REASONS FOR LATE BOOKING OF PREGNANT WOMEN AT ANTENATAL CARE CLINICS IN KING SABATA DALINDYEBO SUB-DISTRICT IN THE EASTERN CAPE, SOUTH AFRICA

BY

NOMVUME SIGNORIA NTSHANGA

DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE MASTERS IN PUBLIC HEALTH, SCHOOL OF HEALTH SCIENCES

SUPERVISOR : PROFESSOR E. SEEKOE

CO- SUPERVISOR: DR W. MUPINDU

2018

SECTION A

DECLARATION

I, Nomvume Signoria Ntshanga, declare that REASONS FOR LATE BOOKING OF PREGNANT WOMEN AT ANTENATAL CARE CLINICS IN KING SABATA DALINDYEBO SUB-DISTRICT IN THE EASTERN CAPE, is my own work and all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any degree at any institution.

_____

Signature **Date: 27 September 2018**

DECLARATION ON PLAGIARISM

I, Nomvume Ntshanga student number 200150154 hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations.

…… ……..

Signature **Date**

CERTIFICATION

This dissertation entitled" Reasons for late booking of pregnant women at antenatal care clinics in King Sabata Dalindyebo sub-district in the Eastern Cape, South Africa" meets the regulation governing the award of the degree of Master's in public health of the University of Fort Hare and is approved for its contribution to scientific knowledge and literacy presentation.

…….. ……

Signature **Date**

ACKNOWLEDGEMENT

- I would like to acknowledge our Lord the almighty who has given me the strength, knowledge and wisdom to complete this dissertation. It is said in the book of Philippian's Chapter 4: 13 "I can do all through Christ who strengthens me".
- My sincere gratitude to the following individuals:
- Professor Eunice Seekoe my supervisor for her professional academic guidance and support. Her contribution made it possible for my studies to be successful.
- Dr Wiseman Mupindu, the core-supervisor for his support during preparation of the research proposal and the execution of this study.
- Dr Chitha my mentor for his contribution during initiation period of the study.
- Ms Nomandi Senti for co-coding and data analysis and mentoring me on qualitative research principles and important landmarks.
- Ms Madolo language specialist (linguist) for her translation of the verbatim responses from Xhosa to English.
- Mr Mkize Jabulani for editing the entire dissertation.
- KSD Sub district Manager and Operational Managers of the clinics.
- Participants who participated in the in the study from different clinics.
- My husband Fika Ntshanga and children for their support.
- Every single person who contributed to my dissertation including Albertina Sisulu Leadership Programme team of Professors and support staff.

LIST OF ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BANC	Basic Antenatal Care
CHC	Community Health Centre
DHB	District Health Barometer
DHIS	District Health Information Systems
DOH	Department of Health
DHP	District Health Plan
HBM	Health Belief Model
HCT	HIV Counselling and Testing
HCW	Health Care Worker
HIC	High Income Countries
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust.
IMR	Infant Mortality Rate
LIC	Low Income Countries
MCWH	Maternal, Child and Women's' Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NHI	National Health Insurance
MTCT	Mother-to-child Transmission of HIV
MTCT	Mother-to-Child Transmission of HIV
NGO	Non-Governmental Organization
NIMART	Nurse Initiated Management of Antiretroviral Therapy
NSP	National Strategic Plan
RPHC	Re- engineering of Primary Health Care
PCR	Polymerase Chain Reaction
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-child Transmission of HIV

SA	South Africa
SAG	South African Government
SANAC	South African National AIDS Council
STI	Sexually Transmitted Illnesses
TAC	Treatment Action Campaign
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ABSTRACT

Background: The initiation of ante-natal care booking is universally recommended in the first trimester of pregnancy. While working in the Oliver Reginald Tambo district in the Eastern Cape Department of Health, the researcher noticed that late booking was the norm in all sub-districts, especially in the King Sabata Dalindyebo (KSD) sub-district, resulting in impaired antenatal care and an increased potential for adverse outcomes such as maternal mortalities.

Purpose of the study: The purpose of the study was to explore and describe the reasons for late booking for antenatal care by pregnant women in the KSD sub-district.

Objectives: The objective of the study was to determine reasons why women were booking late for antenatal in KSD sub district.

Methods: Thirteen in-depth, unstructured interviews were conducted with late bookers (i.e., those who sought antenatal care (ANC) after twenty weeks of pregnancy) between July and August 2015. The interviews were recorded and, subsequently, transcribed by a reputable linguist from Walter Sisulu University (WSU) and analysed using Creswell's thematic analysis model.

Findings: The average gestational age of booking was 22 weeks (ranging from 22 to 28 weeks). Most women were teenagers and young unmarried women, most of whom were still attending school. All were unemployed. Most had experienced previous pregnancies. All these women delayed attending clinic early due to their ignorance of the exact gestational period for one to start the clinic. Although most of the women did not have direct reasons, the bulk of their reasons for delays were linked to long distances being travelled, leading to the payment of expensive taxi fees. This may also be attributed to cultural factors that seem to promote a veil of secrecy regarding pregnancy, the desire for visual evidence of pregnancy first and the practice of married women having to care for sick relatives.

. **Conclusion:** Poor access to clinics is a fundamental systemic failure and a major contributor and one of the reasons why women delayed in attending antenatal care clinics. Low socio economic status and cultural beliefs, coupled with long distance and expensive taxi fare, are other reasons for late booking.

LIST OF TABLES & FIGURES

APPENDICES

TABLE OF CONTENTS

CHAPTER 1: ORIENTATION TO THE STUDY

Introduction and background

The provision of early antenatal care is regarded as the cornerstone for improving maternal and perinatal outcomes. Antenatal care is defined as routine health control to have a healthy pregnant woman and infant without any complications. The World Health Organisation recommends a minimum of four antenatal care visits which should ideally be initiated in the first 12 weeks of gestation (Haddrill Jones,Dilly Anumba et al., 2015 :1).

Ante natal care is generally recognised as an effective method of preventing adverse outcomes in pregnant women and their unborn children. The woman is supposed to book from the period she misses her period of menstruation in a month up to 16 weeks of pregnancy (Myles, 2014:157).

It is expected that a woman who presents herself to a primary health care clinic and is found to be pregnant should be provided with first visit ante natal care. First visit antenatal care entails physical examination, taking of history, family history and previous pregnancies, measurement of mid arm circumference to detect the nutritional status of a woman, the screening for any abnormalities through urine and blood testing, palpation aiming at detecting estimated gestational period and the giving of vaccines and medications, if any abnormalities have been detected (Motsoaledi, 2015: 34).

Antenatal care is generally recognised as an effective method of preventing adverse outcomes in pregnant women and their unborn children. A woman is supposed to initiate her first visit in the month she misses her period and to keep up a schedule of timed visits throughout her pregnancy (Motsoaledi, 2015:33).

Basic antenatal care is a strategy that is aimed at improving antenatal care services. It aims at ensuring that all pregnant mothers attend clinic at least four times during their pregnancy, starting with a visit at less than 12 weeks of gestation. There should be a total of four follow up visits for women who do not have any health risks. Subsequent visits should be 20 weeks, 26-28 weeks, 32-34 weeks, 38 weeks and 41 weeks, if the woman is still pregnant. It is important for women with risks detected

during screening to have a special schedule depending on their specific problems (Motsoaledi, 2015: 38).

The basic aim of antenatal care is the improvement of the quality of health of the mother and her unborn child. The following serve as vehicles for a healthy baby from a healthy mother through:

- Screening for pregnancy related problems;
- Assessment and identification of any health risks;
- Prompt treatment of problems identified during ante natal care;
- Provision of educational information and delivery;
- Preparation of the woman physically and psychological preparedness for child birth and delivery (Motsoaledi, 2015: 33).

The World Health Organisation (WHO), through its “near-miss approach”, has defined maternal complications as “potentially life-threatening conditions that can affect the woman’s life during pregnancy, labour and after delivery or termination of pregnancy.” The following are potential life-threatening conditions that need to be identified early during ante natal care: severe post-partum haemorrhage, severe eclampsia, eclampsia, sepsis /severe systemic infections and ruptured uterus (World Health Organisation, 2011, 6).

According to WHO, there are five life-threatening conditions that should be detected early during pregnancy, these are severe post-partum haemorrhages, severe pre-eclampsia, eclampsia, severe systemic conditions such as HIV/AIDS and ruptured uterus due to obstructed labour (World Health Organization, 2011: 7).

Problems of maternal mortality occur mostly in developing countries, such as South Africa, and have been said to result from poor management of pregnancy. Poor quality of care from health services and the normal risks associated with pregnancy and child birth are both contributory factors. Policies to control these problems have been developed internationally through documents such as the Millennium Development Goals (MDGs), which have been currently changed to Sustainable development goals (Mlambo Courage, 2013:615).

The aim of attending early antenatal care is to detect any pregnancy-related complications which can affect both the life of the mother and the unborn baby. The Medical Research Council's policy on basic antenatal care stipulates that ANC should be started as soon as the woman tests positive for pregnancy, within the first three months of pregnancy, either at a clinic or at a general practitioner's surgery. A minimum of four follow-up visits is required, rather than the twelve visits previously stipulated. The guidelines stipulate how these visits should be organised (Motsoaledi, 2015: 38).

The National Committee on Confidential Enquiries on Maternal Deaths, in their report, "Saving lives of mothers, babies and children in South Africa", shows that the big five challenges facing antenatal care in institutions could be resolved through the strengthening of the healthcare packages at different levels of care. Basic antenatal care (BANC) focusses on pregnancy and child birth complications. The total package also looks at strengthening community participation and involvement through Community Integrated Management of Illness and Immunisations. Attending ante natal care before 20 weeks will have high impact evidence-based coverage when high impact interventions are implemented according to the relevant package when addressing the big five challenges (Confidential Enquiry Report, 2011: 2).

Another component of the package is strengthening the integration of HIV/AIDS and TB so that systemic conditions are treated early, including the initiation of anti-retroviral drugs (ARVs) for all pregnant women who test positive to HIV. National guidelines on Prevention of Mother to child transmission clearly stipulate that all women who tested positive during the first antenatal care visits are eligible for ART treatment initiation of a single combined dose of Fixed dose combination drug (FDC), regardless of the CD4 count at any gestational stage. Attending antenatal care early will enable the woman to be started on treatment early after extensive and ongoing counselling, so that they adhere to treatment and should remain in care for the entire pregnancy, so that the unborn baby is protected, and the life of the mother is long (Motsoaledi, 2014:48).

The National strategic plan for Prevention of Mother to Child transmission in South Africa stipulates incremental targets for pregnant women testing for HIV, therefore, facilities should test 100% of all pregnant women. A new 2012-2016 national

strategic plan, which seeks to improve mother to child transmission has since been developed (Motsoaledi, 2014:36).

Preparation for delivery and safe motherhood is considered an effective means of detecting and treating complications earlier and providing timeous intervention. All the above packages, if implemented well at primary health care facilities through early booking by pregnant mothers, could save as many as 70% more lives of pregnant women. It is assumed that the problem of late antenatal care booking – after 20 weeks – is the overall cause of high maternal deaths in the O.R. Tambo District. Failure or delays in the screening of pregnant women for any complications can negatively affect the lives of the mother and her unborn child. The district figure for quarter three performance was 351/100 000 births – very high for the national target of 38/100 000 births (Department of health, 2014:46).

The specific reasons for women's late attendance of antenatal clinics in King Sabatha Dalindyebo sub-district was not known by the researcher. The phenomenon may be the result of clinic midwives failing to meet the expectations of pregnant women, or the ignorance of pregnant women, coupled with the low socio-economic status of many in the sub-district. These speculations that are both poor antenatal care services as well as ignorance on the part of mothers, have been identified as being the causes for late booking for antenatal care in other countries. These assumptions have been identified and covered in studies in international countries, such as Indonesia, United Kingdom Nationally Zimbabwe, Nigeria, and the Western Cape in South Africa, but have not been investigated in KSD before. There are contributing factors (Agus, 2012:6).

1.2 Problem statement

The general picture of the King Sabatha Dalindyebo sub-district antenatal care services for pregnant women is discouraging, owing to the high numbers of women who attend late, thereby delaying the early detection of complications. However, there is no empirical study conducted to ascertain the truth or otherwise of this phenomenon in King Sabatha Dalindyebo sub-district. Therefore, this study is designed to investigate the reasons for late antenatal care booking amongst pregnant women attending clinics in KSD sub-district. A report for the financial year

2013/2014 of the sub-district is presented below as evidence of poor performance in antenatal care booking:

***Table* 1.1: Interpretation of performance in relation to late booking**

Indicator name	2011/2012	Target	2012/2013	2013/2014	Robot	Trend
Antenatal 1st visit care before 20 weeks	33.6	60.0	30.9	36.5	Very low	Irregular
Maternal mortalities	250.0	130.0	63.2	414.3	Very high	Increasing
Stillbirths in facility	37	12.0	14.4	16.0	Very high	Increasing
In-patient deaths under 1 year of age	68.9	5,2	8.8	21.3	Very high	Increasing

(Department of health, 2014:24)

The above table shows that the three-year trend for late booking was not improving in the KSD sub-district in the three financial years 2011/2012, 2012/2013 and 2013/2014. The national target for ANC before 20 weeks is 60%, and the sub-district is struggling to reach that target; in 2011/2012 the rate of ANC before 20 weeks was 33.6%, in 2011/2012 it dropped to 30.9%, increasing by only 5.6% to 36.5% in the 2013/2014 financial year. This is despite recent strategies in relation to primary health care (PHC) to re-engineer its services through ward-based teams visiting households. These figures are related to an increase in the maternal mortality rate to

414.3 per 100 000 deliveries, while the national target is 130.0 per 100 000 deliveries. The rate of stillbirths increased to 37.9 in 2013/2014 and dropped insignificantly to 37.6 in the third quarter of 2014/2015. The national target for stillbirths is 10.0 (Department of health, 2014/2015:24).

This scenario results in the late initiation of programmes such as the Prevention of Mother-to-Child Transmission (PMTCT) and prevents the early treatment of systemic conditions such as hypertension in pregnancy, which can result in severe eclampsia and death. The consequence of this to the community includes loss of mothers, wives and daughters, as well as denying these women and babies their constitutional right to life (Motsoaledi, 2014:48).

1.3 Purpose of the study

The purpose of this study was to explore and describe the reasons for late booking for antenatal care by pregnant women in the KSD sub-district.

1.4 Research question

The research sought to answer the following questions:

- What are the reasons contributing to the late booking by pregnant women at antenatal clinics in KSD sub-district?
- What recommendations can be made based on this study?

1.5 Objectives of the study

The objectives of the study were to:

- Determine reasons contributing to late antenatal care booking by pregnant women in the sub-district.
- Explore other provider's women are using for antenatal services.
- Draw up recommendations

1.6 Delimitations

This study was limited to users of public antenatal care clinics and did not include users of private obstetric clinics and practices. The study focused on women who booked late, from 20 weeks of pregnancy up to the time of delivery. Women who

booked within the expected benchmark were not included in the study. The facilities where the research was conducted were clinics within the KSD sub-district only.

1. 7 Limitations

The low literacy levels of many participants affected the time spent with each participant, as the nature of the research and many terms had to be explained to each person. The study limited itself to participants in the ten identified clinics.

1.8 Definition of terms

Key terms used in this study are defined below:

1.8.1 Antenatal care

This is the care given to pregnant women by skilled health personnel from the time of conception to the onset of labour and includes both education and therapeutic interventions that benefit the pregnant woman and her unborn child (Titaley *et al.,* 2010:5). In this study, women booked late for antenatal care, which means care that is given to pregnant women from 20 weeks up to time of delivery.

1.8.2 Basic antenatal natal care (BANC)

Basic antenatal care is a quality-improvement strategy that is aimed at improving the quality of antenatal care in all public institutions, especially in clinics that serve as an entry point for a pregnant woman. It is a tool that directs health professionals towards the classification of a pregnant woman – whether she is a low risk or a high risk – depending on the critical vital signs that are monitored during the antenatal care visit, such as blood pressure checking, urine testing, history taking and haemoglobin testing, to mention but a few tests. (Hofmeyer, 2015:903.

This tool also assists the health professionals in monitoring the frequency of visits and what is expected to be done during each visit, at 12 weeks, 20 weeks, 26 weeks, 32 weeks and 38 weeks.

According to Webster Mirriam's Learners' Dictionary (2003:781), "reasons" is defined as statements presented in justification or explanation of a belief or act. Reasons can further be defined as explanations of a situation or circumstances that make certain results seem possible or appropriate. In this study, the researcher was interested in

finding reasons why women do not present themselves early for ANC (Webster, 2003:781).

1.8.3 Late booking

Late booking is defined as an inadequate use of prenatal health-care services by presenting oneself for ANC at a clinic for the first time after 20 weeks of pregnancy. The woman is supposed to book from the month in which she misses her menstruation up to 12 weeks of pregnancy (Feijn, 2011:1). In this study, women booked late, after 20 weeks of pregnancy.

1.8.4 Pregnant woman

A pregnant woman is a woman whose egg or eggs have been fertilised by a sperm of a man, then implanted in the lining of the uterus, which later develops into a placenta, with the egg developing into an embryo and then a foetus (Medical Dictionary, 2016:1).

Pregnancy usually lasts for 40 weeks from the day of conception. The period of pregnancy is divided into trimesters, with the first trimester lasting up to three months, the second trimester up to seven months and the third trimester up to the delivery of the baby (Medical Dictionary, 2016:1). In this study, a pregnant woman is regarded as a woman who presented herself for antenatal care after 20 weeks of pregnancy.

1.8.5 Sub-district

In a policy paper on the development of a district health system for South Africa by Dr McLaren in 2008, a district is defined as “the ideal vehicle for the implementation of PHC. A district health system is regarded as the building block of the South African health system post-1994. A sub-district is the implementing level of health care within a district and is defined as a geographic area within the boundaries of a district. The sub-district is aligned to local municipalities as defined by the Local Government Act. The district in the case of this study is O.R. Tambo, a District Municipality consisting of four local municipalities known as sub-districts, according to the local municipality boundaries. It is defined as a functional area of service delivery and not merely the administrative unit of service delivery (McLaren David, 2008:1).

This study, therefore, took place in the KSD sub-district in the O.R. Tambo Health District, as the sub-district is the point of contact with the patient at community level and the environment within which the patient lives.

1.9 Research method

1.9.1 Study design

The design is a blueprint that guides the researcher in planning and implementing the research in a way that is most likely to achieve the intended goal and maximises control over factors that could affect the validity of findings (Burns & Grove, 2010:696).

A qualitative exploratory and descriptive contextual design was used in this study. Qualitative research is linked with issues of quality and involves validity, practicality and effectiveness. It is suitable to studies focusing on lived experiences in the real lives of individuals, requiring some alteration for improved outcomes. It is descriptive in that the researcher describes his or her findings, with a thick audit trail of how the data was collected, captured and analysed. The most critical factor is that the researcher should be aware of the reasons cited by her participants, above all, and put aside, or bracket, her preconceived ideas, so that they do not influence him/her (Brink, Van der Walt and Van Rensburg, 2015:121).

1.9.2 Sample and sampling procedure

Sampling is a process of selecting a section of the population to represent the whole population. In this study the researcher used purposive sampling, also known as judgemental sampling. This sampling method allowed the researcher to select a sample that was relevant to the phenomenon being investigated.

Pregnant women within childbearing range from over ten to 40 years of age were included. The sample selected was relevant to the research question, and the selected women were able to produce a credible description of the reasons why they booked late. In the case of qualitative research, the researcher does not know in advance the size of the sample; in this case, the researcher continued interviewing women until saturation was reached (Polit & Beck, 2010:7).

Factors that determined saturation were the legibility of the transcript, the clarity of audiotapes and the amount of useful information provided by the participants.

Sufficiency was another factor; sufficiency depends on the number of people of the age required and the sites that make up that sample population (Suri, 2011:10).

According to Polit and Beck (2010:321), there are no rules for sample size in qualitative studies. The sample size depends on informational needs. The guiding principle in determining the size of the sample is saturation. Saturation is the point at which repetition of data occurs during a qualitative study. The number of participants needed to reach saturation depends on many factors, such as participants being good informants and being able to communicate and to reflect on their experiences. Sample size also depends on the type of study undertaken (Polit & Beck, 2010:323).

Phenomenological studies, for example, rely on a very small sample – ten or fewer participants. Phenomenological studies are studies in which all participants must have undergone the same experience (Polit & Beck, 2010:323).

1.9.3 Study setting

The study was conducted in the KSD sub-district. KSD has a total of 49 public health-care facilities. Ten facilities that performed the worst in ANC for women presenting before 20 weeks were used. Four community health care centres – Mbekweni, Ngangelizwe, Mqanduli and Ngcwanguba – and six clinics participated in the study.

The ten facilities were chosen because they were the lowest performing facilities for ANC for women presenting before 20 weeks' gestation according to data collected in the sub-district.

Table 1.2: List of facilities that scored lowest in ANC for women presenting before 20 weeks' gestation (Department of health 2014/2015).

Name of facility	Type	Performance
Baziya	CHC	26.4%
Mqhekezweni	Clinic	23.8%
Ngangelizwe	CHC	29.4%
Ngwenya	Clinic	25.0%
Pakamile	Clinic	33.3%

SOS	Clinic	33.8%
Tyelebana	Clinic	33.3%
Mbekweni	CHC	36.6%
Ngcwanguba	CHC	36.8%
Luthubeni	Clinic	35.2%

1.9. 4 Research instrument

The interview guide research instrument used in this study was semi-structured interviews in which detailed, straightforward, open-ended questions were asked. Semi-structured interviews are flexible in that, although there are guiding questions, there are also opportunities for storytelling by the participant. The questionnaire was developed using a semi-structured interview guide to ensure that there was some standardisation of questions that were asked of all participants (Streubert, 2011:34).

1.9.5 Data collection procedure

Data collection is defined as a precise, systematic gathering of information relevant to the research purpose or the specific objectives and questions of the study (Burns & Grove, 2008:430). The technique used for data collection was semi-structured interviews using a recorder after obtaining permission from the participants. The instrument used was an interview guide. Interviews were conducted with all participants in the same way (Brink *et al*, 2015:93).

Open-ended questions were asked in English and isiXhosa, as it was assumed that most of the participants were sufficiently fluent in English. After collecting the data, as well as recorded information, the researcher asked the participants to go through the transcribed interview, if literate, to verify that it reflected their thoughts. In the case of illiterate people, the recording was played back to them for verification (Brink *et al*, 2015:93).

1.9.6 Data analysis

Brink *et al*. (2015:98) explain that data analysis entails categorising, coding, manipulating and summarising the data and describing it in meaningful terms.

The data were transcribed verbatim by the researcher from tape recordings and field notes that were taken during the interviews. Recordings were listened to as soon as

possible after the interviews to avoid the piling up of data. Non-verbal expressions were noted from the field notes. During the process, key phrases were pointed out after proofing the scripts, and sorting the information according to themes, categories and sub-categories. The transcribed data was given in isiXhosa and translated into English using an accredited translator from Walter Sisulu University. An external independent coder was used to analyse the transcribed data for analysis to identify themes, categories and sub-categories.

1.10 Pilot study

Polit and Beck (2010:195) refer to a pilot study as a small-scale version or trial run designed to test methods to be used in a larger, more rigorous study. A pilot study of the interview guide was conducted. The most efficient way to find out how good an interview guide is, is to pilot it with a group of respondents who have the same characteristics as those involved in the study, which, in this case, were pregnant women who started antenatal care after 20 weeks of gestation. Three pregnant women meeting the criteria were interviewed and the researcher then transcribed and analysed the interview to determine if the research questions as well as the interview technique of the researcher would elicit the desired information. Modifications were made to the research instrument and data analysis procedure. The participants who were used in the pilot study met the inclusion criteria but were not part of those who were involved in data collection.

1.11 Trustworthiness

Rigour in research terms is a way of ensuring the trustworthiness of the data, i.e. to ensure that the data, when tested, proves true. Trustworthiness determines the quality or goodness of research. Trustworthiness involves examining the data collection tools and how the collected data is analysed. It involves asking questions such as, “Are the tools able to produce information that is appropriate and to what degree are the collection techniques likely to generate appropriate levels of detail needed to address the research question?” Also, what standards of evidence are required to ensure that the results are supported (Streubert, 2011:316)?

Streubert (2011:48) identified the following terms which describe operational techniques that support the trustworthiness of work: credibility, dependability,

confirmability and transferability. These principles were used to test the quality of data that was collected in this study.

1.12 Ethical considerations

Ethics refers to a system of moral values that are concerned with the degree to which research procedures adhere to professional, legal and social the study of participants (Polit, 2010:753). To ensure that the ethical issues were taken into consideration, various steps were followed.

In accordance with the protection of the rights of the institution, permission was obtained from the Ethics Committee of the University of Fort Hare and the Eastern Cape Department of Health. At district level, permission was requested from the sub-district manager and operational managers in charge of clinics and community health centres in King Sabatha Dalindyebo (KSD) sub-district (Streubert, 2011:61).

To protect the rights of the participants, consent was obtained from them in the form of written consent so that there was free participation without any pressure being exerted upon participants (Creswell *et al*., 2016:44).

1.13The structure of the dissertation is as follows:

Chapter I: Overview of the study;

Chapter 2: Literature control

Chapter 3: Research Methodology

Chapter 4: Presentation and discussion of the findings

Chapter 5: Conclusion, limitations and recommendations,

1.14 Conclusion

In this chapter the researcher has presented a general overview of the study, which included the background to the study, the research method, a definition of concepts, trustworthiness and ethical considerations. Chapter 2 will present a detailed discussion of the research design and research methodology.

CHAPTER 2

LITERATURE CONTROL IN RELATION TO LATE BOOKING

2.1 Introduction

Literature is written sources relevant to the focus of the study, including articles published in periodicals or journals, internet publication, conferences papers, thesis, dissertations, clinical journal, textbooks and other books (Burns & Grove 2010:165).

Literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in context (Polit & Beck 2012:732). Literature review provides the background for the problem studied, describes current knowledge of a practice problem, and identifies gaps in this knowledge base and explaining how the study being reported contributed to building knowledge in this area (Burns & Grove 2015:163).

This chapter gives an outline of the literature reviewed for deriving the propositions against which the study was undertaken and provides a contextual and theoretical background to the topic under discussion. Ante natal care and basic antenatal care literature have been reviewed to give different perspectives from international perspectives and South African perspectives. Literature on reasons for late antenatal attendance has been reviewed in studies undertaken internationally, nationally and locally. . The theoretical framework used in this study is the Health Belief Model (HBM) that provides factors contributing to late antenatal booking as it relates to the HBM assumptions and constructs at King Sabatha Dalindyebo clinics.

2.2 Antenatal care

The European Board and College obstetric and Gynaecological committee states in their position paper 3 on antenatal care that the health of future generations is determined by the baby's growth and development within the womb. The success of foetal life determines, not only the health of the new born, but also has a major impact on adult health and disease risk. The promotion of preconception health will not only improve women's general health but has a favourable effect on the health of the next generation (European board , 2015:5-6).

2.2.1 Basic antenatal care

Basic antenatal care is an approach that is used in the public institution of South Africa to provide health care service to pregnant women, according to National Department of Health, and was introduced based on the belief that good quality antenatal care could reduce maternal and perinatal mortalities (DOH, 2015: 34).

A study conducted by Ngxongo, Sibiya and Gwele (2016:3) on evidence of application of the Basic antenatal care principles of good care and guidelines in pregnant women's antenatal care records stated that basic antenatal care (BANC) is an approach that is used in the public institution of South Africa to provide health care service to pregnant women, according to National Department of Health, and was introduced based on the belief that good quality antenatal care could reduce maternal and perinatal mortalities (Ngxongo T.P, 2016:3).

The study conducted by Ngxongo and Sibiya (2011:85) on factors influencing successful implementation of basic antenatal care approach in primary health care facilities in eThekwini district, KwaZulu-Natal, revealed that the process of implementing the BANC programme was first initiated as a pilot project in eThekwini district at a few facilities in the 2007. The campaign was done investigating the roll out of BANC in primary health care facilities found the following to impede the implementation process:

- Lack of training of midwives on BANC;
- Shortage of staff;
- Lack of cooperation from referral hospitals;
- Poor support of facility management;
- Challenge with transportation of specimens;
- Unavailability of BANC guidelines.

2.3 Theoretical and conceptual framework of late antenatal care booking

2.3.1 Psychosocial theories of health behaviour

A theory is defined by Glanz *et al*. (2012:27) as a systematic way of understanding events, behaviours and situations. Psychosocial theories basically assisted the researcher in understanding the health behaviours of individuals as they interact with

the social environment. It is critical to understand relevant theories and social behaviours and their application to the research study in question (Glanz Karen, Rimer Barbara., 2012:27).

Psychosocial theories are grouped according to two main groups – social cognition groups and stage models. In this study, the use of a social cognition group refers to a group of similar theories that specify beliefs and attitudes as proximal determinants of behaviour. Social cognitive group models are the health belief model, protection motivation theory, self-efficacy, and the theory of reasoned actions and theory of planned action (Glanz *et al*., 2012:42). In this study, these theories will assist the researcher in understanding certain behaviours and social determinants linked to reasons why women book late for antenatal care services, and the discussion will focus on two of these theories, namely, the health belief model and theory of planned action (Glanz *et al*., 2008:48).

The application of these theories is focused on the patient's behaviour towards the use of antenatal care services in KSD clinics. The focus is on health behaviour as influenced by the reasons given by pregnant women on why they attended clinic late, namely, after twenty weeks of pregnancy. There is a relationship between one's awareness of health issues and one's behaviour in seeking medical care. Health behaviour refers to any behaviour that influences or is believed to influence physical health outcomes, either by increasing or decreasing their risk or severity (Glanz *et al*, 2012:46).

The health belief model was developed by a group of social psychologists who were working in the field of public health and were seeking to explore why some people do not use health services such as screening services (Sutton, 2001:2).

There are five core explanatory variables in this model. These are perceived susceptibility, perceived vulnerability, perceived severity, which refers to the seriousness of the disease, perceived benefits, which are referred to as advantages, and perceived barriers or perceived costs, which are referred to as obstacles that may hinder or prevent its successful performance.

These factors are commonly used in combination or supporting one another or affecting one another (Polit & Beck2012:126).

The combination of beliefs leads to actioned behaviour, for example, combining perceived susceptibility and perceived severity results in the threat of a certain disease. There are modifying factors that indicate relationships between these constructs, such as knowledge and socio-demographic factors, which may influence the health perception of people of a certain health concept. Inaccessible health facilities can influence behaviour to be negative toward a service (Polit &Beck 2012:136).

Health behaviour is a central concern of health education. Health education attempts to close the gap between what is known as an optimum health practice and what is practised. Polit *et al*. (2012:126) state that health education is a process of assisting individuals, acting separately or collectively, to make informed decisions about matters affecting their personal health and the health of others.

A study by Heaman et al. (2015:15) on barriers and facilitators related to use of prenatal care by inner City women in Canada states that there are socio economic disparities in the utilisation of prenatal care, even where health care is universally available and publicly funded. In their findings, they identified barriers that contributed to their underutilisation of prenatal care, as cited by women respondents in their study. These barriers were arranged in themes and subthemes, as this was a qualitative study, such as health system barriers issues like staff shortages, negative attitude of health workers and long waiting times. Personal barriers were also cited, such as long distances being travelled, inaccessibility and rigid operational hours (Heaman Maureen, 2015:6).

2.4 Theory of reasoned actions and planned actions

Ajzen's (2012:450) theory of planned behaviour proposes that attitude, subjective norms and behavioural control can modify intentions towards positive or negative health behaviour. It further states that there are possible background factors that may influence the beliefs of people, such as personality versus life values, demographic variables, such as age and socioeconomic status, which have an influence on the expected intentions of individuals toward certain health behaviour. Therefore, it has been stated in this theory that past behaviour is the predictor of future action, and this can result in habitual behaviour (Ajzen, 2012:450).

2.5 Self-efficacy (modifying factors)

Self-efficacy refers to the strength of an individual's beliefs in his own ability to respond to difficult situations and to deal with any associated obstacles. Among the modifying factors that have been identified are personality variables, patient satisfaction and socio demographic factors (Polit & Beck 2012:136). This is confidence in one's ability to be motivated to act. Pregnant women should have confidence and believe that they are capable of booking antenatal care at less than 20 weeks of gestation so that any complications can be identified and corrected early.

The study conducted by Tshabalala and Mokgatle (2014:149) on utilization of antenatal care services and perceptions of early booking revealed that in East Ekurhuleni sub district clinics women were aware of ANC and PMTCT services. The first trimester was pointed as the best time to start ANC, but women's awareness and practices differed as they booked late. They didn't comprehend the importance of early ANC booking, since the majority booked in their second and third trimester, including those with previous pregnancies. The women perceived ANC utilization as beneficial since they were able to relate to the services they obtained at the facilities. The mere fact that they came for ANC indicated the importance they attached to these services (Tshabalala M F, 2014:143-151).

There is also a strong relationship between the social cognitive theories of the health belief model, the theory of planned action and the attitude of pregnant women towards the utilisation of antenatal care services. This, therefore, means a certain attitude, be it negative or positive towards antenatal care, influences a certain behaviour – either to wait and hide the pregnancy, or to wait until one is seven months pregnant; experience in previous pregnancies strongly influences one in subsequent pregnancies to report late for ANC (Glanz *et al*., 2008:45).

Ignorance or lack of knowledge has been stated repeatedly in many forms, such as lack of knowledge of the importance of attending ANC services early, lack of knowledge on reproductive health, resulting in poor recognition of pregnancy, the influence of a pregnancy mind-set and previous pregnancy experience, and the perceived value of antenatal care (Dilly Anumba, 2015:1).

It has been shown categorically in these studies that the attitude of participants towards early booking was shaped by previous encounters with ANC services, such as long queues, long waiting times, and long distances to be travelled vis-à-vis the high costs of taxis. Personal factors such as cultural values, non-pregnancy disclosure and societal belief system of hiding pregnancy affected the timing of the first ANC attendance (Andrew, 2014:1).

2.6 Personal factors related to late booking

Ignorance has been identified as being the leading reason for late booking in many studies, and has been presented in four categories (ignorance or lack of knowledge has been stated repeatedly in many forms, such as lack of knowledge on the importance of attending ANC services early, lack of knowledge on reproductive health, resulting in poor recognition of pregnancy, influence of a pregnancy mind-set and previous pregnancy experience, and the perceived value of antenatal care (Dilly Anumba, 2015:1).

A study conducted by Downe *et al*. (2009:518) in the United Kingdom confirms that there is a serious challenge in the relationship between the socio-economic conditions of pregnant women, including ethnicity, and late or non-attendance of antenatal care by pregnant women. In addition, the results of the study indicate that participants who were taken from minority ethnic groups, homeless refugees and people of low income cited reasons such as denial of pregnancy, lack of money to attend clinics and culturally insensitive staff as contributing to their non-attendance of antenatal care (Downe *et al*., 2010:519).

A study conducted in Indonesia on factors influencing the use of antenatal care in rural West Sumatra showed that the greater the poverty of a woman, the lower the number of visits to antenatal care. Most women were referred by their families to traditional birth attenders and showed a preference for traditional birth attenders over trained midwives. Thus, the lower the family income, the higher the visit to traditional birth attenders and the lower the health facility visits (Titaley *et al*., 2010:7).

Lack of income clearly plays a role in the late attendance of many of the women in this study. About six of the participants cited long distances having to be travelled and the expensive fees for public transport. The researcher reviewed several studies

by different researchers from different countries, and all of them found common barriers affecting late antenatal care attendance by socially disadvantaged women such as teenagers, unmarried women, women with a lower level of education and lower socio-economic status (Ndidi & Oseremen, 2010:47). This is also confirmed in the results from the study by Duff *et al*. (2010:37), who found that their participants gave economic barriers as a contributory factor to late attendance, especially for those residing far from the clinics.

Although some said they could have walked, the possibility of being raped while walking was a very real fear factor. The issue of ethnicity arose in the case of one woman who could not go to the clinic in the large town nearest her (Rustenburg), as she did not think there were isiXhosa-speaking nurses there. This made her wait until she finally travelled further to be attended by nurses of her own language group. The delay, however, meant that she was first attended to when she was seven months pregnant.

Indonesia is still rated as having a high maternal mortality because of the delays by pregnant women in seeking medical help as they prefer traditional health care. In a study conducted by Agus (2015), rural women were still captured in traditional beliefs and Christianity, and, as a result, they would prefer to go to traditional birth attenders (Parajis) rather than midwives. They would regard certain symptoms, such as headache during pregnancy, as normal and would only get traditional medicine for that. They held a strong belief that traditional birth attenders were more accessible to their homes, were kind and affordable (Agus, 2015:8).

Late booking then contributes to delays in detecting critical abnormalities such as uncontrolled blood pressure and HIV/AIDS status and delaying the initiation of critical strategies such as prevention of mother-to-child transmission. Guidelines on the prevention of mother-to-child transmission clearly inform health workers to enter the woman into the programme during pregnancy and to provide the programme, even during delivery, and then to test the child at six weeks post-delivery and give treatment if positive. This increases the life of the mother and that of the unborn baby (Motsoaledi, 2010:10).

Mlambo et al. (2013:615) discovered that haemorrhage, hypertension and sepsis were the highest causes of maternal mortality for women who booked late for

antennal care in Zimbabwe. In their recommendations, they pointed out a need to review policies on maternal health, and to build capacity through increased funding for training and equipment. They also recommended funding for the purchase of critical drugs, such as Syntocinon and Ergometrine, which assist in the prevention of postpartum haemorrhage (Mlambo, 2013:619).

The role of the positive interaction between women and health providers is viewed as critical for the improvement of client compliance. The midwife, as the first contact person for most pregnant women attending ANC services in clinics in South Africa, has the potential to play a major role in improving women's health status. However, for the midwife to be effective in improving women's health status, ANC services need to be utilised effectively by women (Winnifred, 2007:78)

According to De Vaal (2011:8), ignorance has been linked to many social determinants of health, such as one's socio-economic status, the educational level of an individual and the developmental status of the community in which a person resides.

Factors contributing to late booking have been identified by many researchers in international communities, including many in Africa and other parts of South Africa, for example, two studies from Indonesia – by Titaley *et al*. (2010:50) on factors influencing the use of antenatal care in rural West Sumatra and by Agus (2015) on why some women do not attend antenatal care and postnatal services, and a qualitative study *(Titaley Chriatiana, 2010:50)*

Cultural factors could play a part here – the tendency to hide pregnancy is associated with ignorance, as keeping a pregnancy secret is seen as more important than getting the care that is needed.

2.7 Access to health care

The right of access to health care, including reproductive health care, is enshrined in Chapter 2, subsection 27 of the Bill of Human Rights in the Constitution of the Republic of South Africa (Parliament, 2003:125).

The National Health Care Quality Report defines access to health care as a means of finding personal health service to achieve the best health outcomes by using the following strategies:

- Acquiring good access to care in discrete steps.
- The ability of pregnant women to gain easy access to health-care facilities.
- Entering the health system by getting access to a clinic where patients can receive the needed service.
- Finding providers who meet the specialised needs of individual patients, such as antenatal care services (Health, 2011:217)

Poor access, therefore, equates to inability to access health care. Factors affecting the utilisation of antenatal care were identified according to seven themes: socio-demographic factors, women's education and husband's education, marital status, birth order and interval, caste and ethnicity, knowledge of family planning and the importance of antenatal care. Other important factors are the availability, accessibility and affordability of antenatal services, and transportation to health facilities, which are often far from homes. These factors discourage women in developing countries, such as those in Africa, because both the time required, and costs involved are major barriers (Bhibha Simkhada *et al*., 2010:4).

A quantitative study conducted in Ekurhuleni investigating the utilisation of antenatal care services and prevention of mother-to-child transmission (PMTCT) during the first trimester of pregnancy showed lack of knowledge of the importance of attending ANC, in that, 114 women, out of 390, said their reason was to get an ANC card, and only 96 of the 390 women were able to say they wanted to test for HIV and other potential problems (Tshabalala, 2012:46). They also cited many barriers to attendance of the antenatal care services, such as being afraid of being tested for HIV, the negative attitude of the nurses, distances being travelled before reaching the clinic, long waiting times, transport problem, laziness and a lack of money (Tshabalala, 2012:48).

Teenage pregnancy is defined by UNICEF (2008:2) as a pregnancy in teenage girls aged 13 to 19. Poverty, peer pressure, low educational ambitions, lack of information about reproductive health and lack of access to tools that prevent pregnancies are all considered to be contributory factors in teenage pregnancy (UNICEF, 2008:3).

Phafoli *et al*. (2007), in their study on variables influencing delays in attending antenatal care among teenagers in Lesotho, discovered that, out of 632 pregnant teenagers, only 94 attended antenatal care during the first trimester. A further 268 attended during the second trimester and 270 attended during the third trimester of pregnancy. Other variables were education related. Indications are that, the lower the level of education, the lower the chances of attending an antenatal clinic early. The study concluded by saying that the cause and effect of late booking by teenagers in Lesotho was lack of knowledge by adolescents regarding the results of sexual intercourse. This results in denial of pregnancy and delays in attending antenatal care (Phafoli *et al*., 2007:12).

According to discussions in a workshop on the District Barometer's report on pregnancy, the following factors are very relevant to antenatal care in the OR Tambo district: poverty, which makes the child support grant appear attractive, even though it is only R330 per child per month; and a lack of youth services in the district. These factors have not, however, been proven scientifically by the researcher (Health Systems Trust, 2014/2015:69).

2.8 Systems factors

In a study conducted in three public wards in the City of Johannesburg by Solarin and Black, it was clear that, of 208 women who booked late, failure to recognise that they were pregnant and booking procedures contributed to late booking. Some of the women interviewed said they were told to come back later; that made the women come back more than three months later (Ijeoma Solarin, 2012:359-367).

In a study conducted at Michael Maphongwana CHC, 23 women who booked late (after 18 weeks) indicated personal barriers as contributing to ignorance of the purpose of antenatal care, and denial or late recognition of unplanned pregnancies. They also cited systems barriers, such as a cumbersome booking system, the absence of ultrasound services, and poor quality of care (De Vaal, 2011:13).

A study by Ruwangaruri Andrew *et al*. (2014:14) showed that there were three factors that affected attendance, as grouped into three main categories, namely, accessibility, attitudes to antenatal care and interpersonal issues. It has been discovered that, although women see accessibility as a barrier because of distances and transport costs, those close to the clinics also demonstrated poor attendance

linked to a negative attitude to antenatal care, as shaped by their previous experiences of ANC. These previous experiences were long queues and long waiting times (Akashi, 2014:10).

2.9 Culture and lifestyle

In this study, cultural beliefs have strongly contributed to delaying attending antennal care, especially by young women who were hiding their pregnancy in fear of their mothers, as, culturally, a girl is supposed to get married before she can become pregnant. Although they were married culturally, other women in this study felt that one should hide her pregnancy until it is showing it cannot be hidden.

According to the theory of Health belief model, the following assumptions about health can result in planned actions which can either be positive, if perceived positively, or negative if perceived negatively.

It is assumed that a person will take a health-related action if that person feels that a negative health condition can be avoided.

It is assumed that a person will act if that person has positive expectations that by taking a recommended action they will avoid a negative health condition.

It is clear form the above assumptions that there is a strong relationship between one's belief system and the action one takes towards health servoices. Lack of awarenes is critical; that is, pregnant women who are not aware of these benefits of attending antenatlacare early can positively longavate one's life by getting early diagnosis of any illness and early interventions given, such as Prevention of mother to child transmision and healthy mothers.

Conclusion

This chapter discussed the literature that is relevant to the study. It presented guidelines in South Africa on ANC, which directs health workers throughout the country on when ANC must start and procedures to be followed when offering these services. Low and middle-income countries still experience late ANC booking and there is low uptake of these services, even though this is crucial for the survival of both the pregnant woman and her unborn child. Several factors were shared which affect ANC initiation. There is a relationship between the low socio-economic status

of women, cultural values relating to teenage pregnancy, and ignorance, as influenced by their status in life. Issues of the attitudes of the women to our current quality of health service have been seen to influence the behaviour of women towards their actions regarding clinic attendance, as indicated by comments about issues such as long queues and long waiting times.

Chapter 3 discusses the research design and methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Chapter 3 describes the research design and methodology used in the study. It begins by explaining the research design and methods used, which includes the study population and its eligibility criteria, sample size, sampling technique used, source and method of data collection, data analysis methods, validity and reliability of the research instrument and ethical considerations.

3.2 Research design

This research followed a qualitative approach, which is a way of gaining insight through exploring and describing a situation – in this case, the reasons why pregnant women booked late for antenatal care. It is descriptive in nature as it allowed women to elaborate on their reasons, and it is exploratory as it allowed women to explain their reasons (Brink *et al.*, 2015:122).

Qualitative research has three significant characteristics: it is changeable and can be adjusted during data collection; it is holistic in nature as it defines the phenomenon as a whole; and it requires the active participation of the researcher, requiring that he or she spends much time in the field (Polit & Beck, 2010:259).

3.2.1 Descriptive design

A descriptive design was utilised, as it deals with the exploration of real-life experiences. Through descriptive studies it is possible to generate new knowledge of concepts and relationships between concepts. In generating new knowledge about a concept, it provides a basis for further investigation of the phenomenon (Burns & Grove, 2010:46).

Polit and Beck (2010:268) view descriptive design as involving four steps, that is, bracketing, intuiting, analysing and describing. Bracketing assisted the researcher to avoid the use of any preconceived ideas and prevented the researcher from influencing the participants and the study results. Intuition helped the researcher to concentrate fully on the participants' responses, without criticism or expressing any

opinions. Analysing was implemented utilising the themes; describing should not be used prematurely, as it is used during the analysis of the data (Streubert, 2011:82).

In this study it was easy for the researcher to do both passive observation and to engage in face-to-face interactions with the participants through the interview process.

3.2.2 Exploratory design

The research was also exploratory in nature because it involved listening and analysing the experiences of women who booked late for antenatal care. The main aim of exploration is to discover new dimensions of the subject matter that have not been thoroughly researched (Polit & Beck, 2010:259).

An exploratory design aims at exploring the dimensions of the phenomenon, the way it manifests, and the factors related to it. In this study, reasons why women booked late for antenatal care were explored with the aim of discovering the meaning attached to the reasons given.

3.2.3 Contextual design

Babbie and Mouton (2010:81) state that a researcher should aim at describing and understanding all the events and circumstances that are relevant to the study in the concrete and natural context in which it occurs. A contextual design denotes the environment and the circumstances in which the study takes place (Burns & Grove, 2008:44). The context that the researcher used for the study was public clinics in the KSD sub-district in the Eastern Cape.

3.3 Study setting

The study was conducted in the KSD sub-district. KSD has a total of 49 public health-care facilities. Ten facilities that performed the worst in ANC for women presenting before 20 weeks were used. Four community health care centres – Mbekweni, Ngangelizwe, Mqanduli and Ngcwanguba – and six clinics participated in the study.

Ten facilities were chosen because they were the lowest performing facilities for ANC for women presenting before 20 weeks' gestation, according to data collected in the sub-district.

3.4 Study population

A study population is an entire group or elements with common characteristics. They had the same attributes in this study, as the eligibility characteristics were women who are pregnant and booked late for antenatal care (Ritchie, 2014:78).

3.4.1 Sampling

Sampling is a process of selecting a portion of the population representing the entire accessible population. A purposive, non-probability sampling method was used in this study. The researcher met with participants in the clinics that they were attending, which was convenient for them (Streubert, 2011:29).

Purposive sampling allowed the researcher to select the sample based on knowledge of the phenomenon under study. The sample was relevant to the research question, as it produced credible descriptions of the reasons, thoughts and insights of pregnant women. The size of the sample was determined by data saturation. Data saturation is a stage when further collection of evidence provides little or no further themes, insights, perspectives or information in a qualitative study (Brink *et al*., 2015:141).

Sufficiency was another factor that was considered. Data should be sufficient enough to answer the research question and to permit comparison amongst the selected dimensions. This is reflected in the range of participants and the sites that made up the population (Suri, 2011:10).

The sample was drawn from KSD clinics with low rates of women presenting for antenatal care before 20 weeks' gestation.

3.4.2 Inclusion and exclusion criteria

The participants were selected based on the following inclusion criteria:

- Pregnant women who booked late (later than 20 weeks after conception of pregnancy) using the current data given at their clinics.
- They had to be able to speak English or isiXhosa.
- All pregnant women were considered, irrespective of age – if they had booked late.

- Some were at the clinics for their first visits, and others were on follow-up visits.

3.4.2 Exclusion criteria

Participants were excluded based on the following:

Women who had booked early (before 20 weeks' gestation).

- Pregnant women who were too sick to participate in the study.
- Eligible respondents unable or unwilling to give consent
- Those who could not speak for themselves (mentally retarded).

3.5 Data collection

Data collection refers to the gathering of information that will be relevant to the purpose of the study. To achieve the best results in this exploratory study, the researcher decided to conduct one-on-one interviews with the clients who booked late at the various clinics. Data was collected through audiotape recordings using a semi-structured interview guide with individual participants on their own. Notes were taken while the participants were speaking. A good rapport was maintained at all times, making each session as comfortable for the participants as possible.

3.6 Data collection method

To achieve the best results in this exploratory study, it was decided to conduct one-on-one interviews with the clients who booked late at the various clinics. A common interview guide was used by the researcher. Permission was granted, and appointments were made prior to the researcher's visits to the clinics (see Annexures 3 and 5).

Clinics were notified through the sub-district office about the permission granted to the researcher, and about the dates on which the researcher would be visiting the various clinics. On the day, the researcher selected all those clients who had booked late (after 20 weeks) from the clients who were present in the clinic on that day. A dedicated room was made available by the operational managers. The venue for the interviews was prepared for the sake of the maintenance of privacy. Signed consent letters were obtained when introductions were made and options for participation were also given to each participant.

Privacy and confidentiality were maintained by being offered a separate consulting room, free of noise and interruptions. Every participant was assured that anonymity would be maintained, as this is one of the key principles of justice and forms part of general respect for human dignity. Participants were made aware that any information given to the researcher would be kept under strict confidentiality (Polit & Beck, 2010:125).

Probing questions were asked so that the participants had a chance to give deeper and more expansive responses. Non-verbal communication was observed and noted down.

3.7 Interview process

Semi-structured interviews are verbal engagements in which the researcher interacts with the participants, allowing the researcher to be the leading driver during the process of interviewing (Burns & Grove, 2008:405). These interviews were conducted in an informal manner, much like a conversation (see Annexure 4).

The central questions were:

“What are the reasons for you booking late for antenatal care?”

“Is there anything that you would like to share with me about the antenatal care services in this clinic/CHC?”

“If there were any other providers that offered these services, would you choose them? Can you elaborate on why you would prefer or not prefer to go to them?”

The main question that was asked of all participants was “*Ungakhe undixelel ukuba zithini izizathu zokuba uze emva kwexesha elimisiweyo ukuzokuhlukuhla?”* (“Can you tell me the reasons why you came late for antenatal care – after 20 weeks of pregnancy?”).

During the interview process, participants were given a chance to correct any misrepresentations that may have occurred by listening to the researcher repeating back to the participant what she had just said, and by listening to the audiotape at the end. In this way, ambiguities were avoided, and confirmation of accurate information was obtained.

Probing was done to obtain a maximum amount of data and to verify whether what the researcher heard was what the participants meant. Detailed, oriented probes, follow-ups, elaborative probes and clarification probes were all used to increase detailed exploration (Brink *et al*., 2015:158).

For example, one of the participants responded by saying she had no reason for coming late for the ANC – it was just laziness. The researcher probed by asking, “If it was only laziness, what made you come now?”

The researcher needed to bracket all her personal experiences and feelings and rid herself of her own biases before talking to the participants. Bracketing is defined by Burns and Grove (2008:545) as suspending or putting aside what is known about the experience being studied.

Paraphrasing what the participant had said after each reasonably long response helped bring out the meaning in what the participant had said. The observation of non-verbal gestures or repetition by the participants contributed further information. Pausing to allow time to think was also important. The researcher aimed at being empathetic and understanding while keeping the participants focused during the interviews.

Reflecting, paraphrasing and probing were critical elements that the researcher used during the process of interviews.

Reflecting: The researcher communicated her understanding of the participant’s concerns, feelings and perspectives to the participant in the participant’s own words (Streubert, 2011:314).

Paraphrasing: This involved reflecting what the participant has said in slightly different words in order for the researcher to test whether she had understood the meaning intended (Streubert, 2011:314).

Some of the respondents poured out their hearts, while others, especially the younger women, were not open. However, the researcher utilised her training and experience to observe all important matters concerning interactions, both verbal and non-verbal. This included awareness of her own non-verbal behaviour, such as eye contact and facial expression, and a relaxed, natural posture. These aspects were

noted from the participants too and contributed to the overall message conveyed. All cues were noted down as part of the interview notes.

The following communication skills were used and observed:

Minimal non-verbal responses: These include non-verbal cues such as “Mmh …” and “yho!” during the interviews; also, shyness and non-willingness to talk in some of the participants.

Data collection stretched over two months. Interview times were arranged to suit the needs of the participants. Data collection occurred until saturation was reached.

3.8 Data analysis

The technique of data analysis involves identifying consistent words, phrases and themes that can be grouped into categories. A total of 13 interviews were conducted with participants. The researcher observed participants’ non-verbal responses that could indicate discomfort, irritability or stress; also, hesitation, laughing or any other non-verbal cues. The researcher kept personal notes, which included her own reflections and experiences during the interviews.

The tape recordings of the interviews were transcribed verbatim in isiXhosa and translated into English by an accredited translator from Walter Sisulu University to facilitate content analysis. Field notes were typed, accordingly, as they were taken by the note taker (see Annexure 6).

An external independent coder was used to analyse the transcribed data to identify themes, categories and sub-categories.

The collected data were analysed using Creswell’s six steps of qualitative data analysis:

- Data was organised and prepared for analysis by making use of the transcribed verbatim responses from the participants.
- The data was read, looking for overall themes that emerged, and checking the verbatim data with the field notes.

- Coding of data or sentences was done, and the data was organised into segments representing themes, categories and sub-categories, for example “I have to walk or take a taxi to the clinic.”

- The coded information was then used to generate categories and themes and the developed themes would then appear as major findings of the research study.

- An independent co-coder was used to analyse the verbatim transcriptions, as shown in Annexure 7.

- The developed themes were then used in the qualitative narrative, where categories were assembled and linked to themes (Creswell, 2016:247).

The interpretation of the data indicated that that there were differences in the responses from the participants. There were also similarities in the responses, even though they were given by different participants at different clinics. Qualitative researchers begin their analysis by organising data into small segments (Polit & Beck, 2010:465).

Observational notes are notes that assist the researcher in giving an account of what happened during the interviews, with no attempt to interpret events. The researcher made observational notes of what she observed during each interview (Polit & Beck, 2010:355).

Field notes were also written after each interview to describe the physical setting and the activities that occurred. Field notes are defined as qualitative notes that are recorded by the researcher during field research. These notes are intended to be read as evidence that gives meaning and assists in understanding the phenomenon under study (Polit & Beck, 2010:355).

Theoretical notes are systematic attempts by the researcher to derive meaning from observation notes through hypothesising or trying to identify some relationship between observations made during interviews. The researcher tried to identify repeated patterns during interviews (Polit & Beck, 2010:355).

The interview was finalised by asking if the participant would like to add anything. Participants were thanked and reminded of the agreed-upon confidentiality.

3.9 Trustworthiness

The researcher ensured trustworthiness of the study by applying Lincoln and Guba's (1985:289) framework, which sets criteria for trustworthiness, these being credibility, transferability, confirmability, dependability and authenticity. Lincoln and Guba suggest that the fundamental criterion for qualitative reports is trustworthiness (Guba Egon, 1985:289).

Trustworthiness is described as the ability of the study to persuade the researcher and the reader that the findings of the study are worth paying attention to and worth being considered. Trustworthiness was enhanced, using the audiotape, which ensured that data was transcribed verbatim. The truth value was ensured by the strategy of credibility (Polit & Beck, 2010:492).

During the interviews the researcher invested sufficient time in data-collection activities to ensure an in-depth understanding of the participants' views and experiences. The researcher conducted all interviews. The researcher employed the technique of bracketing to ensure that existing knowledge and preconceived ideas did not interfere with the research process, and that personal views did not interfere with the responses. Close observation of all verbal and non-verbal behaviour was always maintained. Observational notes were kept during the interviews and field notes were made directly after each interview. The researcher conducted the interviews until data saturation occurred, namely, until the collected data began to be repeated and confirmation of previously collected data began to take place, with little variation.

The following table shows how the principles of trustworthiness were applied by the researcher:

Table 3.1: Integrity of findings and how it was ensured

Strategy	**Criterion**	**Applicability**
Credibility	Prolonged engagement	There was prolonged engagement with the participants for the

		researcher to understand their culture and become accustomed with their environment. The researcher was acquainted with the environment as she is a nurse by profession and understands the community and the social setting of the clinic.
Confirmability	Member check	There was a member check during which audiotapes were played back to the participants for them to confirm their responses.
	Authority of the researcher	The researcher is an experienced nurse who has spent most of her time in the community and clinics.
Dependability	Dependability audit	Field notes were kept after use. Use of findings from similar studies
		through literature review. Dependability audits were done by keeping field

		notes and using the findings from similar studies to ensure a measure of control.
Transferability	Structural coherence	This means that the research study findings are applicable to other contexts or similar situations, similar population's similar incidence of late booking.
Authenticity	Faithfulness	The researcher was able to show her faithfulness to the facts. This is shown by the text if it can invite readers into various experiences of the lives being described, giving details.

Source: Polit & Beck (2010:4)

3.10 Ethical considerations

This section explains the procedures that the researcher has taken to obtain approval to carry out research, to protect the respondents and to maintain the scientific integrity of the research. Polit and Beck (2010:727) define ethics as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligation to the study participants.

The researcher observed the fundamental principles underlying the protection of research participants (Polit & Beck, 2010:753).

3.10.1 Informed consent

Informed consent is one of the legal requirements of clinical research. A participant is required to sign a letter of consent in which the purpose and nature of the research, and his or her part in it, is explained. Participants need to be aware of both the benefits and the actual or potential risks involved. Polit and Beck (2010:127) define informed consent as a means of showing that participants have the power of free choice and free participation and the right to decline participation at any stage of the research.

The researcher was obliged to provide all participants with relevant and adequate information when obtaining their consent. The voice recording attests to this fact.

The participants were informed about the purpose and objectives of the study and the critical research questions that needed answering and were given an explanation of how the study would be used to benefit the participants themselves. All the participants were given true and sufficient information to help them make informed decisions regarding their participation, and language of preference (isiXhosa) was an option (Streubert, 2011:62).

Research participants who were within the bracket of vulnerable group, those under the age of 18 years, were ordinarily assured of reasonable accesses to information and their ability to be given a chance to bring their parents in the case of pregnant women within the bracket of 17 years, if they wished to participate.

Duncan Macrae in his book on Distinctive conception of field of Public Policy analysis stated that commitment to public policy decision making is a matter of ethical choice by an informed reasoning of citizens and not merely by technical analysis. In this case of participants under the age of 21, it was their informed decision not to bring their parents to give consent on their behalf to participate in the study (Duncan Macrae, 2007:247).

Those participants said they did not want their parents to be involved and their decision was respected, and the interviews continued after they consented to participate in the study.

3.10.2 Confidentiality and anonymity

Face-to-face interviews were carried out by the researcher. All participants were introduced to the researcher by the operational manager of the clinic. The researcher

explained the written consent letter, reading it aloud in isiXhosa for those who could not read. Each participant was told of the non-use of her name in the written record. The individual right to confidentiality and anonymity was maintained in that participants were guaranteed that the information received from them would not be shared with other individuals, including the sisters in the clinic (Streubert, 2011:62).

No identifying data, such as names and addresses, were required. Participants' names were used only for conversational purposes, and the reference to names in writing was later destroyed. No biographical data that could link the participants to the research was kept. The researcher also assured the participants that the use of the audiotape was purely to capture information and that the recordings would be destroyed after the study.

All these confidentiality measures are in keeping with the guidelines given by Streubert (2011:64).

3.10.3 Privacy

Privacy is defined by Burns and Grove (2010:195) as the individual's right to control and limit the extent to which personal information will be shared with or totally withheld from others. All possible means of protecting the participants were applied. The information under discussion in this study is the participants' attitudes, beliefs, behaviour, opinions and experiences, and their names and personal information were not kept on record (Burns & Grove, 2010:196).

The audiotape and field notes were kept under lock and key. They were to be destroyed on completion of the study.

3.10.4 Respect and dignity

Polit and Beck (2012:154) describes this principle as the right to full disclosure. The respondents have the right to decide voluntarily whether they want to participate in a study or not, without any penalty. The respondents signed an informed consent form which provides details regarding participation in the study; this also ensured that respondents were not forced to take part. Draft of the consent form accompanied the research proposal. They had the rights to ask questions, refuse to give information or to withdraw from the study. The cultural beliefs of the respondents were respected.

The researcher ensured that no name, address and file number of respondents was used during the course of the study.

The participants were not coerced to participate in the study, but were invited to participate voluntarily. The purpose and extent of the study was explained to them and all the information gathered during the study was used only for its intended purpose.

3.10.5 Principle of beneficence and justice

This section explains the procedures that the researcher has taken to obtain approval to carry out research, to protect the respondents and to maintain the scientific integrity of the research. Polit and Beck define research ethics as norms for conduct that distinguish between acceptable and unacceptable behaviour when doing research. They further define ethics as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligation to the study participants (Polit and Beck, 2012:727)

This principle involves the protection of participants from discomfort and harm. The researcher ensured that the risks involved did not exceed the benefits of the study. The researcher tried to avoid anything that could be construed as emotional harm, dishonesty or immorality by maintaining privacy and reassuring the participants of their right to discontinue participation if they were not comfortable (Polit & Beck, 2010:125).

Honesty and transparency were maintained between the researcher and the participants through playing back the voice recordings so that the participant could ascertain that there was no added information – it was her own voice and exact words (Polit & Beck, 2010:125).

The researcher was not part of any of the clinics' staff and participants were free to voice their opinion without fear of being victimised by clinic staff, as the interviews were private (Polit & Beck, 2010:125).

3.11 Conclusion

In this chapter, the researcher undertook to compile a comprehensive outline of the methodology used during data collection. A full description was given of how the data was collected, what instruments were used and the processes that took place to

capture truthful and accurate data. The researcher went to great lengths to ensure compliance with ethical principles; these have been presented in some detail.

CHAPTER 4: PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

In the previous chapter the researcher presented a comprehensive outline of the research methodology used. In this chapter the researcher presents the findings of the research that were obtained through analysis of the data.

4.2 Presentation of results

4.2.1 Demographic data of participants

The thirteen participants interviewed were all pregnant women at various stages of gestation. Their ages ranged from 17 to 37 years. Seven women were not married and six were married. Of the seven unmarried women, four were at school and three were out of school but not working. Of the thirteen women interviewed, six were primigravida and seven were multiparous. They were all isiXhosa-speaking women.

4.2.2 Findings of the study

The participants expressed a wide range of factors that were the reasons to their late booking. None gave very specific reasons, and one seemed to sum up the view of many when she said, "*Hayi, Sister, andinasizathu. Kukwenqena qha"* ("No, Sister, I do not have a reason, it's just I am lazy"). But when the researcher probed this reason, it emerged that the woman had to take a costly taxi to get to the clinic, which was available only early in the morning and returned home in the afternoon. Most of the participants verbalised similar experiences – long distances to be travelled and expenses incurred by them through travelling.

As the women related one of their reasons as being long distances and travelling costs, what was similar was that all of them presented themselves for their first antenatal care at six months up to seven months. Another critical issue was the issue of long queues at the clinic and others cited the unavailability of clinics, where they are served by a mobile clinic, which does not have ante natal care service.

Some of the multiparous women were delaying because they waited to feel the foetal movement and are used to attending on the sixth or seventh month.

Four women that were at school were hiding the pregnancy and did not want to be seen.

A detailed discussion of the identified themes regarding women's reasons for their late bookings follows:

4.3 The findings were summarised into the following themes:

Four major themes emerged from the data analysis: (1) Personal factors linked to the pregnant women; (2) Culture and lifestyle; (3) Inaccessibility of clinics; and (4) Poor service delivery in clinics.

The themes were further classified into categories and subcategories, as indicated in Table 3.3.1.

The findings of this study were the same as those in a study on the identification of variables influencing delays in attending antenatal care amongst teenagers in Lesotho by Phafoli *et al*. (2007:3). The following themes were cited by Phafoli *et al.*: personal barriers, and lack of knowledge regarding importance of early antenatal care attendance. It was identified in the same study that there were also systemic barriers, such as lack of accessibility due to distances being travelled by adolescents to the clinics (Phafoli *et al.*, 2007:6).

In this study, the same themes and categories were identified by the researcher from the data collected from the participants. The following table presents reasons for late booking, as cited by the pregnant women during the interviews.

Table 4.3.1: Identified themes, categories and subcategories based on the reasons why women booked late for antenatal care clinics.

Theme	**Categories**	**Sub-categories**
Personal factors	Ignorance of the purpose of attending antenatal care	• Women had no reason but were just lazy. • Delay in attending antenatal care clinic in previous pregnancies

		• Attending school • Fear of language problems in other outside clinics.
		• First pregnancy and nobody told her when to come • Was waiting to feel movements.
Culture and lifestyle	Hiding pregnancy	• Being pregnant whilst at school is not accepted. • Keeping pregnancy, a secret
Lack of accessibility	Waiting time	• Clinics too far • Nurses start with other people. • Long queues that one must join.
	Distance travelled	• Walk long distances. • High costs of taxis.
Lack of service delivery	Limited resources	• No clinics in the area, clinics are too far.

		• Mobile clinic not providing service. Attended to by a private doctor.

4.4.1 Theme 1: Personal factors

Personal factors are defined by the Oxford Dictionary (2009:689) as individual factors that strongly influence individual behaviour; in this study, therefore, being the reasons why women attended antenatal care late.

The most prominent personal factor was ignorance regarding the importance of attending clinic early when one is pregnant. Ignorance is defined by the Oxford Dictionary (2009:459) as lacking knowledge or awareness in general. As one respondent put it: "*No Sister, there is no tangible reason, because it's just that I last have my last pregnancy long ago so I used to take from this thing that I usually come to the clinic at five months, I did not know that things have changed and one must come now early, before five months of pregnancy*."

This lack of knowledge is linked to many factors, such as socio-economic status, educational level and the developmental status of the community where the person resides (De Vaal, 2011:8). There are studies that have linked these factors to late antenatal attendance.

Studies conducted in developing countries show that there is a relationship between socio-economic conditions and the late or non-attendance of antenatal care by pregnant women. The researcher reviewed five studies on the issue of low income versus late booking – two studies in Indonesia, two studies in Nigeria and one in South Africa. A study conducted by Agus (2015) in a rural town in Sumatra found that, of 74% of 145 women interviewed in a study on "Factors influencing the use of antenatal care in rural West Sumatra in Indonesia", 11% did not work and 24% were earning a low income from farm work. The study showed that the lower the socio-economic status of a woman, the later she attends, or she does not attend, the antenatal care clinic, largely due to the unavailability of money for transport to the clinic (Agus, 2015:5). This shows that there is a strong link between low income as a

personal factor and late, early or non-attendance of antenatal clinic, because women cited the expensive or unaffordable rates of taxis, which has a great deal to do with meagre income.

In a similar qualitative study on “Why don’t some women attend antenatal care and postnatal care services” in Indonesia, Titaley *et al*. (2010:6) found out that financial difficulties emerged as a major factor among women who did not fulfil a minimum of four visits, as expected, and who booked late for antenatal care.

In addition, the results of one study indicated that participants who were taken from minority ethnic groups, homeless refugees and low-income persons cited reasons such as denial of pregnancy, lack of money to attend clinics and culturally insensitive staff as contributing to their late attendance (Downe *et al*., 2009:14).

In a similar study conducted by De Vaal (2011:8), he identified personal barriers such as ignorance of the importance of antenatal care and lack of money to take a taxi to the clinic as a major reason cited by women on why they attended the clinic late.

In this study there are three categories that relate to the theme of personal factors. These are: ignorance of the correct booking time and purpose of antenatal care, doubts about pregnancy, role clash due to social responsibilities, and the language barrier.

4.4.1.1 Category 1: Ignorance regarding when to attend antenatal care clinics

Ignorance is defined by the Oxford Dictionary (2009:459) as lacking knowledge or awareness in general. Many research papers and journals were reviewed by the researcher and these largely showed that lack of knowledge is one of the contributory factors to late booking.

Ifenne and Utoo (2012), in their study in Nigeria, found that there was lack of knowledge on the exact gestational period at which one must attend the antenatal care clinic if one is pregnant. Ignorance on the part of pregnant women contributed to women booking late, thereby increasing the late diagnosis of complications of pregnancy and hence maternal mortality (Ifenne & Utoo, 2012:236).

An Italian study by Cuzollin *et al*. (2010:1151) showed that the use of herbal medicine by pregnant women was very high because of lack of knowledge of the complications these potions might cause in pregnancy and for the unborn child. The study was conducted on 392 women, 60% of whom used different herbal products that resulted in complications, such as threatening abortion and preterm labour (Cuzollin *et al*, 2010:1151).

Mathibe-Neke (2008) defines pregnancy as a phase that makes great demands on the physical, psychological and social well-being of a woman; hence, there is a need for support during pregnancy in the form of health education. The best way this care and support can be provided is through attending antenatal care at a clinic. The purpose of antenatal care is the delivery of a healthy baby born from a healthy mother. This purpose can be achieved through the supervision, health education, physical examination and implementation of treatment that a woman receives at the hands of professionally trained nurses (Mathibe-Neke, 2008:5).

. It is evident that all thirteen participants in this study lacked knowledge of the importance of attending ANC. A study by Monafar (2013:14) suggested that, in their study on three African countries, such as Malawi, Ghana and Kenya, there is little information given to women on the importance of attending antenatal care clinic early. The following are their responses – the women interviewed stated that they were not aware of the importance of coming to antenatal care early, and some women were waiting for foetal movements to be felt (Monafar, 2013:14).

> *"I don't have anything to say … I usually come when I am six months pregnant, I did not know that systems have changed."*
>
> *"I wanted to book at my clinic at home because I did not know that those Tswana nurses would understand my language."*

4.4.1.1.1 Subcategory: "*Hayi asikho kukwenqena qha" ("No, there is none, it's just being lazy").*

"Hayi Sista asikho isizathu tu kukuba nje ndigqibele kudala ukukhulelwa kwisisu sam sokugqibela ndiqhele ukuza eclinic xa sele ndineenyanga eziphaya esihlanwini. Andiyazang ukuba izinto zitshinhile ngoku kufuneka umntu eze phambi kwenyanga ezintlanu/" ("No Sister, there is no tangible reason, because it's just that I had my last

pregnancy long ago so I used to take from this thing that I usually come to the clinic at five months; I did not know that things have changed and that one must come now early, before five months of pregnancy).”

There were two subcategories that were cited by most participants in this study. It is clear from the responses that women are not well informed about issues related to the early attendance of antenatal care. This statement is supported by a research paper by Ruwangaruri Andrew et al (2014:8) in a study on factors affecting attendance of antenatal care in Guinea, where, it *was* discovered that lack of knowledge on attending antenatal care was deliberate due to avoiding long waiting queues, especially women who were delivering for the second and third time. This serves to reaffirm that the higher parity of the late the antenatal care attendance is prevalent worldwide (Andrew Erin, 2014:6).

4.4.1.1.2 Subcategory: *“I felt something moving then quickly I came to the clinic. They asked me whether I was pregnant, and I replied and said I didn’t know. I was preventing in May they then proceeded and checked me and told me I am six months pregnant”*

“I did not know that I am pregnant. I just felt something moving. It’s my first time that I am pregnant, and nobody told me. Waited until I felt something moving.”

“I can’t say there are any reasons; it’s just that I was busy at school, I did not have a chance. We can go to the clinic but it’s not easy to say you are going for an ANC while you’re at school”

“I had to look after my sick mother in law.” “I had no one to leave the children to.”

In this category there were many subcategories, ranging from doubts about pregnancy, not knowing that one had to go early to the clinic, being just lazy and competing responsibilities, such as studying and looking after sick people.

Some participants were not certain about their pregnancy because they were not sure about their last menstrual period, as a few thought that they were on contraceptives but discovered late that they were pregnant. This clearly shows that contraceptives are not used effectively by the women. National contraception and fertility planning policy and service delivery guidelines (National Department of

Health, 2012:26) state that, in order to increase access to contraceptive services for all those in child-bearing age, services should be extended outside the public health facilities to the communities through the use of partnerships with other organisations and other stakeholders, such as ward-based outreach teams under the Re-engineering of Primary Health Care Programme. There is no doubt that the use of other stakeholders at household level will improve effective utilisation of the service (Pillay, 2012:26)

The District Health Barometer Report 2014/2015 (Massyn, 2014:70) showed a low rate of couple protection from pregnancy among women, which implied that the family planning programme is not adequately marketed and not effectively implemented.

In the DHB (District Health Barometer) report, the following factors are cited as contributory to low family planning uptake: The reluctance of the youth to use contraception due to peer pressure; poverty, which makes child care grants a source of income; and myths on the use of contraception. The district is at 40.0% against a target of 55% (Massyn *et al*., 2014/2015:70).

In a research paper by Mengiste and Farrow (2017:10), it is mentioned that there are critical determinants that affect antenatal care attendance, and these are age – be it young or old, and parity – whether multiparous or primipara. These factors are affected mostly by the time factor of not having time to go to the clinic due to other social responsibilities, such as attending school or looking after other children (Mengiste Mesfin, 2017:70).

Others are housewives whose other roles are to look after sick people and after older children. These experiences are presented in the following quotes:

Social responsibility has been identified as another issue that some participants cited, namely, that they have no one to leave their children with while attending the clinic and one indicated that she had to look after her sick mother-in-law.

The study revealed that, although the Department of Health offers family planning services, many young women become pregnant while at school and delay ANC for that reason, thereby increasing the risk of morbidity and mortality.

4.4.1.1.3 Subcategory: "*I can't say there are any reasons; it's just that I was busy at school, I did not have chance. We can go to the clinic but it's not easy to say you are going for an ANC while you're at school."*

The Minister of Basic Education, Angie Motshekga, in her policy on teenage pregnancy in South Africa with specific focus on school-going learners, states that teenage pregnancy is amongst the concerns that pose a threat to the outputs or gains in public schools. She further says the Department of Education is making efforts to ensure that the girl child remains at school to contribute towards her quality of life, thereby fighting poverty (Motshekga, 2009:6).

In this study it was shown that the participants who prioritised attending school were committed to continue with their studies but failed to report early for antenatal care.

4.4.2 Theme 2: Accessibility

Access to health care involves geographic accessibility, availability of the right type of care for those who need it, financial accessibility and acceptability of service by the users. Geographic accessibility relates to distance that must be travelled to use a health facility and it may present an important barrier of access to health services. This barrier is common in South Africa as a developing country where people have to travel long distances to access health (Abdullah AL-Taiar, 2010:1)

Health, according to the Constitution of the Republic of South Africa, is a human right and everyone has a right of access to health care (Parliament, 2003:2).

The White Paper on transforming the public service through the implementation of eight Batho Pele Principles, such as consultation, service standards, access to information, transparency, redress and value for money, is aimed at improving service delivery by the entire public service (Department of Public Administration, 2014:6). This is not possible if facilities are very far from where people live. Many clinics are simply not accessible to communities. These are the responses given by participants:

"I came here today at about past 7 because I have to take the neighbour's car that leaves at around 6 o'clock. Then I arrive at past 7 and have to wait. Because it is too far to the clinic."

“They start late; I think that should be revised because thina singabanye we wake up very early for the clinic.”

In this theme, participants cited long queues, long waiting time, long distances to be travelled and lack of quality services. These experiences were linked by the researcher to possible reasons for late booking.

4.4.2.1 Category 1: Long queues

Participants in this category cited that they wait in long queues before they are attended. They even said these queues are coupled with many stations that one needs to start from registration: queue for vital signs then queue for a midwife to palpate one.

“I currently only attend in this clinic although we wait before we get attended to. We wait for maybe about two hours and I would say you get properly attended to only after 2-3 hours.”

“I came here today at about past 7 because I have to take the neighbour’s car that leaves at around 6 o’clock. Then I arrive at past 7 and have to wait.”

The National Department of Health, in a bid to improve quality health services, established National Core Standards for Health in 2012. An office, referred to as the Office of Standards Compliance for Health Establishments in South Africa, was created to implement this strategy. There are seven domains and six key priority areas. The domain, patient rights, incorporates waiting times. The waiting time in South Africa needs to be reduced to not more than two hours, according to the Department of Health (2012:6). Long queues, as cited by the participants, are certainly a contributory factor to delays in first attendance at clinics (DOH, 2012:6).

A study by Ruwangaruri et *al*. (2014:14) showed that there were three factors that affected attendance, as grouped into three main categories, namely accessibility, attitudes to antenatal care and interpersonal issues. It has been discovered that, although women see accessibility as a barrier because of distances and transport costs, those close to the clinics also demonstrated poor attendance linked to negative attitudes to antenatal care, which is informed by their previous experiences of ANC. These previous experiences were long queues and long waiting times (Ruwangaruri Andrew et al, 2014:10).

4.4.2.1.1 Sub-category: Long waiting times

"We attended very late as pregnant women, queues are long."

"For instance, today I came in at 10 o'clock but there are many areas where you have to queue. You queue for registration, for "Mfaxazo", checking of BPs. Now it's 2 o'clock, since I came at 10."

"They start very late – they need to improve."

"There are many queues that one has to go through: registration, observations and lastly queue for the nurse for antenatal care."

"I came here today at about past 7 because I have to take the neighbour's car that leaves at around 6 o'clock. Then I arrive at past 7 and have to wait."

"They start late, I think that should be revised because thina singabanye*, we wake up very early for the clinic."*

The results of a research study by Duff *et al*. (2010:37) showed that long waiting times at clinics represented one of the greatest barriers to accessing antenatal care cited by pregnant women.

Many participants interviewed for this study cited long waiting times before being attended to by a professional nurse as a problem. Long waiting times are obviously a product of long queues. There is a new strategy that the Department has established, namely for an Ideal Clinic through a Perfect Permanent Team for Ideal Clinic Realisation (PPTICRM). The concept of Ideal Clinic Realisation was initiated by the South African National Department of Health in July 2013 to systematically improve primary health care facilities and look at the quality care they provide. This strategy seeks to transform public health clinics into ideal clinics that provide good quality care to all communities. It is a vehicle towards the full implementation of the National Core Standards (DOH, 2013:3).

4.4.2.2. Category 2: Long distances

According to the World Health Organization, services should be accessible with no undue barriers such as costs, language, culture or geography. A good service should be people centred by the people for the people. Health services should be close to

the people and should be comprehensive in nature (World Health Organisatiion, 2010:3).

Many participants cited the long distances they must travel before they reached the clinics. Some said they had to take taxis, which are expensive and are not available all day. Although World Health Organisation has indicated that the distance to be travelled by an individual to access health services is 5kms this norm is not feasible to be implemented in the terrain of KSD, therefore one must board a taxi.

This is also confirmed by the results of Duff *et al*. (2010:37), who found that participants cited economic barriers as a contributory factor for late attendance, especially when residing far from the clinics.

"Other clinics like Zidindi are too far." "Even here we travel on foot or you pay R10 and the taxis are available only in the morning."

4.4.3.2.2.1 Sub-category 1: Transport costs

"The problem is that other clinics are just too far, you have to hike and still have to take one taxi at a cost of R10 afterwards. This is the only clinic we use as the rest are simply too far."

"The clinics are too far as I board a taxi when I have to come to the clinic and that costs me well over R25." "Here I am, not working, I'm currently unemployed. For pregnant women to get help at the clinics I think we need to have separate nurses for ANC."

Many participants in this category indicated that one had to board an expensive taxi in order for her to reach the clinic. It was overwhelming to find that it was very costly for women to access antenatal care services and one does not doubt the reasons why they presented themselves late, as most of them are not working.

Regarding the issue of free health services, the Reconstruction and Development Programme says, "there must be a programme to improve maternal health and child health through improved access to quality antenatal care and free health services for children and pregnant women," as it was government policy in 1994 that services for children and pregnant women should be free (Parliament, 2003:1255)

According to this study, this means that, for a woman to have an adequate number of four visits per pregnancy, she must pay R200.00. *As one respondent put it: "The clinics are too far as I board a taxi when I have to come to the clinic and that costs me well over R25. Here I am, not out working, I'm currently unemployed."*

4.4.3 Theme 3: Culture and lifestyle

Culture is defined by Porta and Samovar as cumulative deposits of knowledge, experiences, beliefs, values, attitudes, meanings, religion, objects and possessions acquired by a group of people during generations through individuals. Culture is learned and is intergenerationally transmitted (Porter Richards, 2015:105).

Participants who appeared to be affected by culture as a barrier were the teenagers between the ages of 17 and 19 years who were attending school. According to African culture, it is taboo for a girl to fall pregnant before marriage. In such cases, the parents would be shocked and disappointed, and young women who find themselves in this condition would be afraid to reveal their condition. As a result, they would delay attending ANC (Akella, 2011:13).

4.4.3.1 Category 1: Hiding pregnancy

In this study, the six young women were interviewed, four of whom were still at school and said they delayed because they were afraid of their mothers. The one at a tertiary institution essentially expressed the same fear, saying that she was the first in her family to pursue her education further and she knew that she had disappointed her family. She was afraid of their reaction.

Other cultural practices that prevail and play a role are the customs of a married woman having to care for her mother-in-law. One woman was in this situation and, as a result, could not leave her children in the care of this sick mother-in-law. Throughout the interviews, the participants attributed their delays to visit the clinic to cultural factors.

"I don't go to the clinic before my stomach is showing"

4.4.3.1.1 Sub –category 1: Afraid of telling mother

> *"I don't have any reason for not coming early. The only problem I had is that I was afraid of telling my mother that I am pregnant."*

“My mother was told by a neighbour and then she asked me and said I must go the clinic.”

Joni et al. (2015) say cultural beliefs play an integral role in the decision-making process of antenatal care. Furthermore, according to the results of the study, beliefs and practices of when to disclose pregnancy prohibit women from seeking antenatal care in the first trimester of pregnancy. This is done to hide pregnancy to avoid being bewitched (Joni *et al*, 2015:34).

Culturally, it is normal for an African woman who has struggled to conceive to keep her pregnancy secret in her community. There is fear of gossip, and, as a result, secrecy is very common, even when women have had no problem in conceiving. This causes delays in attending ANC. Some women admitted that they were simply lazy or lacked motivation from anyone to attend the clinic – they simply waited until they felt they had to.

One had wanted to see a private doctor first to confirm that she was indeed pregnant. This is confirmed in a study by Dilly *et al*. who discovered that, in their theme, which was referred to as “knowing”, there was deliberate delay on the part of the participants that was linked to avoidance, fear, postponement. In this case, opting to see a private doctor was a deliberate delaying tactic, otherwise the woman knew she was pregnant but preferred a private doctor. This was interpreted as an indication that some women were not valuing the public clinics (Dilly Anumba, 2015:15).

A study conducted at Michael Mapongwana Clinic in Khayelitsha by De Vaal discovered that cultural barriers, such as laziness, prevented women from attending the clinic early during the first trimester of pregnancy. Some participants indicated that they attended clinic in the Transkei, and that this was their reason for attending late (De Vaal, 2011:8).

In this study, a participant delayed attending because she argued that she could not attend a clinic in Johannesburg, as she did not trust the language of the nurses, saying they would not understand her: “*Isizathu sokuba ndize leyithi yintuba bendiseRhawutini emyenini. Ndathi ndisakufumanisa ukuba ndikhulelwe andakwazi ukuya kweza klinik zaphaya ndalinda ukub ndide ndigoduke ndizokuqalisa apha.*

Phaya bendingalwazi olwalwimi lwaphaya futhi bendingaqondi ukuba akhona amanesi athetha isiXhosa yabe andilwazi olwalwimi lwesiTswane luthethwa phaya andiqondi ukuba bayalwazi olu lwam ulwimi."/ "The reason I came late is that I was in Johannesburg to visit my husband when I discovered that I was pregnant. I could not go to the clinic there so I waited until I was home so that I could start here. I could not go there because I did not know the Tswana language. I did not think that they would understand my Xhosa language." This participant delayed booking due to her choosing a place of perceived trust.

4.4.4 Theme 4: Service delivery

According to WHO, (2010:3) service delivery is a vital element of any health system. According to WHO, the six building blocks of a health system is service delivery, health workforce, information system, access to essential medicine and good governance. The following are the characteristics of a good service delivery such as comprehensiveness providing preventive, promotive, curative, palliative and rehabilitative health service - accessible and people catered (WHO, 2010:3).

Throughout the interviews, the issues of the long waiting time and long distances to the clinics, and issues of service delivery such as needing nurses and the unavailability of clinics were prominent.

"*Ewe ndicinga ukuba amanesi okuhlukuhla bafanelukuba babekwe ecaleni bajongane nabantu abahlukuhlayo kuba noba ufike ekuseni baqala late ukuhlukuhla kufaneleke ukuba bazyiphucule le sevisi. Mabayazuba thina sisuka kude ingaske sihambe kwangoko" /* "*Yes, I was thinking that there should be nurses for antenatal care services because even if you are early they start late. They are supposed to improve their services. They must know that we are coming very far."*

"There are no clinics in our area, clinics are too far."

In a discussion on world policy by Le Chan *et al*. (2014:1), he points out that service delivery is a common phrase in South Africa that describes the distribution of basic services such as health, electricity, water, sanitation and housing. It is a set of standards, policies and constraints used to guide the design and development of services by a service provider (Le Chan *et al*, 2014:1).

The Department of Health is obliged to provide quality health services to all South Africans, hence its vision for “an accessible, caring and high-quality health system” (Motsoaledi, 2010:10).

Chapter 10 of the National Development Plan: Vision 2030 of the President of South Africa looks at the promotion of health for all South Africans through inter-sectoral and inter-ministerial collaboration in dealing with social determinants of health in order to reduce the burden of disease to manageable levels. Key health priorities are human capacities, both of professionals and non-professionals, including managers and community health workers, and strengthening the entire health system through the National Health Insurance implemented in phases (Presidency, 2014:10).

In a study conducted in the inner city of Johannesburg, Solarin and Black (2012) discovered that the health system was a barrier for pregnant women to book early, because they were discouraged from attending antenatal care early. “They told me to come back.” Pregnant women were denied access to services by nurses, as, if they happened to book early, they would be told to come back later (Solarin & Black, 2012:359).

In this study it was discovered that participants cited the unavailability of antenatal care in mobile clinics and a lack of prioritisation of pregnant women by nurses as contributing to the long waiting time.

4.4.4.1 Category 1: Limited resources

It was stated categorically by the participants that the issue of limited service delivery contributes to their late booking. It was clear that although mobile services were available, they provide limited services.

“The mobile clinic does not provide ANC services.” Mobile services were not rendering antenatal care services, although they were available and were expected to render a full primary health-care package. Some of the participants interviewed responded by saying they had to travel long distances before they could reach the clinic.

In a study on the determinants of poor utilisation of antenatal care services among recently delivered women in Rwanda (Rurangirwa *et al*, 2017:142), it was discovered

that access to the service was a challenge due to inflexible opening hours and a lack of support from the midwives.

4.4.4.1.1 Subcategory*:* Absence of clinics

"There are no clinics in our area, clinics are too far. The mobile clinic does not provide ANC services."

In KSD, the whole area is served by 49 facilities against a population of 432 848. This is a wide area with poor social determinants of health. The norm of one clinic per 4 500 people, according to the discussion document, Re-engineering of Primary Health Care (reference), is currently not met. The sub-district is supposed to have 96 clinics. The clinics in this study serve 6 000 to 21 000 people in community health centres, and this implies that there are underserved communities and a high need for outreach services closer to the people (DoH, 2014/2015:14).

The current health system needs to be re-engineered and redefined to meet the challenges faced by the communities. There is an indication for health system strengthening and health system reform, utilising five control knobs (Roberts, 2014). These organisational control knobs focus on who does what, persuasion in terms of community mobilisation, health financing to ensure staffing is according to staffing norms, regulations, and payment control knobs (Roberts, 2014:53).

4.5 Summary

This chapter has presented research findings from the data in the form of three major themes, along with categories and sub-categories, which gave the researcher some understanding of the many factors that contributed to women's late attendance at clinics for ANC. What follows is a discussion on the conceptualisation of late booking as reviewed by the researcher internationally and nationally.

CHAPTER 5: SUMMARY AND RECOMMENDATIONS

5.1 Introduction

In the previous chapter, the findings were discussed in relation to the literature to verify the research findings and to highlight possible unique findings. This chapter focuses on the summary, conclusions, limitations and recommendations of the research.

5.2 Summary

The reasons and experiences given by women as causing their delay in initiating antenatal care should assist the sub-district to plan how to improve this service so that it is accessible, and barriers resulting in delays are minimised as much as possible.

Recommendations from the study could also assist the entire district and the Department of Health to decrease maternal morbidity and mortality. Currently, women in the O.R. Tambo district die in high numbers.

Most women cited waiting times as a major obstacle contributing to their late booking. They said that nurses began their work late, leaving them to wait for hours before being attended to. The provision of shelter and chairs while waiting outside was recommended, as well as the prioritisation of pregnant women. They said that nurses started with other programmes and then attended to them afterwards, which discouraged them. In addition, there were many queues, not just one: registration being the first one, followed by a queue for observations, where urine and weight were taken, and, finally, having to queue for the midwife. Long queues can be construed as a systems weakness. This is also confirmed in the results of the study by Duff *et al*. (2010:37) who found that participants cited long waiting times and long queues as contributory factors to delays in attending ANC services.

The issue of the inaccessibility of clinics due to distances they had to travel was cited by many participants. They said they had to take a taxi at six a.m. and reached the

clinic by 7 a.m., although it was not yet open. Taxi fees were another factor causing women to reduce their number of visits, and the tendency was to start late, as early visits were considered less important. Late bookings were indirectly related to crime; many in one clinic would have walked the five kilometres or so but were afraid of being raped. This delayed them from the essential early visits required at the clinic.

It was evident that family planning services were not utilised in the study population, as half of the participants were teenagers and attending school, with the youngest being in Grade 10. All the teenagers were afraid of revealing their condition to their parents. The one who attended a tertiary institution appeared to feel a sense of shame at having fallen pregnant and was acutely aware of how this reflected poorly on her. Ruwangaruri *et al*. (2014:10), in their study on factors affecting the attendance of formal ANC, showed that sociocultural factors of hiding the pregnancy by teenagers was one of the reasons for women attending the clinic late, and this was also revealed by the teenagers in this study (Ruwangaruri Andrew, 2017:10).

It emerged that, despite all the messages regarding safe sex, there are still young people who practise unsafe sex. This is evident both from the number of teenage pregnancies and the HIV-positivity rate of 32% in the district (Health Systems Trust, 2014/2015:69).

Some of the participants preferred to first visit a private doctor to confirm their pregnancy, which contributed to delays in initiating antenatal care. They indicated that they were not told by the doctors to go to the clinic but came because private consultations were expensive. This caused them to delay attendance, as they were not told to report to their clinics early. This indicates that there is a poor referral system between the private doctors and the clinics.

Pearson and Murray (2006,2205), in their journal article on Safe motherhood programme, state that a functioning referral system is a necessary element in maternal health management. There are key prerequisites for a successful referral system, as indicated by Murray such as a developed referral strategy informed by the assessment of population needs and health system capabilities, an adequately resourced referral centre, active collaboration between referral levels and across sectors, formalised communication and transport arrangements, agreed setting of specific protocols for referrer and receiver, supervisors' accountability for providers'

performance, and also their capacity to monitor the effectiveness and functionality of the system(Pearson et al, 2006:2205-2215)

It was also clear that what attracted these women to private general practitioners was the scanning facility. It seems that many women want to be able to see evidence of their pregnancies before they fully accept them. One woman recommended that the Department should have scans available in the clinics.

There was an indication that all participants lacked knowledge and information on the importance of attending antenatal care. During the interviews these women indicated that, even during previous pregnancies, they had started antenatal care only at six to seven months. One said that she did not know that things had changed.

It was very clear to the researcher that there is a relationship between cultural factors and ignorance; both play into late booking. There is a tendency to demand physical evidence, either visual or in some other form, before pregnancy is accepted. This is clear from the comment that a woman waited until she felt movement before booking for care, and also in the tendency to prefer facilities (private doctors) that can provide visual evidence of a pregnancy via a scan (Dilly Anumba, 2015:15).

There is also a tendency towards secrecy, which delayed booking, even where women did not have reasons to want to hide their pregnancy, as was the case with the teenagers interviewed. In the case of teenagers, it seems that constrained family relationships, or a certain lack of openness between parents and offspring, contributed to the fear of revealing pregnancies and, hence, the late uptake of ANC services. In addition, attendance at school made these girls want to hide their pregnancies and a measure of denialism may well have played a part; what is not discussed or attended to is, in some measure, not “there”. In the old days, it is likely that some may have terminated their pregnancies if they were at school, but norms have changed, and the phenomenon is more common. It is still, however, a cause of some embarrassment (Ndidi & Oseremen, 2010:47).

These barriers indicate that health promotion education is lacking in the clinics and communities, despite the introduction of the Re-engineering of Primary Health Care Programme using ward-based outreach teams. In the National Health Act (2003), the government stipulates that health-care workers and the public have a role to play in

strengthening the health systems in South Africa. It further stipulates that the Minister of Health, within limited available resources, has to protect, promote and maintain the health of the population by providing essential free health services to pregnant women and children below the ages of six years.

The Re-engineering of Primary Health Programme, as one of the strategies of increasing access to health care in a National health insurance environment, aims at increasing access to health and improving the quality of health. This strategy is made possible by the availability of ward-based outreach teams as the vehicles for distributing and rendering health services, through giving advice, distributing educational material and conducting awareness campaigns (Pillay, 2012:3).

The role of ward-based outreach teams, according to the policy guidelines, is as follows:

- Conducting community, household and individual assessments and identifying actual and potential risks.
- Facilitating individual and family access to health services.
- Referral for further assessment and testing.
- Providing simple health interventions, such as health education, counselling and support (Pillay, 2012:4).

It is clear from the findings of this study that the Re-engineering of Primary Heath Care strategy is not yet effective in reaching communities, as evident from the low awareness of the basics of antenatal care.

The study has significance for the King Sabatha Dalindyebo sub-district, the O.R. Tambo district and the entire Department of Health regarding the reasons why women book late for antenatal care. The reasons why women book late for ANC may be ascribed to personal, cultural and systemic factors. The Department may more readily address the systemic failures, while working on education to address the personal and cultural factors.

Poor access to clinics is a fundamental systemic failure and a major contributor to late booking. Indeed, it plays a part in the personal and cultural reasons too – when clinics are difficult to reach, it exacerbates the tendency of women to stay away, a

tendency supported by their own reluctance to reveal their pregnancies. The cultural factors should be addressed by the District through health awareness campaigns to increase the knowledge of women of child-bearing age on the importance of attending early antenatal care.

Thus, a combination of personal and provider barriers was found to contribute to late booking in this study.

It was interesting to find that some women had indeed initiated antenatal care timeously at a general practitioner. Favouring private doctors was a result of their desire to make use of the scanning facilities – a cultural preference for evidence. However, their starting at private doctors, coupled with the doctors' failure to refer them to the clinics, meant that, despite their early confirmation of pregnancy, their ANC was delayed. This raises questions about the quality of care clients receive in our clinics and about the poor referral practices of private doctors.

There were mostly negative experiences recorded in this regard. The District will have to devise strategies to change certain processes in the booking system to prioritise pregnant women to overcome the many negative factors. It was clear from the study that pregnant women were waiting long hours before they were attended to.

The other gap identified in the study is the fact that a lot of young women are still engaging in unsafe sex despite vigorous awareness campaigns on HIV/AIDS-prevention strategies. This scenario is attested to by the high numbers of teenage pregnancies, as shown in the high delivery rate to under 18-year-olds, which is sitting at 12.2 instead of 7.5 (District Health Barometer, 2014/2015).

5.3 Limitations of the study

According to Polit and Beck (2010:95), limitations are theoretical and methodological restrictions or weaknesses in a study that may decrease the generalizability of the findings. In the case of this study, the research was conducted in the KSD sub-district, one of four sub-districts in O.R. Tambo district, and so, any generalisation of the results to the entire district may be limited. It included only thirteen participants, which may lead to limited findings.

5.4 Recommendations

The recommendations below are made based on pregnant women's reasons for the late initiation of antenatal care services:

- Strengthen community education, including community dialogues, on antenatal care and its importance. This would encourage women to book early for ANC, thereby preventing maternal morbidity and mortality.
- This will require that the Department increases the number of employed health promoters linked to each team at ward level (the ward-based outreach teams).
- Capacity-building should be implemented for community health workers so that they are able to conduct pregnancy tests for any woman of child-bearing age who reports having missed a period.
- Health education on the importance of attending antenatal care services early should be marketed aggressively.
- Mobile teams should be stepped up so that basic pregnancy services can be provided in communities and so that women are only required to visit clinics for more specialised treatment.
- Health clinics should be established and strengthened, where they already exist, as well as at tertiary institutions to increase access for students.
- The media should be encouraged to market early antenatal services.
- Adolescent youth service initiatives should be implemented to improve family planning.
- The Ideal Clinic Realisation strategy should be implemented in every clinic, where pregnant women will be prioritised, and long waiting times reduced.
- Improve referral between general practitioners and clinics, thereby initiating a stronger private/public partnership.
- The provision of ultrasound services at clinics as a method of attracting young women to attend clinics should be considered.
- Simple but essential resources, such as chairs and shaded waiting areas, should be provided.
- Special attention should be paid to the improvement of the booking system and the reduction of long queues.

5.4 Final words

The results show that antenatal care provided by clinics in KSD is inadequate, particularly about inaccessibility due to long distances. More clinics are needed, as well as mobile clinics. As can be expected, ignorance in this poverty-stricken area plays a huge part in late antenatal care; this can only be addressed by patient and ongoing education at all levels, whether through schools, in clinics, or via the media. All of them are needed.

Poverty contributes to ill-health, as is clear from the fact that people who cannot afford taxi fares will naturally reduce the times they travel to and from clinics. As a result, problems in pregnancy cannot be detected early, with problematic results for women, families and entire communities.

Teenage pregnancy continues to plague the district and must be addressed via the many socio-economic factors that contribute to this phenomenon. Teenagers lack awareness, and a sense of responsibility regarding their own health and that of their unborn children. Their health is frequently not considered to be a priority.

The aim of the study, which was to investigate the reasons why women book late for antenatal care, was achieved.

The exploration of reasons for and barriers to early booking were an eye-opener for the researcher and highlighted that much work remains to be done in educating communities and improving systemic weaknesses in health care. Health is a public right; therefore, every citizen has a right to access health care.

References

Abdullah AL-Taiar, Allan Clark ,Longeneicker Christopher ,Whitty Christopher, 2010. Physical accessibilty and utilization of health services in Yemen. *Internation journal of Health Geographics,* 1(38), pp. 1-8.

Agus, Yenita, 2012. Factors influencing use of anytenatal care by rural women of Est Summatra in Indonesia.. *BCM,* Volume 5, p. 589.

Ajzen Icek., 2012. *Handbook theories of Psychology.* Volume 1.

Akella, 2011. Impact of Social and cultural factors on Teen pregnancy. *Journal of Health disparities Research and practice ,* 8(1).

Andrew Erin, Pell. Christopher, Angwin Angelina, Job Danieals, 2014. Factors affecting attendance and timing of formal antenatal care:Results from a qualitative study. *PLOS,* 9(5), pp. 4-14.

Babbie, Mouton: 2010. *Qualitative Research Practice.*

Beck C.T, Polit D; 2008. *Essentials of Nursing Resarch :Appraising evidence for nursing.* Pretoria.

Bhibha Simkhada, Edwin . R. vanTejilingen,Porter Maureen, Padam. Simkhanda; 2010. *Factors affecting utilisation of ANC in developing countries: A systematic literture review.* Uganda: s.n.

Brink, H. J. Christa Van der Walt and Griesel van Rensburg ; 2015 p121- 122. *Fundamentals of Research methodology for health professionals..* Cape Town: Juta & Company Ltd.

Burns Nancy, Susan K. Grove; 2010 p 540. *The practice of Nursing Research.* Texas: Saunders.

Confidential Enquiry commitee, National; 2011. *Saving mothers saving babies 6th report*.

Creswell J.W, Eberhson L,Eloff I,Ferreira R,Ivan krova N V,Jansen J,Niwenhuis J,Piterse J,Plano Clark V; 2016 page 44. *First step in Reasrch.* Johannesburg: Van Schaick.

Cuzollin Laura, Frasesco-Pesenta,Giovanna Verlanto,Poal Baldelli B; 2010. *Use of herbal products amongst Italian pregnant women:focus on pregnancy outcome,* Italy: Pharmaco epidemiology and drug safety.

Department of Public Administration, 2014. *Batho pele Principles,* Pretoria: DpSA.

Dictionary, O., 2009. *Oxford Paperbag and ThesURUS.* 4TH ed. New york:

Dilly Anumba, Rosallind Haddrill, Jones Goergina, Mitchell Caroline; 2015 :15. Understanding delayed access to antenatal care: a Qualitative research study.

DOH, 2015: 34. *Guidelines for Maternity care in South Africa: A Manual for clinics, Community Health Centres and District Hospitals,* Pretoria: National Department of Health.

DOH, 2012. *National core standards of South Africa,* Pretoria: National department of Health.

DOH, Eastern Cape; 2014/2015. *O.R Tambo District health plan,* Mthatha:

Downe S, Finlyson. K,Walsh D, Lavender T; 2009. Weighing up and balancing out:a meta synthesis of barriers to Antenatal care for marginalised women in high income country. *BJOG:An international journal of Obstetrics and Gynaecology,* 116(4), pp. 518-529.

Duff Putu, Walter Kipp , Wild Cameron, Tom W Rubaale,Joa Okech.-Ojony; 2010. Barrieres to accessing highly active anti retroviral therapy by HIV-POSISTIVE women attending an antenatal clini in regional hospital in western Uganda. *Journal of International Aids Society,* 13(1), p. 37.

Feijn Esther de Jong. Danelle EMC,Frank Baarvld Van der Schans, Frocoiis Shell; 2011 page 1. Deteraminants of late and or inadequate use of prenatal health care in high income countries:a systems review. *European journal,* Volume Volume 22 No 26.

European board of Obstetrics and Gynaecology,2015. Antenatal Care. Position paper no 3.

Glanz Karen, Barbara K, Rimer K. Viswanath; 2008. *Health Behaviour and Health Promotion.* 4th ed. United Kingdom: Jossey-Bass.

Guba Egon, Lincolin Yvonne; 1985. *Naturalistic Enquiry.* London: Sage Publications.

Haeman Maureen, Sword Wendy, Moffatt Michael, Helewa Michael ,Heather Morris, Gregory Patricia;2015.Barrires and facilitators related to use of antenatal care by inner City women :perceptions of health care providers.*BCM1*5(2),pp5-6.

Health Systems Trust, 2014/2015 p69. *District Barometer,* PRETORIA: HST.

Health, National Department of Healtrh; 2007. *Guidelines for Martenity care in South Africa.* 3rd ed. Pretoria

Health, National Department of Health; 2012. *National Contraception and fertility planning and service delivery Guidelines ,*Pretoria: NDOH.

Health, National Department of Health; 2013. *Ideal Clinic Realisation:Getting our Primary Health Facilities to function optimally ,* Pretoria: USAID.

Hofmeyer G.J, Mantrop I; 2015. Time for Basic antenatal care in South Africa. *SAMJ,* 105(11), pp. 902-903.

Ijeoma Solarin, Vivian Black; 2012. They told me to come back: Womens antenatal care booking experiences. *Martenal Child Journal,* pp. 359-367.

Ifenne Isaac Denise, Utoo BenardTaskimbi ; 2012. Gestational age at booking for antenatal care in a tertiary health facility in North Central Nigeria. *A Nigerian Medical Journal,* 53(4), p. 236.

Joni Roberts, Diadrey-Anne Seaaly, Lucinda Manda, Gleason Petre ; 2015:34. Role of cultural beliefs in accessing antenatal care in Malawi. *Public health journal,* 34(1).

Le Chan, Jannice Dean, Jasper Frant,Rachana Kumar ;2014. World Policy on Air. *The Journal,* Volume 1, pp. 1-10.

Macrae Duncan; 2007. *Guidelines on the ethics of clinical trials.* United Kingdom: Council for international Organisations and medical science.

Massyn, Nazia Peer,Asnie Padarath,Barron Peter,Day Candy; 2014/2015. *District Health Barometre,* Durban: Health Systemes Trust.

Mathibe -Neke J.M; 2008. Expectations of Pregnant women regarding ante natal care. p. 5.

McLaren, 2008. A policy for development of district Health System in South Africa. Volume 5.

Medical dictionary, 2016 p 1- 10. Dictionary,Thesus, Legal, Encyclopedia. *Encyclopedia*.

Mengiste Mesfin, James Farrow; 2017. Determinants of antenatal care utilisation in Arsi.

Mlambo Courage, Carlowin Chinamo, Tawanda Zingwe; 2013. An investigation of causes of maternal mortality in Zimbabwe. *Mediterranean journal of social sciences,* 4(14).

Motshekga, 2009:6. *Teenage pregnancy in South Africa with specific focus on school going learners.* Pretoria: Unicef.

Motsoaledi, 2014 ,p 48. *National consolidated guidelines for prevention of Mother to Child transmission of HIV(PMTCT) and management of HIV in children, adolecsents and adults.,* Pretoria: National Departmnent of Health.

Motsoaledi, Dr; 2010. *Clinical Guidelines: PMTCT (Prevention of mother to child transmission),* Pretoria: South African aids council.

Motsoaledi, Dr; 2011, p 2. *Sixth report on Confidential Enquiry into Martenal Deaths in South Africa: Saving mothers saving babaies,* Pretoria: Unicef.

Motsoaledi, Dr; 2015. *Guidelines for maternity care in South Africa:A manual for clinics,Community health centres and district hospitals,* Pretoria: Health.

Mxoli Winnifred; 2012 p 56. *Perceptions and experiences of women on ante natal care.* Port Elizabeth: s.n.

Myles, 2014. *Textbook for Midwifery.* 3rd ed. London:

Burns Nancy and Groove; 2008 : 405. *The Practice of nursing research.* Missorrie.

Ndidi E P, Osereman I G; 2010:47. Reasons given by pregnant women who booked antenatal care in the Niger Delta Nigeria.

Parliament, 2003. *Constitution of the Republic of South Africa,* s.l.: Gorvenment Gazzette.

Pearson, Susan F, Murray and Stephan; 2008. Martenity referral system in developing countries: current knowledge and future research needs. 62(9), pp. 2205-2215.

Peter, Barron; 2011. *Guideline for implementation of three streams of Re-engineering of Primary Health Care,* Pretoria: Department of Health .

Phafoli SH, Van Swagen E J, Albert U; 2007. *Varables influencing delays in ante natal care clinic attendance among teenagers in Lesotho.* Lesotho: s.n.

Pillay, Yogan; 2012. *Re-Engineering of Primary health care,* Pretoria: Health systems trust.

Polit Denise F, Beck C.T, 2010. *ESSENTIALS OF NURSING RESEARCH : Appraisal Evidence for Nursing Practice.* 7th ed. Philadelphia: China.

Porter Richars, Samovar Larry et al ; 2015. *Intercultural communication.* 14TH EDITION

Presidency, 2014. *National development plan:Vision 2030.* Pretoria: Parliament.

Ritchie, Jane Lewis,Carol Nicholls; 2014. *Qualitative research practice:a guide for socilal studies and research.* 2nd ed. New york:

Roberts, Mark; 2014. *Health reforms in South Africa.*

Ruwangaruri Andrew, Ingrid Morren,Nyiranziware Letitia,Joseph Ntangarura; 2017. Determinants of poor utilisation of antenatal care servcies among recently delivered women in Rwanda. *BMC Pregnancy Childbirth,* Volume 17, p. 142.

Streubert H.J, Capenter D.R, 2011 p61-62. *Qualitative research in Nursing.* 5th ed. China: Lippincott William and William.

Suri, HARSH; 2011. Purporseful sampling in qualitative research synthesis. 11 (2).

Sutton, 2001:2. HEALTH BEHAVIOUR : Psycho Social Theories.

Sybrand, De. Vaal; 2011 p 8. *Late booking at Michael Mapongwana clinic in Khayelitsha.* Cpe town: s.n.

Titaley Christiana, H. C. P. M., 2010. Why dont some women attend antenatal and post natal care services in West Java District.

Trust, Health . Systems, 2015 P 16-19. *Primary health Care), RMCH (Reducing Martenal and Child Mortality throgh Primary Health: District clinical specialist stream Review report,* Pretoria: RMCH.

Tshabalala M F, Mogkatle M.M , 2014. Utization of anenatal care and perceptions of early booking. *South African journal for physical Health Education ,* pp. 145-151.

Tshabalala, 2012. *Utilisation of antenatal care and prevention of mother to child transmission in EkuRhuleni sub district.* Johannesburg

UNICEF, 2008. *Child Proyection :Teenage pregnancies*.

Webster, 2003. *Leaners Dictionery.*

WHO, 2010. *Monitoring the building blocks of ahealth system: A handbook of indicators and their measurement strategy.* Geneva: WHO.

World Health Organisatiion, 2011. *Evaluating the quality of care for severe pregnanacy complications:The WHO near miss approach for maternal health,* Geneva: WHO.

Annexure **1**

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	SEE141SNTS01
Project title:	**Reasons for late booking of pregnant women in Ante Natal care clinics in K.S.D Sub-district in the Eastern Cape.**
Nature of Project:	Masters
Principal Researcher:	Nomvume Ntshanga
Collaborating investigator:	N/A
Supervisor:	Prof E Seekoe
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

Eastern Cape Department of Health

Enquir1es: Madoda Xokwe

Tel No: 040 6080830

Date: 07 June 2016

Fax No: 0436421409

e-mail address: madoda.xokwe@echealth.gov.za

Mrs. N. Ntshanga

No.1 Sabata Street Mbuqe Park Mthatha,
5099

Re: Reasons for late booking of pregnant women in antenatal care clinics in KSD Sub-district in the Eastern Cape {EC_2016RP58_209)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after hav approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confiden identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you receiv in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recomm the Epidemiological Research & Surveillance Management. You may be invited to the department to come and research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the D Health as indicated above.

Your compliance in this regard will be highly appreciated.

The Principal Re
applicable, annua

Special conditions:

Note: The UREC is a
matters pertaining t
Nonetheless, as was
and stakeholders o
clearance for researc
of the previous rules

The UREC retain

- Withdraw
  - Any
  - Rel
  - Reg
- Request a after comp
- In addition principle in

The Ethics Comm

Professor Gide
Dean of Researc

25 May 2016

SECRETARIAT: EASTERN CAPE HEALTH RESEAR COMMITTEE

Ikamva eliqaqambileyo!

ANNEXURE 5

EXAMPLE OF AN INTERVIEW INTERACTION (VERBATIM)

Fourth interviewee

A 30-year-old lady gravida 5 para 4 alive 4. Very shy but cooperating. Never went to school, took time to respond to questions.

Question: Can you share with me what are the reasons for you coming later than the required time for antenatal care?

Mmmmh, no there is none. I think the problem was the fact that I did not know that I am pregnant. Sister I did not know that I am pregnant, they asked me if I know that I am pregnant and I told them I had no idea as I was under the assumption that I was on family planning. I felt something moving then quickly I came to the clinic. They asked me whether I was pregnant and I replied and said I didn't know. I was on family planning in May I didn't know that I am pregnant. They then proceeded and checked me and told me I am six months pregnant.

Yho, six months. It cannot be true. That is how I knew that I am pregnant.

Probing question: Now that you were told, how did you take it?

I then decided to come to the clinic but another thing is that clinics are just too far, you have to hike and still have to take one taxi at a cost of R10 afterwards. This is the only clinic we use as the rest are simply too far.

Where do you get the money to take a taxi to the clinic to the clinic?

I take it from the children's grant because I am not working.

Now that you have come to the clinic, how you do feel about the services in this clinic? *No, they do well other time, other times, for instance today I came in at 10 o'clock but there are many areas where you have to queue. You queue for registration for "Mfaxazo", checking of BPs. Now it's 2 o'clock since I came at 10 and I know that I was late, it's my fault.*

Paraphrasing: You say you came here at ten o'clock and the time now is 2 o'clock and you say it's your fault; how does that happen?

The thing is it's my fault to come late at 10 o'clock; if I came early at 7 o'clock I should have been finished by 10 o'clock.

What advise can you give the Department of Health in improving services in this clinic?

I can say they must give us more nurses.

ANNEXURE 6

ISEBE LEZEMPILO DEPARTMENT OF HEALTH
DEPARTEMENT VAN GESONDHEID
King Sabata Dalindyebo

Ingxowa Eyodwa/Private Bag/Privaatsak X5005, UMTATA 5099 SOUTH AFRICA
Batho Pele / People First / Abantu KuQala

Fax No. 047 53131144

Cell No: 0767939691

Enquiries: Ms Mafeke
Ref. No.
Date: 15/07/2015

Mrs Ntshanga Nomvume

PERMISSION GRANTED TO YOU TO CONDUCT A STUDY AT KSD CLINICS.

This serves to permit you to conduct your research at the following clinics as stipulated in your permission letter from the province.
Ngcwanguba
Mqanduli
SOS
Stanford Terrace
Mbekweni
Tyelebana
Xwili
Zidindi
Please be advised that the results of your study you will be shared to the sub district.

N.E Mafeke.....

SUB DISTRICT MANAGER

PGDP EASTERN CAPE 2004 - 2014
Ikamva eliqaqambileyo!

.

VERBATIM TRANCSRIPTION

First interviewee

Reason

There were many problems mama, I am the first to have an opportunity to study in my family, I was also afraid of my parents. I really thought I wasn't pregnant as I was on family planning. I don't know what happened. There is no other real reason mama.

I currently only attend in this clinic except that we wait before we get attended to. We wait for maybe about two hours and I would say get properly tended to only after 2-3 hours. If we can have extra nurses to help out.

Second interviwee

I started at Dr Sodo and didn't know that I am pregnant mama". The doctor didn't tell me to come to the clinic. I only came because I could not afford to go to the doctor anymore. No mama there is no other reason.

I think people from the ANC must have their own nurses because there at the clinic when they open they start with certain people and that can make people very hostile and hesitant to come for ante natal care or go away without being attended.

Third interviewee

The reason is that I was pregnant for the first time, I didn't know anything or how it is. I just started noticing that my stomach was starting to grow bigger and bigger then I decided to come to the clinic.

The clinics are too far as I board a taxi when I have to come to the clinic and that costs me well over R25. Here I am not out working, I'm currently unemployed. For pregnant women to get help at the clinics I think we need to have separate nurses for ANC.

Get a list from those sick, we must get our own nurses that will start with us so that we can find out whether if you come in late at night you can still deliver at the clinic.

I came here today at about past 7 because I have to take the neighbours car that leaves at around 6 o'clock. Then I arrive at past 7 and have to wait. Because it is too far after the clinic.

They start late, I think that should be revised because thina singabanye we wake up very early for the clinic.