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

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ABSTRACT

Although the South African government adopted a primary health care approach to health care service provision in order to ensure equitable access to and utilisation 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, the need to highlight issues of access and utilisation of antenatal care services was significant because poor access to and under-utilisation of health care services could potentially influence the success of this programme and pregnancy outcomes. A qualitative, exploratory, descriptive and contextual study was conducted guided by Thaddeus and Maine's Three Delays Model. The majority of the study participants who were pregnant women reported limited access to health care, with under-utilisation of antenatal services while nurse participants recognised the challenges facing pregnant women regarding the access and utilisation of antenatal care services. Recommendations were made 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 delivered are in line with the South African Department of Health Guidelines.

1. Introduction

Although the South African government adopted a primary health care (PHC) approach in order to ensure health for all and accessibility to health services, the country continued to face challenges especially with regards to the improvement of maternal health outcomes. Globally, the maternal mortality rate (MMR) dropped by 45% between 1990 and 2013, which was an estimation from 380 to 210 deaths per 100,000 live births. Most countries with feeble health care infrastructures continued to have high fertility rates making them unlikely to meet the millennium development goals (MDGs) 5 indicator, as these countries still had poorer MMRs in 2010 (Lawson & Keirse, 2013). These countries included Botswana, Cameroon, Chad, Congo, Guyana, Lesotho, Namibia, Somalia, Swaziland, Zimbabwe and South Africa.

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 access and utilisation of antenatal care (ANC) by pregnant women (Arthur, 2012). The province of KwaZulu-Natal (KZN) is densely populated and has high birth rates and the highest number of maternal deaths (Amnesty International, 2014). The Amnesty International Report further point out that most of these birth rates occurred outside health care facilities, which is an indication that access to health care services remains a challenge especially for rural women in KZN. These challenges to most women in rural communities could be linked to the significantly poorer health outcomes in rural populations, compared with their urban counterparts (Schoevers & Jenkins, 2015). The two commonly used health indicators [MMR and infant mortality rate (IMR)] 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). Furthermore, some rural areas in the Eastern Cape Province have the highest IMR of about 70.11 per 1000 births (Department of Health, 2011). 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

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in KZN rural communities.

1.1. Problem statement

In the eThekwini district the MMRs and the IMRs are the two commonly employed health care indicators used to rate maternal health outcomes which remains in elevation and 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). These mentioned statistics are an indication that poor maternal outcomes exist in the eThekwini district.

The district's poor maternal outcomes potentially impact on people's access to and equal distribution of health care services. This is supported by the Department of Health (2013), stating that inequalities in health care access still exist within population groups and rural geographic locations contributing to poor maternal outcomes. The South African Saving Mothers Report 2011–2013 by the National Committee on Confidential Enquiry into causes of Maternal Death 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, 2014b). KwaMkhizwana being a tribal rural area situated in the West sub-district forms 9% of the informal populations in rural areas of this district. This rural community has one mobile clinic operating once a month and two health posts each operating once a week. A number of operating health care facilities raises concerns regarding access to and utilization of ANC services within this rural community.

1.2. Aim

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

1.3. Research 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.

1.4. Research methodology

1.4.1. Research design

The qualitative design used was exploratory, descriptive and contextual in nature. An exploratory design was used to better understand the accessibility and utilisation of ANC services by pregnant women residing in this rural community while the descriptive design gathered rich descriptive information from both participants regarding access to and utilisation of ANC services which could not have been appropriately explored should the quantitative design was employed.

1.4.2. Thaddeus and Maine's (1994) three delays model

The Thaddeus and Maine's (1994) Three Delays Model (TDM) was used as the framework to guide the study. The TDM was used to provide an organising structure for the study. There are three phases of delay in the model namely delays in deciding to seek care, reaching care and receiving care. Thaddeus and Maine (1994) argue 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, & Roberts, 2010; Wabiri et al., 2013).

1.4.3. Research setting

The study was specifically done in KwaMkhizwana with pregnant women residing within this rural community. In addition, all categories of nurses were part of the study participants. This was aimed at gaining greater insight into both pregnant women and nurses regarding access to and utilisation of ANC services in this rural community. KwaMkhizwana is a rural community area found in the West sub-district area 1; ward 2 of the eThekwini district. It is one of the eleven tribal areas and has seven tribes. This rural community has 629 households mostly composed of traditional and informal dwellings, with an estimated population of 35,000 of which 19,900 are females and 15,100 are males. The three health care facilities which were two eThekwini municipality health posts and one KZN Provincial Authority (KZNPA) mobile clinic as well as the various community gatherings that occurred in this community were used as a setting for recruitment by the researcher.

1.4.4. Study population

The study population consisted of pregnant women residing within this rural community and all categories of nurses working in the three health care facilities in the area.

1.4.5. Sampling process

A two-phased sampling method was used whereby Phase 1 involved pregnant women and Phase 2 included all categories of nurses employed in the three health care facilities in the area. The sampling of both study participants employed a purposive sampling method that of which Burns and Grove (2009) described as judgemental sampling method involving the conscious selection of study participants. Phase 1 participants were pregnant women residing in the KwaMkhizwana rural community from 18 years of age and above. Participants under the age of 18 and those who did not wish to participate were excluded. Phase 2 participants included only nurses working in the three health care facilities servicing this rural community excluding all other categories of staff. The authors believed that the sampling of nurses was to gain greater insight about the three objectives so as to confirm or disconfirm what was stated by pregnant women and thereby conveying different views regarding access to and utilisation of ANC services in order to strengthen the study.

In this study, the sample size for both phases was determined by data saturation. This concept of data saturation is confirmed when the collection of new datum does not shed any further light on the issue under investigation (Mason, 2010). During Phase 1 a total number of 15 pregnant women were interviewed and were between the ages of 20 and 39 years black female Africans. Four were married and 11 were single. Most women had been pregnant before and only five were primigravidas but all were already attending ANC clinic. The majority had first initiated ANC during the second and the third trimester with two initiated ANC during the first trimester. Two participants were employed; one still at school and the rest were unemployed. The phase 2 participants comprised six professional nurses/midwives, two enrolled nurses and one enrolled nursing auxiliary with years of service ranging from 5 to 38 years as qualified nurses

1.4.6. Data collection

The data were collected in two phases taking place between February and March 2016. Data for Phase 1 were collected by means of in-depth semi structured interviews with pregnant women lasting up to 20 to 30 min using an interview guide which was available in English

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