

The accessibility and utilization of antenatal care clinics in the Capricorn District, Limpopo Province, South Africa

F.M. TLADI

Department of Nursing Science, University of Limpopo, Turfloop Campus, South Africa.
E-mail: florah.tladi@ul.ac.za

Abstract

One of the most important factors relating to antenatal care provisions as one of the components of Primary Health Care (PHC) is that they should be easily accessible to all pregnant women for whom these provisions are intended. Accessibility is directly related to the availability, affordability, acceptability, and utilization of the antenatal care clinics by pregnant women. The aim of the study was to explore and describe the factors that influence the accessibility of antenatal care clinics in the rural areas, Capricorn district, Limpopo Province. The researcher used an exploratory, descriptive and contextual design for this approach this study. Data were obtained through interviews with postpartum women, clinic and hospital nurses as well as with nurses from the Maternal and Child Health (MCH) Office in the Provincial Department of Health and Welfare. The results of this research show that several personal and situational factors experienced by both health care users and health care providers have an influence on the accessibility of the antenatal care clinics. Recommendations evolving from this study are that pregnant women, plan their pregnancies, use contraceptives to delay and avoid unplanned and unwanted pregnancies, use the existing clinics and attend regularly.

Keywords: Antenatal care, clinic, accessibility, utilization.

How to cite this article:

Tladi, F.M. (2014). The accessibility and utilization of antenatal care clinics in the Capricorn District, Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, June (Supplement 1:2), 307-317.

Introduction

Antenatal care is a 20th century phenomenon which has generated keen interest amongst obstetricians, midwives and community nurses, and among women, in general. Before 1900, little medical advice was sought by pregnant women. Only those women who could afford to pay for medical attention visited a doctor seeking relief from minor ailments. Until 1901, when Ballantyne called for the establishment of pro-maternity hospitals, little thought had been given to the possibility of conditions responsible for complications during labour, being averted by antenatal detection and treatment (Tew, 1990). The pro-maternity hospitals were established for the benefit of pregnant women who were ill or tired in late pregnancy, but mostly for doctors to learn more about the mother and the foetus during pregnancy, by studying the bodily secretions of the mother. In this way, Ballantyne felt that the mortality rate of mothers could be further reduced and the life and well-being of the child preserved (McClure- Brown & Dixon, 1978). This move of pregnant women into a hospital environment was

encouraged by the report of the Population Investigation Committee, in collaboration with the Royal College of Obstetricians and Gynaecologists in 1946, in the United Kingdom, who claimed that “institutional confinement ensures ‘maximum safety’ of the mother and child” (Health Committee Report, 1991-1992: vii).

February 1990 also saw the birth of a new plan for health care in the Republic of South Africa (Health Policy Forum, 1992), as it was recognised that the separate health services, each with its own administration and variety of services being provided by various authorities led to confusion, increased cost, fragmentation, wastage of resources and thus exclusion from being utilized by those genuinely in need. The aim of the new plan was to put all the services at the lowest cost-effective level to provide health care that is acceptable, available, accessible, affordable, efficient and equitable (Health Policy Forum, 1992). In April 1984, all health services came under the overall administration of the Department of National Health and Population Development with a Regional Health Co-ordinating Committee for each region. This meant that there was "own" and "general health affairs" or separate health departments for the various houses in Parliament (Vlok, 1996).

All women should have access to basic maternity care (Williamson & Thompson, 1996). Basic maternity care comprises quality antenatal standards including clean and safe delivery whether such service takes place at home or in an institutional setting. It also includes early postpartum care for mother and infant to detect and manage complications, such as secondary postpartum haemorrhage, eclampsia and sepsis, and to offer support for breast feeding.

Women should be encouraged to attend antenatal care services in the first trimester, usually 10 to 12 visits during pregnancy (Westaway, Wolmarans & Wessie 1992). Educating women regarding early and regular attendance at the antenatal care clinic is an important measure of preventive primary health care. This applies particularly to those women living in informal settlements as well as in the rural areas where there is lack of facilities.

Utilization

Services or actual coverage is expressed as the proportion of people in need of a service who actually receive it in a given period, usually a year; for example, the proportion of pregnant women who receive antenatal care or have their deliveries supervised by a trained attendant. In estimating actual coverage, countries have to specify the minimum level or standard of care acceptable as coverage. In certain countries and in some parts of South Africa, including the Limpopo Province, facilities exist but lack of drugs or poor quality care results in people not using the services. Another reason for non-utilization is that facilities may be

open at hours of the day when people are not able to use them because they are occupied in the fields or factories (World Health Organization, 1981).

Antenatal care services have been declared free of charge for pregnant women and children under six years of age in public clinics since April 1994. From the investigator's personal observation it would seem that some pregnant women, especially those who live in the rural areas in the Limpopo Province, still do not make effective use of these services. The ReHMIS report on health care in the Limpopo Province (ReHMIS Data Base, 1996) states that more than 20% of antenatal visits are being performed at the hospital level which may not be appropriate and the possibility of performing these examinations outside the hospital should be given serious consideration. The report further states that "it is likely that access to the various facilities may be a consideration." It is important for pregnant women to utilize these services in order that they can be given a thorough medical examination and to ensure a live and healthy baby during and after delivery.

Methodology

Design

A quantitative and descriptive study, which was contextual in nature, was conducted so that more insight could be gained into the factors relating to the accessibility and utilization of antenatal care services from postpartum women and health care providers who have to utilize and work in the rural antenatal care clinics respectively.

The study setting

The study was conducted at two hospitals, three public clinics in the rural Limpopo Province as well as from members of the Provincial Maternal, Child and Women's Health Directorate. The researcher focussed on the question "why are pregnant women in the Capricorn district, Limpopo province not accessing and utilizing the existing antenatal care services?"

Population and sampling

The study population consisted of postpartum women and nurses at the Mankweng and Polokwane hospitals, clinic nurses in three public clinics in the rural areas and members of the Maternal, Child and Women's Health Directorate in the Capricorn district of the Limpopo Province. These respondents were used as volunteers to gather first-hand information on the accessibility and utilization of antenatal care services.

A purposive sampling technique was used which involved a conscious selection by the researcher of certain population groups to include in the study (Burns & Grove, 1993).

Postpartum women who had delivered their babies at the predominantly rural Mankweng and the urban Polokwane hospitals, who were still hospitalised for about 8 hours post-delivery, and who were residents in the area and were conversant with the Northern Sotho (Sepedi) language were requested to participate in the study.

Data collection

Interviews provided information about the experiences and views of postpartum women, clinic and hospital nurses, and nurses from the Maternal, Child and Women's Health Directorate on the factors relating to the accessibility and utilization of antenatal care services in the Limpopo Province rural clinics. These were structured like conversations about insights into the respondents' values and experiences about these services. The interviews were tape recorded.

Reliability and validity

The reliability of the instrument was established prior to the commencement of the study by pre-testing the questionnaire at a clinic that was not going to be part of the study. Validity of the instrument was ensured by conducting intense literature surveys on the accessibility and utilization of antenatal care clinic issues.

Ethical considerations

Permission to undertake the study was obtained from the Limpopo Province Superintendent General through the Department of Health And Welfare Research Office. All the respondents in this study had the broad aims of the study explained to them and confidentiality assured. Consent for the use of a tape recorder was obtained and, where given, consent forms were signed by the respondent, the researcher and a witness. Respondents were advised that they could terminate the interview at any stage without any repercussions. Postpartum women respondents recruited through the two hospitals, clinic and hospital nurses as well as the MCWH office respondents were advised that their participation in the study would in no way affect their health care or employment status. The data were processed ensuring anonymity and confidentiality.

Data analysis

Data relating to the demographic profile of postpartum women were analysed by means of the Statistical Package for Social Sciences (SPSS) version 15. Tape recorded interviews were analysed independently by the researcher and an independent coder.

Results and Discussion

Table 1 presents the attendance at the antenatal clinic.

Table 1: Attendance at the antenatal care clinic

Antenatal care attendance	N	%
Pregnant women who attended the clinic	34	33.6
Pregnant women who did not attend the clinic	76	66.4

N = 110

The total number of respondents was 110 of which 34 (33.6%) were “booked” and the remaining majority of 76 (66.4%) were “un-booked. Provided in Table 2 are data regarding the number of antenatal care visits and bookings.

Table 2: Number of antenatal care visits and booking status

Antenatal care visits and booking status	N	%
Pregnant women who did not attend the clinic	76	69.1
Those who made one visit	1	.9
Two visits only	20	18.2
More than two visits	13	11.8

N = 110

Seventy-six (66.4%) of the one-hundred -and - ten respondents did not attend the antenatal care clinic and were thus “un-booked” during the present pregnancy. The remaining thirty-four (33.6%) who attended and were thus “booked” women made very few visits to the antenatal care clinic. Only 13 (11.85%) of the thirty-four respondents who attended the antenatal care clinic made more than two visits. According to De Kock and Van der Walt (2004), the comprehensive aim of antenatal care services is to prepare the pregnant woman and her family for pregnancy, labour and the puerperium, including lactation and subsequent care of the new-born baby. In 2007, a survey was conducted among nursing students to determine the factors that influence their decision-making with regard to contraceptive use and pregnancy. It was, at that time, found that a lack of guidance issues of sexuality and sex education which was reinforced by cultural taboos inhibit such discussions and that the pregnancy was unplanned for all the respondents (Arhin & Cormier, 2007). In Table 3, results on respondents’ age and booking status are presented.

Table 3: Respondents' age and booking status

Age and booking status	N	%
Un-booked under 16 years	9	8.2
Un-booked 16-20 years old	32	29.1
Booked 21-30 years old	32	29.1
Booked 31-40 years old	19	17.3
Booked over 40 years	18	16.4

N = 110

Results in Table 3 provide answers to question 1 on the interview schedule that asked the question "how old are you?" from both the "booked" and the "un-booked" respondents. 41 or 37.3% of the women between the ages <16 and 20 years old and were un-booked, only 8 out of 32 in the age group 21-30 years, 16 out of 19 in the age group 31-40 years were booked and 10 out of 18 of the >40 years were booked patients at the antenatal care clinic. Age seemed to be a factor that influenced the decision to utilize or not to utilize the antenatal care clinic.

It was also of interest in this study to examine the respondents' marital status and their booking status. Results are presented in Table 4.

Table 4: Respondents marital, booked and un-booked status

Marital status of respondents	N	%
Single women	72	65.5
Married	18	16.4
Divorced	2	1.8
Widowed	3	2.7
Living with partner	15	13.6

N = 110

The above were the responses to the question "What is your marital status by all the 110 respondents irrespective of whether they were "booked" or "un-booked". 72 or 65.5% of the respondents were single, 18 or 16.4% were married, 2 or 1.8% were divorced, 3 or 2.7% were widowed and 15 or 13.6 were living with their partners. There were more single pregnant women than married, divorced, widowed or those living with their partners who did not attend the antenatal care clinic.

Results concerning the respondents' educational level and booking status are provided in Table 5. The majority of the respondents, (71.8%) had a lower than Standard 10 level of education. The table suggest that women with a lower educational below a standard 10 do not attend the antenatal care clinic as frequently as those with an education level above a Standard 10.

Table 5: Education and booking status of respondents

Level of education	N	%
Illiterate	1	.9
<Std 3	17	15.5
Std 3-4	9	8.2
Std 5-7	27	24.5
Std 8-9	26	23.6
Std 10	22	20
Tertiary	8	7.3
Total = 110		

The majority of the respondents, that is, 71.8%, had a lower than Std 10 level of education. The table as well as the figure seems to suggest that women with a lower educational level below a standard 10 do not attend the antenatal care clinic as frequently as those with an education above a Std 10.

The possible impact of the respondents' employment, income and booking status was also investigated. The results are summarized in Table 6.

Table 6: Respondents employment, income and booking status

Employment, income and booking status	N	%
Employed	19	17.3
Unemployed	61	55.5
Scholar/student	30	27.3
N = 110		
Respondents Income		
Income	N	%
None	91	82.7
R100-R999	3	2.7
R1000-R1999	9	8.2
R2000-R2999	7	6.4
Total = 110		

All the students below the age of 16 years, 41% of the 16-20 years, 19% of the 21-30 years and 11% of the over 40 years were not employed whilst 13% of the 21-30year old, 47% of the 31-40 year old and 33% of the over 40 year old were employed.

Respondents past antenatal care clinic attendance

The next questions were on "Did you attend the antenatal clinic or see a doctor or midwife during your previous pregnancies?" The results are provided in Table 7.

Table 7: Previous attendance at the antenatal care clinic and booking status

Previous antenatal care clinic attendance	N	%
Booked women who attended	39	35.5
Women who did not attend	48	43.6
Primigravid women who attended	23	20.9

N = 110

Most of the respondents, that is, 94% started attending the clinic late during the third trimester and only made two visits; a further 70% started in the second trimester and made > than two visits and 86% during the first trimester of pregnancy and made more than two visits to the antenatal care clinic.

Means of getting to the clinic and booking status

Table 8 summarises the data on how the respondents got to the clinic and an answer to the question “How did you get to the clinic?” In this sample, only 11 respondents (10.1%) walked to the clinic whilst 23 (19.61%) either used a bus, car or taxi to access the nearest clinic. The clinics seem to be situated far away from the respondents such that it becomes difficult for them to walk to the clinic. Transport money also seemed to be a problem as most of the respondents were unemployed whilst others were scholars/students.

Table 8: Means of getting to the clinic

Never attended the clinic	N	%
	76	69.1
Walk to the clinic	11	10
Travel by bus	4	3.6
Uses a car	3	2.7
Uses a taxi	16	14.7

N= 110

The question asked was “how long did it take you to get to the clinic?” (Table 9). Twenty - two (N = 22 or 20%) took 30 - 45 minutes to reach the clinic whilst eleven (N = 11 or 10%) took about 45 - 60 minutes to get to the clinic.

Table 9: Time taken to reach the clinic and booking status

Time taken to reach the clinic	N	%
Un-booked women	76	69.1
30-45 minutes	22	20
45-60 minutes	11	10
1-2 hours	1	.9

Total = 110

Results concerning the question “were you attended to by a midwife in the clinic?” are presented in Table 10. All the 76 (69.1%) respondents who attended the antenatal care clinic preferred being attended to by the midwife. Only 34 (30.90) wished to be attended to by a medical practitioner or doctor.

Table 10: Attendance by a midwife or doctor at the antenatal care clinic

Preferred health care worker	N	%
Prefers a midwife	76	69.1
Wish to be seen by a doctor	34	30.9

Total = 110

In Table 11, results regarding waiting time at the antenatal clinic are provided. Out of a total of thirty - four respondents, twenty - three (N = 23 or 20.9%) had to wait for 30 - 60 minutes and eleven (N = 11 or 10.0%) for 1 - 2 hours before they could be attended to by the midwife. The long waiting times of up to 2 hours duration at the clinic seemed to be a factor that influences the accessibility and utilization of the antenatal care clinics.

Table 11: Waiting time at the antenatal care clinic

Waiting time before consultation	N	%
Number of late attenders'	76	69.1
30-60 minutes for booked women	23	20.9
1-2 hours for booked women	11	10

N = 110

The results from the postpartum women's responses on various issues relating to their demographic data which might have an influence on the accessibility and utilization of antenatal care clinics are discussed. The booking status of the respondents, age, marital status, educational standard, employment status, the number of antenatal care visits made, income, the trimester during which the woman started attending the antenatal care clinic, means of transport to the nearest clinic, distance travelled to the clinic, provider preference and waiting time to be attended to at the clinic will be analysed in relation to their association to the accessibility and utilization of the antenatal care clinic.

South Africa is experiencing a steady increase in the population, the major cause of this being attributed to the rate at which the youth are becoming pregnant (Sepota & Mohlake, 2004). It was suspected that the University of Limpopo, Turfloop campus is experiencing an increase in pregnancy despite the presence of the health centre and freely available condoms in the halls of residences. Out of total of 110 respondents, 76 or 69% did not attend the antenatal care clinic. This figure comprises 9 (100%) of the below 16 year old, 32 (100%) of the age group 16 - 20 years, 20 (62.5%) of the 21 - 30 years old, 3 (15.8%) of the 31 - 40 years old and 8 (44.4%) of the over 40 years old. Furthermore, these women were also single in comparison with their married counterparts and those who were living with a partner. The respondents' marital status seemed to play a part in whether the respondent attended or did not attend the antenatal care clinic.

The 80 educational level and the unemployment status of the respondents could also play a part in whether they attended or did not attend the antenatal care clinic. The 30 (27.3%) respondents who attended the antenatal care clinic quite frequently had an educational level of above Standard 10 and tertiary education

level. More of the employed respondents (19 or 17.3%) compared to the unemployed and **students** attended the antenatal care clinic. Age was another factor that seemed to influence the accessibility and utilization of the antenatal care clinic. The older the respondents (37; 33.7%), the better the chances that they will make use of the antenatal care clinic. Income also seemed to determine whether the respondent attended or did not attend the antenatal care clinic. Some of the respondents (12; 10.9%) who had some form of income attended better than the 91 (82.7%) without any source of income.

The lack of transport to the clinic, the long-time of up to 2 hours taken to reach the clinic as well as the long waiting time of more than 2 hours in some cases to be attended to at the clinic can be seen to be influencing the accessibility and utilization of the antenatal care clinic.

Recommendations

In order to provide antenatal and other comprehensive health care services for adolescents/teenagers the following recommendations are made based on the results of the study:

- Pregnant women should book early at the antenatal clinic and make regular visits of up to 10-12 visits.
- Travelling distances to the clinics should be shortened to 5-10km from where pregnant women live.
- Mobile clinics should be used for women who stay far away from such clinics.
- Fertility control that involves contraceptive education to prevent unplanned and unwanted pregnancies, as well as referral for contraceptive services are recommended.
- Women are advised to concentrate on their education before they engage in sexual activities.
- Waiting time by pregnant women should be shortened in order to encourage these women to attend the clinics.

References

- Arhin, A.O. & Cormier, E. (2007). Factors influencing decision-making regarding contraception and pregnancy among nursing students. From the World Wide Web:<http://www.Sciencedirect.com> August 22, 2009.
- Burns, N. & Grove, S.K. (1993). *The Practice of Nursing Research, Critique and Utilization*. London: WB Saunders Company.
- De Kock, J. & Van der Walt, C. (2004). *Maternal and Newborn Care: A Complete Guide for Midwives and Other Health Professionals*. Cape Town: Juta & company limited.

Health Committee Report: 1991-1992 (1992). *Maternity Services. Second Report to the House of Commons on the Maternity Services, 1972-1992, Volume 1*. London: Majesty's Stationery Office.

Health Policy Forum (1992). ANC Policy Guidelines on Health. *South African Medical Journal*, 82, 392-393.

McClure-Brown, M.C. & Dixon, G. (1978). *Brownne's Antenatal Care* (11th ed.). Edinburgh: Churchill Livingstone.

ReHMIS Data Base (1996). *Health Care in the Northern Province. Implications for Planning*. Durban: Kwik-Kopy Printing.

Sepota, M. & Mohlake, M. (2004). Pathways to higher education. World Wide Web:<http://www.pathwaystohighereducation.org/institutions/i.php?id=128>. March 2, 2010.

Tew, M. (1990). *Safer childbirth? A Critical History of Maternity Care*. London: Chapman and Hall.

Vlok, N.E. (1996). *Manual of Community Nursing and Communicable Diseases*. Cape Town. Juta & Company Ltd.

Westaway, M., S., Wolmarans, L. & Wessie, G., M. (1992). *Perceived health status, health values and the need for health education*. Unpublished report on Ivory Park Project. Pretoria. Medical Research Council.

Williamson, S. & Thomson, A., M. Women's satisfaction with antenatal care in a changing maternity service. *Midwifery*. Dec 12(4), 1996.198-204.

World Health Organization (1981). *Global Strategy for Health for all by the year 2000*. "Health for all" Series, No 3, 26. Geneva: WHO.