

Strategies for making antenatal care clinics accessible to teenagers in rural Limpopo Province, South Africa

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Abstract

The goal of community health care service is that it should be geographically, financially, culturally and socially accessible to its consumers. Services or actual coverage is expressed as the proportion of pregnant teenagers in need of antenatal care services who actually receive it in a given period. This study was conducted in the rural Capricorn district in the Limpopo Province in South Africa to identify the reasons why pregnant women fail or delay to attend antenatal care clinics. The objective of this study was to develop strategies for improving accessibility and utilization of the antenatal care services in the area. A qualitative, descriptive study was conducted. Postpartum women, clinic and hospital nurses as well as nurses from the Maternal and Child Health (MCH) Office in the Provincial Department of Health and Welfare were interviewed. 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. This study was conducted in two phases: Phase 1 and Phase 2. This article reports on Phase 1 of the research which recommends that adolescents should focus on their studies, delay pregnancy until adulthood, and if they find themselves pregnant should attend antenatal clinics regularly.

Keywords: Strategies, antenatal care, clinics, accessibility.

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Introduction

The accessibility of clinics in this study refers to the appropriate type of antenatal care made available to the individuals, that is, pregnant adolescents and teenagers who need it when necessary. It means properly trained personnel provide all types of care according to the Primary Health Care Package (Strategy for Primary Health Care in South Africa, 1994).

From the researcher's observation, study findings, and from the literature, adolescents and teenagers do not avail themselves of the antenatal care clinics because they do not want to disclose their pregnancy status to their parents, as it is expected of them not to be engaging in sexual activities as teenagers but to concentrate on their school work. When a service is not readily accessible, as was the case in this study, then such a service should be brought nearer to the

patients (Van Vuren, 1994). Taking mobile clinics to rural people in the rural areas of South Africa and providing adequate out-patient facilities are examples of efforts to make services more accessible (Booyens, 2001). Antenatal care clinics should not be situated more than five kilometres from where the users of the service live (Monamodi, 1998). Mobile clinics will increase coverage (accessibility).

Enkin, Keirse, Renfrew and James (2000), report that the accessibility of antenatal care services is imperative in ameliorating the well-documented health problems which pregnant adolescents often encounter. The needs of pregnant adolescents/teenagers will have to be met in order to overcome the health problems associated with early childbearing such as non-attendance of the antenatal care clinic. Accessible, available, affordable, comprehensive, and coordinated healthcare for teenagers are an important service component both in the primary prevention of adolescent pregnancy and in caring for pregnant and parenting teenagers.

In view of the need to have access to basic maternity care (Williamson & Thomson, 1996), South Africa and the Limpopo Province have adopted the World Health Organization's (WHO) perspective on the accessibility of primary health care and antenatal care services. In her budget speech on 16 May 1990, the then Minister of National Health and Population Development identified the principles involved in providing health care, which today are still relevant to the provision of antenatal care services in the Limpopo Province (Department of Health & Welfare, 1999). The WHO and South Africa refer to accessibility in a primary health care context, and include antenatal care as part of this primary health care mortality.

Methodology

A qualitative, exploratory, descriptive (Mouton & Marais, 1993; Burns & Grove, 1993), and contextual research was conducted to determine the reasons why adolescents and teenagers do not use the antenatal care clinics in rural Capricorn district, Limpopo province when they are pregnant.

Study sample location

The study was conducted at three public clinics, two Provincial hospitals and the Maternal and Women's Health Directorate in the Capricorn district in rural Limpopo Province, South Africa.

Study population and sampling

The study population consisted of consenting postpartum women who had delivered their babies at the Mankweng and Polokwane hospital maternity units where all pregnant women are expected to deliver their babies. Officers in the Maternal and Women's Health Directorate were also interviewed. A purposive sampling technique was used to select the sample. This involved the conscious selection by the researcher of certain subjects or elements to be included in the study, and included "typical" subjects (Burns & Grove, 1993).

Data collection

Data for this study were gathered using personal interviews and by reviewing patients records in order to determine whether the patient was "booked" or "un-booked" and to determine the number of antenatal care visits they had made during pregnancy. Data were collected until saturation was reached, that is, when the researcher experienced a redundancy in the descriptions and explanations from the participants (Parse, Coyne & Smith, 1995; Morse, 1995).

Measures to ensure trustworthiness

According to Krefting (1991), there are four aspects of measuring trustworthiness, namely, credibility, transferability, dependability and conformability. The researcher wanted to discover the reasons why adolescents and teenagers do not utilize the existing antenatal care clinics. Strategies like triangulation (interviews and observation), prolonged engagement in data collection to get more clarity increased the credibility of the study. The interviews were conducted in "naturalistic setting" (Krefting, 1991), in the wards and office of the Directorate. In ensuring consistency (dependability) the variability of the interviews were noted by noting personal, theoretical and non-verbal communications (observations) from the participants. To ensure neutrality, the researcher's findings were based solely on the participants' information and conditions of research. To ensure that data were free from bias, the researcher adhered to rigours in the methodology. The data were confirmed as a product of the phenomenological narratives of the participants by comparing these with the literature on accessibility and utilization of antenatal care services in South Africa and internationally.

Ethical Considerations

Permission to conduct the study was obtained from the Limpopo Department of Health, as well as from the Research Committee, the Nursing Service Manager and institutional Ethics Committees of the two hospitals and from the participants. Participants were asked to give consent after they had been assured

that their information would not be made available to unauthorised persons. They were also assured their right to confidentiality and anonymity. Anonymity was assured by allocating numbers to the participants and confidentiality by guarding against unauthorised access to raw data. Participants were further informed of their rights to withdraw from the study at any time without experiencing any repercussions to them.

Data analysis

In this study, qualitative analysis was done, similar topics were clustered together, categorised and common themes identified. Tesch method of data analysis was used (Creswell 2003). Data were grouped into five themes, namely, lack of special antenatal care services for the adolescents/teenagers; no health education lessons for adolescents/teenagers to attend antenatal care clinics regularly; the long distances to attend the nearest clinic; lack of quality staffing at the clinics and lack of minimum resources at the clinics.

Results and Discussion

Themes and sub-themes which reflect the non-utilization of the antenatal care clinics by adolescents/teenagers which emerged from data analysis are summarised in Table 1.

Table 1: Themes and sub-themes which reflect the non-utilization of the antenatal care clinics

Themes	Sub-themes
Theme 1: Lack of special antenatal care Clinics for adolescents/teenagers	1.1 Provide suitable and user-friendly antenatal care services 1.2 Provide a Comprehensive health service for adolescents
Theme 2: Pregnant adolescents lack of knowledge about pregnancy and antenatal care services	2.1 Poor standards of education
Theme 3: Long travelling distances to the nearest antenatal care clinic	3. 1 Travel distance to the clinic
Theme: 4 Provision of adequately trained personnel	4.1 Provision of adequate staffing at the clinics
Theme 5: There Should be Provision of Minimum Resources at the Antenatal Care Clinic	5 1 Lack of material resources at the clinic

Theme 1: Lack of special antenatal care clinics for adolescents/teenagers

Adolescents/teenagers are expected to attend the same antenatal care clinics with other age groups, including their mothers. This age group should be provided with health education lessons and separate antenatal care services at existing clinics. Antenatal clinics in rural Limpopo Province do not have services intended for teenagers.

There is a need for management of antenatal clinics to consider providing separate and special antenatal care services for this group.

Sub-Theme 1.1: Provide suitable and user-friendly antenatal care services

The school-based clinics are recommended as a strategy for making antenatal care services and other forms of Comprehensive Primary Health Care accessible to the adolescents and teenagers (Brindis & Jeremy 1988).

Sub-Theme 1.2: Provide a Comprehensive health service for adolescents

Services such as antenatal care and other comprehensive health care should be provided on a daily basis at the school clinic for two hours during the afternoons and for a full two to three days later on, as soon as the service is well established. The provision of school-based clinics will assist in making antenatal care clinics more accessible for pregnant teenagers and adolescents.

Theme 2: Pregnant adolescents/teenagers lack knowledge about pregnancy and antenatal care services

Thaddeus and Maine (1994), report that education is measured by the number of years of formal schooling. In developing countries, men generally have attained higher educational levels than women; 71.8 % of the respondents had a lower than Standard 10 level of education. The conclusion in relation to the role education plays in the decision to seek antenatal care is that better educated women tend to access the antenatal care services more readily than the women with a lower educational status. The empirical findings of the study are in line with the findings of Thaddeus and Maine (1994) who report that “most of the studies reviewed show that utilization of health services increases with increasing levels of education. The positive association repeatedly documented is that between the mother’s education and use of maternal and child health service” where Kalmuss and Fennelly (1990), Sculpholme, Roberts and Kamons (1991) report that women who did not complete their high school education were less likely to seek or obtain antenatal care.

According to Nolte (1998) antenatal care is often thought of as preventive care, and the relationship between early- and continued- antenatal care and a positive outcome for the mother and baby is well established. The contents of antenatal preparation are adapted to the needs of the individual. In this study, the needs of pregnant adolescents/teenagers are that they be educated about the importance of availing themselves early and regularly at the antenatal care clinic.

Sub-Theme 2.1: Poor standards of education

Benn (1994) reports that age at time of pregnancy and level of education are related factors in that the younger a woman is at the time of pregnancy, the more likely she is to drop out of school and thus tends to have a lower level of education. The level of education has been cited by a number of authors as having an influence on the utilization antenatal care services (Kalmuss & Fennelly, 1990; Pettiti, Hiatt, Chin & Croughan-Minihane, 1991; Young, McHahon, Bowman & Thompson, 1990; Scupholme, Roberts & Kamons, 1991; Willis & Fullerton, 1991; McClanahan, 1992). According to the research findings of the latter three authors, women who did not complete their high school education were less likely to obtain antenatal care. In this study adolescents interrupted their studies by becoming pregnant whilst they were still at school with the possibility of not completing their studies.

Theme 3: Long travelling distances to the nearest antenatal care clinic

Although geographic accessibility is usually measured in terms of distance (Vos, Borgdorff & Kachidza, 1990), the area and the population density of the area have to be considered too. Poland, Taylor & Hayes (1990) indicate that the distance from the central location to the nearest health facility is measured in terms of kilometres and ease of access to that facility. People living more than five kilometres from a static clinic and more than three kilometres from a mobile clinic site have poor access to health care. Garrett (1995), reports that a lack of transport, as the case in many developing countries and including the findings in this study, explains why people may not make use of the health services. According to Giamb Bruno, Cowell, Barber-Madden & Mauro-Bracken (1997), transportation relates not only to the availability thereof, but also to costs, accidents, safety of the vehicles and their maintenance. Although health care services such as antenatal care services may be rendered free of charge at clinics, as is the case in Limpopo Province, making use of the service is still expensive in that unemployed pregnant women could not afford transport costs to the clinic thus limiting the geographical accessibility to the health care service

Casey, Wellever and Moscovice (1997) indicate that a minimum set of health care services must be available within certain distances. This will improve the utilization of health care services such as antenatal care. Antenatal care clinics have to be geographically, functionally, financially and culturally accessible in order for the services to be in line with the principles of *Batho-Pele* directed at the delivery of a patient-friendly service. According to Myles (1996), the timing and number of antenatal care visits will depend on the individual. Currently, visits are monthly for pregnancies up to 28 weeks, fortnightly for 36 weeks old pregnancies and weekly until delivery. New schemes of antenatal care encourage referral to the midwife much earlier in pregnancy. This would help to make the

midwife's support and advice far more effective. Frequency of visits for those women who are considered at low risk is being reduced in order to decrease the number of times that they need to travel to the clinic, and by so doing, cut down on travelling costs. Pregnant women are invited to attend the clinics only at particular times or when a specific reason for examination exists. The frequency of these visits could be decided upon by the woman and her midwife with the option of self-referral if necessary between agreed visits. Should any risks develop during pregnancy, the woman will be invited to attend more frequently and the place of confinement will be reviewed.

Sub-Theme 3.1: Travel distance to the clinic

The provision of transport in developing countries, including South Africa is, according to Thaddeus and Maine (1994), a harsh reality. This was evidenced by the fact that pregnant women, spent up to 2 hours to reach the nearest clinic. Several comparatively inexpensive measures that could make antenatal care services more accessible could be achieved by reducing travel distance to the clinic. Simply expressed, either pregnant women have to move closer to the services, or the services have to move closer to them. The existing clinic committees that consist of influential community leaders and the clinic staff will have to address the transport problem as a factor for the non-accessibility to the antenatal care clinic.

Thaddeus and Maine (1994) report that the inhabitants in rural areas generally walk in order to reach a health care facility. Transport to the rural Limpopo Province antenatal care clinics is usually problematic and sometimes unavailable. Where there is a bus service, the schedule is such that it will be available early in morning only to be available for a return trip in the late afternoon. Taxi fares are very expensive, especially because most women in this study were unemployed and therefore did not enjoy a stable monthly income to enable them to pay for transport to the clinic. Due to lack of transport, most pregnant women in the rural areas do not access the antenatal care clinic until late in the third trimester of pregnancy, and thus make very few visits to these clinics.

Theme 4: Provision of adequately trained personnel

The Department of Health (1999) defines human resource management in terms of staffing which entails recruitment, (advertising, selection, appointment and placement), utilization (determination of requirements, productivity, allocation of duties), development (training, induction/orientation, in-service education training and continuous education) and retainment (fair labour practices and remuneration). The quality of antenatal care service personnel has to be addressed to improve the poor service that is presently being rendered.

The Department of Health (1999) further reports that primary health care and antenatal health care are about people and their interactions. Thus the quality of antenatal health care services rendered, depends very much on the calibre of the service providers, and the manner in which they interact with the community.

Sub-Theme 4.1: Provision of adequate staffing at the clinics

Participants views were that there should be adequate staffing at the clinic with well qualified staff who will provide quality antenatal care services. Muller (2002) states that the provision of personnel (also known as staffing) is primarily the responsibility of the nursing service manager. When a philosophy and the principles of participative management are pursued in the nursing service, the unit manager should also play a role in the provision of personnel in the unit. In other words, she/he should effect inputs into the identification of the type of personnel required, as well as participate in the selection of the personnel member. An under-supply of personnel in the unit gives rise to poor nursing; it has a demoralising effect on personnel and causes frustration and exhaustion. An over-supply may be just as improper and lead to role confusion, boredom, interpersonal conflict, communication problems and low productivity. An inappropriate staff mix in the unit thus causes endless problems. Staff employment should be in line with the size of the population to be served (Muller, 2002).

It is important to provide adequate health care personnel in each clinic to facilitate the provision of good quality antenatal care services. Transformation and restructuring of the clinic staffing pattern as well as service provision (Department of Health, 2000) is necessary if the ideal of the accessibility of the antenatal care clinic is to be reached. The Department of Health Guidelines for Clinic/Community Nurse Managers suggest certain procedures that have to be considered in the staffing of the clinic. These include the strengthening and provision of quality clinic services and sufficient number of staff that are properly orientated about clinic activities.

Theme 5: There should be provision of minimum resources at the antenatal care clinic

The findings in this study show a lack of material resources at the clinics. In a study undertaken by the Women's Health Project (1998) in the now Limpopo Province, North West and Northern Cape Provinces on Maternal Health Services in South Africa, the lack of resources and management issues rated high as some of the obstacles to providing quality care services.

Sub-Theme 5: Lack of material resources at the clinic

The Department of Health Norms, Guidelines and Standards (1999) dictate that health personnel have to be provided with enough standardized equipment, stocks and medical supplies (including Essential drugs) required to provide antenatal health care services and also to avoid discharging patients without dispensing essential medications.

Resources can be financial or non-financial. While the value of non-financial resources such as labour, supplies, or space, is often overlooked, these are important sources of support. Moreover, they exist in every community (The Manager, 2002). The challenge for health programs is to identify these resources and use them effectively to meet community health needs. There is a need to review the present health facilities, especially in rural areas.

Recommendations

The following are recommended based on the findings of the study:

- Intensify education, at schools to ensure that adolescents/teenagers concentrate on their basic education before they can engage in sexual relationships.
- Provide fertility control that involves contraceptive education to prevent unplanned and unwanted pregnancies, as well as referral for contraceptive services.
- Ensure adequate access to health care services and develop coping and assertiveness skills in raising young girls.
- Encourage mothers to talk to their adolescent/teenage girls on sexuality issues thus breaking the cultural taboo of not discussing such matters.
- Awareness campaign by the University Health Centre to all female students on sexuality issues.

Conclusion

The “accessibility” of antenatal care services generally refers to the extent to which appropriate antenatal care services are available and the scale on which those in a given location are seeking such care and can obtain the services (Bertrand, 1995). In a broad sense, accessibility is a multidimensional concept that not only includes physical proximity and travel time to services, but also involves economic, psychological and attitudinal costs, cognition and the perceptions of potential patients. The above-mentioned strategies, if adhered to, may assist in making antenatal care services more accessible for pregnant adolescents/teenagers and thus help reduce the complications of antenatal care. From the researcher’s observation, pregnancy is an opportunity for health

promotion and education. Therefore, prophylactic measures, such as iron and folate supplementation; management of diseases, like malaria and sexually transmitted infections; as well as early detection and management of complications should be implemented by health care providers.

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