the most cost-effective and efficient means of improving access and ensuring the country's equal distribution of health care services since 1994 (African National Congress 1994).

The PHC services became fully comprehensive, hence the PHC service package was developed to outline the execution of health care services at all community health care levels (Department of Health 2001: 8). The main targeted health objectives of the PHC service package included maternal, child and women's health (MCWH) care services, where antenatal care (ANC) services became a highly defined priority area that needed to be protected (Department of Health 2001: 11). The ANC services then became the cornerstone for reducing maternal and perinatal deaths (Department of Health 2005; Pattinson 2007 and Hoque, Hoque and Kader 2008). In order to ensure that ANC services were accessed and utilised by every woman requiring them, and to MMRs, the South African Government deployed several strategies. Some of these strategies included:

- An announcement and implementation of free health care services for pregnant women and children under the age of five, and the provision of

skilled midwifery and obstetric services (Department of Health 2007: 7-9).

- The introduction of the Basic Antenatal Care (BANC) approach in 2007, which was regarded as an ANC quality improvement package strategy (Department of Health 2010: 10).

Although the South African Government adopted a PHC approach in order to ensure health for all and accessibility to health services, the country continued to face challenges especially with regard to the improvement of maternal health outcomes. Globally, the MMR dropped by 45% between 1990 and 2013, which was estimated as 380 to 210 deaths per 100,000 live births. Most countries with feeble health care infrastructures, however, continued to have high fertility rates making them unlikely to meet the MDG 5 indicator, as these countries still had poorer MMRs in 2010 (Lawson and Keirse 2013: 96). These countries included Botswana, Cameroon, Chad, Congo, Guyana, Lesotho, Namibia, Somalia, Swaziland, Zimbabwe and South Africa. Almost 300 000 women died worldwide in 2013 from preventable causes related to pregnancy and childbirth, which was an indication that much more still needed to be done in the provision of pregnancy care (United Nations 2014: 5).

In most remote African rural areas, disparities in health care which still exist are due to the inaccessibility and unavailability of health care facilities and human resources; poor road infrastructure to facilitate the utilisation of ANC and difficult access to health care providers by pregnant women (Arthur 2012: 1). The province of KwaZulu-Natal (KZN) is densely populated with high birth rates and the highest number of maternal deaths (Amnesty International 2014: 11). The highest prevalence of Human Immune-deficiency Virus (HIV) in pregnant women contributes to most of the maternal deaths. The Amnesty International Report further point out that the majority of the births occur outside health care facilities, which is an indication that access to health care services remains a challenge especially for rural women in KZN.

Although until 2015 the country remained beyond its targeted timeframe for achieving MDG's 4 and 5, the improvement of MCWH remained essential to improving the quality of life of families and communities. The Department of Health (2010: 6) included in the priorities of the Medium Term Strategic Framework the need to have an accelerated prevention of the mother-to-child transmission (PMTCT) programme. Furthermore, there was a need to scale up a five-year strategy for integrated MCHW and nutrition programmes, which was one of the strategies to hasten progress towards achieving targets of the MDGs. The scaling up of PMTCT would also reduce non-pregnancy related causes of maternal deaths, with deaths due to HIV being one of these and accounting for 34.7% of the maternal deaths (Department of Health 2014a: 1).

Access to and the utilisation of health care services, including ANC services, often depends on where one lives (Gaede and McKerrow 2011: 540). These remain a challenge to most women in rural communities and could be linked to the significantly poorer health outcomes in rural populations, compared with their urban counterparts (Schoevers and Jenkins 2015: 750). The two commonly used health indicators [infant mortality rate (IMR) and MMR] are significantly poorer in rural than in the urban areas. In South Africa, the IMR is 52.6 per 1000 births on average in rural areas, compared with 32.6 per 1000 births in urban areas (Department of Health 2011: 31). Furthermore, some rural areas in the Eastern Cape Province have the highest IMR of 70.11 per 1000 births (Department of Health 2011: 31). These figures could be attributed to the challenges in access to and utilisation of health care services, compounded by a shortage of human resource, which remains a challenge in rural communities. A total of 43.6% of the rural population in South Africa is served by only 19% of nurses and 12% of doctors (Department of Health 2011: 31). One of the recommendations in the Saving Mothers 2011-2013 Report is for high risk ANC clinics run by advanced midwives to be established and made accessible to all pregnant women, especially in rural areas (Department of Health 2014d: 4). The current study aimed to explore and describe access to and utilisation of ANC services in a rural community of the eThekwini district in KZN.

1.2 PROBLEM STATEMENT

In the eThekwini district the MMRs and the IMRs are the two commonly used health care indicators, which remain in elevation and are used to rate maternal health outcomes which further reflects on access to and utilisation of ANC services. The eThekwini District Health Plan Survey 2014/2015 Report indicates that the MMRs remained at 220 per 100 000 live births, with a total of 128 maternal deaths in 2012/2013 (Department of Health 2014a: 19); and MMR of 172 per 100 000 live births, with a total of 97 maternal deaths during 2013/2014 (Department of Health 2015: 18).

The above-mentioned statistics are an indication that there are poor maternal outcomes in the eThekwini district. Despite being highly urbanised and densely populated, the eThekwini district still has rural communities existing on the outskirts of the West, South and North sub-districts (Figure1.1), which potentially impacts on people's access to and equal distribution of health care services. This is supported by the Department of Health (2013b: 11), stating that inequalities in health care access still exist within population groups and geographic locations, and contribute to poor maternal outcomes. The South African Saving Mothers Report 2011-2013 by the National Committee on Confidential Enquiry into causes of Maternal Death (NCCEMD) also reveals that there is lack of attendance at ANC clinics and the pregnant women's delay in seeking care continue to be the most common patient related avoidable factors leading to maternal deaths, (Department of Health 2014d: 13-14).

The West sub-district is the most densely populated area within the eThekwini district and has 9% of both formal and informal populations, where informal populations are mostly in rural areas (Department of Health 2014a: 12). It also has the majority (44%) of mobile clinics, which could be attributed to the low number of health posts or fixed clinics in this area (Department of Health 2015: 19). KwaMkhizwana is a tribal rural area situated in the West sub-district which forms 9% of the informal populations in rural areas of the eThekwini district. The area has one mobile clinic operating once a month and two health posts each operating once a week. The number of health care facilities in this area raises some concerns regarding access to and utilization of ANC services. South Africa's 2012 In-Depth Training and Research Centres of Excellence

(INTREC) Report highlights that the disease profile in rural areas emanates from poverty-related illnesses, including maternal deaths, which are critical evidence of health care inequalities (Maredza *et al*. 2012: 11). The findings of the INTREC Report support the need to explore and describe access to and utilisation of ANC services within the KwaMkhizwana community as part of the strategies to ensure access to and utilisation of ANC services.

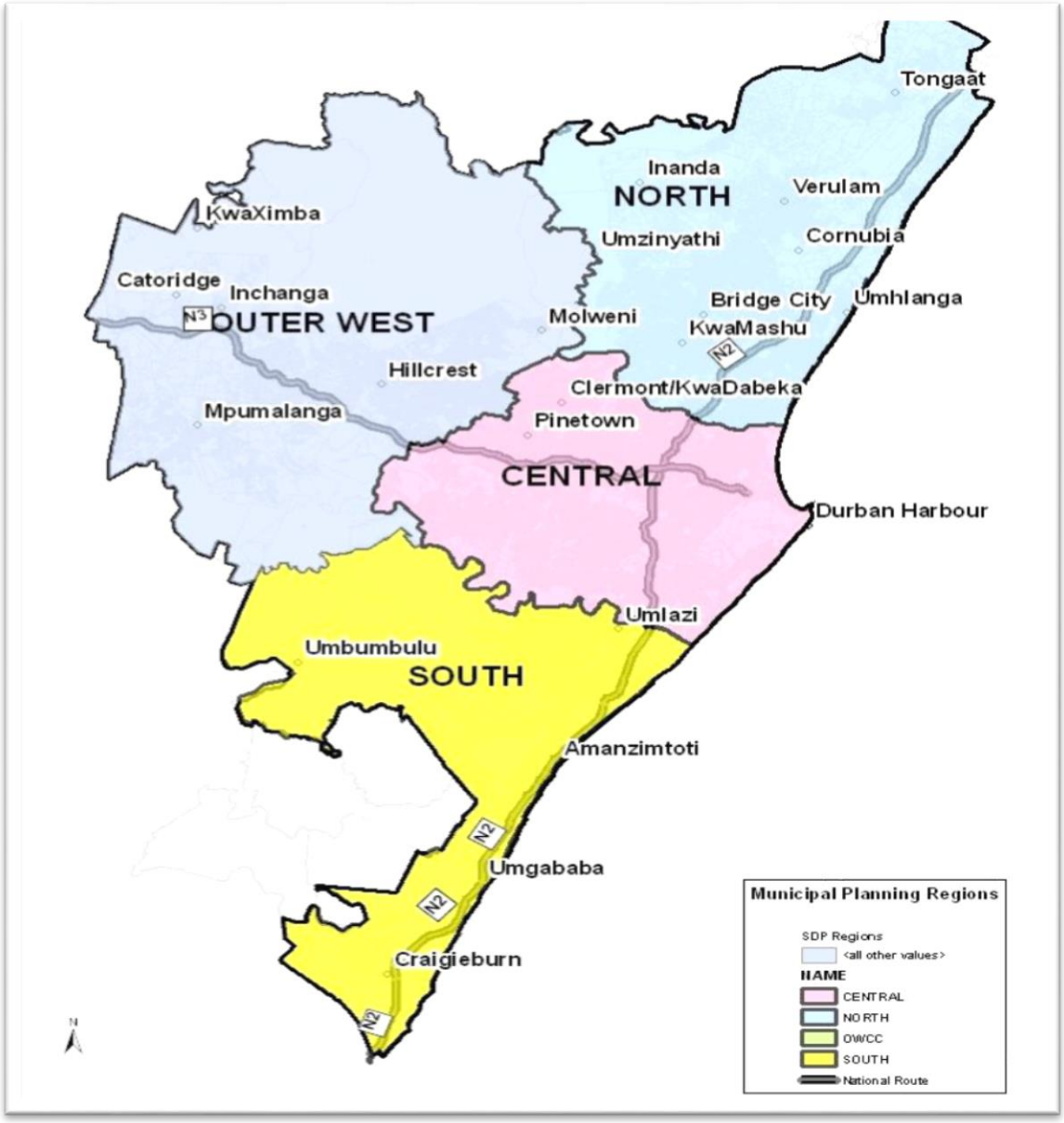

Figure 1.1: Map showing the rural areas situated in the outskirts of eThekwini districts (EThekwini Municipality 2013: 42)

1.3 AIM OF THE STUDY

The aim of this study was to determine whether pregnant women from the KwaMkhizwana rural community had access to and were utilising ANC services.

1.4 STUDY OBJECTIVES

The objectives of the study were to:

- Describe how ANC services were accessed and utilised by pregnant women from the KwaMkhizwana rural community.
- Explore the factors that influenced the access to ANC services by pregnant women from the KwaMkhizwana rural community.
- Explore the factors that influenced the utilisation of ANC services by pregnant women from the KwaMkhizwana rural community.

1.5 MAIN RESEARCH QUESTION

The study aimed to answer one main research question:

- Do pregnant women from the KwaMkhizwana rural community have access to, and utilise, ANC services?

1.6 SUB-QUESTIONS

There are three research sub-questions that needed to be answered in order to achieve the study objectives:

- How are the ANC services accessed and utilised by pregnant women from the KwaMkhizwana rural community?
- What are the factors that influence access to ANC services by pregnant women from the KwaMkhizwana rural community?

- What are the factors that influence the utilization of ANC services by pregnant women from the KwaMkhizwana rural community?

1.7 SIGNIFICANCE OF THE STUDY

South Africa remains challenged by persistently high levels of maternal and perinatal mortality rates. The national Government in its population policy and Negotiated Service Delivery Agreement (NSDA) 2010-2014 has expressed its concern regarding the country's MMR (Department of Health 2013a: 71). The new South African health system post-1994 adopted a PHC approach, which was expected to be the most cost-effective and efficient means of improving and ensuring health for all through accessibility to health care services (African National Congress 1994).

Although PHC was expected to improve accessibility to health care services, Pattinson (2007: 7) points out that access to ANC in the rural areas remains poorer than in the urban areas. According to the Department of Health (2011: 31), there is a need to improve PHC services and programmes in rural areas in order to ensure reduced MMR and IMRs. The latest eThekwini district health plan survey 2015/2016 confirms that the MMR was 172 per 100 000 live births, with a total of 97 maternal deaths during 2013 /2014 in the eThekwini district (Department of Health 2014a: 18). The issues of rural disparities in health care include poor road infrastructure to facilitate the utilisation of ANC, and difficult access to health care providers by pregnant women (Arthur 2012: 1). Such disparities contribute to the under-utilisation of ANC services. Kawungezi *et al*. (2015: 132) attest that the under-utilisation of ANC greatly contributes to persistently high rates of maternal and neonatal mortality.

KwaMkhizwana, a rural community in the West sub-district, faces the same health care access inequalities as it has no health care facility but receives health care services from the two health posts and a mobile. This suggests that access to health care services remains a challenge for pregnant women. The researcher believes that exploring access to and utilisation of ANC services will help to determine whether pregnant women from the KwaMkhizwana rural

community have access to, and are utilising, ANC services. The study findings could help improve accessibility, utilisation and the equal distribution of health care facilities whereby maternal and perinatal outcomes may improve. The findings of the study will be presented to relevant stakeholders through recommendations about the access to and utilisation of ANC services within health care facilities, in order to ensure access that will provide an effective quality ANC. Strategies may be developed by the health sector of the eThekwini district, including Chief Executive Officers (CEOs), District Managers, Clinical Managers, and other relevant stakeholders in order to strengthen and sustain access to and utilisation of health care facilities available in the area. Improved access to and utilisation of ANC services may contribute to positive maternal and child health outcomes, making it achievable to reduce MMRs and IMRs. The results of the study would not only benefit the eThekwini district, it could also be useful to policy makers at provincial and national levels and therefore be of benefit to the whole country.

1.8 SUMMARY OF THE CHAPTER

This chapter presented an introduction and background, purpose and objectives of the study. It also highlighted the need to describe access to and utilisation of ANC services within available health care facilities in the KwaMkhizwana rural community. Chapter 2 will place emphasis on relevant reviewed literature in order to gain more insight and understanding, and to support the significance of this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 provided the background and rationale for the study. It focused on exploring access to health care and whether the ANC services are utilised by pregnant women. It also highlighted the problem statement and significance of the study, thus creating an understanding as to why this study needed to be done. This literature review presents the thoughts, views, assumptions and investigations made by various authors and researchers on access to and utilisation of ANC services.

2.2 STRATEGIES USED TO SEARCH FOR LITERATURE

Initially the Durban University of Technology (DUT) library was used to search for books and journals that related to the topics of access to and utilisation of ANC services. The use of libraries is usually seen as an excellent starting point as it allows for the gathering of information. Access to other alternative information sources included free access to a wide range of online articles (Petre and Rugg 2010: 75). Concurrently, the electronic databases were used to offer a wider range of literature. Wentz (2014: 87) emphasised that it was important that the reviewer possessed essential skills to perform a comprehensive search of the available literature, and effort was given to gain familiarity with a range of health-related databases.

Before engaging in the searches, a set of keywords was decided upon. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that core elements and arguments could be highlighted. Beel and Langer (2011: 465) emphasised that mind maps are well suited to structure document collections because the structure of the mind map is similar to an outline; hence mind maps are also used to draft documents. The creation of a mind map to aid in the formulation of keywords helped to identify key search

terms. Identifying keywords for the subject before initiating any literature search ensured that the correct results were obtained.

The keywords and phrases that were used as search terms included: ANC access; ANC services; access to a health care facility; ANC access and maternal outcomes; MNCWH outcomes; and rural utilisation of health care facilities. Each of the search terms was initially used individually, and then combined using Boolean operators AND, OR and NOT, which are the three most widely used to expand or delimit the search (Polit and Beck 2012: 99). The resources that were available for the literature search were books and journals, which included both hardcopy and electronic sources. The initial hardcopy library search did not reveal many current sources; therefore, the primary focus was on searching various electronic databases as summarised below:

- Host search engine focusing on nursing journals (EBSCO).
- The Cumulative Index of Nursing & Allied Health Literature (CINAHL).
- Medical literature online (MEDLINE).
- PubMed-Public/Publisher Medline databases.

The DUT library resources were used, including the institutional repository. There was optimal use of databases utilised for local and international input through the inter-library loan system. The latter enabled the researcher to obtain documentary and electronic information and data only available from other academic institutions and organisations, to which the DUT library is affiliated. The archives, databases and websites of other local and international sources of information, such as reputable research institutions and organisations, were also utilised. The South African Nursing Council (SANC); Statistics South Africa (Stats SA); the South African Department of Health; and the World Health Organisation (WHO) were consulted in the mission of gaining a multi-perspective approach on the research topic. Google Scholar was also

one of the search engines used to retrieve documents and listing publications related to the conceptualisation of access.

2.3 ACCESS TO HEALTH CARE SERVICES

2.3.1 Globalisation trends regarding access to health care services

Access to health services is a key factor in the human development of any country (WHO 2008: 1). The globalisation of public health has important implications for access to essential healthcare. The rise of inequalities among and within countries negatively affects access to healthcare. Access to health services means the timely use of health services to achieve the best health outcomes (Peters *et al.* 2008: 162; WHO 2008: 1). Gulliford *et al*. (2002: 186) defined access as the potential or the actual entry of an individual or population group into the health care system, and further highlighted that 'having access' denotes potential utilisation of a service when required. Gaining access refers to the initiation process of utilising a service; this gained access to health care is viewed as a realised need to utilise health care services.

Access to health care is predominantly determined by factors such as the availability, cost and quality of health resources and supplies (Levesque, Harris and Russell 2013: 19). Furthermore, access to and utilisation of services is usually measured using indicators such as the numbers of skilled health care professionals, hospital beds, number of public healthcare facilities and costs incurred by individuals to obtain health (Gulliford *et al*. 2002: 186). These indicators are used to access and utilise services and influence the type of health outcomes that occur. Mostly the regular adverse health outcomes that result are due to differences in access to health care services and are major public health priorities (Graves 2009: 49). Additionally, the high quality of healthcare, easy accessibility of health services and reduction of health care disparities depend on diversifying the health work force in terms of education, as they provide services to different population groups (Williams *et al*. 2014: 33).

There are different views and thoughts shared by various authors regarding access to and who utilises health care services, and how this impacts on health outcomes. The view of Appiah-Denkyira *et al*. (2013: 4) was that in rural areas a lack of access to skilled service providers, or human resources for health (HRH) and financial obstacles, particularly prevent critical health services from being accessed and adequately delivered to those who need them the most. This resulted in hampered health outcomes. The suggestion by Peters *et al*. (2008: 165) was that good roads in poor areas are not only required for people to reach health facilities, but also to ensure the distribution of drugs and other supplies as a means of geographic access. Furthermore, these authors emphasised that the ability of the Government to allocate and sustain financial accessibility to its health systems highlights some strategies towards facilitating access to health care, more especially in developing countries. According to the WHO (2008: 2), disparities in access to health care services affect individuals and society. Limited access to health care affects the quality of life negatively, thereby impacting on people's ability to reach their full potential. Short life expectancy and high IMRs are indicators of inadequate or inaccessible health care services.

2.3.2 Access to health care services in South Africa

The Constitution of the Republic of South Africa was adopted in 1996 as the supreme law of the country through freely elected representatives, in order to restore the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights (Republic of South Africa 1996: 1). The Constitution is the supreme law of the Republic of South Africa. It is the law or conduct whereby all obligations imposed by it must be fulfilled (Republic of South Africa 1996: 3). Chapter 2 of the Constitution, which is the Bill of Rights, forms the basis of democracy and protects the rights of all people in South Africa by affirming the democratic values of human dignity, equality and freedom.

Access to health care is a democratic right in South Africa, meaning that all South African citizens have a right to health care and the right to life. Different

sections and sub-sections of the Constitution attest to these democratic rights of citizens. According to Chapter 2, section 11, of the Constitution, “everyone has a right to life”. Section 27 (1a) affirms that everyone has the right to have access to health care services, including reproductive health care. It places an obligation on the State to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right (Republic of South Africa 1996: 7). The Constitution of the Republic of South Africa therefore acknowledges the fact that access to health care is a fundamental right of all citizens and should be respected. It also highlights the emphasis on access to reproductive health care.

There are South African studies that highlight the inequalities and disparities that still exist in health care access and utilisation. The findings of Moodley and Ross (2015: 631) revealed that socio-economic status, race, and urban-rural locations were associated with access to health care in South Africa. The indication was that black Africans, poor, uninsured and rural respondents experienced the greatest barriers to health care access. The results of a study in the eThekwini district on challenges regarding BANC implementation highlighted that staff shortages, problems with the transportation of specimens as well as lack of material resources and management support, had an impact on the delivery of ANC services (Ngxongo and Sibiya 2013: 1). The above studies affirm that access to health care, especially ANC services, remains a challenge in the district’s health care services and the utilisation thereof. The current study aims to explore and describe whether pregnant women from the KwaMkhizwana rural community are able to access and utilise ANC services.

2.4 UTILISATION OF ANC SERVICES

2.4.1 The global view regarding utilisation of ANC services

The utilisation of health care services has a link with health outcomes. It is believed that good health outcomes are a result of access to skilled health care workers and the utilisation of health care services using specific guidelines. Inadequate HRH have been identified globally as a major hindrance to the delivery of health services (Mangham and Hanson 2010: 87). This is a contributing factor to most

developing countries' inability to achieve the health-related millennium development goals (WHO 2010; Vujicic, Ohiri and Sparkes 2009).

The guidelines that are used during the provision of ANC services generally guide the quality of care received by pregnant women. In a study by Bar-Zeev *et al*. (2014: 289), conclusions were drawn that poor adherence to the use of local guidelines had some negative influence on the success of the ANC programme and the quality of ANC. The authors recommended that the identified problems in the local guidelines needed urgent attention if equity in women's access to high quality ANC (with the aim of closing the gap in maternal and neonatal health outcomes) is to be achieved. The factors relating to access to and utilisation of ANC services may, in one way or the other, impact negatively or positively on maternal outcomes.

According to Cobos Muñoz *et al*. (2015: 2) the different approaches that have been used to improve access to and utilisation of ANC services include education, counselling, screening and treatment, which could effectively be completed in six visits. This is in line with the WHO ANC model which states that all pregnant women should have at least a minimum of four ANC visits, which should include all the specified interventions (WHO 2006: 1). Kaur and Singh (2011: 2) agreed that based on a review of the effectiveness of different models of ANC, a minimum of four visits remains a WHO recommendation. These ANC visits ensure that pregnant women receive important services and that all risk factors are identified.

The access to four ANC and more visits for pregnant women is now used as a global benchmark indicator to track maternal health programme performance (Hodgins and D'Agostino 2014: 174). Furthermore, these authors specified that the ANC 4+ indicator is a marker of receipt of adequate ANC that ensures access to ANC. Hodgins and D'Agostino (2014: 173) argued for the adoption of a summary indicator that better reflects the content of ANC than does the current ANC 4+ indicator. These authors further proposed the availability of a simply specified set of ANC content indicators through surveys and routine health information systems

Although seeming to be effectively used, and having shown positive maternal outcomes, not all countries use a recommended WHO ANC model. A study in Vietnam showed that despite three ANC visits recommended by the Vietnamese Government, the MMR is estimated to be 150 per live births with a neonatal mortality of 19 per 1000 births, when compared with other countries in the same income category or geographical area (Graner *et al*. 2010: 609). Downe *et al*. (2009: 518- 519) disagreed with fewer ANC visits being effective and improving maternal health. The authors posited that there is no significant difference noted in MMRs between women attending fewer antenatal appointments (4-9 visits) compared with those adhering to the traditional ANC model of 12-14 visits. Furthermore, the authors state that lately it was evident that infrequent or non-attendance at ANC services has limited adverse maternal outcomes. This is contrary to the recent United Kingdom Confidential Enquiry into Maternal and Child Health which highlighted late booking or poor attendance is an important associated factor in cases of maternal death. Therefore the conclusions drawn were that good ANC impacts positively on good maternal outcomes and mostly if the outcomes are negative they could be preventable with focused and goal-directed ANC.

2.4.2 Utilisation of ANC services in African countries

The initial access to health care for pregnant women is through MCHW services and ANC is regarded as a core component of routine MCHW services (Campbell, Graham and Lancet Maternal Survival Series Steering Group 2006: 1294). The ANC core component strategies target pregnant women in order to identify early signs or risk factors for diseases. The ANC needs to be utilised in order to early initiate specified interventions. The provision of timeous interventions during screening is done with an aspiration of reducing maternal and perinatal morbidity and mortality. Additionally, ANC covers an increasingly multipurpose role, and is one of the most widespread health services with a very high coverage that serves as a means of distribution for other packages. These include the rolling out of anti-malarial drugs or antiretroviral therapy

(Campbell, Graham and Lancet Maternal Survival Series Steering Group 2006: 1294).

The ANC is typically provided by midwives and doctors, not all of whom have obstetric qualifications. In rural and remote areas, registered nurses who do not necessarily have midwifery skills also provide this care (Kildea *et al*. 2010: 1383). In Africa the shortage of HRH is more prevalent in rural areas which places an incredible strain on the health care system, resulting in preventable deaths and an increased burden of disease (Buchan and Calman 2004: 13). Many women in sub-Saharan Africa attend ANC visits, which becomes an opportunity to reach pregnant women with messages and interventions. An evaluation of ANC in an African context has resulted in the recommendation to deliver ANC services in four focused ANC (FANC) visits. The FANC approach allows one visit within the first trimester and three after quickening. These include counselling, examinations, and tests that serve an immediate purpose with proven health benefits within all four visits (WHO 2002: 1). This FANC approach is now used in most African countries.

Several studies have been done regarding the use of the FANC approach. According to Ouma *et al.* (2010: 2), the Kenyan Ministry of Health, in conjunction with the Johns Hopkins Programme for International Education in Gynae and Obstetrics (JHPIEGO), trained healthcare workers in FANC. This was in order to ensure that FANC emphasised goal-oriented and women-centred care by skilled providers, whereby the quality instead of the quantity of visits is important. Mason *et al*. (2015: 2) attested that Kenya offers FANC for all pregnant women, to provide an integrated care package which includes the identification and management of obstetric complications and infections. These authors concluded that the distance travelled to health care facilities and a lack of transport contributed to Kenyan women not accessing and utilising health care facilities based on birth deliveries, thus opting to deliver with a traditional birth attendant.

As much as access to ANC in most African countries uses FANC, this strategy has made ANC attendance generally satisfactory but did not improved maternal

and neonatal outcomes (Kyei, Chansa and Gabrysch 2012: 151). In Zambia there is a weak relationship between the utilisation of ANC and maternal outcomes, even though the ANC attendance is high but maternal mortality is estimated at 591 per 100 000 live births. Kyei, Chansa and Gabrysch (2012: 151) concluded in the study done in Zambia that the gap in the quality of ANC indicates missed opportunities in the delivery of effective interventions. ANC attendance alone may therefore not improve maternal outcomes; however it should be goal directed and aimed at the provision of quality ANC rather than just counting the number of ANC visits (Ouma *et al.* 2010: 2).

A study in Tanzania documented that there are identified factors influencing health workers' performance with regard to national FANC guidelines (Gross *et al*. 2011: 36). The ANC practices of health workers were poorly implemented due to a lack of trained staff, absenteeism and supply shortages. There are generally satisfactory maternal outcomes even when a pregnant woman has attended ANC at least once. In rural Northern Africa, the proportion of pregnant women who received four or more antenatal visits increased from 50% to 89% between 1990 and 2014, with better progress on maternal outcomes (United Nations 2014: 6). On the contrary, a Zambian study reported a 94% ANC attendance of at least once, although the maternal mortality is estimated at 591 maternal deaths per 100,000 live births, and neonatal mortality at 34 neonatal deaths per 1000 live births (Kyei, Chansa and Gabrysch 2012: 152). These authors further state that the weak connection between the use of ANC services and maternal and newborn survival has driven the focus towards content and the quality of care provided, rather than mere ANC attendance. The use of a FANC approach in most African countries has provided some intense progress with regard to access to and utilisation of ANC services. However, it has not been widely implemented.

2.4.3 Utilisation of ANC services in South Africa

The Saving Mothers' Report 2011-2013 by the NCCEMD in South Africa indicated that the top three causes of maternal deaths accounted for just more

than two thirds of all the maternal deaths in South Africa (Department of Health 2014d: 1). The researcher believes that these preventable maternal deaths mostly indicate poor quality of care during the ANC, intra-partum and postnatal periods. This committee recommends three key aspects which are essential in the prevention of maternal deaths (Department of Health 2014d: vii). These include: knowledgeable and skilled health care providers, appropriately resourced and accessible health care facilities, including equipment and human resources and a rapid inter-facility emergency transport system. All these key aspects could be facilitated by access to health care and utilisation of ANC services.

Attendance at ANC services, which many pregnant women in sub-Saharan Africa do, offers an opportunity to reach them with interventions enhancing improved maternal and newborn health impacting on the survival and health of the infant (Ouma *et al*. 2010: 2). Mostly in KZN pregnant women in the urban areas are able to reach these interventions due to the better access to health care that they have when compared with 23.8% of the poor living in rural informal tribal areas with limited access to health care (Wabiri *et al*. 2013: 5). These authors state that deficiencies in the utilisation of maternal health services and poor skilled health care providers make a critical contribution to maternal deaths especially in rural areas. They further state that 8% of women in rural areas had not attended ANC and 9% delivered without a skilled attendant. Wabiri *et al*. (2013: 2) argued that apart from early ANC attendance, the deficiencies of care in rural-informal areas and inequalities in the utilisation of services were higher among the poorer in rural areas, with considerably large differences noted in maternal health status. There was still very little detailed information available about the distribution of access to maternal health services across the country's population groups in South Africa. The timing of the utilisation of ANC services described the inequities of access to maternal health services.

In South Africa, the capacity of HRH has declined since the 1990s, resulting in insufficient doctors and nurses working in the public sector. This raises concerns, especially considering that South Africa has the world's largest HIV

epidemic with more than six million people infected, and a prevalence rate of 12.3% in the general population (Department of Health 2011: 32). This high disease burden has put pressure on health facilities, creating a substantial burden on HRH. This has resulted in the need to increase the health care workforce in order to alleviate the workload especially in the rural areas

South Africa included the BANC approach in the ten-year strategic plan for 2006-2015 as the key implementation strategy for MCWH, in an attempt to reduce maternal and perinatal death rates (Department of Health 2010: 23). The initiation of the BANC approach in all the provinces of the country allowed a pregnant woman the opportunity to be seen and treated when she made first contact with the health system (Pattison 2007: 7). This ensured access to ANC services at the first encounter with the health care service by the pregnant woman. Access to ANC by a pregnant woman needs to be at least four times during the entire pregnancy, starting before 20 weeks gestation in order to improve ANC coverage (Department of Health 2007: 7). This will prevent ANC clients from either being turned away or asked to come back another day, a practice which creates missed opportunities for early ANC attendance.

The findings of the study by Ngxongo and Sibiya (2013: 2) on the implementation of BANC revealed that a BANC approach improves both quality and accessibility in the delivery of ANC. This is supported by the findings of Snyman (2007: vi), which showed that the implementation of a BANC approach can assist to re-organise services at PHC level. This optimises the impact on professional nurses to improve the quality of ANC for pregnant women, resulting in good pregnancy outcomes, survival of the woman and her new-born baby. Pattinson (2007: 7) recommended that BANC services should be available every day of the week and at every health service where a pregnant woman is present. Ngxongo and Sibiya (2013: 7) recommended that full integration of PHC services is required to ensure the accessibility and availability of BANC services. These authors agree that the accessibility and utilisation of ANC services relies on the availability of integrated PHC services, the availability of BANC services in every health service, and a re-organisation of PHC services to improve the quality of ANC for the betterment of pregnancy

and women's' outcomes. Sibiya and Gwele (2013: 391) attest to full integration of PHC services as they define integrated PHC as a health care provision strategy that ensures clients receive essential services with the aim of improving service accessibility to communities.

2.5 SUMMARY OF THE CHAPTER

Chapter 2 presented literature that explored different approaches to ANC with regard to access to and utilisation of ANC services from other countries, in order to describe the link of access to services and maternal outcomes. The next chapter will focus on the methodology that was adopted for the study and the approaches that were undertaken in sampling, data collection and analysis.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In order to explore approaches regarding access to and utilisation of ANC services, this chapter will describe and justify the research design and method used for this study. The focus will be on the research design; theoretical framework; research setting; study population; sampling process; pre-test study; data collection; data analysis and ethical considerations.

3.2 RESEARCH DESIGN

Grove, Burns and Gray (2013: 195) explained that the research design is a detailed plan according to which the research is conducted. Mouton (1996: 107) described the research design as a set of guidelines and instructions which are followed in addressing a problem. A qualitative, exploratory descriptive and a contextual research design was employed to guide this study.

3.2.1 Qualitative research

A qualitative design is suitable when the researcher wants to examine the understanding of human beings in an environment. According to Polit and Beck (2012: 739), a qualitative design is defined as an investigation of occurrences through the collection of rich storyline materials using a flexible research design. This study used an in-depth and holistic method in providing an overview of pregnant women's' access to and utilisation of ANC services in the rural community of KwaMkhizwana.

3.2.2 Exploratory research

Polit and Beck (2012: 18) expressed that an explorative study investigates the full nature of the phenomenon, the manner in which it manifests, and the other factors to which it is related. The key aim of exploratory research is to discover general information about the research topic (Offredy and Vickers 2013: 48). Hence, this design was intended to gain more information about characteristics within the MCWH field of study, especially on access to and utilisation of ANC services. An exploratory design was used by the researcher to better understand the accessibility and utilisation of ANC services by pregnant women.

3.2.3 Descriptive research

As stated by Polit and Beck (2012: 725), descriptive research is a type of research which classically has main objectives aimed at exposing individuals' situations accurately and the frequency with which phenomena occur. The use of exploratory descriptive studies was to facilitate a greater understanding of the target populations' needs, in order to assist in the development of specific interventions that might alleviate the problem (Burns and Grove 2005: 233-236). The descriptive research design was used to gather information from both pregnant women and all categories of nurses working within the three health care facilities, with regard to access to and utilisation of ANC services. The main purpose for using a descriptive design is to show the real picture of what is happening in real life situations.

3.2.4 Contextual research

Burns and Grove (2009: 34) pointed out that contextual studies focus on specific events in naturalistic settings. Naturalistic settings are uncontrolled real-life situations, sometimes referred to as field settings. An enquiry conducted in a natural setting may mean that the enquiry is free from manipulation. The study was done specifically in KwaMkhizwana with pregnant women in the context of residing in this rural community. In addition, all categories of nurses working in health care facilities in the area were part of the study participants. This was aimed at gaining greater insight on opinions of both

pregnant women and nurses regarding the access to and utilisation of ANC services in this rural community. Thaddeus and Maine's (1994) Three Delays Model (TDM) was used as the framework to guide the study.

3.3 THADDEUS AND MAINE'S THREE DELAYS MODEL AND ITS APPLICATION TO THE STUDY

Qualitative researchers mostly link research to either a theory or model (Polit and Beck 2012: 140). The TDM of Thaddeus and Maine (1994) was used to provide an organising structure for the study. There are three phases of delay in the model as described by Thaddeus and Maine (1994: 1092): delays in deciding to seek care, reaching care and receiving care. The authors highlight that these delays are contributory factors to poor health outcomes leading to maternal deaths. Although the TDM is an old model dating as far back as 1994, it continues to be amongst the most useful and reliable paradigms for describing contributory factors leading to poor maternal health outcomes. Several studies attest that the three phases of delay still contribute to maternal deaths (Titaley, Dibley and Roberts 2010 and Wabiri *et al*. 2013). Mbaruku *et al*. (2009: 85) supported the use of the TDM developed by Thaddeus and Maine to audit maternal deaths for the analysis of perinatal mortality in a regional hospital in Western Tanzania. The conclusions were that most of the sub-standard care occurred after admission to the health care facility for women who delivered in the hospital.

In the current study, the TDM by Thaddeus and Maine was selected in order to explore the factors that influenced access to and utilisation of ANC services in the rural community of KwaMkhizwana. The study aim was to determine whether pregnant women from the KwaMkhizwana rural community had access to and were utilising ANC services. The three phases of the model are described below, with its application to the study.

3.3.1 Phase 1: Delay in deciding to seek health care

Phase 1 includes the delay in deciding to seek care by an individual and in this study it is the pregnant woman, the family, or both. Thaddeus and Maine (1994)

highlighted that the delay in deciding to seek medical care may be influenced by various factors such as pregnancy characteristics; the individual's experience with the health system; the distance from the health facility; costs; previous health care facility experience; perceived rendered quality of care; and several other factors. The authors further stated that the factors informing the decision to seek care mainly depend on the people involved, which may include individual, partners or spouse, and relatives or other family members. The current study explored the factors that influence the access and utilisation of ANC services and how these influenced decisions to seek medical care.

3.3.2 Phase 2: Delay in reaching health care

Phase 2 includes the delay in reaching a health care facility. The delay in reaching an appropriate medical facility is affected by the distribution of health facilities, the availability of transportation, road conditions or the cost of transportation (Thaddeus and Maine 1994: 1092). These factors are influenced by, the travel time to and from the health care facility, and the transportation cost. In the current study, factors that led to delays in reaching care were explored as part of the factors that influence the access and utilisation of ANC services.

3.3.3 Phase 3: Delay in receiving adequate health care

Phase 3 includes the delay in receiving adequate care. This delay in receiving adequate and appropriate care occurs once the facility is reached. Thaddeus and Maine (1994: 1092) indicated that this delay is mainly due to operational difficulties in the health care delivery system. This may be characterised by shortages in supplies or equipment; a lack of trained personnel; incompetence of the available staff; and/or unco-ordinated emergency services.

The factors that are relevant and included in this phase are prompt referral systems, shortages of supplies and equipment, as well as shortages of trained and competent personnel. In the current study, such factors were explored and described as part of the factors that influence the accessibility and utilisation of ANC services in the KwaMkhizwana rural community. Figure 3.1 presents the

three phases of delays as described by Thaddeus and Maine (1994: 1093). The figure demonstrates how the three phases of delays relate to each other according to the authors' description, and how in the current study the delays relate to access to and utilisation of ANC services.

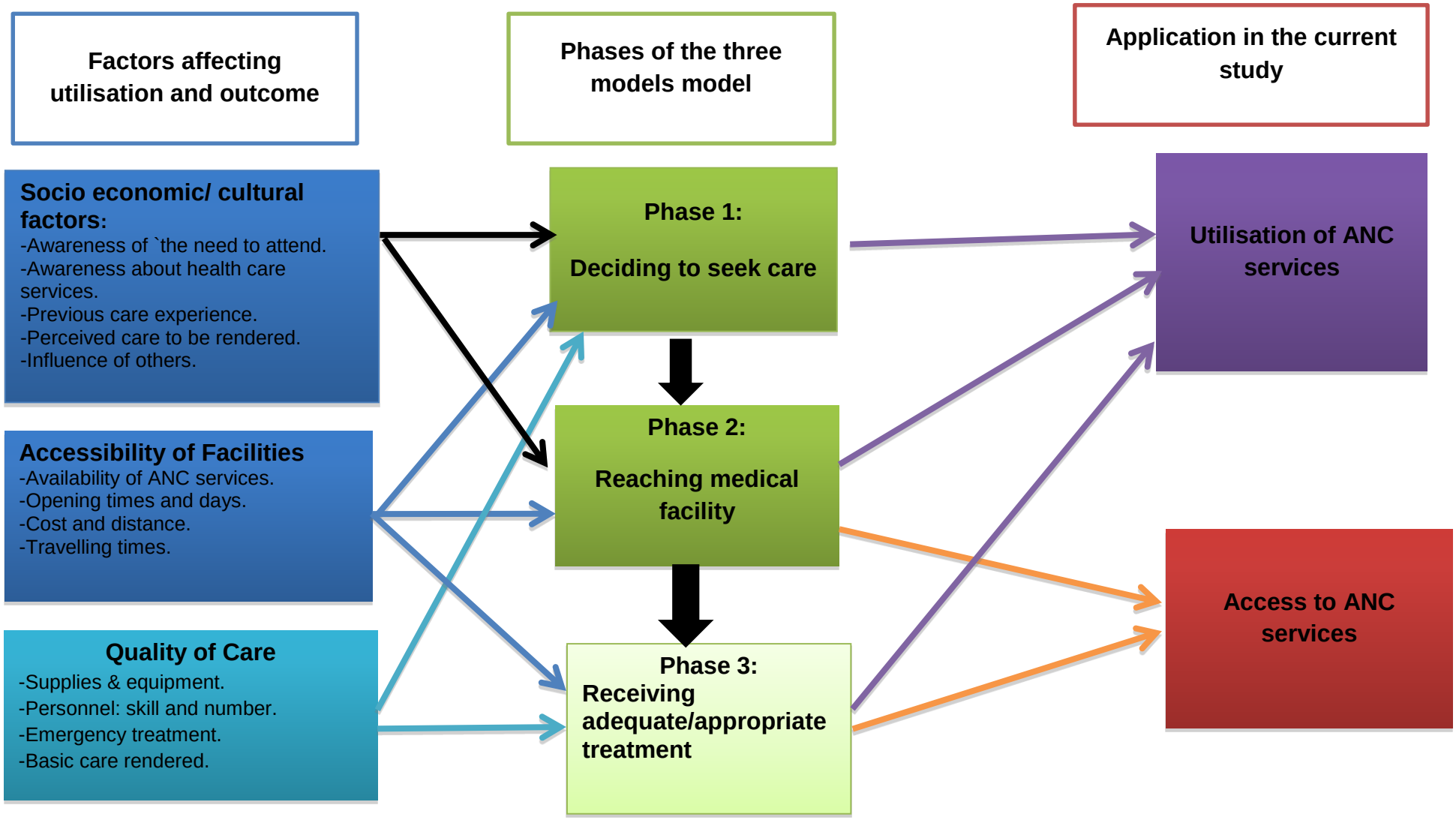

Figure 3.1: The Three Delays Model (Thaddeus and Maine 1994: 1093) and its application to the current study.

3.4 RESEARCH SETTING

Polit and Beck (2012: 743) described a setting as an environment where data is collected for the study. The study was conducted in the KwaMkhizwana rural community, one of the rural tribal authorities in the West sub-district of eThekwini district in KZN. The eThekwini district is a Metropolitan Health District which is divided into three sub-districts, namely North, South and West. The eThekwini district comprises of 103 wards that are urban, rural and peri-rural. The municipal area covers 2 297 square kilometres and includes rural areas in the North, South and the West (Department of Health 2014a: 12). KwaMkhizwana is a rural community area found in the West sub-district area 1, ward 2. It is one of the eleven tribal areas in the West sub-district and has seven tribes. These include the Mlahlanja, Mqeku, Qhodela, Imbubu, Dangwini, Amapofu and Gudlintaba, under the tribal authority of the late Chief Shangase and local authority Councillor Maxwell Mvikelwa Mkhize. The KwaMkhizwana rural community has a total number of 629 households mostly composed of traditional and informal dwellings, with a total estimated population of 35 000 of which 19 900 are females and 15 100 are males.

Health care services in the eThekwini district are jointly provided by the KwaZulu-Natal Provincial Administration (KZNPA) and the eThekwini Municipality, following the health care service level agreement between the two health authorities. The ANC services are provided by both health authorities in eThekwini district. The KwaMkhizwana area receives health care services from the two eThekwini municipality health posts (each operates once a week) and one KZNPA mobile clinic, which operates once a month. There are no other health care facilities in the area. The closest and accessible health care facility, operating seven days a week and providing a wider range of health care services, is a fixed PHC clinic called UMsunduzi Bridge which is approximately nine kilometres away from this community area. This is not in the KwaMkhizwana rural community; it is located in the neighbouring tribal area called KwaXimba. The issues of unequal distribution of health care facilities especially in rural outskirt areas of this district are shown in Figure 3.2

The setting for recruitment was the KwaMkhizwana rural community area. Participants were recruited from various community gatherings within the area. These included church meetings, community meetings (*Izimbizo*), wellness days organised by the DUT community engagement project, together with any other form of gathering that took place in the area at the time of the study. The three health care facilities in the area, which included the two eThekwini municipality health posts and the KZNPA mobile clinic, were also used to recruit the participants and to collect data.

Figure 3.2: Map showing distribution of health care clinics in eThekwini district (EThekwini Municipality 2011: 74)

3.5 STUDY POPULATION

A population refers to a set of individuals with common characteristics that the researcher wishes to study (Polit and Beck 2014: 61). The study population consisted of pregnant women residing in the KwaMkhizwana rural community and all categories of nurses working in the three health care facilities in the area.

3.6 SAMPLING PROCESS

According to Polit and Beck (2012: 742), sampling is a process used to select a portion of the study population to represent the full population. Brink, van der Walt and van Rensburg (2012: 130) described a sample as a sub-group of a population selected by a researcher to participate in the study. A two-phased sampling method was used. It included pregnant women from the KwaMkhizwana rural community and all categories of nurses. All study participants were sampled using a purposive sampling method. Burns and Grove (2009: 716) described purposive sampling as a judgemental or selective sampling method that involves the conscious selection of certain participants or elements by the researcher to be included in a study.

Phase 1 involved sampling of the pregnant women and phase 2 included sampling of all categories of nurses employed in the three health care facilities in the area. The sample size for both phases was determined by data saturation. Data saturation is a collection of qualitative data to a point where a sense of closure is attained because new data produces redundant information (Polit and Beck 2012: 742). This concept of data saturation is also confirmed when the collection of new data does not shed any further light on the issue under investigation (Mason 2010: 12).

3.6.1 Phase 1: Sampling of pregnant women

The participants included pregnant women who were residing in the KwaMkhizwana rural community area.

Inclusion criteria

- Only pregnant women who were eighteen years and above and residing in the KwaMkhizwana community area were included in the sample.

Exclusion criteria

- All pregnant women who did not wish to participate in the study were excluded.
- All other women in the area were excluded.

3.6.2 Phase 2: Sampling of nurses

All consenting categories of nurses working in the three health care facilities in the KwaMkhizwana rural community area were included in the study.

Inclusion criteria

- Only the nurses working in the three health care facilities in the KwaMkhizwana rural community area were included.

Exclusion criteria

- All other categories of staff working in the three health care facilities in the KwaMkhizwana rural community area were excluded.

3.7 PRE-TESTING OF THE DATA COLLECTION TOOL

The pre-test study was conducted before the actual commencement of data collection, in order to establish that the research methods and data collection procedures were appropriate for the current study. Polit and Beck (2012: 738) described pre-testing as the collection of data before the intervention. It is

used to test the possibility of developing a greater and stronger investigation on the same topic.

Brink, van der Walt and van Rensburg (2012: 174) described pre-test participants as patients who meet the inclusion criteria; however their data are not included in the actual study. Two pregnant women and two nurses from the KZNPA mobile clinic outside KwaMkhizwana, but with similar characteristics as the KwaMkhizwana rural community were included for the pre-test study. The characteristics included that the area was rural with health care services provided in a mobile clinic once a week. The results of the pre-test study revealed that the nurses as participants clearly understood the questions and therefore no changes were made with regard to the nurses' interview guide. However there were changes made with regards to the interview guide for the pregnant women. The changes included adding sections to the interview guide, Section A addressed the demography of participants and section B included the main research questions. This was to ensure that factors influencing both access to and utilisation of ANC services were clearly explored and the demographic data analysis would be expedited. Participants in the pre-test as well as the results from the analysis of the information gathered were not included in the main study.

3.8 DATA COLLECTION PROCESS

Data collection is the process of selecting and gathering data from participants. A qualitative interviewing researcher considers all factors that determine the choices of data collection involving the problem statement, research question, study aim and clear description of the research methods in a research design (Burns and Grove 2009; Botma *et al*. 2010; Babbie 2010). The data collection process was inclusive of all participants who met the inclusion criteria respectively and took place between February and March 2016. A one-to-one interview method of data collection is frequently used in exploratory and descriptive designs (Brink, van der Walt and van Rensburg 201: 151). In-depth semi- structured interviews are used when seeking information on an

individual's personal experiences about a specific issue (Hennink, Hutter, and Bailey 2011: 109). All interviews lasted for 20 to 30 minutes. Data in the current study was collected in two phases.

3.8.1 Phase 1: Interviews with pregnant women

The data was collected by means of in-depth semi structured interviews with pregnant women. The field notes were made and audio taping recorded the interviews. Permission was sought from the participants to use an audio recorder to record the interviews. Field notes were also taken to supplement the recorded information and to record any non-verbal cues. An interview guide was used to conduct the interviews in order to facilitate the discussions with the pregnant women regarding access to and utilisation of ANC services. The guide used for the pregnant women was available in English and IsiZulu (Appendices 7a and 7b). All interviews with the pregnant women were conducted in IsiZulu, however, which is the local language used in the area. Each interview with the pregnant women lasted for 20 to 30 minutes. The interview guide consisted of one grand tour question and a few guided tour questions aimed at achieving the objectives, as indicated by Thaddeus and Maine's (1994) TDM model. Probing during the interviews was done depending on the need and the responses, which helped to direct and facilitate the interviews.

Interviews with the pregnant women were conducted by the researcher in a separate room in the hall and a few were conducted in the in the researcher's car for privacy. Most interviews took place in the two eThekwini health care facilities. This was due to the fact that not many community gatherings occurred in the area but only one community gathering ensued at the time of the study. The number of pregnant women interviewed was guided by data saturation which was reached after nine interviews conducted. In order to confirm data saturation, five extra interviews were conducted. All the interviews took about three to four weeks to complete, spending about a week in each health care facility over period of two months between February and March 2016.

3.8.2 Phase 2: Interviews with nurses

The second phase entailed interviews with all categories of nurses. Nurses were interviewed early in the morning at the main clinic before departing to mobile and health posts. This was at a convenient time selected by the participants to avoid disruption of the delivery of health care once the mobile and health posts were operating. An interview guide was used to facilitate the discussions (Appendix 8). Interviews with the nurses were conducted in English. The interview guide consisted of one grand tour question and a few guided tour questions. Probing during the interviews was done depending on the need and the responses, which helped to direct and facilitate the interviews. All interviews with nurses were conducted by the researcher in a separate room in the main clinic and each lasted for about 20-30 minutes. The number of nurses interviewed was guided by data saturation. A total of nine interviews were conducted with nurse participants. Data saturation was reached after interviewing five nurses and four further interviews were conducted to confirm data saturation. The data collection process with the nurses only took two weeks to complete. This was because nurses working in the mobile clinic were interviewed in one week and in another week interviews were conducted with the nurse working in the health posts

3.9 CODING FOR ANONYMISATION

All three study sites and participants were assigned codes in order to ensure confidentiality and anonymity. The codes were as follows:

- The mobile clinic is referred to as study site A.
- The two health posts are referred to as study site B1 and B2.
- All the community gatherings are referred to as study site C.
- The neighbouring fixed clinic is referred to as clinic D. [It was important to code the neighbouring fixed clinic to ensure its anonymity, although it was not a study site but because it was mentioned by the majority of participants as an alternative clinic that is used by pregnant women.]
- Phase 1 participants (pregnant women) appeared in numbers according to a specific study site as follows: (A: P1) meaning pregnant woman participant number 1 in study site A; (B1: P2) meaning pregnant woman participant number 2 in study site B1; (B2: P3) meaning pregnant woman

participant number 3 in study site B2; and lastly, (C: P1) meaning pregnant woman participant number 1 in study site C.

- Phase 2 participants (the nurses) also appeared in numbers according to the study site the nurse was working at, for example (A: N1) meaning nurse participant 1 from study site A; (B1: N2) meaning nurse participant 2 from study site B1; and (B2: N3) indicating nurse participant 3 from study site B2.

3.10 DATA ANALYSIS

Qualitative data gathered from the interviews was analysed using thematic analysis guided by Tesch's method of data analysis. Data analysis was done concurrently with data collection in order to monitor data saturation. Tesch's method involves the researcher listening to audiotapes and reading and re-reading all the transcriptions to get a sense of the full data, jotting down ideas as they emerged (Cresswell 2009: 186).

At the end of each interview the researcher listened to the recorded responses from the participants several times, in order to gain a clear understanding of the data collected. The recorded information was transcribed by the researcher and co-coding was done by supervisors in order to ensure research rigor. The researcher read and re-read the field notes, comparing these with the transcribed information. Data was analysed and systematically explored to generate meanings and existing data was re-coded. In this study, data was organised into categories which were further arranged into themes and sub-themes.

3.10.1 Data interpretation and triangulation

Data from each of the two data sets, which included interviews with the pregnant women and those from the interviews with the nurses, were analysed independently and findings were triangulated. LoBiondo-Wood and Haber (2014: 125) defined triangulation as the use of two pieces of information in order to locate a third unique finding. In this study, the triangulation process was used where more than one source of information of collected data from pregnant

women, as well as all categories of nurses providing ANC services, might lead to the same conclusions. The identified themes were discussed by the researcher and verified with relevant literature. The data interpretation and triangulation were used to guide the researcher towards making recommendations from the study. Direct quotes from the participants were used to support the discussion of the study results.

3.11 TRUSTWORTHINESS AND RESEARCH RIGOUR

Trustworthiness was ensured throughout the study. According to Babbie and Mouton (2001: 276) trustworthiness is the extent to which a research study is worth paying attention to, worth taking note of, and the extent to which others are convinced that the findings are to be trusted. In qualitative research, trustworthiness establishes research rigour without sacrificing relevance. Lincoln and Guba (1985 cited in Polit and Beck 2012: 584) suggested four criteria for establishing the trustworthiness in a qualitative inquiry: credibility, dependability, confirmability and transferability. These authors later added authenticity as the fifth criterion for ensuring trustworthiness (Guba and Lincoln 1994). All five criteria were used to ensure the trustworthiness and/or validity of data in this study.

3.11.1 Credibility

Credibility refers to the confidence in the truth of the data and interpretations thereof (Lincoln and Guba 1985). The researcher ensured credibility of the data by investing or spending more time in the field and developing a sense of trust with the participants during interviews. The researcher spent three to four days per week in each research study site at the time of data collection except for one community gathering that occurred only on the specified date. This was achieved through the manner in which the researcher presented herself during all the contact sessions with the participants, and how the information-giving sessions were conducted. Furthermore, credibility was ensured by interviewing both the pregnant women residing in the area and all categories of nurses working in the available health care facilities. There were two interview guides

used separately, one for pregnant women and the other for all categories of nurses. These interview guides were used throughout the research process.

3.11.2 Dependability

Lincoln and Guba (1985) described dependability as the stability of data over time and over conditions. The researcher ensured this by using the same main research questions for similar participants interviewed on different dates. The sub-questions were also not changed. This assisted the researcher to establish that the measure was stable when used on different participants, because participants gave similar or almost similar responses. The researcher kept personal and reflexive notes which provided a thick description of data collected and could be used to trace the methods used in order to ensure an audit trail.

3.11.3 Confirmability

Confirmability refers to the potential for congruence between two or more independent people about the accuracy of data, relevance and meaning (Lincoln and Guba 1985). The researcher developed and maintained an audit trail to ensure the confirmability of data by reporting and describing the entire research process and ensuring that data would be securely stored for availability should the need arise. There was ongoing documentation regarding the researcher's decisions about data analysis and the collection process. Documentation from the audit trail included the recorded information on the tape recorder and the field notes about the process of data collection. All these records were kept should there be a need for re-analysis by others. This was achieved by including large amounts of data in the written report to show data objectivity and neutrality. Confirmability was also achieved by means of obtaining direct and often repeated affirmations, of what the researcher heard with respect to the experiences of research participants regarding access to and utilisation of ANC services in the KwaMkhizwana area.

3.11.4 Transferability

Lincoln and Guba (1985) referred to transferability as the generalisability of data as the extent to which the findings can be transferred to have applicability in other settings or group. The researcher ensured transferability of the results for this study by providing a thick description of the research setting and research processes. This confirmed the transferability and authenticity of the study, making it possible to build on these findings when performing further research. A rich and vigorous presentation of the findings, together with appropriate quotations by participants, also enhanced transferability.

3.11.5 Authenticity

Polit and Beck (2012: 720) indicated that authenticity is the extent to which qualitative researchers fairly and loyally show a range of different realities in the collection, analysis, and interpretation of data. The researcher strove to ensure authenticity by using direct narratives from the study participants. This ensured that the 'feeling' tone of the study participants was conveyed as it was lived.

3.12 ETHICAL CONSIDERATIONS

As espoused by Burns and Grove (2009: 61), ethics is the one part of philosophy that deals with morality. Polit and Beck (2012: 727) defined it as a system of moral values where research procedures adhere to professional, legal and social obligations to the study participants. The researcher conducted this study after ethics clearance had been received from the Institutional Research Ethics Committee (IREC) (159/15) (Appendix 1), so as to ensure full ethical research adherence.

Data collection commenced only after permission was granted from the District Manager of the eThekwini Health District (Appendix 2b), the KZN Department of Health (Appendix 3b), and the Head of Health Unit of the eThekwini Municipality (Appendix 4b) respectively. This was following initial discussions of the research project and permission to utilise identified study settings. The information letters given to pregnant women participants were available in English and IsiZulu, which are the two main official languages used by this

community in the eThekwini district (Appendices 5a and 5b). The letters outlined the aim of the study and the data collection process.

Participants from Phase 1 gave informed consent, which was written both in English and IsiZulu (Appendices 5a and 5b). Phase 2 participants also consented in order to participate in the study (See Appendix 6). Participants were informed that they had the right to withdraw from the study at any point in time and that there would be no penalty. Permission was sought from the participants to use an audio recorder to record the interviews. The researcher was ready to deal with and risks or emotional distress that could have been aroused in participants, particularly the pregnant women, as she is a trained experienced midwife and counsellor by virtue of her profession. All paper-based data was kept under lock and key and will be stored for a minimum of five years; it will then be destroyed by shredding. All electronic data will be stored on a computer and secured with a personal private password known only by the researcher; the data will be deleted from the computer after five years.

3.13 SUMMARY OF THE CHAPTER

This chapter reflected on the research methodology, the theoretical framework and ethical considerations used in the study. The following chapter will present the results of the study.

CHAPTER 4

PRESENTATION OF RESULTS

4.1 INTRODUCTION

The previous chapter outlined the methodology adopted in conducting the study. Chapter 4 presents the findings of the study, highlighting the themes and sub-themes that emerged from the interviews with the pregnant women and the nurses with regard to access and utilisation of ANC services in KwaMkhizwana rural community area.

4.2 SAMPLE REALISATION

Data was collected in two phases from February to March 2016. A total of four study sites were used which for the purpose of this study are referred to as site A, B1, B2 and C. Data for Phase 1 was collected from the pregnant women in all four study sites and Phase 2 data was obtained from the nurses at study sites A, B1 and B2. The sample size for both phases was guided by data saturation.

During Phase 1, a total of fifteen pregnant women were interviewed. Data saturation was reached after nine interviews were conducted and further six more interviews were conducted in order to confirm data saturation and to ensure that data was collected from all identified study sites. During Phase 2, a total of nine nurses were interviewed. Data saturation (which was concurrently monitored for all the study sites) was reached after five interviews were conducted. Four further interviews were conducted to confirm data saturation. Table 4.1 represents the sample realisation for the current study.

Table 4.1: Sample realisation for the current study

Data collection phase	A	B1	B2	C	Total
1	3	4	4	4	15
2	4	2	3	N/A	9

4.3 DEMOGRAPHIC DATA

All the pregnant women were black Africans between the ages of 20 and 39 years, of which four were married and eleven were single. Most women had been pregnant before and only five were pregnant for the first time. All the participants stated that they were already attending an ANC clinic. The majority had first initiated ANC either during the second or the third trimester. There were two exceptions, who stated that they initiated ANC during the first trimester. The interval for clinic visits was four weeks for the majority of participants, except for the two participants who said the interval for clinic visits for them was 2-4 weeks.

A total of six women had studied up to between grade three and seven (primary school education level), and nine had studied up to grade 10-12 (high school education level). None of the participants had pursued tertiary education. Two participants were employed as domestic workers and the rest were unemployed. Only one pregnant woman was still schooling. Table 4.2 presents the demographic data for all the participants who were included in the first phase of the study.

Table 4.2: Demographic data of the pregnant women

Participants in No. as per study sites code	Age in years	Marital Status	No. of pregnancies	Previous deliveries	Current age of pregnancy in months	Attending ANC	Gestational age at 1st visit in months	Interval between clinic visits in weeks	Level of education in grade	Employment status	Still schooling
A:P1	36	M	4	3	8	Yes	6	4	4	No	No
A:P2	29	S	1	0	5	Yes	4	2-4	5	No	No
A:P3	32	M	3	2	6	Yes	4	4	4	No	No
B1:P1	39	M	4	3	8	Yes	6	4	3	No	No
B1:P2	34	S	2	1	4	Yes	5	4	11	No	No
B1:P3	26	S	2	1	4	Yes	3	4	12	No	No
B1:P4	20	S	2	1	4	Yes	4	2-4	11	No	Yes
B2:P1	20	S	1	0	6	Yes	4	4	12	No	No
B2:P2	27	S	3	2	6	Yes	5	4	12	No	No
B2:P3	23	S	2	1	8	Yes	1½	4	12	No	No
B2:P4	39	M	1	0	4	Yes	1	4	10	Yes	No
C:P1	24	S	1	0	6	Yes	5	4	12	Yes	No
C:P2	28	S	1	0	7	Yes	5	4	11	No	No
C:P3	28	S	3	2	7	Yes	5	4	6	No	No
C:P4	19	S	2	1	8	Yes	4	4	5	No	No

Key: *M=married S=single*

All the participants who were included in the second phase were the nurses who were working at study sites A, B1 and B2. The participants comprised six professional nurses/midwives (PNs/RMs), two enrolled nurses (ENs), and one enrolled nursing auxiliary (ENA). Their ages ranged from 28-55 years, and their years of service as qualified nurses were from 5-38 years. All the participants were females except for two males. Table 4.3 below presents the demographic data of all the participants who were included in phase two of the study.

Table 4.3: Demography and categories of nurses

Participants in codes	Nursing category	Health post	Gender	Age in years	Years of service

N1	PN/RM	A	F	46	24
N2	ENA	A	M	55	33
N3	PN/RM	A	F	50	30
N4	EN	A	F	28	5
N1	EN	B1	M	35	15
N2	PN/RM	B1	F	38	14
N1	PN/RM	B2	F	63	38
N2	PN/RM	B2	F	31	10
N3	PN/RM	B2	F	50	32

Key: *PN/RM=professional nurse and registered midwife, EN=enrolled nurse and ENA=enrolled nursing auxiliary*, *F= female, M= male*

4.4 OVERVIEW OF MAJOR THEMES AND SUB-THEMES

Similar themes and sub-themes emerged from the two data sets. Data from the two phases are therefore presented concurrently and highlights are made where the data complement or contradict each other.

4.4.1 Major Themes

There were six major themes that emerged from the data:

Major theme 1: Access to health care and emergency services.
Major theme 2: Availability of human and material resources.
Major theme 3: Social and cultural beliefs.
Major theme 4: Past pregnancy experiences.
Major theme 5: Communication and transparency regarding service delivery.
Major theme 6: Quality of ANC services.

4.4.2 Major Themes and Sub-themes

Several sub-themes emerged from the interviews in line with the six major themes. The themes and sub-themes are presented in Table 4.4 below.

Table 4.4: Themes and sub-themes that emerged from the interviews

Major themes	Sub-themes
1 Access to health care and emergency services.	1.1 Health Care facility operation days.
	1.2 Health Care facility operation times.
	1.3 Transport and financial issues.
	1.4 Number of clients accepted per clinic session.
	1.5 Provision of services per clinic session.
2 Availability of human and material resources.	2.1 Availability of nurses and other categories of staff
	2.2 Treatment and other supplies
	2.3 Availability of maternity case record cards.
	2.4 Designated nurse to attend to the pregnant women.
	2.5 Health care facility infrastructure
3 Social and cultural beliefs.	3.1 Traditional and cultural norms and beliefs regarding ANC attendance.
	3.2 Clients awareness regarding importance of ANC attendance.
	3.3 Peer and community influence regarding ANC attendance.
	3.4 Approval of Pregnancy by parents and community.
4 Past pregnancy experiences.	4.1 Previous experiences in the local health care services.
	4.2 Previous Pregnancy outcome
	4.3 Attitude of staff towards pregnant women.
5 Communication and transparency regarding service delivery.	5.1 Information regarding service days and operational hours.
	5.2 Information regarding services provided in the local health care facilities.
	5.3 Information regarding clients' rights to health care.
	5.4 Information regarding importance of ANC clinic attendance.
	5.5 Information regarding other relevant health issues
6 Quality of ANC services.	6.1 Organisation of health care services.
	6.2 Provisions for pregnant women when clinics are closed.

4.5 PRESENTATION OF STUDY FINDINGS

The study findings are presented according to the major themes and sub-themes.

4.5.1 Major Theme 1: Access to health care and emergency services

The participants reported that there was limited access to all the available health services in KwaMkhizwana rural community, which led to limited utilisation of these services. This was evident in the following statements shared by the participants that were interviewed during the first phase of the study:

> *"…Health Post B1 is rendering services only on Wednesdays and when we need help during the other days we are forced to go to other clinics. Most of the time we use clinic D because it is always opened."* (B1: P3).

> *"…I therefore do not use either clinic B1 or B2 because they are opened only once a week worse with clinic A because it opens once a month."* (C: P1).

> *"…Each time when it is towards my clinic day I leave home to go and stay with the relatives that live closer to the clinic that I now use to make sure that I am able to attend the clinic. When it is my delivery month I will stay with them permanently so that I am closer to my place of delivery in case I go into labour"* (B2: P2).

The participants highlighted various reasons for inaccessibility of ANC services. These were with regards to clinic operational days and times; transport and financial issues and the number of clients accepted per clinic session.

4.5.1.1 Sub-theme 1: Health care facility operation days

The Phase 1 participants stated that the health care services in the area were inaccessible due to limited operation days. They also stated that the two health posts operated once a week and the third one, which is a mobile clinic, operated once a month. The three were situated very far from each other and therefore each was responsible for servicing the community from a specific tribe, as there

are seven tribes in the area. It was almost impossible to attend just any of the three. Both the interviewed pregnant women and nurses had similar opinions regarding this aspect. This was evident in the following quotations from the Phase 1 participants:

> *"…I do attend here but the problem arises when I need services not on a Wednesday then I have to go to clinic D which is outside this area even when I need emergency services I have to hire a car to go to clinic D or even go straight to hospital"* (B1: P2)

> "…*I have high Blood Pressure (BP) therefore, when I am told to go back to the clinic to check BP may be in 2-3 days, there is a problem. I can't go to clinic A although it is opened on Thursday because it is too far so I either must go to clinic D or any other clinic in town or else wait for the following Monday.*" (B2: P4).

The following statements from Phase 2 participants attest to the problem of inaccessible health care due to limited clinic operational days, as stated by the Phase 1 participants:

> *"…Well I think the fact that we open once a month have a huge impact on the number of ANC cases that we see…."* (A: N3).

> *"…We get very few clients coming for ANC, may be it is because we are only opened once a week"* (B2: N1).

> *"…Well maybe the dates they are given elsewhere do not match the first Thursday of the month so that they can come to our clinic, who knows this could be the reason of the low numbers that we see for ANC."* (A: N2).

4.5.1.2 Sub-theme 2: Health care facility operation times

The participants related their concerns about the limited operation times of the health post, which according to them led to inaccessibility of the ANC services.

The majority of the participants from Phase 1 stated that they had resorted to using the health care facilities situated outside the KwaMkhizwana community

area because these facilities had more accessible clinic operation times. The direct quotes below support that clinic operation times contributed to ANC services being inaccessible and not being utilised.

> "…. *I like to use health post B1; the only problem is that even on a Wednesday; it starts late and closes early. So if you are a bit late there is a problem."* (B1: P2).

> *"……They (referring to staff from health post B2) come late sometimes after 9 in the morning and they leave early by 2 in the afternoon they are long gone…..that is why I use clinic D because they are open at all times even at night and on weekends".* (C: P1).

The statements from Phase 2 participants concur that health care services were inaccessible due to operation times. According to these participants this also contributed to the small number of ANC clients accessing and utilising health care facilities in the community. Participants in Phase 2 concurred with Phase1 participants that there were no set times to start and leave after a day's session, as reflected in the excerpts below:

> *"….The clinic is only open once a week on a Wednesday at health post B1 and once a week on a Monday at health post B2 and we leave soon after the clients are finished there is no set time to leave."* (B1: N2).

> *"….I thinks because we do not operate as a fixed clinic we do not start at seven and close at four just like most usual clinics this contributes to the small numbers that we see and us not having set times for starting and closing."* (B2: N3).

> *"Maybe because we come once a month and we leave as soon as the clients are finished, this may contribute to our mobile clinic not being used by pregnant women.*" (A: N4).

4.5.1.3 Sub-theme 3: Transport and financial issues

Participants from Phase 1 verbalised that they had transport and financial challenges that interfered with them accessing the ANC services. With regard

to transport, they stated that there was not enough transport and mostly transport was available during the early hours of the mornings and later hours in the afternoon. This was because it was mainly for people travelling to and from work. There was hardly any transport during off-peak hours. There were no buses, only public taxis. Transport fare was also very expensive because the taxis charged a flat fee for going to town, even if you were not going there. This was noted in the following excerpts by Phase 1 participants:

> "*….The clinic is far with no available local transport and it's expensive and this is a challenge as I am not working."* (B1: P4).
>
> "*It is costly to go to clinic D which is outside this community; it cost R12 per trip which means I must have R24.00 each time I need to attend the clinic."* (C: P1)
>
> *"……When staying in this community I must have money to hire a car because even an ambulance does not come so when you are not working it is hard and you may not get services or urgent help."* (B1: P2)
>
> *"….Apart from being expensive, getting transport to the clinic is a challenge; one is fighting and pushing for space in the taxi together with people going to work; it is not safe for us being pregnant."* (C: P3).
>
> "….*It's either you must get up as early as five o'clock or else you will not get transport because there is hardly any during the day. The sad part is that even if you finish early you will have to remain at the clinic until late in the afternoon to get a taxi back home, so frustrating."* (A: P4).

4.5.1.4 Sub-theme 4: Number of clients accepted per clinic session

The Phase 1 participants indicated that the number of clients who were accepted at the health post during each clinic session was a contributory factor for inaccessible health care services. Some participants were concerned about clients being too many, while the other participants stated that very few clients were accepted. These were expressed as follows:

"….S*hame! I feel sorry for the clinics staff, there is usually so many of us, all coming with different problems , that is why most of the time they do not manage to attend to all of us."* (A: P3).

"….But it is not fair; you wake up to travel all the way only to find that the nurses tell you that they cannot see you because they have taken enough number of patients for the day." (B2: P3).

"....I just fail to understand….It is like we do not have a clinic at all; they come once a week and worse; nurses see few clients and then announce that they are full they cannot accept any more clients; so you have to wait till the following week with no guarantee that you will be accepted even that day." (B1: P2).

There were a few of the Phase 2 participants whose statements contradicted the information by the Phase 1 participants stating that they see all clients that come to the clinic for health care. This was evident in the following statements. *"We do not operate like a fixed clinic, we only come once on a first Thursday of the month but we see to all clients that present to the clinic for care".* (A: N3)." *"Because we are not a fixed clinic client's think we have inaccessible health care, I think that's why ANC clients do not come to our mobile but whoever comes to our clinic when we are there gets the health care they need".* (A: N1)

4.5.1.5 Sub-theme 5: Provision of services per clinic session

The pregnant women participants were not in favour of being combined with the clients who came for other health care services when they came for ANC. They claimed that this led to long waiting times at the clinic, especially when there was not enough staff in the health posts. The following excerpts highlight the views of the Phase 1 participants in this regard:

"….On my first ANC visit I attended health post B2 just to get the ANC card and will continue elsewhere, the reason is that only one nurse attends to all clients and we all have different problems coming for

different things and we end up waiting a long time before being attended" (C: P2).

"….We were holding one queue with all other clients but we were only two who were pregnant, the nurse said "lucky you are not first time ANC clients because I am alone today so I will only see few clients." (B2: P2).

One Phase 2 participant agreed that health care is inaccessible due to the provision of more than one service during one day in the health posts. This is supported in the quotation below:

"…Let's say you have sixteen clients waiting, two are ANC clients, others are sick babies, sick adults and geriatric clients coming for their medications ……may be the two ANCs will need pap smear as they may be above 30 years and also need HCT and when they test positive the pulling of bloods must be done by this time the pressure is rising because you are working alone which sometimes tempts you to send them away and tell them to come back the following week for the care that was not done e.g. come back next week for pap smear otherwise….." (B1: N2).

4.5.2 Major Theme 2: Availability of human and material resources

Quality, safe and appropriate health care can only be provided if there is access and availability of essential resources for the different PHC programmes. The participants shared their concerns about the limited/unavailable resources in the health care facilities in KwaMkhizwana compared to the other health care facilities outside the area. Various human and material resources were reported by the participants as lacking in the health care services in the area. Some of these included staff; treatment and other supplies; maternity case record cards; designated nurse to attend to the pregnant women; infrastructure; and equipment.

4.5.2.1 Sub-theme 1: Availability of staff in the health care facilities

The study findings revealed that there were staff shortages in the health posts; this was revealed by both the pregnant women and the nurses. It as evident from the comments of the Phase 1 participants that this for the majority of pregnant women was one of the deciding factors as to where the pregnant women will seek ANC. The delays of seeking and reaching care by pregnant women were linked to the limited staff allocated to the health posts and the mobile clinic within this rural community. The voices from Phase 1 participants below confirmed the shortage of staff in the health care facilities in KwaMkhizwana rural community:

> "….*At clinic D there is an HIV Lay counsellor that offers information about testing and all get tested and this is very important when you are pregnant ….I do not think a counsellor is available at health post B1 as only limited staff comes and I have not seen any one doing same duty here. At clinic D, most of the time there are two or more nurses attending just to the pregnant clients only. This does not happen here at this clinic one or two nurses attend to everyone."*(B2: P1).

> *"….Only one nurse attends to all clients that are waiting and this takes long about 5 to 6 hours; you are lucky if there are two nurses. Hai!.. This is what was I observed with my first pregnancy and for my second pregnancy I just decided to go somewhere else even if it meant travelling far and paying for transport"* (B2: P2).

> *"….Even with my first pregnancy I used clinic B2….. There is always just two nurses working, one nursing sister and one other nurse who only gave us injections…."* (B2: P3).

This was supported by the views of nurses who reported that staff shortages were amongst the challenges facing nurses working in the health care facilities in the area:

> *"….Here, I work alone as a nursing sister and do everything and this increases the amount of work that I do"* (B2: N2).

"….I work alone and do everything and the workload increases… include doing pap smears, pulling bloods and everything else; it is worse when I have a client needing emergency care the queue will not move." (B1: N2).

4.5.2.2 Sub-theme 2: Availability of treatment and other supplies

The study findings revealed that the unavailability of treatment and supplies influenced access to and utilisation of ANC services. This was evident in the following statement by one of the participants:

"…. I prefer to attend at clinic D because they always have medications for us" (B2: P1).

"…What compounds our problem is when besides all the other challenges, you get to be seen by a sister and at the end the sister tells you there is no medicine, it is out of stock, either come back next week, or go to another clinic or even say go and buy it." (C: P1).

The Phase 2 participants attested to that the supplies that were reported lacking influenced reaching and receiving care by pregnant women. The following views were shared by the participants in this regard:

"….We do pregnancy test, diagnose and start ANC and do HCT if it is positive we then refer to the nearest clinic as we do not initiate ARVs in mobiles. May be that is the reason why we get very few pregnant women coming to us because they know they will still be referred so that just go to clinic D on their own" (B2: N1).

"….yes occasionally but not always we do run out of stock. It depends on the number of clients that we get per day which is usually very difficult to predict" (A: N3).

Some of the information shared by Phase 2 participants was contradictory. While others stated that certain types of medication were not kept in the heath post and mobile clinics (as is indicated in the statements above) others stated

that it was kept but for selected type of clients (as indicated in the statements below:

> *"….We do pregnancy test, diagnose pregnancy and start ANC and do HCT if it is positive we then initiate ARVs. This is the only time we initiate ARVs in health posts; we only initiate ANC clients other clients get referred."* (B1: N2).

> *"….There was a time when we did not have pregnancy test kits and could not test for pregnancy this mostly affected our defaulting Family Planning (FP) clients, therefore, these clients were referred to nearest clinic."* A: N3).

4.5.2.3 Sub-theme 3: Availability of maternity case record cards

The unavailability of maternity case record cards contributed to delay in accessing and receiving ANC care. The clients were not attended to because there were no maternity case record cards onto which to record the consultation and other health care procedures. The pregnant clients who presented for ANC for the first time were not accepted and those or who were diagnosed in the health facility as being pregnant were sent home without being offered first ANC consultation. The following direct quotations from a pregnant woman attest to this:

> *"….I came last Wednesday and I was told to come back the following Wednesday because there were no ANC cards"* (B1: P2).

> *"….I went to mobile clinic A because it is within a walking distance from my home luckily it was the first Thursday of the month and I suspected that I was pregnant, but after pregnancy test was done and was positive I was told I could not start ANC clinic that day because there were no ANC cards but I was told to go to the nearest clinic ……"* (B2: P4)

This was attested by the Phase 2 participants who stated that when maternity case record cards were unavailable, ANC clients were rescheduled for the next date or asked to go to other health care facilities.

"….Not that we do not attend to them at all when there are no cards but we always tell them to come back the following week and we try and prioritise them when they come like we see them first." (B2: N1).

"…remember we carry everything in the mobile van an so we cannot carry big stock, we take a little of everything, so we do run out of stock for the cards and unfortunately there is no way that we are able to see them without cards it is illegal where do we record? I t is safer to defer the consultation" (B2: N1).

4.5.2.4 Sub-theme 4: Designated nurse to attend to the pregnant women

Most pregnant women commented that the fixed clinics have a designated ANC section with a nurse who is assigned to attend to pregnant women only. However, the set up was different in the health posts, all clients were seen together and there was just one professional nurse to do consultations for all the clients. This was evident in the following excerpts by some of the Phase 1 participants:

"….Well here one nurse sees to all clients we hold one long queue in the same waiting area unlike in clinic D where there is a separate ANC area and two nurses to attend to the pregnant women." (B2: P1).

"….I went to health post B1 once just to get an ANC card, the queue was so long and only one nurse was seeing to everyone. We were all following one queue which was moving very slow. I spent the whole day at the clinic." (C: P4)

"….I attended health post B2 for my second pregnancy. There was only one nurse and all clients had to wait for her. Sometimes we would wait for five to six hours before we were seen. The clinic where I am attending now has a separate section for ANC services and more than two nurses attend to the pregnant women. The queue goes faster." (B2: P2).

Three participants from Phase 2 supported the above pregnant women's view which is highlighted in the statements below:

"….I overhead the pregnant woman in the waiting area commenting that the reason why she did not like to come to this health post was because the pregnant women are made to follow the same queue with all other clients and this takes longer because only one nurse is working." (B1: N2).

"…. I think pregnant women prefer clinic D because they are seen at the ANC section and by a designated nurse (nursing sister) who only see to pregnant women." (B1: N1).

"….Pregnant women prefer clinic D because they are attended by nurses only designated to antenatal clients and in a designated ANC section, this only happens in bigger fixed clinics, it is not possible here." (B2: N2).

4.5.2.5 Sub-theme 5: Health care facility infrastructure

The participants interviewed during the first phase of the study indicated that the mobile clinic and health posts had limited space compared to the other clinics. They also indicated a shortage of ablution facilities. The following statements by some of the participants highlight the views of the participants in this regards:

"….If they can build a big clinic may be it will be better this one is small with one waiting area for everyone." (B2: P1)

"….The clinic that I am currently using is much bigger than this one. It has a separated ANC section and adequate toilet facilities unlike health post B2 which is very small and with just one toilet." (B2: P2).

"….I attended the clinic nearer to where I work, that is where I initiated my ANC visits and it is big with a separate area for pregnant women." (B1: P1).

The Phase 2 participants who were nurses alluded to the views of the Phase 1participants regarding limited space in the health posts and mobile clinic. The following quotations highlight the views of the Phase two participants in this regards

"….Our health post is very small with only three consultation rooms and one small waiting area that all clients share and a portable outside toilet which is shared by the staff and the clients ….the actual fact is that we do not have a toilet in this health post." (B1: N4).

"….*ANC consultation is not just like any other consultation; a lot of material resources are required. It is very difficult to examine a pregnant client in a mobile van, almost impossible…..really for ANC we need to have a fully set room with all the necessary equipment like a couch, screen, foot stool, desks, chairs etc. and even asking the highly pregnant woman to climb into the mobile van, no, no, it is really high risk; you are scared because medicolegal hazard, may occur."* (A: N1).

"The challenge is we do not have a room we work from a mobile van, even examination of clients is done there, space is so limited…It is very difficult for the majority us as nurses to climb into the mobile van and what about the client worse when she is pregnant." (A: N2).

"….Our mobile van is not fully designed for examining pregnant women and she can fall in the process the couch is small we can't even do a Pap smears comfortably as the space does not allow free movement." (A: N3)

"……The health post is too small just the size of the match box, they converted a very small residential dwelling into a clinic. It is really not ideal all the rooms are abnormally small" (B1: N1).

4.5.3 Major theme 3: Social and cultural beliefs

The theme of social and cultural issues emerged as participants described elements of delays in seeking and reaching care. There were four sub-themes that emerged from this major theme: a) traditional and cultural norms and beliefs regarding ANC attendance; b) ignorance of clients regarding the importance of ANC; c) peer and community influence regarding ANC; and d) fear of the parents and the community.

4.5.3.1 Sub-theme 1: Traditional and cultural norms and beliefs regarding ANC attendance

Participants interviewed at all study sites reported cultural beliefs that existed in the community with regards to pregnancy and pregnancy management. It was noted that most of these cultural beliefs influenced both access to and the utilisation of ANC services. The majority of them believed in witchcraft with fear of being bewitched being one of the reasons that pregnancy was kept a secret during early months. Most of the pregnant women participants believed that the earlier the pregnancy status is known by other members of the community, the higher was the risks of being bewitched and that this can lead to the risk of losing the baby. This was evident in the quotes below:

> *"…..You cannot start ANC early, it is not safe at all, not in this community; because people, including your enemies, will see you going to the clinic and get to know that you are pregnant…. you may be bewitched and end up losing the pregnancy."* (B1: P2).

> *"….Although I started ANC clinic just after three months I did not use health post B1 which is nearer to my home but I went to clinic D which is outside this community because nobody knows me there therefore, no one will bewitch me."* (B1: P3).

> "….*Starting ANC clinic too early is a problem, you can't be seen early in the community that you are pregnant, you may lose the baby."* (B2: P1).

> *"…. We have heard that pregnant women had miscarriages and babies have been lost; a lot of witchcraft exists in our community and it does work. That is why I make sure nobody knows until my pregnancy is advanced, I do not even go to the clinic."* (A: P3).

> *"….It is a norm that we do not disclose pregnancy status before they (people) suspect because witchcraft exists and it is worse when pregnant ….you may have miscarriages and no woman wants that."* (C: P3).

It was evident from the statement made by Phase 2 participants that the nurses working in this community were aware of this cultural belief. This was evident in the following statements:

> *"….When I asked the community care givers (CCGs) why were the pregnant women not coming to our clinic, they told me that may be it was because of a cultural belief that a pregnant women is not supposed to disclose early when she is pregnant and cannot attend clinic in the area because she may be bewitched and lose the baby* (A: N3).

> *"Clients here in this community have their own cultural views regarding when and where to attend ANC."* (B1: N1).

4.5.3.2 Sub-theme 2: Clients awareness regarding importance of ANC attendance

It was evident from the comments made by Phase 1participants that some of them were not aware of the importance of attending ANC clinic. Some of them only attended the clinic to get an ANC card which they called" booking the bed"; so that they could deliver in hospital

> *"I attended once at health post B1 just to get an ANC card, after that I continued with my private doctor as you cannot risk attending in the community….but at least I know I will get a bed to deliver in hospital."* (C: P2).

> *"….At 7 months when I stopped work I also stopped going to the clinic hence I will only go when I deliver."* (B1: P1).

> *"….I have been to the clinic about two times and they said all is fine so from now I will only go to hospital to deliver, I can't continue going to the clinic, after all there is nothing much that they do except touching on my tummy"* (C: P3).

In support of the above views from pregnant women, nurse participants stated that:

"….the pregnant women from this community do not really see the importance of attending the ANC clinic because they do not attend regularly, they disappear after the first visit" (A: N2).

"…They start the clinic very late and some of them do not even attend regularly, most of them deliver at home. It is like this community do not acknowledge the importance of attending ANC clinic" (B2: N3).

"… It is sad that we do not have time to give health education but I feel the community here needs a lot of information regarding the importance of ANC" (B1: N2).

4.5.3.3 Sub-theme 3: Peer and community influence regarding ANC attendance

The study findings revealed that there was peer and community influence regarding ANC. This is evident in the statement reported by participant from the first phase of the study:

"…*Most pregnant women from here attend clinic D therefore I also attend there. I don't know why but also this clinic is only opened on a Wednesday and may be that is the reason why it is not used so I also do not use it."* (B1: P3).

" ….You hardly see a pregnant women coming to this clinic to check the pregnancy , most of them go to the big clinics , so I feel it is safer to do the way other people do" (B1: P3).

"…..I am currently going to a private doctor every month. All my friends and relatives who have been pregnant first attended the doctor until they were at least six months pregnant thereafter moved to the city to attend the clinic there; none of them have used the clinics in this area, they say it is not safe to attend here….not sure why" (C: P1)

The peer and community influence regarding ANC attendance that prevailed in the community was also witnessed by the nurses who were working in the area. A participant from the second phase stated that:

> *"…I think pregnant women convince each other to visit clinic D. May be it is because they think services of the fixed clinic are better than those of health post."* (B2: N1).

4.5.3.4 Sub-theme 4: Approval of pregnancy by parents and community

The findings of the current study revealed that young pregnant women feared disapproval from parents, relatives and other community members regarding their pregnancy status especially those whose pregnancy was unplanned and out of wedlock. They felt attending ANC will result in unintentional disclosure of their pregnancy status before they were being fully prepared to do so. This was evident in the following statements:

> "….*If you suspect pregnancy urine gets tested and if you are pregnant you are then given the big ANC card to start clinic and all other clients including family members recognise the card and see that you are pregnant."* (B2: P1).

> *"….Although I started as early as 7 weeks my partner and I went for ANC to the clinic far away from home. I did not want to attend in the area because I did not want my mom to find out. I even gave the maternity card to my boyfriend to keep because I was still hiding my pregnancy."* (B2: P3).

The nurse participants shared the same views in support of what pregnant women participants reported regarding a fear of parents and the community:

> *"….They (pregnant women) leave the clinic and go if they see relatives or mother-in-law entering the clinic."* (B1: N1).

"….*I guess because this is a closed community they are afraid of in-laws and friends so they go elsewhere ….. We rarely get follow-ups even those we initiate ANC they disappear."* (B2: N2).

"….*They have fear of being known in the community that they are pregnant therefore, I think that is why they do not use our health posts."* (A: N2).

4.5.4 Major theme 4: Past pregnancy experiences

It was evident from the comments by the Phase 1 participants that their past pregnancy experienced influenced their decision to attend ANC services. The bad experiences and attitude of clinic staff towards them were the two common experiences that according to the participants made them not to be keen to attend the local clinics. On the other hand the clients whose previous pregnancies were without complication stated that they did not see the need to attend the ANC clinic.

4.5.4.1 Sub-theme 1: Previous experiences in the local health care services

Several Phase 1 participants commented that they were not keen to attend ANC in the local health care facilities because of the bad experiences that they or other fellow community members had experienced in these facilities. The previous bad experiences included what they considered as maltreatment by staff, lack of resources that led to untoward pregnancy outcomes and transport problems. The majority decided to attend ANC elsewhere in an attempt to avoid these problems recurring

"….*I was attending health post B1 for my second pregnancy and had to go to deliver in the hospital that is very far when I was in labour. I delivered in the car on the way to hospital and I was so scared I could have lost my baby. This is why I have decided to use a clinic where I am*

able to attend while I am pregnant and will also be able to give birth there." (B2: P2).

"….*We like to stay and access services in our community but even the ambulance fails to reach the area and they say they get lost. My sister waited for the whole night for the ambulance and ended up giving birth at home and the baby died. I cannot take that chance so I am staying with my relatives in the city attending clinic there….."* (B2: P2).

"….During my last pregnancy I was scolded and criticised by the hospital for late booking and poor ANC attendance yet it was not my fault but it was because of how this clinic is working. I cannot make this happen again I am an adult and do not like to be scolded as a child so I rather pay transport fare to go and attend clinic D. It is also safer for me and my child the clinic." (C: P3).

4.5.4.2 Sub-theme 2: Previous pregnancies outcomes

Several Phase 1 participants claimed that it was not necessary to attend for ANC when the previous and current pregnancies had no complications. This was evident in the following statements made by the participants:

"….When I stopped work at seven months I stopped going to the clinic and because I have no pregnancy problems I will no longer go to clinic but wait and go to deliver ….well even with my previous pregnancies I had no problems, I do not usually have pregnancy problems hence I do not attend ANC regularly as long as I go just once or twice to book for the delivery bed." (B1: P1).

"….*When I don't have money I do not go to the clinic after all there are no problems with my pregnancy and same things are done every time"* (C: P4).

"…..as long as I see my tommy is getting bigger I know the baby is growing and I have been pregnant before I can sense when something is wrong and can feel the baby kicking. This is my fifth pregnancy and I

have never experience any problems during pregnancy and delivery so even if I do not go to the clinic I know nothing will happen" (C: P1)

4.5.4.3 Sub-theme 3: Attitude of staff towards pregnant women

Some of the Phase 1 participants commented about the attitude of staff in the local health care facilities towards clients which according to these participants was not good. According the pregnant women the clinic staffs were sometimes rude on the clients, scold them and continuously complained about being short staffed and overworked. The statements below support the claims made by pregnant women participants.

"….At health post B2 different nurses comes every week nurses (nursing sisters) some have attitude and say seeing to pregnant woman takes longer especially when they are first visits. And the sister will complain continuously until she is done examining you" (B1: P2).

"….I attended clinic B2 with my previous pregnancy there was this one nurse who always had a bad attitude; she will say 'do not to ask too many questions during consultations I do not have time' and you could also tell from her facial expression that she really did not have time" (B2: P3).

"….Not all nurses like to see to pregnant women some do not even smile. It is like they hate attending to pregnant women. Others even say it that it is not easy when working alone to attend to the pregnant woman because there is so much to do and it takes a lot of time." (B2: P3).

4.5.5 Major theme 5: Communication and transparency regarding service delivery

In the current study the Phase 1 participants stated that the delay in receiving ANC emanated from poor communication and lack of transparency regarding service delivery. There was evidence of lack of information given regarding service days and operational hours; services provided in the local health care

facilities; client's rights to health care; importance of ANC clinic attendance and information regarding other health issues.

4.5.5.1 Sub-theme 1: Information regarding service days and operation hours

The findings of the current study revealed that there was a lack of information regarding service days and operational hours by health posts. This was pronounced by pregnant women participants as they described in the following statements:

> *"….I was referred to nearest clinic following a pregnancy diagnosis in clinic A, then when I went to attend health post B2 on Monday as I was referred, we waited and at about 10h00 I went to clinic D as B2 staff did not come and nobody knew why they did not come or why there was no clinic.*" (B2: P4).

> *"….I leave home coming to attend clinic only when I see the clinic van parked at the clinic site, this is because if they (staff) are not coming we don't know we just see that there is no clinic van parked at the clinic"* (B1: P2).

> *"….When the clinic is not going to open we do not know we wait and wait and the clinic van does not come then we only we will know that the clinic staff is not coming...this is really irritating "* (B2: P1).

One participant from Phase 2 acknowledged stating that it was hard to inform the health posts if not coming to provide health care services as there are no strategies set for reporting.

"…there is only the two of us (nurses) working in health B1. Thus, when I am off sick the staff nurse does not go to the health post, he cannot work alone unless there is a relief that is allocated from the main office. Poor; clients

they suffer as they do not know when we are not going to come and provide the service" (B1:N2)

4.5.5.2 Sub-theme 2: Information regarding services provided in the local health care facilities

The current study revealed that there was a lack of information regarding services provided in the health posts. Some study participants from Phase 1 stated that very little or no information is given to pregnant women clients attending at health care facilities in the community. Phase 1 participants made this claim in the following statements:

> "*Well this clinic here does not have different areas for different services available like other fixed clinics, e.g. in other clinics there is a TB unit, immunisations, ANC area, FP area and its even written in the doors of the rooms, here this is not available and we are not informed we sit and follow one queue waiting to be seen by one nurse*" (B1: P2).

> *"In big clinics it's written on doors that this room is for ANC clients, FP clients, Injection and blood rooms and where we collect our medications this information is written and we are also told but here only three small rooms are used and all doors not labelled so we don't know what can be provided*" (B2: P1).

> *"Nurses work in a tribal court which is not a clinic and only three rooms are used therefore the doors are not written we don't know what is provided we only say what we came to the clinic for on that day"* (A: P2).

The Phase 2 participants acknowledged that most services are not provided in health posts and mobile clinic hence not much information is provided to clients. There were claims that the services were not provided because of the staff

shortages, and other challenges that nurses face when working in mobiles during the delivery of health care.

> *"We work in the tribal court and we are only allowed to use three rooms and therefore, it is not easy to provide all services and care, I know pap smears are not done, we don't initiate ARVs and doing other examinations is hard due to poor setting and mobile vans too high to climb and not designed to do examinations. Clients do not know what we offer clients will often say I'm here for e.g. Pap smear is it done here"* (A: N3).

> *"We refer newly diagnosed HIV ANC clients in order to be screened and initiated on ARVs, we sometimes refer clients suspected of TB because we come once a week and it will be late to collect and send a sputum a week apart …it's frustrating we have to decide whether to screen for TB or just refer"* (B2: N1).
> *"Even our colleagues thinks that we do not do much work, they even say you leave at 08h00 to go the mobile clinic and by 3pm you are back and you refer mostly for services that you don't provided mh……they don't realise the circumstances we work under "(*A: N1).

> *"Our colleagues working in fixed clinics have a mind-set that we (mobile staff) does not do much work because more services are not provided but the thing is we don't choose to work in mobiles we are placed, I personally think that even our managers have the same mind set when placing and that is why only limited staff works"* (B1: N2).

4.5.5.3 Sub-theme 3: Information regarding client's rights to health care

The study revealed that health information was not given to clients when they attended ANC in the health posts available in the community. Most participants from Phase 1 stated that information regarding patients' rights to health care was not shared with them in the health care facilities available in the community,

except when attending health care facilities outside the area. This is verified by the Phase 1 participants in the following direct quotations:

> "….*When I attended clinic D it was very full and we were not seen until it was around 1 pm we were then addressed by HIV Lay counsellor that most nurses worked last night and we have shortage of day nurses that is why the queue was slow moving …she also said the nurse in charge of the clinic says we can go and come back the next day and we will be seen first unless you are unwell you can wait."* (B2: P3).

> *"….When I attended at health post B2 previously with my first pregnancy HIV testing was either done or not done or was done on certain days…I remember that it depended on the nurse and not all of them offered HIV testing and when you ask about it, you are told that you must ask during the next visit."* (B2: P3).

The nurses interviewed during the second phase attested there was a lack of information given regarding client's rights to health care and this was due to staff shortages, unshared workload and pressure of working alone.

> *"….You can't even give health education about what other services are offered because of workload e.g. educate about Pap smears if all clients want to do the Pap smears this whole workload will be yours alone and may delay the time to finish the clients. When you go home you feel guilty knowing very well you did not do what you were supposed to do"* (B1: N2).

> *"….Health education can be done to encourage ANC clients to attend and this may help increase ANC client's numbers attending but to be honest it is not done in our health posts we are always under pressure yet it can be done."* (B2: N3).

4.5.5.4 Sub-theme 4: Information regarding importance of ANC clinic attendance

The Phase 1 participants who are pregnant women outlined differences in what was done in other health care facilities, which included information given during ANC visits, with what was not done in the health posts in the community. This was clearly revealed by participants from Phase 1 during the findings of the study, confirming that there was a lack of information regarding the importance of ANC and clinic attendance:

> *"Clinic D has ANC classes where a nurse gives health information about pregnancy and the importance of attending the ANC clinic when pregnant but here there are no classes and I think even the nurses here can provide ANC classes because there is lot that we gain about the pregnancy."* (B1:P4)

> *"….Where I'm attending now in the morning we start with group ANC classes every time you attend ANC clinic even with my first pregnancy in health post B2 this was not done, now that I think of it this motivated me to attend ANC visits"* (B2: P3).

> *"….There was no health education given here when I was attending health post B2 for my second pregnancy but now that I relocated and attends elsewhere …….health education is given every morning before nurses start see to us. It is also given on one on one during the consultation with the nurse"* (B2: P2).

Nurse participants added the following statements complementing the views of pregnant women relating to the lack of information given to pregnant women regarding the importance of ANC and clinic attendance:

> *"….We should encourage pregnant women to come to our clinics…this can be achieved through giving health education something that is not usually done in our facilities.*" (B2: N3).

> *"We can involve CCGs to encourage pregnant women to come for clinic attendance in our mobiles because ANC visits are important"* (A: N3).

"We can provide health education to all other clients attending the clinic to inform pregnant women that we provide ANC services and that pregnant women can also get all ANC services in our facilities in this way we will be marketing our ANC services" (A: N1).

4.5.5.5 Sub-Theme 5: Information regarding other relevant health issues

The Phase 1 participants were concerned that the information-giving session was not done in all the three health facilities available within the community. The concerns were based on the fact that health information giving is an old common method used to highlight important aspects regarding relevant ANC health information to strengthen adherence to interventions. These concerns were expressed in the following quotes:

"We gain a lot from the ANC classes we learn about diet and about what causes BP but here in mobile clinic A it is not done, I was only told that I'm pregnant and have BP. I feel that nurses here can also conduct ANC classes and give health information mainly because it is done in other clinics especially in clinic D where I go now" (B2: P4).

"….Where I'm attending now in the morning we start with group ANC sessions every time you attend ANC clinic but this was not done even with my first pregnancy in health post B2" (B2: P3).

"….There was no health education given here when I was attending health post B2 for my second pregnancy but now that I attend elsewhere this is done every morning when you attend ANC as a group and when alone with the nurse." (B2: P2).

"I was told that health information is an old practice done to groups of pregnant women but to my surprise this was not done here (B2) but it's done at clinic D… hey... this is confusing" (C: P4).

The views shared during the interviews with Phase 2 participants who were nurses affirmed that health education was the commonly used and an identified

strategy that could improve ANC services. Health education was not used to enlighten pregnant women on ANC interventions and the importance of ANC services. The Phase 2 participants were also aware that the health education is a widely used strategy to improve maternal outcomes. This was evident following statements:

> *"….We can use the CCGs to mobilise pregnant women to use our ANC services through health education and also alert our chronic clients to tell pregnant women at home or in the community that we offer ANC and pregnant are free to utilise these services."* (A: N1).

> *"….Health education can be done by us and involve the CCGs to encourage pregnant women to use our mobile clinic because may be if numbers increase we can even visit twice a month and even once week and I believe that issues of space and lack of equipment can be sorted once the numbers increase."* (A: N3).

> *"….If the staffing improves health education in the morning will be given freely about all available services without any pressure knowing that the workload will be shared amongst all staff I definitely think that ANC clients from the area attending clinic D will come back to us.*" (B1: N2).

> *"….Well nothing much in health posts that can be done unless in a fixed clinic but may be improved operational days and times may help improve the utilisation of our ANC services."* (B2: N1).

> *"….Maybe if we give appropriate health education of what are the services offered and also come twice a week in the health posts, maybe ANC attendance can improve or have a fixed clinic because all the clients attending clinic D those numbers can be ours."* (B2: N2).

There was one different opinion from a nurse participant working in the mobile clinic with regard to the giving of health information on health issues. The following expressed views refuted all the other views raised by the nurse participants above:

*"……I doubt if any health information can change client's cultural beliefs particularly in this community area. I just think they do what they feel is culturally right for them" (*A: N2).

4.5.6 Major Theme 6: Quality of ANC services

The findings of the current study suggest that the quality of ANC services rendered within the health care facilities in the community is not up to the expected standard. This rural community does not have a fixed PHC clinic, which impacts on the type of services delivered to this community. There were three sub-themes that emerged from the above major theme and these included fragmented and non-comprehensive health care services, provisions for pregnant women when clinics are closed and health education used as a strategy to improve ANC services.

4.5.6.1 Sub-theme 1: Organisation of health care services

The comments from Phase 1 participants indicated that there was no integration of health care services in the health posts and mobile clinic. These local health care facilities were also not providing comprehensive health care services. This resulted to the delays in reaching care by the pregnant women residing within this rural community as the first visit ANC consultations were not provided on the first day the pregnant women presented at the clinic or the very first day that the pregnancy was diagnosed. The following comments by some of the Phase 1 participants are evidence to this:

"…..I wanted to do a pap smear because it was broadcasted on the radio that it is important for every woman to have it done but the nurse told me that they do not do pap smears " (B2: P3).

"….I expected that they will also test me for TB because I had already been coughing for a long time but they said I should go to a big clinic if I want to be tested for TB" (B2: P4).

".I noticed most of the services are not done in this clinic, they only treat minor colds and flu, immunise babies and give treatment for high blood pressure and sugar otherwise for all other problems we are either sent to the big clinic or hospital and unfortunately all the clinics in this area do the same" (B2: P2).

"….The nurses do not allow that you present more than one problem, they say they can only attend to one problem at the time because they have a long queue and limited time" (B1: P2).

The Phase two participants attested to that while they try to attend to the pregnant women but it was not feasible to provide comprehensive care. The logistics in the health posts and mobile clinic such as time, infrastructure and resources did not allow for some health care procedures to be performed. This was expressed in the following quotations:

"….As much as you know and want to do everything for the clients but most of the tine it is not possible the time and space does not allow it." (B2: N1).

"….people need to understand that we are not able to operate like a fully fleshed PHC clinic we can only do so much given the limited human and material resources that we have" (B2: N3).

"….At times we are forced by time and resources constraints to refer the ANC clients to a nearby PHC clinic. We know there is not much that we can do for them in the mobile clinic; cannot test the risk with them, so we just advise them to go and start ANC in the nearby PHC clinic where they are assured a comprehensive care" (A: N4).

"….We do pregnancy test, diagnose and start ANC and do HCT if it is positive we then refer to nearest clinic as we do not initiate ARVs in mobiles (B2: N1).

4.5.6.2 Sub-theme 2: Provisions for pregnant women when clinics are closed

It was apparent from the comments by participants that there were no provisions made by the local health care facilities to cater for the pregnant women during the days when these health facilities were closed. Both the pregnant women and the nurses agreed with each other in this regards. The following statements were made by the pregnant women:

> *"….I went to attend health post B2 on Monday, we waited and waited but the staff did not come and nobody knew that they were not coming on this particular day and no arrangements were made for us for the day, so it was either you go to clinic D or you go home until the next week*" (B2: P4).

> *"….Sometimes the mobile van does not come for the whole moth and we are left without any help and what is worse is nobody tells us that the van is not coming and when they will be coming again every week you will go to the place and wait just in case they come"* (B1: P2).

> *"….The nurses only come once a week and if you are sick during these other days you have a problem"* (B2: P2).

> *"….The main reasons I do not attend in the area is because….. what do you do and where do you go on the days the clinics are not open and I am working , the day I am off the clinic is closed so no luck for me"* (C: P1).

The nurse participants attested that there were no provisions that were made for the community on the days when the clinics are not open. The Phase 2 participants further highlighted that these were some of the reasons why the health care services were underutilised; hence very low numbers of ANC clients are seen:

> *"……Well there are no provisions made for accessing health care services when the clinic is not open. The clients just decide on their own to either use clinic D or go to the nearby hospitals"* (A: N1).

“…..No arrangements can be done on our side as staff but maybe at management level it can but I think these are the reasons for the low numbers that we see because clients just use fixed clinic for its availability” (B1: N3)

“…..there is nothing that we as staff can do, we are allocated for one day per week and during the other days we are out servicing the other points there is nothing much we can do regarding what pregnant women must do when the clinic is closed, until the government decide to building a fixed clinic in the area” (B1: N2).

”…… As much as you understand and feel for the people but there is not so much that you are able to do except just to advise them to attend the nearby clinics”(B2: N2).

4.6 SUMMARY OF THE CHAPTER

This chapter presented the results of the study. The next chapter involves a discussion of the results.

CHAPTER 5

DISCUSSION OF RESULTS

5.1 INTRODUCTION

This chapter presents the discussion of the study findings that were reported during the presentation of results in the previous chapter. The literature used in the previous chapters as well as new relevant literature was integrated to contextualise the meaning of the themes and sub-themes that emerged from the data analysis of the study.

5.2 OVERVIEW OF THE RESEARCH DISCUSSION

The aim of the study was to gain in-depth knowledge in order to determine whether pregnant women from the KwaMkhizwana rural community had access to and were utilising ANC services. The objectives used to achieve this aim included: describing how ANC services were accessed and utilised by pregnant women from the KwaMkhizwana rural community; and an exploration of the factors that influenced both access to and utilisation of ANC services by pregnant women from the KwaMkhizwana rural community.

The discussion of results was based on Thaddeus and Maine's (1994) TDM as a theoretical framework that was used to guide the study. The current study discovered that the three delays as described by Thaddeus and Maine (1994: 1092) which are delay in seeking care, delay in reaching care, and delay in receiving care prevailed in the KwaMkhizwana rural community and interfered with the women from this area accessing and utilising ANC services. Several factors which emerged as themes and sub-themes were responsible for each delay and influenced access to and utilisation of ANC services by pregnant women from this rural community. The six major themes that emerged during the data presentation became the principal factors influencing access to and utilisation of ANC services in the community.

Figure 5.1 below clearly outlines the three phases of the model in relation to the six major themes.

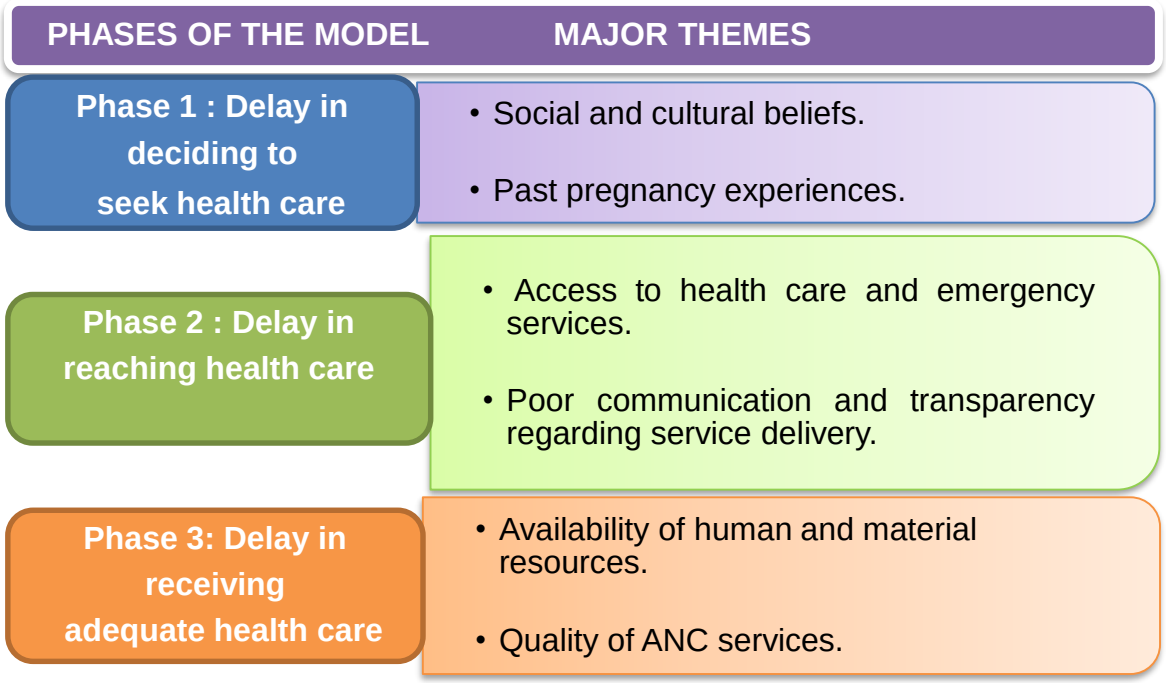

Figure 5.1: Major themes and phases of the model

5.3 PHASE 1: DELAY IN DECIDING TO SEEK HEALTH CARE

There were two major themes that emerged in relation to delay in seeking health care. These were social and cultural beliefs and past pregnancy experiences.

5.3.1 Social and cultural beliefs

Participants in the current study reported that there were a number of social and cultural issues that influenced pregnant women to seek and reach care. Amongst these factors were: traditional and cultural norms and beliefs regarding ANC attendance; client's awareness regarding the importance of ANC; peer and community influence regarding ANC attendance and approval of pregnancy by parents and the community. According to Purnell (2014: 1) culture is defined as socially accepted behaviours, beliefs and ways of life of a population which guide their decision-making and cultural competency.

Diversity must be observed by health care professionals when dealing with these populations.

Understanding social and cultural issues is necessary to recognise ‘seeking care’ behaviours of the population or communities. This is supported by the findings of a Chinese study by Lee *et al.* (2009: 104), which revealed that antenatal taboos generally exist and are still practiced by Chinese women. The authors further revealed that miscarriages, foetus malformation and foetal ill-health were the key cultural fears that obligated these women to practice traditional taboos. The expected cultural fears and effects on pregnancy in the above study were similar to those revealed by pregnant women participants, which is believed to be a result when initiating ANC services early and within the area. The fears of the women participants in the current study were based on being bewitched, rather than not practicing certain cultural taboos as indicated in the Chinese study.

In the current study, the social and cultural issues influenced an individual’s decision towards accessing health care. Umberson, Crosnoe and Reczek (2010: 140) placed emphasis on various social connections influencing health behaviours at different life stages and life experiences. There is a need for women’s awareness in order to inform decision-making regarding their pregnancy and maternal and child health. As posited by Agus, Horiuchi and Porter (2012: 1), an understanding of the obstacles within the local culture is vital in order to improve women’s awareness about their pregnancy. As most pregnant women participants believe that pregnancy must be kept a secret until it was visible and apparent, this may have serious implications for the early identification of problems during ANC. This is because women may delay seeking care until later, when the pregnancy was recognised.

The other delay in seeking care was due to the fear of parents and the community, which was revealed by most pregnant women participants. This resulted in the health posts available within the community either not being accessed or utilised for ANC services. Family support is a vital component for early access to ANC services within this community. Recommendations of the

study by Wulandari and Klinken-Whelan (2011: 867) conceded that the family members' involvement during pregnancy should be encouraged and re-enforced by health promotion programmes. The authors further recommended that community and religious leaders should be involved to support these key messages.

In the current study one woman revealed that although the fear of parents prevailed during her early pregnancy, her partner supported her in order to access ANC services. He attended with her when she initiated ANC away from the community. Yargawa and Leonardi-Bee (2015: 1) expressed that the benefits of male involvement in maternal health in both developing and developed countries embraced increased maternal access to ANC. In this study, one pregnant woman stated that her partner's involvement contributed to her early access and utilisation of ANC services. The study by Simkhada *et al*. (2008: 244) revealed that cultural beliefs, age, religion and other views regarding pregnancy influenced the use of ANC services. Unlike that study, the current study revealed social and cultural beliefs as influencing factors of under-utilisation of the rural health care facilities in the area. The social and cultural beliefs have major influences on the access and utilisation of ANC services, especially at health care facilities in the rural areas.

5.3.2 Past pregnancy experiences

Phase 1 participants who were pregnant women in the current study revealed that a past pregnancy experience was a deciding factor on where the women would seek care with subsequent pregnancies. The results of the current study revealed that previous experiences in the local health care facilities, previous pregnancy outcomes and attitude of staff towards pregnant women were amongst the factors that influenced the choice for utilisation of ANC services. A study in Zimbabwe concurred with the findings of the current study in that barriers to first booking for ANC services was negative attitude from the service providers (Gore, Muza and Mukanangana 2014: 119). In the current study, the attitude of staff towards pregnant women emerged as a sub-theme from a major theme past pregnancy experiences. The staff attitude to pregnant women was

one of the factors that led to a non-utilisation of ANC services in the KwaMkhizwana rural community, although no claims were made by nurses in this regard.

During the literature search there were not so many studies that explored past pregnancy experiences in relation to access and utilisation of ANC services. There were, however, studies which exposed the impact of previous bad experiences leading to depression with subsequent pregnancies. The study by Charm, Sundby and Vangen (2005: 359) supported the findings of the current study, stating that a bad experience with the health care system had an influence on deciding when to seek care. This could be a recommendation for subsequent studies: to look into past pregnancy experiences as a factor that influences access and utilisation of ANC services.

5.4 PHASE 2: DELAY IN REACHING HEALTH CARE

Pregnant women tend to underutilise ANC services at the health care facilities available in the area, which contributed to delays in reaching adequate care. This was evident in the two major themes that emerged during the data analysis. These themes were limited access to health care and emergency services, and poor communication and transparency regarding service delivery.

5.4.1 Access to health care and emergency services

The findings of this study revealed that pregnant women had limited access to health care and emergency services. The nurses who participated in the study confirmed that having just the two health posts and one mobile clinic in the area was responsible for the limited access to health care by pregnant women. The pregnant women participants stated that residing in this rural community was a major contributory factor when requiring to access health care and emergency services. The factors that influenced access to health care and emergency services were inaccessibility to health care due to clinic operation times and operation days; transport unavailability and other financial issues, the number of clients accepted per clinic session and the provision of services per clinic session.

According to Levesque, Harris and Russell (2013: 18), health care access is defined as access to a service, a provider or health care facility, whereby there is an opportunity for health care customers or communities to use suitable services relating to their health needs. The participants from both phases agreed that the health care facilities in the community were inaccessible due to clinic operational times and operational days, which became major contributory factors for the under-utilisation of ANC services. The pregnant women concurred that the major contributory factors became a deciding factor in the delay to reach care, thus leading to utilisation of ANC services elsewhere outside the community. There are two studies which support that limited health care access is influenced by cost and financial implications, whereby rural communities experienced greatest access obstacles (Levesque, Harris and Russell 2013; Moodley and Ross 2015).

The findings of a study by Okuttu (2011: xi) revealed that rural women were more disadvantaged regarding access to and utilisation of ANC services when compared with their urban counterparts. The author further indicated that the factors that prevented respondents from receiving medical treatment or attending health care, included getting money for treatment and using transport when travelling long distances to reach a health care facility (Okuttu 2011: 53). The author's findings concur with the findings of the current study, where pregnant women participants revealed that there were shortages of staff in the health posts available in the community. Some nurse participants experienced great workloads as they were allocated alone in attending to the needs of all clients entering the health posts. There was also a lack of an ANC-designated nurse to attend to pregnant women's ANC needs. Kawungezi *et al*. (2015: 132) further added that the underutilization of ANC greatly contributes to persisting high rates of maternal and neonatal mortality. The current study only included a determination of the factors influencing utilisation of ANC services. Further studies could confirm or refute whether the under-utilisation of ANC services contributes to high MMRs.

Arthur (2012: 1) proposed that in the most remote rural areas disparities in health care still exist and are due to the inaccessibility and unavailability of

health facilities, human resources, and poor road infrastructure to facilitate utilisation of ANC. Wabiri *et al*. (2013: 5) concurred with the above author, when stating that in KZN pregnant women concentrated in the urban formal areas have better access to health care, compared with 23.8% of the poor living in rural informal tribal areas with limited access. These authors agree that deficiencies in access to and utilisation of maternal health services and poor skilled health care providers make a critical contribution to maternal health outcomes.

The findings of the current study also conform to the above authors, in that limited health care access in this rural community was due to inaccessibility and unavailability of health care facilities and a lack of human and material resources. The factors that influenced limited access to health care were therefore inaccessible health care due to clinic operational times and days; the number of clients accepted at the health posts; the provision of more than one service during one day; and transport and financial issues. These factors brought about an under-utilisation of ANC services within this rural community. In relation to the Constitution of the Republic of South Africa, the rural community of KwaMkhizwana has a fundamental right to have access to health care services. Chapter 2 section 27(1a) of the Constitution affirms that everyone has the right to have access to health care services, including reproductive health care (Republic of South Africa 1996: 13). Pregnant women in the KwaMkhizwana rural community therefore, needed to benefit fully from this constitutional right by obtaining accessible health care and emergency services.

5.4.2 Communication and transparency regarding service delivery

The findings from this study relate to the delays in receiving health care being connected to poor communication and lack of transparency with regards to information about ANC service's access and utilisation. Communication is an important element of patient care that requires training in communication skills and has a positive impact on health outcomes (Caswell *et al.* 2015: 1).

Several studies identified a number of variable factors and different indicators determining health care service access respectively (Arthur 2012; Gulliford *et al*. 2002; Kawungezi *et al*. 2015; Levesque, Harris and Russell 2013; Okuttu 2011). None of these studies identified poor communication and lack transparency regarding service delivery as either one of the factors or indicators of health access and utilisation determinants. Levesque, Harris and Russell (2013: 2) stated that the determining factors for health care access are health care service availability, cost and quality of health resources and supplies. Gulliford *et al*. (2002: 186) claimed that the number of skilled health care professionals, hospital beds and the number of public healthcare facilities and costs incurred by individuals to obtain health are the most frequently used indicators for access to and utilisation of services.

The Batho Pele principles pinpoint accurate information for citizens about the use of the available public health care services (James and Miza 2015: 2). These authors further stated that the public believes that nurses as professionals will provide appropriate information regarding health issues and health care services. Additionally, that nurses have the responsibility to notify patients about changes and new developments in health care. A lack of information regarding service days and operational hours for services provided, a patient's right to care and the importance of ANC attendance, were the sub-themes of the major theme of poor communication and lack transparency regarding service delivery in the current study. These findings are not similar to the conclusions of the study by Adewoye *et al*. (2013: 192), who claimed that there was a high level of awareness about ANC services and attendance displayed by pregnant women during ANC interventions. The findings of the current study have therefore incorporated poor and lack of transparency as one of the factors influencing access and utilisation of ANC services within rural communities.

5.5 PHASE 3: DELAY IN RECEIVING ADEQUATE HEALTH CARE

During data analysis in the current study revealed that pregnant women had delays in receiving health care. There were two major themes that emerged relating to Phase 3 of the model. These themes were availability of human and material resources, and quality of ANC services.

5.5.1 Availability of human and material resources

Both groups of participants in the current study revealed that a lack of human and material resources became an influencing factor to women's 'seeking care' behaviour within the community at the three health care facilities. The pregnant women's seeking care behaviours were associated with staff shortages of nurse working in the health care facilities, together with the unavailability of treatments and maternity case records cards. According to Appiah-Denkyira *et al.* (2013: 4), a lack of HRH prevents health services from being accessed by those mandated to receive it. The participants in this study reported that they attended ANC services elsewhere, based on the fact that the community health posts only had one or two nurses attending to all clients and there was no designated nurse attending to pregnant clients. The utilisation of ANC services mostly depended on the availability of staff and required material resources. This was supported by the Department of Health (2014a: vii), in that well-resourced and accessible health care facilities include the availability of human and material resources. In the current study, delays in receiving care resulted when pregnant women were referred to other health care facilities or booked for the next available date to access ANC services. The later bookings were due to the unavailability of maternity case records cards; treatment and other supplies; staff shortages; a lack of an ANC-designated nurse attending to pregnant women; as well as a lack of resources relating to infrastructure and equipment. Cele (2014: 18) confirmed that all women who attend ANC services should be issued with an antenatal card for essential ANC. The availability of human and material resources is a marker of health care access to and utilisation of ANC services.

A study in five sub-Saharan African countries, which included Ghana, Kenya, Nigeria, Uganda and Zambia, concurred with the findings of the current study

in stating that obtaining money for transport was the most important problem for rural women when accessing health care (Tawiah 2011: 23). The author further indicated that money-related barriers emerged as the most important predictors of inadequate ANC. The lack of human and material resources is major contributors as to how health care services are accessed and utilised. This was further confirmed by Ngxongo and Sibiya's study (2013: 906), which revealed that challenges with regards to the problems of transportation of specimens, a lack of material resources and unavailability of BANC guidelines, had a negative influence on the delivery of ANC services in the eThekwini district.

A number of research studies suggest that there is a maldistribution of health workers in rural areas (Hegney *et al*. 2002; Jenkins *et al*. 2015; Sibiya and Gwele 2013). Human resource strategies should be more focused on nurses, as they are the frontline health care professionals in PHC settings in South Africa (Sibiya and Gwele 2013: 387). Although many nurses are needed for the overburdened health care system, the shortage of nurses continues to widen with increasing demand without a commensurate increase in the supply of trained nurses (Mokoa, Oosthuizen and Ehlers 2010: 3). This is in part a result of the provincial health care budget cuts that nurses rely on for training finance (Daviaud and Chopra 2008: 48). Consequently, with health care resources becoming increasingly limited, the need for innovative strategies to maximise the effectiveness of the care delivered with the existing human resources becomes even more crucial.

5.5.2 Quality of ANC services

The findings of the current study revealed that ANC services delivered in the mobile and health posts are disorganised and non-comprehensive. The observations were made by participants from both phases. The ANC services rendered were inadequate, inefficient and sometimes not according to the specified guidelines. According to the BANC guidelines, women should initiate ANC as soon as the pregnancy is diagnosed (Pattison 2007: 7). There is a dissimilar situation in the rural community of KwaMkhizwana, where pregnant

women do not receive ANC in line with the guidelines. This is because they were referred to other health care facilities for ANC services. Additionally, other ANC-related services were not offered due to the health care facilities being understaffed, existing nurses overworked and poor clinic infrastructure as described by some nurse participants in the previous chapter during data analysis.

According to the Department of Health (2014c: 62) the National TB Management Guidelines indicate that the TB prevalence in pregnancy has dramatically increased. This is a result of the HIV epidemic, which is now ranked number three in the causes of maternal mortality (Department of Health 2014c: 62). The guideline further stated that all pregnant women should be screened for TB symptoms and be investigated. Should they be TB diagnosed then an HIV test must be offered immediately unless the HIV status is already known (Department of Health 2014a: 62). On the other hand, the South African Department of Health 2014 National Consolidated HIV (PMTCT) Guidelines pinpoint that all pregnant women whose HIV status is unknown should be offered HCT, and safely initiated regarding treatment (Department of Health 2014b: 22). Both these guidelines outline specific ANC services that should be rendered to pregnant women in screening for TB and HIV, and further clarify the role of PN/RM with regard to accessibility and utilisation of ANC services. The nurses in the mobile clinics are sometimes unable to uphold and work in line with the guidelines, thereby exposing the pregnant women (especially in rural communities) to a fragmented and poor quality of ANC services.

In the PHC Service Package, the services of the mobile clinics were well-defined using the level of skills of staff and not the facility size. Common services can be delivered by professional nurses, which is important for rural areas to access health care because CHCs and hospitals were distant (Department of Health 2001: 14). The findings of the current study showed that although the mobile clinics were established in order to bring accessibility to health care when hospitals are far away, health care access remains limited and inaccessible. The implementation of effective and comprehensive health programmes in a district is dependent on the availability of adequate resources.

Being able to provide transport to a referral centre for emergencies that occur during normal working hours, as well as after-hours, is vital for a well-functioning health service. In their study on developing a model for the integration of PHC services in KZN, Sibiya and Gwele (2013: 494) argued that the implementation of effective and comprehensive health programmes in a district is dependent on the availability of adequate resources.

5.6 SUMMARY OF THE CHAPTER

This chapter discussed the findings of the study, which was aided by the integration of new relevant literature and the ones used in the previous chapters. The next chapter presents the summary of findings, limitations and recommendations of the study.

CHAPTER 6

SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

6.1 INTRODUCTION

This chapter discusses the summary of findings, conclusions, limitations and recommendations of this study.

6.2 SUMMARY OF STUDY FINDINGS

The information gathered from the two data sets concurs. It both highlights poor access and utilisation of ANC services in the area. Almost all the pregnant women accessed and utilised the ANC services outside KwaMkhizwana area. The majority of the pregnant women who participated in the study knew the importance of attending ANC services and where and how to access ANC services but the problem was with the availability. The nurse participants attested to this. There were a number of factors with regards to access and utilisation of ANC services that hindered utilisation of the local health care services. These factors included; limited health care access, lack of human and material resources; strong social and cultural beliefs, past pregnancy experiences, poor communication and lack of transparency regarding service delivery and quality of ANC services.

Furthermore, there were several challenges facing rural African pregnant women in the study regarding access and utilisation of ANC services. Amongst those challenges were a shortage of staff at the health posts; expensive and unavailable transport; unavailability of treatment and other supplies; traditional and cultural norms and beliefs regarding ANC attendance; and fragmented and non-comprehensive health care services. These challenges brought about an under-utilisation of available ANC services in the area. Significantly, health education was identified as a proposed strategy that could be used to improve the rural access to and utilisation of ANC services.

6.3 LIMITATIONS OF THE STUDY

The research was conducted on pregnant women who were 18 years and above residing in the KwaMkhizwana rural community. This rural community does not have a fixed PHC clinic in the area. It is serviced by a mobile clinic and two health posts, which are somehow underutilised or not used at all by pregnant women.

The pregnant women could not be reached in the three study sites as most of them did not use the available health care facilities in the area. Additionally, during data collection in one community gathering that occurred, most women who were at least months post-delivery were willing to be interviewed. However, they could not participate in the study as they were no longer pregnant. This may have brought more relevant prospects to the study. Few women under the age of eighteen were mentioned to be pregnant and attended school, and did not use the three study sites; therefore, they could not be interviewed.

6.4 RECOMMENDATIONS OF THE STUDY

The following recommendations are made with special reference to policy development and implementation, institutional management and practice, community education and further research.

6.4.1 Policy development and implementation

The recommendations were made with regards to policy development and implementation. The fundamentals of the South African National Health System state that health care services must be coordinated amongst PHC clinics, Community Health Centres (CHCs) for the provision of comprehensive services at the local level (African National Congress 1994). Moreover the local catchment area should have access to a clinic, a CHC with a 24 hour maternity and casualty units (Department of health 2001: 14). The recommendations were based on the two existing developed policies and these were that:

- The Department of Health to consider building a centrally located fixed PHC clinic in the area. This would equally service the area in order to

uphold the fundamental constitutional right to health care access for this rural community. Proactively it would support other rural communities in sub-districts that may have similar limited health care services.

- According to the eThekwini District health plan an ambulance response time in rural areas is 40 minutes and 15 minutes in urban areas (Department of Health 2015: 106). This is argued by the findings of the current study. Therefore, there is a need to involve the Department of Emergency Medical Care and Rescue services in order to improve the accessibility of ambulance services to this rural community. This could be achieved by deploying strategies through visiting the area to identify landmarks known to them and the community. This would facilitate easy access to pregnant women needing urgent medical care, and for the community at large. The involvement of prominent community leaders and structures in the area could be used to fast-track this process.
- In the PHC service package it is stated that clients attending the referral section will need a letter from the clinic and referral should be in line with health care facility referral procedures (Department of Health 2001: 15). There is a need for the Department of Health to revise and provide an updated standard referral system that would be followed at the available health care facilities in the area. This would be used in partnership with the ambulance services department servicing the area during client referral to hospitals.

6.4.2 Institutional management and practice

The area mangers and operational managers of health posts and mobile clinics servicing this rural community should include:

- Interventions to ensure the provision of essential material resources during the execution of planned duties, with little or no shortcomings to ANC services in facilitating access to health care.
- Employing strategies to ensure that the ANC services delivered are in line with the South African Department of Health Guidelines. There should be an improvement of staff shortages to implement and sustain the adherence of working according to these guidelines. These include

ensuring that all PHC services, including ANC services, are rendered according to National Health Guidelines and those guidelines adopted provincially in order improve accessibility and utilisation of ANC services.

- Nurses to display a caring and positive attitude to ANC clients in order to promote accessibility and utilisation of ANC services in the available health care facilities in the area.

6.4.3 Community education

The recommendations of providing education to the community could be initiated by operational mangers and staff of the clinics servicing the area. This could be done in conjunction with the two prominent organisations, which are Maternal Adolescent and Child Health and the South African Medical Research Council. These organisations support MCWH services in the eThekwini district. This should include:

- Initiation of campaigns to educate the community, in particular, women within the child-bearing age range. Such campaigns would be on the importance of early ANC clinic attendance, early family involvement, and the development of complications and its prevention in pregnancy to enhance the understanding of ANC access.

6.4.4 Further research

Further studies on provision of ANC services in the area are recommended in order to enhance access to and utilisation of ANC services, and to positively influence pregnancy and maternal care outcomes. These studies could be:

- Phenomenological studies on women who have been pregnant and are residing in the area, regarding barriers and motivators to access and utilisation of ANC services while residing in the area.
- Research studies on experiences of nurses working in mobile and health posts with regard to the delivery of comprehensive PHC services.
- Assessment of past pregnancy experiences as influencing factors in accessing and utilising of ANC services in rural areas.

6.5 FINAL CONCLUDING REMARKS

The current study's findings indicated that most pregnant women encountered challenges to the access and use of ANC services available in the rural community of KwaMkhizwana. The women encountered major challenges that were established in all three phases of the model. These included delays in seeking, reaching and receiving care that was pregnant women-related, services access-related and community-related. The major challenge related by pregnant women was that most of them had limited access to health care, with none at all or under-utilisation of ANC services consequently delaying the decision to seek and/or reach ANC services. This could have negative implications for pregnancy and maternal health outcomes.

The staff shortages at the health posts was identified as one of the factors that influence access and utilization of ANC services and contributed to a failure by nurses to adhere to essential guidelines, sometimes deciding to postpone ANC and displaying a negative attitude to ANC clients. These were the major service-related challenges that led to delays in reaching care. The unavailability of a fixed clinic with different designated service areas also contributed to the under-utilisation of available services. Lastly, the community-related challenges were that the access and use by all other clients visiting the health posts posed a risk to pregnant women, who delayed seeking early ANC as they were not ready to disclose their pregnancy status.

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Appendix 1: DUT Ethics clearance

Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

19 January 2016

IREC Reference Number: **REC 159/15**

Ms T J Bhengu
13 Peace Crescent
Sarnia
3610

Dear Ms Bhengu

Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the questionnaire has been approved. Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC

DUT DURBAN UNIVERSITY OF TECHNOLOGY

2016 -01- 19

INSITUTUTIONAL RESEARCH ETHICS COMMITTEE
P O BOX 1334 DURBAN 4000 SOUTH AFRICA

Appendix 2a: Permission letter to eThekwini District Health Manager

13 Peace Crescent
Sarnia
3610

Ms. P. Dladla
The Acting District Manager
EThekwini Health District
Mayville
4001

Dear Madam

REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Nursing Department. The title of the research project is "*Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal*".

The aim of the study is to determine whether the pregnant women have access to and are utilising available ANC services in KwaMkhizwana, a rural community in a tribal area of the West sub district of eThekwini in KwaZulu-Natal. A descriptive exploratory qualitative research design will be used to guide the study. Data collection will be done using semi structured interviews with the pregnant women residing KwaMkhizwana area and also with all categories of nurses who are working in the health care facilities in the area.

I hereby request your permission to conduct a research project at your facilities. My research proposal has been attached for your perusal.

Your support and permission to conduct the study in your facility will be appreciated.

Sincerely

…….
Ms. TJ Bhengu (Student)
Telephone: 083 953 4132
Email: bhengutj2@gmail.com

……
Prof MN Sibiya (Supervisor)
Telephone: 031-373 2606
Email: nokuthulas@dut.ac.za

Appendix 2b: Approval letter from eThekwini Health District

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
eThekwini District Office

Physical Address : 83 Kind Cetshwayo Highway, Mayville, Durban, 4001
Postal Address: P Bag X54318, Durban 4000
Tel: 031 - 2405308 Fax: 031 2405555 Email: somaroo@ukzn.ac.za

6 January 2016

Dear Ms Bhengu

Re: Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal.

I have pleasure in informing you that your application to conduct research in Ethekwini district has been approved at the KZNPA moblile clinic in KwaMkhizwana.

Please note the following:

i. All research activities must be conducted in a manner that does not interrupt clinical care at the mobile clinic,
ii. logistical details must be arranged with the PHC supervisor, or operational manager, of the Halley Stott clinic,
iii. this research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted, and
iv. a report of your findings should be forwarded to the Ethekwini district office on completion of your project.

Yours sincerely

H Somaroo (Dr)
Medical Officer- Public Health Medicine

Appendix 3a: Permission letter to Department of Health

13 Peace Crescent
Sarnia
3610

17 December 2015

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Dear Dr Lutge

REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. The title of the research project is "*Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal*".

The aim of the study is to determine whether the pregnant women have access to and are utilising available ANC services in KwaMkhizwana, a rural community in a tribal area of the West sub district of eThekwini in KwaZulu-Natal. A descriptive exploratory qualitative research design will be used to guide the study. Data collection will be done using semi structured interviews with the pregnant women residing in KwaMkhizwana area and also with all categories of nurses who are working in the health care facilities in the area.

I hereby request your permission to conduct a research project at your facility. My research proposal has been attached for your perusal.

Your support and permission to conduct the study in your facilities will be appreciated.

Sincerely

…….
Ms. TJ Bhengu (Student)
Telephone: 083 953 4132
Email: bhengutj2@gmail.com

……..
Prof MN Sibiya (Supervisor)
Telephone: 031-373 2606
Email: nokuthulas@dut.ac.za

Appendix 3b: Approval letter from Department of Health

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
Health Research & Knowledge Management

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference: 18/16
KZ_2015RP35_394

Date: 5 February 2016

Dear Ms T.J. Bhengu
Email: bhengutj2@gmail.com

Approval of research

1. The research proposal titled **'Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Halley Scott Clinic and mobile clinic in kwaMkhizwana area.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 12/02/16

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4a: Permission letter to eThekwini Health Municipality

13 Peace Crescent
Sarnia
3610

The Head of Health Unit
EThekwini Municipality
9 Archie Gumede Place
Durban
4000

Dear Dr Gxagxisa

REQUEST FOR A PERMISSION TO CONDUCT A STUDY

I am presently registered for a Master's Degree at the Durban University of Technology in the Nursing Department. The title of the research project is "*Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal*".

The aim of the study is to determine whether the pregnant women have access to and are utilising available ANC services in KwaMkhizwana, a rural community in a tribal area of the West sub district of eThekwini in KwaZulu-Natal. A descriptive exploratory qualitative research design will be used to guide the study. Data collection will be done using semi structured interviews with the pregnant women residing KwaMkhizwana area and also with all categories of nurses who are working in the health care facilities in the area.

I hereby request your permission to conduct a research project at your facilities. My research proposal has been attached for your perusal.

Your support and permission to conduct the study in your facility will be appreciated.

Sincerely

…… ……
Ms. TJ Bhengu (Student) Prof MN Sibiya (Supervisor)
Telephone: 083 953 4132 Telephone: 031-373 2606
Email: bhengutj2@gmail.com Email: nokuthulas@dut.ac.za

Appendix 4b: Approval letter from eThekwini Health Municipality

ETHEKWINI MUNICIPALITY

Dear TJ Bhengu

15 February 2016

Subject: Approval of a research proposal.

The research proposal titled: **Access and utilisation of antenatal care services in a rural community of eThekwini District in Kwazulu Natal** was reviewed by the eThekwini Municipal Health Department research Committee. The study is hereby **approved to be conduct at Kwamkhizwana and Mqeku clinics.**

The following conditions need to be noted:

- Submission of the indemnity form obtainable from the EThekwini Municipality Health Unit before commencement of the study.
- Prior arrangements to be made with the facility and an assurance that all services will not be disrupted.
- No staff member should be used for collecting data for the researchers.
- Progress reports to be provided and the final report of the study to the eThekwini Municipality Health Unit or emailed to:**ntombifuthi.mangeni@durban.gov.za and Cc: grace.mufamadi@durban.gov.za**
- Obtain permission from the eThekwini municipality health department for press releases and release of results to communities/stakeholders.
- The department has to receive recognition for the assistance given.
- Any amended to the study to be communicated with the eThekwini Municipality Health Unit and the relevant amendment form obtainable from the unit to be submitted.
- Withdrawal of permission to conduct research will be left to the discretion of the eThekwini Municipality Health Unit.

Yours faithfully

DR AJ OLOWOLABA

Deputy Head of Health

Signature:

Date: 2016/03/07

Appendix 5a: Letter of information and consent for pregnant woman in English

Thank you for agreeing to participate in this study.

Title of the Research Study: The access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal

Principal Investigator/s/researcher: Ms. T.J. Bhengu (B Tech: Nursing)

Co-Investigator/s/supervisor/s: Prof. M.N. Sibiya (D Tech: Nursing) and Ms. T.S.P. Ngxongo (M Tech: Nursing)

Brief Introduction and Purpose of the Study: I will be conducting the study regarding the access and utilization of antenatal care (ANC) services to pregnant women residing in KwaMkhizwana.

Outline of the Procedures: If you agree to participate in this study, you will be requested to participate in an in depth interview where semi structure questions will be asked regarding your pregnancy and how you have been accessing and utilizing ANC services now that you are pregnant and also in the past if you have been pregnant before. The interview should take about 15 to 20 minutes of your time.

Discomforts to the Subject: There is no unforeseen discomfort when participating in this study.

Benefits: The study findings will be used to make recommendations on how access and utilisation of health care services for the pregnant women in your area could be improved.

Reason/s why the Subjects may be withdrawn from the study: You are free to withdraw from this study at any point in time and there will be no penalty.

Remuneration: You will not be expected to pay anything for taking part in the study, and also no payment will be given to you for taking part in the study.

Confidentiality: All the information gathered will be kept anonymous and will not be linked to your name in whatsoever way. Your name will not be written on any of the study materials except on the consent form which will be kept in strict privacy all the time. The information gathered will only be used for the purpose of this study.

Research-related Injury: No compensation, however the nature of the study does not pose any risk of injury to you or your pregnancy.

Persons to Contact in the Event of Any Problems or Queries:

Supervisor: Prof. MN SibiyaDurban University of Technology Tel: 031-373 2606
Co-supervisor: Ms. TSP Ngxongo Durban University of Technology Tel: 031-373 2609
Institutional Research Ethics administrator on: 031-373 2900.
Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za.

Consent

Statement of agreement to participate in the research study: If you are pregnant and 18 years and above and willing to participate in the study may I request that you sign the agreement below.

Statement of Agreement to Participate in the Research Study:

I …… (Subject's full name)

ID number: …..... have read this document in its entirety and understand its contents. Where I have had any questions or queries, these have been explained to me by ……to my satisfaction. Furthermore, I fully understand that I may withdraw from this study at any stage without any adverse consequences and my future health care will not be compromised. I, therefore, voluntarily agree to participate in this study.

Subject's name (print)
……

Subject's signature: ..... Date……..

Researcher's name (print) ……..…….....

Researcher's signature: …… Date: .....

Witness name (print) signature:
……..

Witness signature: …… Date: ……....

Appendix 5b: Letter of information and consent for pregnant women in IsiZulu

Siyabonga ukuba uvume ukuba yingxenye yalolucwaningo.

Isihloko socwaningo: Ukufinyelela nokuvunyelwa ukusebenzisa izinhlelo zokusiza abakhulelwe emphakathini osendaweni esemaphandleni esifundazweni esiseThekwini kwa KwaZulu-Natal.

Umcwaningi: Ms TJ Bhengu (oneziqu zeB: Tech)
Abambisene nabo: Solwazi. M.N. Sibiya (oneziqu zobudokotela) kanye noNkosikazi T.S.P. Ngxongo (oneziqu zemastazi)

Isingeniso kafishane mayelana nenjongo yalolucwanongo: Ngizoqhuba ucwaningo mayelana nokufinyelela kanye nokusetshenziswa kwamasevisi okusiza abakhulelwe abahlala endaweni yakwaMkhizwana. Njengomcwaningi ngithanda ukwazi ukuthi ingabe abakhulelwe bazithola futhi bazisebenzise kanjani izikhungo zokunakekelwa zezempilo ikakhulukazi lezo ezihlinzeka ngamasevisi okusiza abakhulelwe kulendawo.

Uhlelo ngokuyokwenzeka: Uma uvuma ukungenela lolucwaningo uyacelwa ukuba ube yingxenye ngokubuzwa imibuzo ehleliwe ngokukhulelwa kwakho nezinhlelo ozisebenzisayo ukufinyelela nokusebenzisa amasevisi okusiza abakhulelwe kanye nangokukhulelwa kwakho okudlule. Lokubuzwa kwemibuzwana kungathatha imizuzu eyishumi nesihlanu kuyakwengamashumi amabili kugcwalisa kungathatha imizuzu eyishumi nanhlanu kuya emashumini amabili esikhathi sakho.

Ukungaphatheki kahle kwabangenele ucwaningo: Abukho ubungozi nokungaphatheki kahle kuwe nasekukhulelweni kwakho okuyobangelwa ukungenela lolucwaningo.

Inzuzo: Imiphumela yocwaningo izosetshenziswa ukwenza imibono ezothuthukisa izinga lokufinyela nokutholaka kwezinhlelo zokisiza abakhulelwe ngenjongo yokuthuthukisa ukusizakala kwabakhulelwe endaweni

Izizathu ezingenza labo abayingxenye yocwaningo bengabe besaqhubeka nocwaningo: Uvumelekile noma yingasiphi isikhathi ukuphuma ekubeni yingxenye yocwaningo uma ufisa ukwenze njalo.

Inkokhelo: Awulindelekile ukuba ukhokhele ukuba yingxenye yocwaningo kanjalo ayikho inkokhelo kulabo abayingxenye yocwaningo.

Ukugcinwa kwemfihlo: Yonke imininingwane etholakele iyogcinwa iyimfihlo kanti futhi ngeke ihlanganiswe negama lakho noma ngabe ingayiphi indlela. Igama lakho ngeke libhalwe ezimpendulweni ozinikile zocwaningo. Igama lakho liyobhalwa kuphela kulencwadi yokuvuma ukungenela ucwaningo zonke izimpendulo ozinikile zizosetshenziselwa lolucwaningo kuphela.

Ukulimala okungenzeka ngenxa yocwaningo: Akukho ukubhekelelwa, kube kungekho ukulimala kuwena nasekukhulelweni kwakho kuloluhlobo locwaningo.

Ongabathinta uma unemibuzo noma kukhona ofuna ukuchazelwa ngakho mayelana nalolucwaningo:

Umbhekeleli: uProfesa M.N Sibiya Durban University of Technology kulenombolo 031-373 2606

Osizana naye: uNkosikazi T.S.P. Ngxongo Durban University of Technology kulenombolo 031-373 2609

Isikhungo sokuphathwa kwemithetho yocwaningo: 031-373 2900

Izikhalazo zingabikwa kusolwazi F. Otieno kulenombolo: 031-373 2382 noma dvctip@dut.ac.za

Imvume

Isitatimende sokuvuma ukuba yingxenye yocwaningo: Uma ukhulelwe futhi uneminyaka eyishumi nesishagalolumbili nangaphezulu futhi ufisa ukuba yingxenye yalolucwaningo uyacelwa ukuba usayine lesisivumelwano esilandelayo ngezansi.

Isitatimende sesivumelwano sokuba yingxenye yocwaningo:

Mina……
(Igama nesibongo).

Inombolo yomazisi …….., ngiyifundile yonke incwajana futhi ngiyaqonda konke okuqukethwe kuyo. Ngichazelwe konke lapho benginemibuzo khona ngu …….. (umcwaningi) ngendlela enganelisayo. Ngaphezu kwalokho ngiyaqonda ukuthi ngivumelekile ukuthi ngingaqhubeki nokuba yingxenye yalolucwaningo noma yinini uma ngifisa ukwenza njalo ngaphandle kokuthi kube nemiphumela emibi futhi nokunakekelwa kwempilo yami esikhathini esizayo ngeke ngiphazamiseke. Ngaleyondlela ngiyavuma ngokuzikhethela ukuba yingxenye yalolucwaningo.

Igama laloyo oyingxenye yocwaningo…….

Sayina…….Usuku mhlaziwu……..

Igama lomcwnaingi……

Sayina…….Usuku mhlaziwu…….

Igama likafakazi……...……

Sayina …….Usuku mhlaziwu……

Appendix 6: Letter of information and consent for nurses

Thank you for agreeing to participate in this study.

Title of the Research Study: Access and utilisation of antenatal care services in a rural community of eThekwini district in KwaZulu-Natal

Principal Investigator/s/researcher: Ms.TJ Bhengu (M Tech: Nursing candidate)

Co-Investigator/s/supervisor/s: Ms. T.S.P. Ngxongo (M Tech: Nursing) and Prof. M.N. Sibiya (D Tech: Nursing).

Brief Introduction and Purpose of the Study: I will be conducting the study regarding the access and utilization of antenatal care (ANC) services to pregnant women residing in a rural community of eThekwini district in KwaZulu-Natal.

Outline of the Procedures: If you agree to participate in this study an in-depth interviews will be conducted with you regarding access and utilization of ANC services by the pregnant woman from KwaMkhizwana area. This will only take about 30 minutes of your time.

Discomforts to the Subject: There is no risk or discomfort that will be inflicted to the participants.

Benefits: The study findings will be used to make recommendations on improvements to access and utilisation of ANC services so as to improve quality of ANC at PHC clinics especially in rural areas. This will benefit the community especially the pregnant women of KwaMkhizwana area where the research project will take place.

Reason/s why the Subjects may be withdrawn from the study: You will be allowed to opt out from the study or withdraw at any time should you wish to do so.

Remuneration: You will not be expected to pay anything for taking part in the study, and also no payment will be given to you for taking part in the study.

Confidentiality: All the information will be kept in strict privacy. Your name will not be written on any of the data collection tools except on the consent form which will be kept in strict privacy all the time with your responses. The information gathered will only be used for the purpose of this study.

Research-related Injury: No compensation, however the nature of the study does not pose any risk of injury to you.

Persons to Contact in the Event of Any Problems or Queries:
Supervisor: Prof. MN Sibiya Durban University of Technology Tel: 031-373 2606
Co-supervisor: Ms. TSP Ngxongo Durban University of Technology Tel: 031-373 2609
Institutional Research Ethics administrator on: 031-373 2900.
Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or dvctip@dut.ac.za

Statement of agreement to participate in the research study: If you are willing to participate in the study may I request that you sign the agreement below.

Statement of Agreement to Participate in the Research Study:

I …… (Subject's full name)

ID number: …..... have read this document in its entirety and understand its contents. Where I have had any questions or queries, these have been explained to me by ……to my satisfaction. Furthermore, I fully understand that I may withdraw from this study at any stage without any adverse consequences and my future health care will not be compromised. I, therefore, voluntarily agree to participate in this study.

Subject's name (print)……

Subject's signature: ..... Date:……....

Researcher's name (print) …….

Researcher's signature…….. Date: .....

Witness name (print).....

Witness signature: …… Date: …….

Appendix 7a: Interview guide for pregnant women in English

Participant Code: [ ]

Date of interview: …….

Section A: Demographic data

1. Age…….

2. No of pregnancies……..

3. Gestational age at first visit……

4. Interval for clinic visits……

5. Level of education/Grade……..

6. Employment Yes/No…….....

Section B: Main research questions:

1. Are you attending antenatal care clinic as you are pregnant?

Yes
No

2. The following question will be asked to all those participants who answer 'No' to Question 1:
Tell me why you are not attending antenatal care services.

3. The following question will be asked to all those participants who answer 'Yes' to Question 1:
3.1 Where are you attending for antenatal care services?
3.2 Tell me more about why you chose this particular health care facility.

Probing questions will be guided by responses from the participants.

Appendix 7b: Interview guide for pregnant women in IsiZulu

Ikhodi yongenele ucwaningo:

Usuku lokubuzwa kwemibuzo: …….

Isigaba A: Imininingwane yakho

1. Iminyaka ……
2. Inani lokukhulelwa ……
3. Izinyanga zokukhulelwa ngesikhathi sokuqala ukuya emtholampilo....
4. Uhlelo lokubuyela emtholampilo ……
5. Izinga lwemfundo/isigaba ……..
6. Ukuqashwa: Yebo/Cha …….....

Isigaba B: Umibuzo evelele walolucwaningo

1. I*ngabe uyawuhamba umtholampilo wabakhulelwe njengoba ukhululwe?*

Cha
Yebo

2. Umbuzo olandelayo uyobuzwa bonke abangenele ucwaningo abaphendule ngo ‘Cha’ embuzweni wokuqala:

Ake ungixoxele ukuthi kungani ungahambi umtholampilo wabakhulelwe.

3. Umbuzo olandelayo uyobuzwa bonke abangenele ucwaningo abaphendule ngo ‘Yebo’ embuzweni wokuqala:

3.1 Isiphi isikhungo sezempilo ohamba kuso?

3.2 Ake ungixoxele kabanzi ukuthi kungani ukhethe lesisikhungo sezempilo?

Imibuzo yokuphenyisisa iyosekelwa izimpendulo zalabo abangenele ucwaningo.

Appendix 8: Interview guide for nurses

Participant Code:

Date of interview: ……..

Main research question

Tell me about “how do the pregnant women from KwaMkhizwana access and utilise ANC services in your health care facility”?

Guiding questions

Probing questions will be based on the nurse’s responses:

- What do you think are the reasons for the number of pregnant women that are seen at the facility where you are working?
- What provisions are available for the pregnant women during the days when the facility where you are working is not open?
- What happens if a pregnant woman presents in your facility when you are not providing ANC services?
- What can be done to ensure accessibility and utilisation of ANC services in your facility?

NB: Further probing will be done as required.

Appendix 9a: Transcription of an interview with the pregnant woman in English translation

Study site	Participant No.	Age	Marital status	Previous pregnancies	Current pregnancy	Level or Grade	Date	Recorded Information	Themes and sub-themes
B1	B1:P2	34	S	2	1	11	02/3/16	**Main research questions:** **Are you attending ANC clinic as you are pregnant?** Yes I do attend ANC clinic. **Where are you attending for antenatal care services?** I attend health post B1 but I also go to clinic D. **Tell me more about why you chose this particular healthcare facility?** There are a number of reasons why I use this clinic and also I am sometimes forced to use clinic D. *Firstly it's because I don't use transport to go B1 and I don't pay any money. This clinic is not used by pregnant women so I'm using it because it is nearer to my home and I would like to see it continue to operate. But there are a number of problems regarding using this clinic and these are:* *When I attend here the problem arises when I need services not on a Wednesday then I have to go to clinic D which is outside this area and even when I need emergency services I have to hire a car to go to clinic D or going straight to hospital* *As much as I like to use health post B1 but even on Wednesday it starts late and closes early as soon as there are no patients at the clinic.*	**Access to health care and emergency services** **Access to health care and emergency services** **Number of clients accepted per clinic session**

								Another thing is that when staying in this community I must have money to hire a car because even ambulance does not come so when you are not working it is hard and you may not get services or urgent help. *It is like we do not have a clinic at all; they (staff) come once a week and worse nurses see few clients and then announce that they are full.* *They cannot accept any more clients; so you have to wait till the following week with no guarantee that you will be accepted for consultation* *Sometimes they don't have ANC cards and I was told to come the next Wednesday because there were no ANC cards so when I came I was seen first.* *Another issue is that you cannot start ANC early in the area because you may be bewitched once people in the community know that you are pregnant you may lose the pregnancy.* *Now I have decided that I leave home coming to attend clinic only when I see the clinic van parks at the clinic site, because if they (staff) are not coming and we don't know we just see that no clinic van comes.* **And another thing that happens is that:** *This clinic here does not have different areas for different services available like other fixed clinics, e.g. in other clinics there is a TB unit, immunisations, ANC area even if it's written on the doors of the rooms here this is not available (no ANC area) and we are not informed we sit and wait to be seen by one nurse.* *They also do not have all the things they need to use for seeing pregnant women. When I came last Wednesday and I was told to come back the following Wednesday because there were no ANC cards. I was seen today but one test was*	**Availability of human and material resources** **Number of clients accepted per clinic session** **Number of clients accepted per clinic session.** **Availability of maternity case records cards** **Social and cultural issues** **Communication and transparency regarding service delivery** **Information regarding services provided in the local health facilities** **Designated nurse to attend to pregnant women** **Lack of human and material resources** **Quality of ANC services** **Organisation of health care services**

								not done because the machine is now not working mhh…..this means I'm here again next week for this test now when I asked what test the nurse said HB (haemoglobin test). As much as I like health post B1 the only problem is that on a Wednesday when they (staff) are not coming we do not know and no provisions are there for us, it's upon one to decide to come next Wednesday or got to clinic D. It is on such occasions we choose to go to clinic D. **These are all the reasons we seem to use clinic D a lot situations forces us.**	**Provisions for pregnant women when the clinics are closed**

Appendix 9b: Transcription of an interview with the pregnant woman in IsiZulu

Study site	Participant No.	Age	Marital Status	Previous pregnancy	current pregnancy	Level or Grade	Date	Imniningwane eqoshiwe	**Izihloko** kanye nezihlokwana
B1	B1:P2	34	S	2	1	11	02/3/16	**Umbuzo ovelele walolucwaningo:** **Ingabe uyawuhamba umtholampilo wabakhulelwe njengoba ukhulelwe?** Yebo ngiyawuhamba umtholampilo wabakhulelwe **Yisiphi isikhungo sezempilo ohamba kuso?** Ngihamba isikhungo sezempilo u B1 kodwa ke ngibuye ngiyphoqeleke ukusebenzisa u kliniki D **Ake ungixoxele kabanzi ukuthi kungani ukhethe lesisikhungo sezempilo?** Ziningana izizathu ezingenza ngisebenzise lesisikhungo kanti ke futhi ngiphoqeleke ukusebenzisa ikliniki D. *Okokuqala nje ukuthi angisebenzisi izinqola zokuthutha uma ngiya eB1 futhi angikhokhi mali. Lomtholampilo awusentshenziswa omama abakhulelwe manje ke mina ngiyawusebenzisa ngoba useduze kwasekhaya lami kanti futhi ngingathanda ukuwubona uqhubeka usebenza. Kodwa ke kunezinkinga eziningana ezimayelana nokusebenzisa lelikliniki kungabalwa nalezi:* *Uma ngihamba la inkinga ivela uma ngidinga amasevisi kungelona uLwesithathu beseke ngihambe ngiye ekliniki D yona engaphandle kwalendawo kanye futhi uma ngidinga amasevisi aphuthumayo kumele ngiqashe imoto ezongiyisa ekliniki D noma ngihambe ngiqonde ngqo esibhedlela.* *Kaningana ke njengoba ngithanda ukusebenzisa lesisikhungo sezempilo u B1 kodwa ke nangawo*	**Ukufinyelela ekunakekelweni kwezempilo kanye nezinsizakalo eziphuthumayo** **Ukufinyelela ekunakekelweni kwezempilo kanye nezinsizakalo eziphuthumayo** **Ukufinyelela ekunakekelweni kwezempilo kanye**

								uLwesithathu lesisikhungo siyephuza ukuqala siphinde sisheshe futhi ukuvala emuva nje kokuphela kweziguli. *Okunye ke futhi ukuthi uma ngihlala kulomphakathi ngimele ngibe nemali yokuqasha imoto njengoba nama ambulensi awezi kulendawo lento eyenza ukuthi uma ungasebenzi kubenzima okwenza ke ugcine ungakwazi ukuthola amasevisi noma usizo oluphuthumayo.* *Lokuke kuyafana nje nokuthi asinawo umtholampilo ngoba laba(abasebenzi) bafika kanye nje ngeviki kanti ke okubi kakhulu ken je onesi babona iziguli(amaklayenti) abaliwe bese bememezela ukuthi sekugcwele ukuthi abasezukuthatha muntu manje loku kusho ukuthi ke uyoze ulinde iviki elizayo nakhona awunaso isiqiniseko sokuthi uzokwamukelwa ukuba usentshenzwe* *Kokunye abanawo amakhadi asetshenziswa uma ukhulelwe futhi ngatshelwa ukuthi angibuye ngoLwesithathu oluzayo ngoba babengenawo amakhadi awabakhulelwe ngakhoke ngathi uma sengifika ngabonwa kuqala.* *Okunye ken je ukuthi awukwazi ukusheshe uqale umtholampilo wabakhulelwe uma ulapha endaweni ngoba uyathakathwa uma nje abantu bala endaweni sebazi ukuthi ukhulelwe ungakuswela lokukukhulelwa* *Manjena ken je sengicabanga njalo ukuthi ngisuka ekhaya ukuya ekliniki uma sengibona imoto yasemtholampilo isima egcekeni lasemtholampilo yingoba bavele bangafiki (abasebenzi) futhi asitshelwa muntu asazi uma bengezukuza siye sibone imoto yekliniki ingafiki*	**nezinsizakalo eziphuthumayo** **Izikhathi nezinsuku zokusebenza Kwezizinda zezempilo Ezezokuthutha kanye nezezimali** **Isibalo samaklayenti amukelwayo nge sesheni eyodwa yekiliniki** **Ukubakhona kwabantu abasenzeayo kanye nezidingo zokusetshenziswa** **Izinga lokunakekelwa kwabakhulelwe. Ubudlelwane bomphakathi nezinkolelo zamasiko** **Ukuxhumana nokuveza izinto obala** **Ukuba nolwazi mayelana namasevisi anikezwa esikhungweni sezempilo**

								Nakuke okunye futhi *Lelikliniki lalana alinazo izindawo ezahlukene zamasevisi atholakalayo njengakweminye imitholampilo ezimele njengokuthi la ikwa TB, la esemgomweni, la indawo yabakhulelwe noma ngabe ken je kubhalwa emnyango yezindlu zokusebenzela kepha lana akukho (ayikho indawo yabakhulelwe) futhi asitshelwa lutho siyahlala nje silinde ukubona uNesi oyedwa.* *Abanako konke abakudingayo uma bezobona besize omama abakhulelwe. Ngenkahti ngifika ngoLwesithathu oludlule ngatshenwa ukuhti angibuye ngoluzayo uLwesithathu ngoba awekho amakhadi abakhulelwe. Namhlanje ngifike ngabonwa kodwa futhi umshini wokusheka enye yamathesti ubungasebenzi manje mh….lokukusho ukuthi ngilana futhi nangesonto elizayo ngizele lethesti ngathi mangibuza unesi ukuthi ithest yani unesi wathi iHB (haemoglobin test).* *Nakuba ngithanda ukusebenzisa isikhungo sezempilo u B1 Inkinga ukuthi nangalowo Lwesithathu abasebenzi(staff) uma bengezi asazi futhi akhukho okuhlelelwe thina kuye kube kumuntu azicabangele ukubuya ngoLwesithathu oluzayo noma avele aye ekliniki D.* ***Lezi izizonke izizathu ezenza sisebenzise ikliniki D ziningi izimo ezisiphoqayo.***	**Ukubakhona kwabantu abasenzeayo kanye nezidingo zokusebenza** **Ukuhleleka kwamasevisi ahlukene zezempilo** **Ukubakhona kwabantu abasenzeayo kanye nezidingo zokusetshenziswa** **Amalungiselelo ahlinzekelwa omama abakhulelwe lapho imitholampilo ivaliwe** **Ukuba nolwazi mayelana namasevisi anikezwa esikhungweni sezempilo**

Appendix 10: Transcription of an interview with a nurse

Study site	Participant No.	Age	Gender	Years of Services	Date	Recorded information	**Themes** and sub-themes
B1	N2	38	S	14	04/3/16	**Main research question:** **Tell me more about "how do pregnant women from KwaMkhizwana access and utilise ANC services in your health care facility"? And how?** *Pregnant women do utilise by coming for mainly first visits but numbers are very low. In the last three to six months that I have been working here I have only seen three in that period and all were first visits. No repeat visits at all.* *They come and do pregnancy test and if positive and they start ANC I think two out of the three came knowing their pregnancy status. Not all on the same day but with the estimated 3-6 month period.* *We do pregnancy test, diagnose and start ANC and do HCT if it is positive we then initiate ARVs this is the only time we give ARVs in mobiles this affects our statistics as we only initiate and issue ARVs only to ANC clients."* ***But then numbers are very low meaning we initiate low numbers and do HCT but repeats don't come*** **Probing based on nurses responses** **What do you think are the reasons for the numbers that are seen at the facility where you are working?** *The clinic limited operational days and times may be challenging for pregnant women. The clinic is only open once on a Wednesday at health post B1 and once on the Monday at health post B2 and we leave soon after the clients are finished there is no set time to leave."*	**Access to health care and emergency services** **Quality of ANC services** **Organisation of health care services** **Access to health care and emergency services.** **Health care facility operation days and times**

						Another reasons may include that may be pregnant women were referred or told to go to fixed clinics by nursing sisters (PNs) before "*I am not sure the numbers are too low. I also heard they have their own socio-cultural influences although I am not sure because this is a deep rural area.* Maybe the shortages of staff also make them not use our facilities because even you yourself as a nurse you hide the service that are provided and clients then go where they know services are rendered e.g. in the fixed clinic *"Let's say you have 16 clients waiting, two are ANC clients, others are sick babies, sick adults and geriatric clients coming for their medications ……may be the two ANCs will need pap smear as they may be above 30years and also need HCT and when they test positive the pulling of bloods must be done by this time the pressure is rising because you are working alone which sometimes tempts you to send them away and calling them the following week for the care that was not done e.g. come back next week for pap smear"* This is what I think maybe are the reasons, because of one nurse seeing to all clients they do not want to stay long and be with all other clients coming for other services may be they prefer to be seen by nurse only designated for them in an designated ANC area. **These are the comments I hear while consulting** *"When I am busy consulting, the women in the waiting area commented and said the reasons why we don't like to come here is that we hold the same queue with all other clients and this takes longer because only one nurse is working."* Maybe because we do not give health education regarding services available and about the ANC and importance of ANC clinic attendance I don't know but I just think may be these are the reasons for low numbers.	**Socio and cultural beliefs** **Availability of human and material resources** **Provision of service per clinic session** **Organisation of health care** **Lack of human and material resources** **Designated nurse to attend to pregnant women.** **Communication and transparency regarding service delivery** **Designated nurse to attend to pregnant women.** **Information regarding importance of ANC attendance**

						Because really *"….You can't even give health education about what other services are offered because of workload e.g. educate about Pap smears if all clients want to do the Pap smears this whole workload will be yours alone and may delay the time to finish the clients. When you go home you feel guilty knowing very well you did not do what you were supposed to do"* **Another probing question was:** **What provisions are available for the pregnant women during the days when the facility where you are working is not open?** **This is what the nurse had to say:** *"No arrangements can be done on our side as staff but made at management level it can but I think these are the reasons for the low numbers that we see because clients just use fixed clinic for its availability and maybe I think that it can be a management decision we as staff there is nothing much we can do regarding what pregnant women must do when clinic is closed, may be building a fixed clinic in the area may solve the issue"* **What happens if a pregnant woman presents to your clinic when you are not providing ANC services?** *"This does not happen ANC services are provided all the time they (pregnant women just do not come as we would like to see them coming, the numbers are too low as I have said earlier on only 3 came in the period of 3-6 months. Mh….This is very low".* *"What is surprising is that even the very first visits that came initially they hardly come as repeat visits so this means our clinics are not accessible to them but they don't say well I have never asked". Maybe our ANC services are not easily available Yah… we have limited times and days.* **Another probing question:**	**Information regarding other relevant health issues** **Information regarding clients rights to health care** **Provisions for pregnant women when clinics are closed** **Access to health care and emergency services** **Quality of ANC services** **Access to health care and emergency services** **Quality of ANC services** **Organisation of health care** **Access to health care and emergency services**

						What can be done to ensure accessibility and utilisation of ANC services in your facility? The nurse stated that if staffing can improve and then health education can be given freely and ANC services can be promoted and quality of ANC can also improve. "…*If the staffing improves health education in the morning will be given freely about all available services without any pressure knowing that the workload will be shared amongst all staff I definitely think that ANC clients from the area attending clinic D will come back to us"* *Well giving of more health education about ANC services but may be increasing operational days to twice a week can also help but I think a fix clinic is needed in the area not only for pregnant women but for daily accessibility of all services for everyone in the community.*	**Communication and transparency regarding service delivery** **Information regarding other relevant health issues**

Appendix 11: Professional editor's certificate

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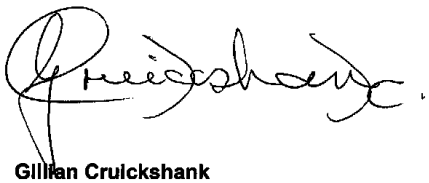
TO WHOM IT MAY CONCERN

13th May 2016

re: **Ms T.J. Bhengu – Master's Dissertation: Nursing**

I confirm that I have proof-read Ms Bhengu's Master's dissertation text in respect of grammar, punctuation, sentence length, spelling, use of tenses, referencing method and accuracy. It is to be noted that verbatim quotations (referenced or study participants) have not been amended in any way due to the nature of the material. A correlation has also been done regarding the in-text references and the reference list. Some recommendations have been made to the student regarding realignment or the correction of specific elements, where she needs to refer to her own notes or other source material.



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