

# **CHAPTER ONE**

## **OVERVIEW OF THE STUDY**

An overview to the study is provided in chapter one. The background of the study followed by the problem statement is discussed in chapter one. The problem statement led to the formulation of the research questions. The aim of the study is described and addressed through the objectives of the study. Objectives are followed by the significance of the study, the researcher's assumptions, and an overview of the research design and research method.

### **1.0 INTRODUCTION**

The South African report on confidential enquiries into maternal deaths identified delayed and/or infrequent antenatal care as a significant avoidable factor contributing to maternal mortality in South Africa (SA) (Department of health (DOH), 2001). In 2006, the maternal mortality rate for SA was 175 for every 100 000 births (Pregnancy education week, 2006). The extend of morbidity was not known but it is estimated that for every woman that dies of a pregnancy related complication, 20 more suffer from morbidity which may be severe and lead to long term disability (Jackson and Debra, 2006). Cunningham, Gant, Leveno, Gilstrap, Hauth and Wenstromet (2001), reported that patients cited the following reasons for late antenatal booking: 'I didn't know that I was pregnant; I didn't have enough money to pay for my visit; and I could not get an appointment'. In 1994, the National Health System in SA adopted strategies to improve access to antenatal care. Despite the strategies which included free antenatal care services, pregnant women initiated antenatal health care at a late stage of their pregnancy, that is, during the third trimester. Consequently it is important to understand the reasons for the late attendance in order to make recommendations with the intention of improving antenatal clinic attendance by primigravidae.

## **1.1 BACKGROUND**

The background of my study is discussed under the following headings: definition of antenatal care, purpose of antenatal care, levels of health care, initiation of antenatal care, and description of antenatal clinic visits.

### **1.1.1 Definition of antenatal care**

Antenatal care is defined by various authors as:

- Care offered to pregnant women from the period commencing when the woman books at an antenatal clinic and ending at the time of onset of labour (Bodkin, 2004).
- Care that is given to a pregnant woman from the time that conception is confirmed until the beginning of labour (Fraser, Cooper and Nolte, 2006).

### **1.1.2 Purpose of antenatal care**

The Department of Health (DOH) (2002) states that antenatal care attempts to ensure, by antenatal preparation, the best possible outcome for women and their babies. The aims of antenatal care are described by different authors as follows:

- To prepare the pregnant woman and her family for the pregnancy, labour, puerperium, lactation, and subsequent care of the baby; in a physical, spiritual, psychological, and social way (in a holistic view) (Sellers, 1997).
- To monitor and promote the wellbeing of a mother and her developing baby (British united provident association's (BUPA) health information team, 2004).
- According to Cunningham, et al. (2001), the aims of antenatal care are to:
  - Define the health status of both the mother and fetus,
  - To determine the gestational age of the fetus,
  - To initiate a plan for continuing antenatal care.

Sellers (1997) and the Department of Health (2002) set the following objectives to achieve the preceding aims:

- Ensure a normal pregnancy and good general health by education on healthy living habits;
- Early detection, management and referral of complications which can be spiritual, physical, or psychological;
- Administration of medications that may improve pregnancy outcome;
- Assessment of pregnancy risk;
- Careful screening of pregnancy problems and referral where necessary;
- Physical and psychological preparation for childhood and parenthood;
- Prepare for and promote breastfeeding if not contra-indicated;
- Provide the mother and her family with information regarding the possible abnormalities without alarming them;
- Promote family planning to improve the quality of life of all people;
- Provision of health education to pregnant women.

In 2000, the Gauteng Department of Health (GDOH) published an antenatal care policy. The policy is in response to an identified need to define a minimum standard of antenatal care in the Gauteng province. The policy will assist with the following aspects:

- Facilitation of central and regional budgeting;
- Guidance for service providers about the content of antenatal care;
- Definition of standards;
- Communication to consumers- pregnant women and their families.

The GDOH antenatal care policy document states the following regarding the provision of antenatal care:

- The institutions that can provide antenatal care are mobile clinics, day clinics, midwives obstetrical units (MOU), and hospitals;

- Only registered midwives and medical practitioners (doctors) may provide antenatal care;
- Antenatal care and delivery of pregnant women with low risk can be done at an MOU; and
- All of the examination findings, identified problems, test results, and medication given are recorded on the antenatal clinic card that is retained by the pregnant woman.

### **1.1.3 Levels of health care**

Different levels of health care are implemented in districts and regions for efficient functioning of the health service (DOH, 2002). The three levels of health care in SA, are primary, secondary and tertiary (South African National Defense Force (SANDF), 2005).

**Primary health care (PHC)** – At the primary health care level equity must be ensured through maximum accessibility (SANDF, 2005). PHC is provided in clinics and community health centers (CHC). The clinic renders comprehensive, integrated PHC services for at least 8 hours a day; 5 days a week (DOH, 2000). A CHC is defined as a facility that provides the normal range of PHC services and additional services, and additional services such as 24 hour maternity, accident and emergency services and a maximum of 30 beds where patients can be observed for a maximum of 48 hours (Cullinan, 2006). The community health center must have at least one person who has completed a recognized PHC course. The primary health care course is a post basic qualification registerable with the South African nursing council. The primary health care nurse is trained in health promotion and disease prevention, assessment and evaluation of undiagnosed symptoms and physical signs, management of common acute and chronic medical conditions, and identification and appropriate referral for other needed health care services (Stanhope and Lancaster, 2000). Doctors and other specialized professionals are accessible for consultation, support and referral and provide periodic visits.

Where only midwives provide maternity services in an obstetric unit, it is referred to as an MOU (DOH, 2002).

According to the DOH, 2002; the functions of a community health center are as follows:

- Antenatal care for low risk women including on-site routine blood testing;
- Treatment of common problems of pregnancy;
- 24 hour labour and delivery for low risk women;
- Postnatal checks including contraception;
- Referral of problems to hospital;
- Management of emergencies.

If a more specialized level of care is required, patients are referred to the secondary level by clinic staff (Cullinan, 2006). Referrals within and outside the PHC center are recorded appropriately in the relevant registers (DOH, 2000).

This study was conducted at a level 1 MOU, where antenatal care is provided by registered midwives. The medical doctor, who is a medical officer, is accessible for periodic consultations. According to the DOH, 2002, MOU is a stand alone maternity service center which operates for 24 hours a day, 7 days a week. The MOU is staffed by advanced midwives, midwives with perinatal education programme training, enrolled nurses, nursing assistants, and a visiting or resident medical doctor (DOH, 2002). A full discussion of the staff at the MOU where this study was conducted is provided in chapter two of this study.

**Secondary health care (SHC)** – Secondary health care is provided at district and regional hospitals. SHC is the environment in which small surgical interventions and short admissions to a health care facility are required to determine initial patient response or to finalize the diagnosis before the patient is referred if necessary to the tertiary level (SANDF, 2005). The SHC center has critical roles to play (Kwik-Skwiz 9, 1998; and DOH, 2002) such as:

- Provide support to health workers in clinics and community services, both in terms of clinical care and public health expertise;
- Provide first level of hospital care;
- A referral place for the clinic and/or CHC, when necessary;
- Management of severely ill pregnant women;
- Specialist supervision of the care of pregnant women;
- Prenatal diagnosis, for example, genetic amniocentesis;
- Multidisciplinary care.

In order to fulfill its roles, the district hospital has the following features (Kwik-Skwiz 9, 1998):

- Clinical departments such as: emergency care, medicine, surgery, obstetrics, paediatrics, psychiatry and out patients services;
- It provides 24 hour services and has more than 30 beds;
- Provides in service training and support to PHC services and facilities in the district;
- And has the capacity to interact with the community and other sectors.

**Tertiary health care** – Tertiary health care is the environment where specialist services, including rehabilitation, are rendered (SANDF, 2005), for example, academic hospitals. Some services provided are beyond the normal scope of a specialist and require the input of a registered sub-specialist (DOH, 2006). A specialized level 3 hospital will have specialized services such as: cardiology and respiratory medicine, hepatology, oncology, plus associated anaesthetic and diagnostic facilities (DOH, 2006). These hospitals consist of highly specialized national referral units that together provide an environment for multi-speciality clinical services, innovation and research (Cullinan, 2006). The services provided are generally expensive and used by few patients, and require high technology and/or multidisciplinary teams of people with scarce skills to provide sustained, high

quality care. According to the DOH, 2002 tertiary health care has the following functions:

- Specialist combined clinics, for example, diabetic pregnancy clinics;
- Advanced prenatal diagnosis such as cordocentesis;
- Management of extremely ill obstetric patients;
- Responsibility for policy and protocols in the regions reserved.

The initiation of antenatal care is discussed next.

#### **1.1.4 Initiation of antenatal care**

Pregnant women are encouraged to book for antenatal care as soon as pregnancy is detected; from as early as 4 or 5 weeks gestation (DOH, 2002). However, Baiden, Ampnsa-Achiano, Oduro, Mensah, Baiden and Hodgson (2006), reported that 56% of pregnant women first attended antenatal clinic during their second trimester. Late initiation of antenatal care was found to be associated with factors such as maternal age, smoking status, ethnicity, the planned pattern of antenatal care and type of hospital (Kupek, Pelrou, Vause and Maresh; 2002). Teenagers were significantly more likely to book late for antenatal care (Ebeiqbe and Gharoro, 2000). According to Myer and Harrison (2003), women initiated antenatal care late as they perceived no significant health threat during their pregnancy. Consequently, more than one antenatal care visit was viewed as unnecessary (Myer and Harrison; 2003).

#### **1.1.5 Description of antenatal clinic visits**

According to the GDOH's antenatal clinic policy (2000), antenatal visits are divided into the first antenatal/ booking visit and the follow-up visits. During antenatal clinical visits the following services are provided: routine investigations, ultrasound scanning, prescription of medications, and providing information to pregnant women. The preceding visits and services are discussed in the following section.

#### 1.1.5.1 The first antenatal/ booking visit

The first antenatal visit represents the first contact made by the pregnant woman with the level 1 MOU's antenatal clinic for health assessment and care. The purpose of this visit is to introduce the woman to the maternity services (Fraser et. al, 2006). During the first antenatal visit, pregnant women are assessed and the following information is obtained and recorded on the antenatal clinical card:

- Personal details such as age, address and telephone number;
- Past obstetrical history including complications and outcomes of all previous pregnancies;
- Medical history of conditions affecting or affected by pregnancy, psychological health;
- Family history of congenital abnormality, chronic medical or mental conditions, or twins;
- Gestational age and method used to determine it, with an estimated date of delivery (EDD);
- Full physical examination including weight;
- A problem list of risk factors found or anticipated, with a brief delivery plan, for example, for hospital or MOU delivery.
- Routine investigations are done and these are described in section 1.2.5.3.

The findings of physical examination and pregnancy assessment are used as baseline reference for follow-up examinations. The preceding information is used to determine the women's risk factors and is helpful in planning and deciding on the continuation of antenatal care. The subsequent visits that the pregnant women make to the antenatal clinic are referred to as follow-up visits.

#### 1.1.5.2 Follow-up visits

At the end of each visit, women are given return dates for follow-up visits. The purpose of follow-up visits is to determine the wellbeing of both the mother and the fetus (Cunningham, et al. 2001). It is important for the midwife to review the complete record of the pregnant women prior to conducting the follow-up antenatal examination. The records are reviewed to establish whether any problems were identified, if the problems have been resolved, or if alternative actions need to be taken (Fraser et al, 2006). During the follow-up examination, the following data is obtained and recorded:

- Blood pressure;
- Urinalysis;
- Fetal movements, fetal lie, fetal heart beat and rate, and fetal presentation; and
- Symphysis fundal height (SFH) in centimeters.

If any problems are detected at these visits, the woman is referred to the doctor or hospital for further management.

#### 1.1.5.3 Routine investigations

The midwife explains the investigations that are to be performed to the pregnant women. The following investigations are done on all women at the antenatal clinic to detect if any abnormalities are present:

- Urinalysis to exclude abnormality is performed at every visit;
- Blood:
  - **Syphilis screening at the first visit:** If the test results are positive, treatment is prescribed according to the advancement of the infection. Early syphilis is treated with an intramuscular injection (IMI) of benzathine benzyl penicillin 2.4 million units one dose. If the pregnant woman is allergic to penicillin, erythromycin 500mg four times a day is prescribed for oral intake. Late syphilis is treated with benzathine benzyl penicillin 2.4 million units imi once a week for three weeks. For penicillin

allergic pregnant women, erythromycin 500mg is prescribed to be taken four times a day orally for a duration of one month (The national essential drug list committee; 1998).It is well established that active syphilis infection during pregnancy results in high rates of fetal and infant death and disability (Gloyd; 2001);

- **Blood grouping and rhesus (Rh) factor:** If the Rh factor is negative, the blood is screened for Rh antibodies. If the woman does not have Rh antibodies, the specimen is repeated every four weeks. If she continues to have no Rh antibodies, she is managed at a local hospital when she has a potentially sensitizing event by being given 100 micrograms of anti-D immunoglobulin imi within 72 hours of the event. Sensitizing events are such as amniocentesis, abdominal trauma, and termination of pregnancy. If the fetus or neonate is Rh negative, ant-D is not given to the woman. In cases where the pregnant woman has Rh antibodies of <32, the antibody test is repeated every 3 weeks along with an ultrasound scan. If the Rh antibody remains below 32 and there is no fetal hydrops, the woman is managed at a regional hospital and ant-D immunoglobulin is not given. If the Rh antibodies >32 and / or fetal hydrops, the woman is referred to a specialized unit (DOH province of KwaZulu-Natal, 2005).
- **Haemoglobin level:** It is important to monitor haemoglobin levels in pregnancy because, during pregnancy there is normal dilution of blood which starts at approximately the 8<sup>th</sup> week of pregnancy and progresses until the 32<sup>nd</sup> and to the 34<sup>th</sup> week of pregnancy (Health 24.com).The haemoglobin readings range from 11g/dl in the first and third trimesters, to 10.5g/dl in the second trimester (Fraser et al, 2006). If the haemoglobin levels are below 10.5 g/dl, the condition is called anaemia (Health 24.com).Iron deficiency anaemia is treated with ferrous sulphate oral 200mg three times a day with food for 1 month thereafter as for prevention, which is oral 200mg daily with food (The national essential drug list committee, 1998). If anaemia is due to folic acid deficiency, it is treated with folic acid supplements 1 to 5 mg once a day (Health 24.com);

- **Human immunodeficiency virus (HIV):** Written, informed consent is obtained from the pregnant women before the test is performed. If the test is positive, blood is taken for a CD4 cell count. The CD4 cell count determines if the pregnant woman will be commenced on antiretrovirals (ARV), or the prevention of mother to child transmission (PMTCT) programme. ARVs are commenced when the pregnant woman is prepared to commit herself to long-term treatment and to adherence, if she has HIV-related symptoms, if she has a primary infection, or if her CD4 count is below 200 (Millera S, 2005). The PMTCT programme is initiated by the HIV positive pregnant woman taking a nevirapine tablet at the onset of labour (HIV AIDS clinic, 2008).

All the investigative findings are recorded on the pregnant woman's antenatal clinic card.

#### 1.1.5.4 Ultrasound scanning

At the level 1 MOU where the study was conducted, ultrasound scanning is performed on Wednesdays. Although not necessarily done in every pregnancy, an ultrasound can be used to help date the pregnancy and obtain information about the health of the fetus (Babynet storyview, 2000). An ultrasound scan can be used for the following purposes (Baby centre, 2007; DOH, 2002 and Obstetric ultrasound, 2006):

- Diagnosis and confirmation of early pregnancy from as early as four weeks of gestation, and to confirm that the site of pregnancy is within the uterus;
- To check viability of the fetus. A fetal heart beat can be depictable by 7 weeks gestation;
- To confirm dates, ideally at 10-13 weeks gestation;
- To diagnose fetal malformations usually before 20 weeks;
- To locate the placental site;
- Diagnose multiple pregnancy;
- Diagnose polyhydramnios and oligohydramnios;
- Confirm fetal presentation; and

- Monitor fetal growth from 28-40 weeks.

#### 1.1.5.5 Medications

Medications may be administered to pregnant women for supplementation, prophylaxis, or therapeutic use. The purposes of administering some medications during antenatal clinic attendance are described below:

- Supplementation with ferrous sulphate 200mg daily to prevent anaemia is given to all pregnant women;
- Folic acid tablets 5mg daily, is administered during the first trimester to help prevent neural tube defects (DOH, 2002). Repeated studies have shown that women who take 0.4mg of folic acid daily prior to conception and during early pregnancy reduce the risk that their babies will be born with a serious neural tube defect by up to 70% (Nemours foundation, 2007).
- Tetanus toxoid (TT) vaccination to prevent neonatal tetanus should be given to all pregnant women according to standard protocol (DOH, 2002). During the first pregnancy, the women are given 3 doses of 0.5ml TT vaccines imi in the right deltoid muscle. The first dose is given at the first antenatal clinic visit, the second dose is given four weeks after the first dose, and the third dose is given six months after the first dose even if it is in the puerperium (DOH, 2005). In the two subsequent pregnancies, only one dose of TT is given at the first antenatal clinic visit. If there are no records of the previous TT vaccinations, all pregnant women are vaccinated as primigravidae. Five adequately spaced doses of TT provide life long protection against tetanus (DOH, 2005).
- Common ailments and sexually transmitted diseases are treated according to the essential drug list.

Care should be taken when prescribing and / or administering medications to pregnant women not to overdose or give medications with teratogenic effects. Medications are prescribed by a registered doctor or a practitioner with a diploma in advanced midwifery

and are administered by midwives. Pregnant women are advised to be cautious about taking over the counter medication as some have unproven safety or are known to adversely affect the fetus (Ronald A, Black MD and Ashley Hill MD, 2003).

#### 1.1.5.6 Information for pregnant women

Certain essential information must be provided to all pregnant women, verbally and in the form of written or illustrated cards or pamphlets (DOH, 2002). The information provided includes:

- A delivery plan includes the expected date of delivery based on the estimation of gestational age, expected place (clinic or hospital) and mode (vaginal or caesarean section) of delivery;
- Five danger symptoms that should be reported to the staff at a health care facility are:
  - Severe headache;
  - Abdominal pain (not discomfort);
  - Reduced fetal movements;
  - Passage of liquor from the vagina;
  - Vaginal bleeding.
- Preparation for childbirth and motherhood by providing antenatal education and exercises;
- Self care in pregnancy which entails:
  - Diet and exercise;
  - Personal hygiene and breast care;
  - Use of medications; and
  - Non-abuse of alcohol, tobacco and recreational drugs.
- Information regarding routine clinical tests that are not performed at the clinic as they are expensive, for example, rubella serology; and where they can be done;

- Different contraceptive methods that can be used to space pregnancies if they wish to fall pregnant again, or to prevent pregnancy if they decide that their family is complete.

The preceding information that is provided to pregnant women empowers them and gives them confidence in knowing what to expect and to do.

## **1.2 PROBLEM STATEMENT**

A research problem is a knowledge gap that warrants filling and can be addressed through systematic study (Macnee, 2004). Late initiation of antenatal clinic attendance was identified as a problem that warranted this research being conducted. Antenatal care should be initiated as early as a few days after the first missed menstrual period (Cunningham, et al., 2001). In 2004, Ikamari conducted a study on maternal health care utilization in Teso district and the results obtained indicated that most respondents in the study were aware of the importance of antenatal care but the majority sought antenatal care late and made very few antenatal clinic visits. Teso district is an administrative district in the western province of Kenya (Wikipedia, 2007). Despite the widespread availability of free antenatal care services, most women in rural South Africa attend their first antenatal care late in pregnancy (Myer and Harrison; 2003). Some 25% of pregnant African women attended their first antenatal clinical visit in the third trimester of their pregnancy (Africa Malaria Report; 2003). Being specific to SA, many women continue to make their first appearance at an antenatal clinic after the 20<sup>th</sup> week of gestation (Sellers, 1997). Abrahams, Jewkes and Mvo, (2001) conducted a study in Cape Town entitled 'Health seeking practices of pregnant women and the role of the midwife'. The research findings of the study by Abrahams, et al. 2001 suggested that late/inadequate antenatal attendance is associated with social, health care and educational factors. No similar study has been conducted in the Gauteng province. The study of the health seeking practices is recommended in Gauteng as the findings of the Cape Town study cannot be generalized to the Gauteng population. The reason why the Cape Town study cannot be generalized to the Gauteng population is that the population in the Cape Town study consisted of

Xhosas, Coloureds and Whites. In the Gauteng province though, the population varies widely. The Gauteng population and the clinic attendees at the level 1 MOU include African immigrants, as well as members of different South African tribal groups such as Zulus and South Sothos.

The participants interviewed will be primigravidae as they are considered to be more of a high risk for obstetrical complications, compared to multigravida, as it is their first pregnancy and labour (Sellers, 1997). In addition, they lack knowledge and experience gained from previous pregnancies and labours. The South African National statistics on maternal mortality rates of primigravidae reported that 47.7% of maternal deaths were due to hypertensive disorders of pregnancy and 35.6% of maternal deaths were caused by Acquired Immuno-Deficiency Syndrome (AIDS) (DOH, 2001). Maternal deaths due to pregnancy induced hypertension HIV and AIDS could be prevented through timeous and adequate antenatal care. All the preceding aspects necessitates that the reasons for late attendance at antenatal clinics be investigated and recommendations be made for early initiation of antenatal care.

### **1.3 RESEARCH QUESTION**

Emanating from the problem statement, the following questions were posed:

- Why do primigravidae initiate antenatal clinic attendance at the level 1 MOU late in their pregnancy?
- What needs to be done to promote early antenatal clinic attendance?

### **1.4 AIM OF THE STUDY**

**The aim of this study was to determine the health seeking practices amongst primigravidae at a level 1 midwives obstetrical unit, based in a peri-urban area in Gauteng province, South Africa. The intention thereof was to make recommendations of encouraging primigravidae to initiate antenatal care in their first trimester.**

## **1.5 OBJECTIVES OF THE STUDY**

The following objectives were set to answer the research questions and achieve the aim of the study:

- To explore and describe the health seeking practices of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy; and
- To make recommendations with the intention of encouraging primigravidae to initiate antenatal care in their first trimester.

## **1.6 SIGNIFICANCE OF THE STUDY**

Early antenatal care allows psychological, physiologic, cultural and social concerns to be addressed while maternal and fetal well-being and the overall pregnancy status are simultaneously monitored (Littleton and Engebretson, 2001). This study is significant to midwifery practice because the research results will help midwives in identifying the reasons why primigravidae book at the antenatal clinic in their third trimester of pregnancy for antenatal care, and thus help midwives to encourage pregnant women to initiate antenatal clinic attendance in their first trimester. This study provides recommendations on how to ensure early attendance of antenatal clinic by primigravidae. If antenatal care is started in the first trimester, the goals for antenatal care that are described in section 1.2.2 can be achieved by the midwives. These goals include monitoring the health of both the mother and her baby throughout the pregnancy; and early detection, management and referral of maternal and fetal complications; preparation of the mother for labour and puerperium and education about child care and future family planning (Cunningham, et al, 2001). If the described goals for antenatal care can be met, maternal mortality rate will be decreased.

## 1.7 RESEARCHER'S ASSUMPTIONS

Researcher's assumptions are beliefs that are held to be true but have not necessarily been proven (Nieswiadomy, 2002). The researcher's assumptions provide a point of departure for the research. Two types of assumptions that were applied to this research were meta-theoretical and theoretical assumptions.

### 1.7.1 Meta-theoretical assumptions

Meta-theoretical assumptions are non-epistemic statements about the researcher's values and beliefs that are not meant to be tested (Nieswiadomy, 2002). The researcher assumes that the antenatal care provided to primigravidae is aimed at maintaining a complication free pregnancy, which will lead to the delivery of a healthy baby by a healthy mother. In this research, the midwife who provides **antenatal care** to primigravidae views them as **individual holistic beings** who are members of a **family and society**. Members of the **multidisciplinary health team** are involved in the provision of care to the primigravidae. In the next section; the meta-theoretical assumptions are discussed in detail.

#### 1.7.1.1 The individual, family and society

The researcher views the primigravidae as an individual who has rights like any other human being. As a person who seeks health care, the primigravidae also have patients' rights.

Some relevant human rights include the right to privacy, the right to confidentiality, the right to self-determination, the right to autonomy, the right to fair treatment, and the right to protection from harm (Burns and Grove; 2001). Patients' rights include respect for human being, protection of their rights and privacy and the rights to make decisions regarding their own health (Searle; 2000).

When a woman discovers that she is pregnant, she has to consider notifying her family members so that she may get support from them. Family is defined as a group of people living together and functioning as a household, usually consisting of parents and their children (World English Dictionary, 2007). The diagnosis of pregnancy may come as a shock to primigravidae, especially if the pregnancy was unplanned, and to teenagers who may not be financially independent. The families need to provide emotional support to the pregnant women, especially because it is their first pregnancy and they have limited knowledge about pregnancy. Emotional support may comprise of: ensuring that the primigravida receives health care during pregnancy, especially if she is a scholar or a teenager who may not be able to, or want to make time to attend antenatal clinic.

Some primigravidae may be scared to reveal their pregnancies as they may fear being seen as unmarried mothers, or sexually active teenagers. The society plays a huge role in the life of a primigravida as she belongs to it and needs to be accepted as a mother. Society is defined as a structured community of people bound together by similar traditions, institutions, or nationality (World English Dictionary, 2007). The society may be faced with children who are abandoned by their teenage mothers. Thus the society needs to provide a strong social support to the pregnant woman to prevent being faced with school leavers and abandoned children.

#### 1.7.1.2 The primigravida as a holistic being

The holistic person encompasses the body, mind and spirit (Chang, 2007). The holistic health care provided to primigravidae involves promoting psychological wellness, physiological wellness, encouraging socio-cultural interactions and supporting the fulfillment of spiritual aspirations. The holistic care given to primigravidae is supported by Wung, Chen and Hwu (2007). These authors conducted a study on ‘Teaching patient centered holistic care’ and stated that ‘The holistic aspect addressed clients’ physical, psychological, and spiritual needs and related factors.’

It is important to promote psychological wellness of the primigravidae as this is their first experience of pregnancy. The primigravidae needs psychological support during pregnancy, especially if the pregnancy may not have been planned, they are teenagers and / or single women. The psychological support they need will be aimed at helping them to accept the pregnancy. Accepting the pregnancy is the first step that will motivate the woman to seek health care during pregnancy.

With every antenatal clinic visit, the woman is examined to assess her wellbeing and that of her unborn baby. Ensuring good physiological wellness of the primigravida may produce the delivery of a healthy baby. In some unfortunate circumstances, a woman may give birth to a neonate who is not well, or is stillborn. When a mother delivers a stillborn, her most immediate need is for emotional support (Cole MR, 2004). During antenatal care, any problems that the primigravida may present with will be managed promptly when detected.

When the primigravida has accepted her pregnancy and is happy about it, she will have little difficulty interacting with members of her society. Interaction with society is good for primigravidae as they may form support groups within the community. The support groups will advise the woman about pregnancy, which will make her feel secure and happy.

The primigravidae's human rights should be respected. Consequently, they should be treated with dignity by all health care providers and their ethnicity should be respected.

#### 1.7.1.3 Antenatal care

Antenatal care involves ensuring a good pregnancy progress and outcome. Good child care is also an aspect to be focused on and will be ensured by practicing child spacing.

Ensuring good pregnancy progress is ensured by thorough antenatal care provision. Antenatal care includes assessment of the mother's physiological and physical wellness,

assessment of fetal wellbeing and growth and education of primigravidae about pregnancy, labour and the puerperium.

A study by four University of San Francisco (USF) nursing students recommends that mothers wait two and half to three years between pregnancies (USF News, 2007). Child spacing is ensured by educating the primigravidae about the use of contraceptives. The women have a wide range of contraceptive methods to choose from. Some methods of contraception offered at the level 1 midwives obstetrical unit are: intrauterine contraceptive device, injectable contraceptives, oral contraceptives and barrier contraceptives. The aim of child spacing is to ensure proper care of the child both physically and physiologically by the mother. Having children too close together has long been associated with increased risk of various adverse health outcomes, including infants, children and maternal deaths. Increasing the interval between pregnancies can reduce infant, child and maternal mortality significantly (Catalyst consortium, 2007). In addition to this, short interpregnancy intervals significantly increased the risk of early spontaneous preterm births (Rodrigues and Barros, 2007).

#### 1.7.1.4 Multisectorial and multidisciplinary health team collaboration

Multisectorial health team collaboration is necessary to provide effective health care provision. The legal team provides a framework for human rights. Social welfare agencies are needed for referral of primigravidae who want to put their children up for adoption after delivery. The department of education is responsible for training candidates to become health care providers. The provincial departments of health provides further training for health care providers. Political leadership is necessary to ensure that multisectorial collaboration is achieved. The community is essential in socializing the individual in society and understanding the community's culture assists the health care providers to understand and respect their norms and values.

Multidisciplinary describes a programme that involves several branches of medicine, science, or other professions working together toward a common goal (Hyperdictionary;

2005). Some of the multidisciplinary team members involved in antenatal care provision are nurses, midwives, medical doctors, HIV counselors, laboratory technicians and the physiotherapist. Each member of the multidisciplinary health team has a role to play.

The nurses have more direct contact with the primigravidae during antenatal care. The medical doctors treat primigravidae for ailments, while the counselors provide pre- and post-test counseling for HIV testing. The laboratory technician analyses the specimens, which are taken from primigravidae. The physiotherapist helps with antenatal exercises and the social worker arranges for adoption, safe homes and other social services.

#### 1.7.1.5 Conclusion to the meta-theoretical assumptions

In conclusion, I (the researcher) formulated the following meta-theoretical assumptions: the primigravida is an individual holistic being who belongs to a society. Health care is provided by the multidisciplinary team with intervention and / or guidance by the multisectorial team. In the next section the theoretical assumptions are discussed.

#### 1.7.2 Theoretical assumptions

Theoretical assumptions are epistemic statements that are testable. The theoretical assumptions that guided this research were the conceptual framework, and the definitions. The conceptual framework is an abstract set of concepts and theories that are related to one another and may be used to organize ideas and guide analysis within a study (Lacey and Gerrish, 2006). The conceptual framework that guided this research was the health belief model (HBM), by Alder, Kegeles and Genevro (1992) and Schwarzer (1992). The model focuses more on the general aspect of precautionary health behaviour (Messer and Meldrum, 1995).

### 1.7.2.1 The health belief model (HBM)

The HBM is a psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals (The communication initiative, 2007). The HBM was applied in this study in order to interpret the results of the interviews. In this research, the precautionary health behaviour is antenatal clinic attendance. The HBM is one of the mostly widely used conceptual frameworks for understanding health behaviour (Theories and approaches, 2007). The purpose of introducing the HBM was on increasing the use of preventive services. The HBM is a framework for motivating people to take positive health actions that uses the desire to avoid negative health consequences as the prime motivation. It is important to note that avoiding a negative health consequence is a key element of the HBM (Theories and approaches, 2007). In this research the negative health effect is the negative pregnancy state; such as pregnancy induced hypertension (PIH). The HBM considers main areas that are likely to influence whether a patient will choose to seek help about health related issue. These areas are also referred to as key variables or major concepts namely perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self efficacy (onlineconsultation.org, 2007).

#### *1.7.2.1.1 Perceived susceptibility*

Perceived susceptibility is one's subjective belief of the risk of contracting a health condition. In this research, perceived susceptibility can be defined as the primigravida's belief of the chances of developing PIH. The primigravida may believe that she may be at risk of developing PIH.

#### *1.7.2.1.2 Perceived severity*

Perceived severity is one's belief of how serious a condition is and its consequences if it is left untreated. The primigravida's belief of how serious is PIH and its complications if she does not obtain treatment, will determine if she will try to avoid it or not.

#### *1.7.2.1.3 Perceived benefits*

Perceived benefits are one's beliefs in the efficacy of the advice action to reduce risk or seriousness of the threat of illness. They will often weigh the benefits and disadvantage regarding each course of action. The primigravida may believe that if they attend/ walk to the nearest antenatal clinic they would be safe from PIH and its complications, possibly by early diagnosis and prompt treatment/ intervention.

#### *1.7.2.1.4 Perceived barriers*

Perceived barriers are the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands. The primigravida will identify the barriers preventing attendance at antenatal clinic. For example, she may not be attending antenatal clinic because she does not have money for transport to the clinic of her choice and she will have to identify a way to overcome that barrier. For example, she may choose to walk to the nearest clinic.

#### *1.7.2.1.5 Cues to action*

Even when patients have developed perceptions about their health, a trigger is required to initiate action. Cues to action, are the strategies to activate readiness. The trigger may increase the pregnant woman's perception of susceptibility to PIH, its seriousness, increased benefits, decreased disadvantages and barriers, increase motivation to change, or convince the pregnant woman that she may in fact be able to make any required changes herself. The cues to action may either be bodily, for example, persistent headache or environmental, for example; information about PIH published in the newspaper). These cues to action motivate the primigravida to attend antenatal clinics.

#### 1.7.2.1.6 *Self-efficacy*

Self-efficacy is a term used to describe how a person views their own ability to carry out a particular action. The primigravidae need to be confident and believe that they are capable of attending, or walking, to the nearest antenatal clinic. During visits, the pregnant woman will receive guidance or advice about pregnancy.

#### 1.7.2.2 Definitions

Key concepts that are used in this research are defined as follows:

- **Antenatal care** is defined as medical, physical and psychological health care provided to the primigravidae and her fetus during pregnancy, preceding labour and childbirth. Antenatal care should ideally be initiated as early as a few days after the first missed menstrual period (Cunningham, et. al, 2001). In this study antenatal care is provided by the midwives, the medical officer and allied health professionals to pregnant women who do not have any complications, such as hypertension in pregnancy
- **First trimester:** A period of pregnancy counted from the first day of the last normal menstrual period to the end of the twelfth week of pregnancy (Sellers, 1997). This term is applied in this study as the preferred time that primigravidae must initiate antenatal clinic attendance at the level 1 MOU.
- **Health care provider:** Is an organization or a person who delivers proper health care in a systematic way professionally to any individual in need of health care service (Wikipedia, 2008). In this research, this term refers to the midwives, doctors and allied health professionals such as the HIV counselors and laboratory technicians.
- **Health seeking practices:** Efforts taken by pregnant women to seek health care during their pregnancy for the purpose of monitoring the progress of their pregnancy.

- **Maternal mortality rate:** The number of maternal deaths which occurs during pregnancy or puerperium divided by the number of live births in that year (Medical dictionary, 2007). This term was used in this study to emphasize on some of the complications of inadequate or no antenatal care.
- **Maternal morbidity:** Is defined as disease condition or state, the incidence of a disease or all diseases in a population (The online medical dictionary, 2007). This term was used in the study to emphasize on some of the complications of the complications of inadequate or no antenatal care.
- **Midwives obstetrical unit (MOU):** Decentralized delivery units staffed by midwives who assume responsibility for ante-, intra-, and postpartum care of normal risk mothers (Nolte, 1998). In This study, the MOU is where the research data was collected.
- **Normal risk pregnancy:** Defined as the risk determined at the first antenatal booking visit. It includes all pregnant women with no risk factors (Bodkin, 2004). Antenatal care at the level 1 MOU where this study was conducted is rendered to pregnant women whose pregnancies are classified as normal risk.
- **Primigravidae:** Women who are pregnant for the first time, irrespective of their age and / or marital status (Sellers, 1997). Only primigravidae were selected as the population and sample for this study.
- **Puerperium:** A period of time extending from the end of the third stage of labour to the end of the sixth week following delivery (Sellers, 1997).
- **Second trimester:** A period of pregnancy from the beginning of the thirteenth week up to the end of the twenty fourth week (Sellers, 1997).
- **Third trimester:** A pregnancy period from the twenty fifth week until birth (Sellers, 1997). The third trimester is the time by which the primigravidae who participated in this study initiated antenatal clinic attendance at the level 1 MOU.

## **1.8 RESEARCH DESIGN AND RESEARCH METHOD**

The research design is a plan of how, when, and where data are to be collected and analyzed (Parahoo, 1997). The research design and research method describe the whole study's strategy, from identification of the research problem to the final presentation of the research results. In this chapter, an overview of the research method and the research design is provided. For a more detailed description, the reader is referred to chapter two.

### **1.8.1 OVERVIEW OF THE RESEARCH DESIGN AND RESEARCH METHOD**

A qualitative, descriptive, exploratory and contextual research design was used to explore and describe the health seeking practices of primigravidae who commenced attending antenatal clinics in their third trimester of pregnancy. The research design and research method were structured in accordance with the exploration and description of the health seeking practices of the primigravidae. Purposive sampling was utilized to select participants to be included in the study. In order to explore and describe the health seeking practices of primigravidae, individual in-depth interviews were used to collect data.

A brief overview of the research design and research method is provided in table 1.1.

**Table 1.1** Overview of the research design and research method

<u>Objective</u>	<u>Population</u> <u>And sample</u>	<u>Data</u> <u>collection</u>	<u>Data</u> <u>analysis</u>	<u>Conclusion</u>
Explore and describe the health seeking practices of first time pregnant women who started attending antenatal clinic in their third trimester.	Maximum variety purposive sampling of 10 first time pregnant women	Tape recorded individual in-depth interviews	Tesch's steps of data analysis. Emerging themes were identified	Synthesized from data analysis
Make recommendations to encourage first time pregnant women to initiate antenatal care in their first trimester		Evidence from the first objective	Synthesized from data analyzed	

### 1.8.2. TRUSTWORTHINESS

In this section, an overview of trustworthiness is provided; refer to chapter two (section 2.7) for a detailed description.

Guba and Lincoln's framework for ensuring validity and trustworthiness of qualitative research was applied to in-depth interviews with the primigravidae. The four main

aspects of trustworthiness are credibility (truth-value), transferability (applicability), dependability (consistency), and confirmability (neutrality) (in Polit and Beck, 2001).

### **1.8.3. ETHICAL CONSIDERATIONS**

All research involving human participants must be conducted in an ethical manner that respects the dignity, safety and rights of research participants and that recognizes the responsibilities of the researcher (World Health Organization (WHO), 2007). To be ethical, all health research on human participants must be scientifically sound (DOH, 2007). The participants' right to privacy, anonymity and confidentiality were maintained. The co-operation with authorized review groups was ensured. Consent was obtained from the Postgraduate and the Human Research Ethics Committees of the Faculty of Health Sciences, University of the Witwatersrand, and from the management at the health center where the MOU is based. See chapter two (section 2.8) for a detailed description of the ethical considerations.

## **1.9. RESEARCH LAYOUT**

Chapter one:	Overview of the study
Chapter two:	Research design and research method
Chapter three:	Research results and literature control
Chapter four:	Conclusion, limitations and recommendations

## **1.10. CONCLUSION**

Chapter one provided an overview of the study. The overview included an introduction, aim of the study, objectives of the study, significance of the study, operational definitions and the conceptual framework. Brief overviews of the research design and research method were provided. The research design and research method are described in detail in chapter two.

## **CHAPTER TWO**

### **RESEARCH DESIGN AND RESEARCH METHOD**

#### **2.0 INTRODUCTION**

In the first chapter the study's aims, objectives, research question and significance were described and a brief overview of the research method was provided. Chapter two describes the research design and research method in detail. The methodology includes the research design, research setting, research population, sampling, data collection, trustworthiness and ethical issues.

The aim of this study was to determine the health seeking practices amongst primigravidae at a level 1 MOU, based in a peri-urban area in Gauteng province, SA. The health seeking practice of concern was the first antenatal clinic attendance. From the results of the study, recommendations were made to encourage primigravidae to initiate antenatal care in their first trimester.

The following objectives were set to achieve the aim of the study:

- To explore and describe the health seeking practices of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy; and
- To make recommendations with the intention of encouraging primigravidae to initiate antenatal care in their first trimester.

The research design was qualitative, descriptive, exploratory and contextual. The research method was unstructured, individual in-depth interviews. The population consisted of primigravidae who were attending antenatal clinic at a level 1 MOU. Maximum variety purposive sampling, with inclusion and exclusion criteria, was used and sampling continued until data were saturated. The sample consisted of primigravidae

who initiated antenatal clinic attendance at the level 1 MOU in the third trimester of their pregnancy. The sample size was 10 participants, whereby two were from the pilot study, and eight from the subsequent interviews.

Individual in-depth interviews were used to collect data. One question was asked: ‘What made you to come for your first antenatal visit when you did?’ Interviews were audio taped with participants’ informed consent (see annexure C), transcribed and analyzed by using Tesch’s eight steps of data analysis (in Creswell, 1994). Lincoln and Guba’s four strategies for trustworthiness were applied and ethical considerations were implemented.

## **2.1 RESEARCH DESIGN**

A research design is a blueprint for conducting the study that maximizes control over factors that could interfere with the validity of the findings. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns and Grove, 2001). The purpose of the design is to achieve greater control and thus improve validity of the study in examining the research problem (Burns and Grove, 2001). It also sets up a situation that maximizes the possibilities of obtaining accurate responses to objectives and questions (Burns and Grove, 2001). The research design applied to this study was a qualitative, descriptive, exploratory and contextual.

**Qualitative research** is a systematic, subjective approach used to describe life experiences and give them meaning (Burns and Grove, 2001). It is a way to gain insights through discovery of meanings. It is also a way of exploring the depth, richness and complexity inherent in phenomena. Qualitative studies are based on a world view that is holistic and has the beliefs that: reality is not single, reality varies from person to person and changes over time, and what we know has meaning only within a given situation (Burns and Grove, 2001). A qualitative research design was used to gain insight about why do primigravidae initiate antenatal clinic attendance at the level 1 MOU where this study was conducted in their third trimester of pregnancy. The insight from this study

will guide midwifery practice on what can be done to improve antenatal clinic attendance by primigravidae

**Descriptive studies** are research studies in which phenomena are described. Descriptive studies are designed to gain more information about characteristics within a particular field of study. A descriptive design was used to get information as to why did primigravidae initiate antenatal care at the level 1 MOU in the third trimester of their pregnancy. It was also used to identify problems, if any, with the current antenatal clinic practice. The problems were identified using individual in-depth interviews with the participants whereby one open-ended question was asked. The research question was open-ended so as to allow the participants to give a detailed description in their response. Bias was prevented by linking operational and conceptual definitions, relevant sample selection and size, using the researcher as a valid and reliable instrument and data collection in the natural environment (Burns and Grove, 2001). This design included identification of a phenomenon of interest (antenatal clinic attendance by primigravidae) and concepts within the phenomenon, developing conceptual and operational definitions of the concepts and description of the concepts.

**Exploratory studies** are not intended for generalization to large populations. An exploratory study design was used to explore the health seeking practices of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy. Exploratory studies are not expected to have large samples and to use random sampling technique (Burns and Grove, 2001). This study had ten participants and a non probability sampling method was used.

The study design was selected to attain the aims of exploring and describing the thoughts, feelings, experiences and the deeper meaning of the phenomenon under study from the perspectives of the participants. This perspective is the experiences that influenced primigravidae to initiate antenatal clinic attendance in their third trimester of pregnancy.

**Contextual studies** are studies that incorporate ethnographic methods, which present varying degrees of qualitative descriptions of human social phenomena based on fieldwork, to gather data that is relevant to the topic of research (Wikipedia, 2008). The researcher aggregates data from the participants in the original context. The goal of using contextual studies is to understand how and why something is done or not done (Wikipedia, 2008). This study was contextual as it took place in real environments, which was the antenatal clinic, and did not include researcher designed treatments. The aim of this study was to explore and describe the health seeking practices of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy.

## **2.2 RESEARCH SETTING**

The research setting is elaborated upon in detail so as to ensure replicability of the study and thus validity. The research setting is a site where the research data was collected. The research setting is described under the following headings: the SA health system, the peri-urban area where the MOU is located, the MOU where I conducted the study, the antenatal clinic statistics for July 2006, the first visit and the follow-up visit.

### **2.2.1 The SA health system**

The SA health system lays a foundation of health care in SA. SA exhibits major disparities and inequalities amongst its population. This is the result of former apartheid policies which ensured racial, gender and provincial disparities. The health system was transformed and a white paper released to: present to the people of SA a set of policy objectives and principles upon which the Unified National Health System of SA is based. The following goals were set: to unify fragmented health services at all levels into a comprehensive and integrated national health system; to promote equity, accessibility and utilization of health services; to extend the availability and ensure the appropriateness of health services; to develop health promotion activities; to develop the human resources available to the health sector; to foster community participation across the health sector and to improve health sector planning and the monitoring of health status and services.

The SA health system consists of a large public sector and a smaller but ever expanding private sector. Health care varies from the most basic primary health care, offered free by the state to highly specialized hi-tech services available in the private sector for those who can afford it. The public sector is under resourced and over utilized. Although the state contributes approximately 40% of all expenditure on health, the public sector is under pressure to deliver services to about 80% of the population. Over the past few years the health sector has undergone rapid change to make it more equitable and accessible to the indigent. The main aim of the transformation process was to change the health system from a mainly curative, hospital centered system to one underpinned by the primary health care philosophy, the principles of which are equity, accessibility, availability and affordability. It prescribes a comprehensive continuum of promotive, preventive, curative, rehabilitative and palliative care, with good communication and referral channel between the different levels and components (Shung-King, McIntyre and Jacobs, 2005) and (DOH, 1997).

In the following section, the peri-urban area where the MOU was conducted is discussed.

### **2.2.2 Description of the peri-urban area where the MOU is located**

The site for this research was an antenatal clinic department in a level one MOU based in one of the peri-urban areas in the Gauteng province, South Africa (SA).

The peri-urban area where the MOU is located is one of the oldest townships in Johannesburg (Gauteng provincial government (GPG), 2004). The following demographic data was obtained from the background information for the pro-poor tourism pilot (PPT) project in SA (2004). The population is estimated at an official count of 35 000 people with an unofficial estimate of 70 000 people. The 70 000 people is said to be an unofficial count because not all the residents were counted. The area is overcrowded with a population density of around 45 000 people per square kilometer, which is 100 times the average population density of Gauteng. The population is estimated to consist of 87% blacks, 11% whites, and 1% coloured. The black population

was further sub divided into 30% Zulus, 26% Pedis, 12% Tswanas, and 10% Xhosas. The population is mostly young, with 70% aged below 35 years, and the average age is 23 years. Approximately 50% of the population aged between 5-24 years did not have any schooling. Unemployment was also a worrying issue, with an estimated official index of 32%, and 60% as the unofficial index. Population overcrowding caused problems such as increased crime, poor sanitation and heavy strain on engineering services, social services and hospitals. There is a high incidence of crime and HIV in the community.

There are six primary health care service centers in the peri-urban area where the MOU is based. Five of them are local government clinics (working 8 hours a day, 5 days a week), and only one is a community health center with an MOU (working 24 hours a day, 7 days a week). All the deliveries are to be conducted at the MOU, while only emergencies are delivered at the other clinics.

### **2.2.3 Description of the MOU where the study was conducted**

The community health center where the MOU is based is in a non governmental organization, that is funded by the provincial government, donors and charitable organizations (Wits; 2004). In 2004, the clinic was 75 years old and had 180 employees (GPG, 2004). The health center serves a population that has increased over the past four years from 250 000 to approximately 500 000 people (Wits, 2004). The services provided include antenatal care, delivery, postnatal care and family planning. The antenatal clinic staffing is described next as it impacts on the quality of service provision at the level 1 MOU's antenatal clinic.

During the data collection period, the antenatal clinic was staffed as follows:

- One visiting medical doctor (a medical officer) who attended clinics on Thursdays. If the doctor was required on other week days, the doctor from casualty (there was always a medical doctor on duty in casualty) was called in;

- One advanced diploma midwife, who did first antenatal visits and prescribed treatment for minor ailments, worked at the antenatal clinic on Mondays, Tuesdays, Wednesdays and Fridays;
- Three midwives. Two midwives who took blood for grouping, Rh, and syphilis testing and did the follow-up antenatal visits. The other midwife who had completed a PMTCT course, did rapid HIV testing and assisted the other two midwives with the follow-up visits;
- One enrolled nurse who did rapid haemoglobin testing in the antenatal clinic with a haemoglobinometer;
- One enrolled nursing assistant who did urinalysis and weighed pregnant women during antenatal visits;
- Four HIV counselors who did pre- and post test counseling.

The record keeping was done by all the staff members. The MOU's antenatal clinic statistics, for the month of July 2006, are discussed next.

#### **2.2.4 The antenatal clinic statistics for July 2006**

The antenatal clinic statistics are provided to give a picture of the workload that the health care providers at the antenatal clinic are faced with. The following statistics were retrieved from the health center's monthly statistics record book. There was a total of 911 antenatal clinic visits over the month of July 2006. The term 'visits' is used here to describe both the number of pregnant women who came for their first antenatal visit and those who came for follow-up visits, irrespective of their parity, unless otherwise mentioned. Refer to table 2.1 for the parity of women who attended the antenatal clinic during the month of July 2006.

**Table 2.1** Parity of women who attended the antenatal clinic during the month of July 2006.

<b>Gravid and parity</b>	<b>Number of visits</b>	<b>Percentages</b>
Primigravidae	385	42%
Multigravidae	526	58%
<b>TOTAL</b>	<b>911</b>	<b>100%</b>

Table 2.1 indicates a small difference of parity amongst the women who were attending antenatal clinic at the MOU throughout the month of July 2006. 58% (n=526) of the women were multiparous, whilst 42% (n=385) were primigravidae.

Tables 2.2, 2.3, 2.4 and 2.5 illustrate only the first visits by pregnant women. Follow-up visits are not tabled as this study focuses on the timing of the **first** antenatal clinic visits.

Eleven of the visits were by young women under the age of 18 years. These young women attended antenatal clinic for the first time in their pregnancy. Refer to table 2.2 for the gestational age at which women under the age of 18 years initiated antenatal clinic attendance.

**Table 2.2** Gestational age of women below 18 years at first antenatal clinic visit.

<b>Gestational age</b>	<b>Number of visits</b>	<b>Percentages</b>
< 20 weeks	01	9%
> 20 weeks	10	91%
<b>TOTAL</b>	<b>11</b>	<b>100%</b>

Table 2.2 represents women below the age of 18 years who do fall pregnant. These women are still teenagers which illustrate that teenage pregnancy is still happening, despite the free availability of contraceptives at government institutions. Only 9% (n=1) of the teenagers initiated antenatal clinic attendance at a gestational age below 20 weeks, which is a very low percentage.

Amongst all 911 visits, 387 were by women older than 18 years of age (both primigravidae and multiparous). Refer to table 2.3 for the gestational age at which women above the age of 18 years initiated antenatal clinic attendance.

**Table 2.3** Gestational age of women above 18 years at first antenatal clinic visit.

<b>Gestational age</b>	<b>Number of visits</b>	<b>Percentages</b>
< 20 weeks	05	1%
> 20 weeks	382	99%
<b>TOTAL</b>	<b>387</b>	<b>100%</b>

Table 2.3 reflects that only one percent of the first visits by women above the age of 18 years initiated antenatal clinic attendance at a gestational age below 20 weeks. This percentage shows that most pregnant women initiated their antenatal clinic attendance late in the second trimester of their pregnancy. This rate is very low.

The parity of those visits above the age of 18 years, who started antenatal clinic attendance prior to 20 weeks gestation, is shown in table 2.4.

**Table 2.4** The number of first antenatal clinic visits below 20 weeks gestation by women over 18 years of age.

<b>Gravid and parity</b>	<b>Number of visits</b>	<b>Percentages</b>
Primigravidae	01	20%
Multiparous	04	80%
<b>TOTAL</b>	<b>05</b>	<b>100%</b>

Table 2.4 shows that 80% (n=4) of pregnant women who initiated antenatal clinic attendance at less than 20 weeks gestation were multigravidae. The women were above the age of 18 years. Only 20% (n=1) of first antenatal clinic visits below 20 weeks gestation were by primigravidae. This percentage is alarming because the primigravidae do not have sufficient knowledge regarding pregnancy. Therefore, the primigravidae

would be expected to be the one's who initiate antenatal clinic attendance earlier than the multiparous women.

The parity of visits above 18 years who initiated antenatal clinic attendance after 20 weeks gestation is shown in table 2.5.

**Table 2.5** The number of first antenatal clinic visits above 20 weeks gestation by women above 18 years.

<b>Gravid and parity</b>	<b>Number of visits</b>	<b>Percentages</b>
Primigravidae	335	88%
Multiparous	47	12%
<b>TOTAL</b>	<b>382</b>	<b>100%</b>

Table 2.5 indicates that of all the pregnant women who initiated antenatal clinic attendance at more than 20 weeks gestation, 88% (n=335) of them were primigravidae. Such a high percentage of primigravidae is a matter of concern. The multiparous women, who supposedly have more knowledge and experience about pregnancy, are the ones who initiate antenatal clinic attendance earlier.

Of the 911 visits, 513 visits were follow-up visits and their gestational ages were not specified in the statistics. Of the 911 antenatal clinic visits, only one woman was referred to the hospital for antenatal care. One referral appears unrealistic for an MOU and may possibly be explained as follows:

As one of the health care providers at the MOU's labour ward, I believe that pregnant women with problems were not properly referred during the antenatal period. Pregnant women with obstetric complications came to the labour ward for delivery. The most common obstetric complications observed were hypertensive disorders of pregnancy. When the pregnant women's antenatal clinic cards were reviewed, it was found that they either had some degree of elevated blood pressure, proteinuria, and/or oedema during the antenatal period. This shows that those pregnant women were not managed properly, as

they should have been referred to the regional hospital for continuation of antenatal care and management of the obstetric complications that they had.

As the research setting is a primary level of health care, only women with normal risk pregnancies are seen at the MOU. Normal risk women are those with no risk factors during their pregnancy (Bodkin, 2004). On their first antenatal clinic visit they were seen by the doctor or an advanced midwife. Subsequent check-up visits were performed by the registered midwives, unless the condition warranted a referral to the doctor or an advanced midwife. The first antenatal clinic visits are explained in the next section.

### **2.2.5 The first visit**

The first time that the pregnant woman presents at the antenatal clinic for antenatal care, is defined as the first visit. In contrast, if the woman had commenced antenatal clinic attendance somewhere else and are in possession of their clinic cards, they are defined as subsequent visits.

At the first visit, pregnant women are screened for any pregnancy risk. Pregnant women who are classified as an intermediate risk or high risk pregnancy are referred to the regional hospital for antenatal clinic attendance and delivery. The pregnancy risk may be identified during history taking, after analysis of the special investigatory' results, or after a full physical examination at the first or follow-up visit. The risk factors are listed as pre-existing or arising during antenatal care, in boxes 2.1 and 2.2 (DOH, 2002).

**Box 2.1** List of pre-existing risk factors in antenatal care.

**LIST OF PRE-EXISTING RISK FACTORS**

**High risk**

- Primigravida aged 35 years and above
- Previous infertility treatment and myomectomy
- Previous cervical or vaginal surgery
- Previous operations to the uterus (hysterotomy, caesarean section)
- Previous perinatal death
- Last baby preterm at 7 months or less
- Previous pre-eclampsia
- Three or more previous miscarriages
- Diabetes mellitus, epilepsy, heart disease, active tuberculosis, chronic hypertension or renal disease, autoimmune disease, current symptomatic asthma, thyroid disease or thyroidectomy, or history of venous thrombosis
- Psychiatric disease, including previous post partum depression or psychosis
- Serious disease or deformity of the spine

**Intermediate risk**

- Previous postpartum haemorrhage requiring blood transfusion
- Parity of 5 and above

**Box 2.2** List of risk factors that arise during antenatal care.

**LIST OF RISK FACTORS THAT ARISE DURING ANTENATAL CARE**

**Requiring non-urgent referral to hospital**

- Anaemia
- Uterus large for dates (SFH above 90<sup>th</sup> centile)
- Uterus small for dates (SFH below the 10<sup>th</sup> centile)
- SFH decreasing
- No maternal weight gain in woman less than 60 kilograms (kg)
- Known multiple pregnancy
- Breech or transverse lie from 36 weeks
- Rh negative blood group with antibodies
- Extensive vulval warts that may obstruct vaginal delivery
- Pregnancy beyond 41 weeks
- Abnormal glucose screening (random blood sugar)
- Mild hypertension

**Requiring urgent transfer to hospital, by ambulance if necessary**

- Reduced fetal movements from 28 weeks
- Eclampsia or imminent eclampsia
- Pre-eclampsia
- Antepartum haemorrhage
- Severe illness, e.g. with pyrexia, shortness of breath or abdominal pain

The women who are to be seen at the MOU are given antenatal clinic cards. The following information is recorded on those cards: the woman's history, results of the special investigations performed, ambulance telephone numbers and a full physical examination. The antenatal clinic card is taken home by the women and they bring it along to the clinic for follow-up visits, when sick and when they come for delivery. The information that is recorded on the antenatal clinic card is explained in detail in the next section.

- History taking.

A history assessment provides the care giver, that is, the registered midwife with background information about her client. As the information obtained is confidential, a private venue is utilized with each pregnant woman. History taking consists of the following aspects:

- The **demographic data** obtained is the name and surname, physical address, date of birth, and telephone number of the patient or her relative.
- An accurate **menstrual history** is taken to determine the expected date of delivery (Fraser, Cooper and Nolte, 2006). Patients' menarche, last normal menstrual period and menstrual cycle days are obtained and recorded.
- The past childbearing experiences play an important part in predicting the possible outcomes of the current pregnancy (Fraser, et al, 2006). The **obstetric history** is taken according to the following guidelines: number of pregnancies, year and duration of each pregnancy, type of delivery, baby's sex and birth weight, whether baby was alive or not and any antenatal intrapartum or postpartum complications such as haemorrhage. Information is obtained and recorded about previous contraception and future family planning method.
- A **social history** is important to assess the response of the whole family to the pregnancy. The social history includes who the woman lives with and the woman's employment status.
- During pregnancy, both the mother and fetus may be affected by a medical condition, or the medical condition may be altered by the pregnancy; if untreated there may be serious consequences for the woman's health (Fraser et al, 2006). Under **medical history** the data obtained includes presence of hypertension, cardiac and renal disease, diabetes, epilepsy, asthma and tuberculosis contact. The history and/or presence of any of the above are explained to the client. Any medications that the pregnant woman may be taking are recorded, **surgical history** is obtained and allergies are noted.

- Smoking and alcohol consumption falls under **general history**. In case of alcohol consumption, the estimated quantity consumed weekly is obtained and recorded. If the woman is smoking, she is asked how many cigarettes she smokes daily. Good habits are reinforced and advice is given when required (Fraser et al, 2006), for instance if too much alcohol is consumed.
- A **family history** of multiple pregnancies, diabetes; and congenital abnormalities is recorded and specified whether from the maternal or paternal family. A family history is important because certain conditions are genetic in origin, while others are related to ethnicity (Fraser, et al, 2006).

After history taking, blood is taken from pregnant women for special investigations which are discussed in the next section.

- Special investigations and prophylaxis

Blood specimens are taken from pregnant women for special investigations. The investigations are done so that intervention can begin in case of any abnormal findings. Blood is taken for the following tests:

- Haemoglobin. This is done in the clinic on a portable haemoglobinometer and the results recorded immediately on the antenatal clinic card.
- Blood for grouping and Rhesus factor is taken to the laboratory and the results come on the same day and are recorded on the card.
- Blood for rapid plasma reagin (RPR) is also taken to the laboratory and the results come back on the same day. Women with positive RPR are started on treatment as per clinic protocol.
- Counselors counsel all women in a group and then individually for Human Immuno-deficiency Virus (HIV) tests. Women who agree to be tested for HIV sign a consent form before being tested. A rapid HIV test is done in the antenatal clinic. If the rapid test results are positive, more blood is drawn for a CD4 count. The CD4 count is done at the health center's

laboratory and the results are received after one week. The HIV test results are given to the women by the counselors.

- All women receive anti-tetanus toxoid (ATT) on their first visit. This is repeated twice at four weekly intervals. In total, they receive three ATT shots.

- A full physical examination

During a full physical examination, the pregnant woman is thoroughly examined from head to toe. This is performed by the medical doctor or an advanced midwife and it entails the following: The height of the woman, body mass, blood pressure, urine test (for blood, proteins, glucose, nitrites, leucocytes and ketones); edema, general wellbeing, examination of the thyroid gland, breasts, heart, lungs and abdomen and a vaginal examination. The person who performs the full physical examination determines the pregnancy risk, records all the information obtained and signs the clinic card. The examiner is responsible for providing health education to the pregnant woman about issues such as health personal hygiene, breast care and advising her to report any problems to the clinic staff.

In the case of a breech presentation, small or large for gestational age pregnancy, unstable lie, or a suspected multiple pregnancy; the women are booked for an ultrasound. The ultrasound is performed in the MOU's labour ward by the medical doctor on Wednesdays. If an urgent need for an ultrasound arises, such as no fetal heart heard on auscultation, the doctor from the health center's casualty performs it. After the first antenatal visit, women have to return for continuation of antenatal care.

#### **2.2.6 Follow-up visit**

After each visit, including the first visit, women are given return dates for follow-up visits. The interval for follow-up visits is as follows: monthly when below 28 weeks gestation, then every two weeks up to 36 weeks gestation, and weekly from 36 weeks

gestation to delivery. These intervals between antenatal visits' are in accordance with the recommendations made by the DOH, 2002 and Olds, London and Ladewig, (2000).

The follow-up visits are performed by the registered midwives. At each visit the following aspects are performed and recorded:

- Weight measurement and urinalysis;
- Taking of blood pressure;
- Asking about fetal movements;
- Abdominal palpation for determination of SFH; lie; presenting part and engagement;
- Auscultate for fetal heart beat;
- General examination for pallor; oedema and ailments.

Women with ailments are referred to the doctor or an advanced midwife who are always in the antenatal clinic. Pregnant women who develop any pregnancy risk during antenatal care are referred to the regional hospital for continuing antenatal care and for delivery. Pregnancy risks that may develop during antenatal care are listed in box 2.2.

Health education is part of antenatal care. Health education is given to pregnant women at every visit either as a group or individually during the check-ups. Health education includes issues about pregnancy and labour, nutrition, personal hygiene and exercise (both antenatal and postnatal).

## **2.3 RESEARCH METHOD**

### **2.3.1 Population**

The target population is the entire set of individuals (or elements) who meet the sampling criteria (Burns and Grove, 2001). Sampling criteria lists the characteristics essential for membership to the target group (Burns and Grove, 2001). This study's population

included all primigravidae who commenced attending antenatal clinic in their third trimester of pregnancy. A sample was selected from the population.

### **2.3.2 Sample selection**

A sample is the subset of population elements (Polit and Beck, 2004). Sampling involves selecting a group of people with which to conduct a study (Burns and Grove, 2001). Sampling for this research was done while the women were attending antenatal clinic. The kind of sampling and data collection strategies employed by qualitative researchers often allow very detailed and deep description of personal accounts (Newell and Burnard, 2006). A purposive sampling method which is also referred to as judgmental sampling was utilized (Burns and Grove, 2001). It is a conscious selection of certain subjects to be included in a study by a researcher. It is a non probability sampling method whereby not every element of the population has an equal opportunity to be included in the study (Burns and Grove, 2001). Purposive sampling is based on the belief that the researcher's knowledge about the population can be used to hand-pick sample members (Polit and Beck, 2004). A purposive sampling method was helpful because as data collection continued, insight from initial data helped the researcher to decide to seek subjects with a particular characteristic, such as a different age and race, to increase theoretical understanding of the phenomenon being studied (Burns and Grove, 2001). After conducting seven interviews, I (the researcher) noticed that all the participants were under the age of 24 years. I announced to the potential participants that I would like the next participants to either be above the age of 24 years and/or married.

Inclusion and exclusion criteria were applied. Primigravidae were used in this study as they are considered to be high risk as compared with multigravida as it is their first pregnancy and labour (Sellers, 1997), and they lack knowledge and experience from previous pregnancies and labours. The inclusion criteria are listed below.

### 2.3.2.1 Inclusion criteria

Inclusion criteria are characteristics that must be present for the element to be included in the sample (Burns and Grove 2001). The participants in this study had to have the following characteristics:

- Primigravidae aged 18 years and above as they are of legal age to sign informed consent;
- Initiated antenatal care at a level one MOU in their third trimester of pregnancy;
- Able to speak English;
- Voluntarily agreed to participate in the study and signed informed consent.

The sample selection method was as follows:

- All pregnant women who had come for antenatal care were gathered in a hall, in the antenatal clinic, where they were given health education in the mornings.
- I (the researcher) introduced myself to the potential participants as a health educator (my normal role at the antenatal clinic) and as the researcher for this study.
- I introduced my research topic, explained the sampling method and the inclusion criteria and asked them to think about participating. In the mean time, I continued with the health education sessions.
- The health education sessions were about antepartum, intrapartum, and postpartum health issues. The health education was given in form of a lecture and discussion. These discussions allowed prolonged engagement and helped me to develop a trusting relationship with the potential participants. The population was sampled after the health education session.
- To identify the population, I requested the pregnant women who met the inclusion criteria to raise their hands. After that, I reviewed the patient's antenatal clinical cards. A review of all pregnant women's antenatal clinic cards assisted me to identify all the pregnant women who met the inclusion criteria.

- I asked pregnant women who met the inclusion criteria to participate, taking into consideration their age, employment status and ethnicity. This ensured a maximum-variety sample as I needed views from a varied sample.
- The data collection process was explained to the potential participants. I told them that I was going to interview them individually and that the interviews will be tape-recorded. I also explained that they needed to sign a consent form for being interviewed and for the interviews to be tape-recorded out of their own free will.
- The potential participants were given information letters (see annexure A) and they voluntarily signed consent forms for the interview (see annexure B) and for tape-recording the interview (see annexure C).

A maximum variety sample was selected whereby the sample varied by age, employment status and ethnicity. I had a total of ten participants including the pilot study. Sampling continued until data were saturated. Table 2.6 summarizes the variety of the research sample in no particular sequence.

**Table 2.6** Description of the research sample.

<b>Age in Years</b>	<b>Race</b>	<b>Marital status</b>	<b>Employment Status</b>	<b>Gestational age at first antenatal visit</b>
18	Tsonga	Single	Student	30 weeks
19	Pedi	Single	Student	28 weeks
19	South Sotho	Single	Unemployed	28 weeks
20	Pedi	Married	Unemployed	30 weeks
20	Tswana	Single	Employed	27 weeks
21	Pedi	Single	Student	30 weeks
24	Pedi	Single	Employed	32 weeks
26	Xhosa	Married	Employed	30 weeks
26	Tonga-Zimbabwean	Single	Employed	32 weeks
31	South Sotho	Single	Unemployed	28 weeks

Table 2.6 shows that all the participants that I interviewed were of legal age in SA, which 18 years and above. This was so as it enabled to give voluntary informed consent to participate in the study. The participants' age ranged from 18 years to 31 years. Nine of the participants were South African and only was non South African. Eight participants were single and the other two were married, whereas four of them were employed, three were unemployed and the other three were students. All the participants that I interviewed had initiated antenatal clinic attendance at the level 1 MOU after the 27<sup>th</sup> week of pregnancy, which is in their third trimester. The reason why the sample is described is to show that I had a maximum variety sample. Sampling continued throughout the period of May and June 2006; that is the period in which data was collected.

### **2.3.3 Data collection**

Data collection is the process of gathering data from the selected participants. It is a precise, systematic gathering of information relevant to the research purpose (Burns and Grove, 2001). Data were collected from the subjects by audio taping the interviews.

#### **2.3.3.1 The instrument**

The following one open-ended question was asked to all the participants: '*What experiences influenced you to come for your first antenatal visit when you did?*' An audio tape recorder was used to record all the interviews. Any misunderstandings regarding the question were clarified during the interviews.

I, the researcher, was the instrument and my role in data collection is described with reference to literature by Kaplan and Sadock (1998). Before and during the sampling process, I had prolonged engagement with the potential participants. I was a registered midwife who was employed at the MOU where this study was conducted. I gave health education to pregnant women every morning in the antenatal clinic. The participants were

aware from the beginning that I was a health care provider, as well as a researcher. The data collection procedure is described in detail next.

#### 2.3.3.2 The procedure

Data were collected between May and June 2006. I conducted all the interviews. The participants were first greeted in a friendly manner to establish trust and to make them comfortable. Each interview lasted between 20 to 50 minutes and was conducted privately in one of the consulting rooms in the antenatal clinic. This ensured privacy and a comfortable environment for the participants. Privacy was ensured as most participants speak freely in private. Ensuring privacy, quietness, and lack of interruptions assured the participants that what was to be said in the interviews was important and worthy of consideration.

Unstructured, individual in-depth interviews were conducted as they are the most direct method of obtaining information from subjects in a face to face encounter (Polit and Beck, 2001). All the interviews were tape recorded. I commenced the interviews by introducing myself to the participants and stating my professional status. I told the participants that I was a midwife at the MOU and am also a master on nursing student at the University of the Witwatersrand. I told them I was conducting the research as part of my study requirements. I asked the research question and gave the participants time to respond. The research question was open ended as it was meant to allow the participant's story to unfold at will. Further questions were generated from the participants' responses in order to get a clearer picture of their response (probing). The participants' names were not mentioned during the interviews to ensure anonymity. During the interviews, I did not lead the participants in their way of responding; I remained calm to make the participant comfortable; listened attentively when the participant responded and did not use medical jargon that the participants could not understand (Morse and Field, 1996). Field notes were taken during each interview. Field notes included participants' non-verbal cues and on the researchers' feelings about the interview.

During the interviews, I demonstrated the SOLER method of attentive body listening (Kaplan and Sadock 1998). I sat squarely facing the participant, demonstrated an open posture, leaned slightly forward without crowding the participant, maintained eye contact that was not intimidating to the participant and was also relaxed. The following techniques were also used during the interviews:

- In reflection, I repeated what the participant said in a supportive manner, which showed that I was listening, and ensured that I understood what the participant said.
- Facilitation helped continue the interview as I provided verbal and non-verbal cues to encourage the participant to keep talking.
- Clarification was used in an attempt to get detail about what the participant had said.
- I summarized the responses when necessary to ensure that I heard what the participant conveyed.
- Positive reinforcement made the participant comfortable to open up and give honest replies. It made the participant feel that I was not upset by what she stated (like the negative comments about nurses).
- The participants were given a chance to ask questions, which they did.
- I thanked the participants for the interviews and ensured them that the information was helpful.

## **2.4 PILOT STUDY**

The research question was tested on two women who met the inclusion criteria for this research. Pilot study interviews were conducted in the same way that the subsequent research interviews were conducted. No problems were encountered with the interpretation of the question and it was included in the main study.

## 2.5 DATA ANALYSIS

The data analysis strategy details the specific procedures for addressing each of the research questions and the nature and form of the expected results (National institute of health, 2007). Data were analyzed following Tesch's steps of data analysis (in Cresswell, 1994) whereby I:

- Transcribed the recorded interviews verbatim and numbered each interview and each page of the interview. For example: page1 of interview number 1 was numbered as (1.1)
- Read through the transcribed interviews to get a sense of the whole;
- Read through all the transcribed interviews and added field notes;
- Selected the most interesting interview and underlined the main emerging topics.
- Added comments in the margins;
- Repeated the process for the remainder of the interviews;
- Wrote a list of all emerging topics;
- Grouped similar emerging topics into categories;
- Those categories formed the basis of the development of the main emerging themes;
- Gave each emerging theme a descriptive title;
- The sub-categories were evolved into sub-themes;
- Added supporting participant's comments for each theme and sub-theme;
- Substantiated each theme with supporting literature;
- Gave all the transcribed interviews to a co-coder to do independent analysis of data and to check that they concurred with emerging themes. The co-coder did not make any alterations or additions to the themes that were already identified by the researcher. The co-coder was an individual who obtained a master of nursing degree from the University of the Witwatersrand The co-

coder was suitable as she is in the nursing profession and understands the content of this research.

- Attempted to restrict categories to approximately 5;

After the process of data analysis, the data was assessed for trustworthiness.

## **2.6 TRUSTWORTHINESS**

The four criteria for establishing the trustworthiness of qualitative data by Lincoln and Guba (in Polit and Beck, 2001) were applied namely, credibility, dependability, confirmability and transferability.

### **2.6.1 Credibility**

Credibility refers to the power, quality, or capacity to elicit belief (Masys, 2006). Credibility was used to evaluate qualitative data quality with reference to confidence and truth of the data. For the research data to be credible, the investigation was carried out in a way that people reading the report can interpret it in the same way and believe it (Polit and Beck, 2001). Credibility involves prolonged engagement and triangulation (Polit and Beck, 2004).

#### **2.6.1.1 Prolonged engagement**

The following measures were taken by the researcher to ensure data credibility by prolonged engagement:

- I invested sufficient time in data collection to build trust and rapport with participants, thus the researcher had an in-depth understanding of the culture, language, or views of the study subjects (Polit and Beck, 2001). I was one of the health care providers in the antenatal clinic, who gave health education to pregnant women every day. My interaction with pregnant women and

prolonged engagement, gave the participants an opportunity to trust the researcher, thus making them more likely to describe their health seeking practices truthfully.

- Depth of the study was obtained by focusing on the aspects of the situation relevant to the phenomena being studied. To further provide depth, the research design and research method and the emerging themes and sub themes were described in detail.

#### 2.6.1.2 Triangulation

Triangulation is the use of two or more data sources in a study (Burns and Grove, 2001). The two methods of triangulation applied to this study were data triangulation and person triangulation.

##### 2.6.1.2.1 *Data triangulation*

Data triangulation means collecting data on the same phenomenon or about the same people at different points in time (Polit and Beck, 2004). To ensure data triangulation in this research, data was collected over a period of two successive months.

##### 2.6.1.2.2 *Person triangulation*

Person triangulation means collecting data from different levels of persons: groups, individuals and collectives, with the aim of validating data through multiple perspectives on the phenomenon (Polit and Beck, 2004). The following measures were taken to ensure person triangulation:

- Multiple referents were used to draw conclusions regarding what constitutes the truth. The researcher strived to distinguish between true information by

eliminating errors by convergence of the truth. This was done by interviewing diverse participants (*maximum variety sample*).

- Triangulation was implemented within the qualitative description of the health seeking practices of primigravidae. Themes and sub themes were identified. To support the truthfulness of those themes and sub themes, a literature control was done. The researcher searched for disconfirming evidence by prolonged engagement with a maximum variety sample who could offer conflicting viewpoints.
- After data analysis, in February 2007, I returned to the antenatal clinic as a health educator. I asked approximately 70 pregnant women at the antenatal clinic, if there were any primigravidae amongst them. More than half of the pregnant women were primigravidae. I checked their antenatal clinic cards to confirm that they were primigravidae and had not been included in my research study. During a discussion with the women, I mentioned the study's themes to them (both primigravidae and multigravidae). The pregnant women were asked, as a group, if they concurred with the identified themes and sub themes.
- Extensive field notes which were written by the researcher also added to the credibility of the study.

### **2.6.2 Dependability**

Dependability of qualitative data is like reliability in quantitative data. It refers to confidence in the stability of data over time (Polit and Beck, 2001). Dependability was ensured by the following aspects:

- During the health education sessions in the antenatal clinic, the pregnant women were all aware that their health educator was also a researcher and that they were potential participants.
- This research provides a full description of the whole research process and the choices made were justified.

### **2.6.3 Confirmability**

Confirmability refers to the objectivity or neutrality of data, whereby two or more different people reading the data would agree about its meaning (Polit and Beck, 2001). To ensure data confirmability, the following strategies were implemented:

- The research design and method were described in detail to reduce bias in the research design and method.
- I systematically collected data that allowed an independent auditor to reach a conclusion about the data (that is an audit trail). Data were collected in the same way, of tape-recording the individual in-depth interviews throughout the whole data collection process. An adequate audit trail consisted of interview transcripts (see annexure F and G).
- The research findings were confirmed by doing a literature control on all the identified themes and sub themes, which were also described in detail.

### **2.6.4 Transferability**

Transferability refers to the extent to which the findings from the data can be transferred to other groups or settings. This was achieved by rich, thorough description of the research setting and the transaction and processes observed during the enquiry (Polit and Beck, 2001) and data analysis. The researcher's responsibility is to provide sufficient

descriptive data in the research report so that consumers can evaluate the applicability of the data to other contexts (Polit and Beck, 2004). Strategies to ensure transferability are as follows:

- This study's feasibility was determined by the continuation of primigravidae continuing to initiate antenatal clinic attendance in their third trimester of pregnancy.
- A dense description of the research population was provided under the subheading 'research setting' for the purpose of transferability.
- The research findings can be transferred to any public sector MOU in the Gauteng province of SA with the same population as the sampling technique applied was maximum variety sampling, so as to obtain a heterogeneous sample. The reader can compare the study to other populations and samples as the research design and method are described in detail.

## **2.7 ETHICAL CONSIDERATIONS**

The ethics of science concerns what is wrong and what is right in the conduct of research (Mouton, 2005). Research misconduct is defined as fabrication, falsification or plagiarism in proposing, performing or reviewing research, or in reporting research results (Cathedral of Learning, 2007). Neuman (1994, in Kühn 2003), is of the opinion that ethics begins and ends with the researcher and that the researcher's personal moral code is the strongest defense against unethical behaviour. I took the following measures to protect the rights of human participants and the standards of any scientific enquiry:

- Presented the research proposal to the University of the Witwatersrand's Department of Nursing Education for peer review and the feasibility of the study.

- The research proposal was presented to the Postgraduate Committee of the University of the Witwatersrand, Faculty of Health Sciences for their approval and permission to conduct the study (see annexure J).
- Ethical clearance was obtained from the Human research ethics committee (medical) of the University of the Witwatersrand (See annexure I).
- Permission to conduct the study at the health center's MOU was obtained from their Nursing Service Manager (see annexure H).
- The ethical principle of respect for person which means that the individuals had the right to decide whether or not to participate in the study was ensured through the following (Brink, van der Walt and Gisela, 2006):
  - Information letters (see annexure A) were given to and explained to each participant.
  - Voluntary informed and written consent was obtained from the participants (see annexure B). The principle of voluntary participation requires that people are not coerced into participating in the research (William, 2006).
  - Written consent was obtained for the interview to be tape-recorded (see annexure C).
  - Informed the participants about their rights to withdraw from the study at any time they may wish to and that they would not be penalized for that.
- The ethical principle of justice which includes the participants' rights to fair treatment, anonymity, privacy and confidentiality was ensured as follows (Brink, van der Walt and Gisela, 2006):
  - The participants were treated equally irrespective of their age, marital status, nationality, employment status or any other factor.
  - The participants' names nor address were never mentioned or written in any of the interview material to ensure anonymity.
  - The interviews were conducted in a private consulting room without interruptions to ensure privacy.
  - The recorded interviews were only accessible to the researcher and the person helping to transcribe; thus ensuring confidentiality of the study.

- Taped interviews will be destroyed two years after publication of the research report or six years later if the research report is not published.
- All participants were treated equally and no one was discriminated against for any reason.
- The ethical principle of beneficence which is protection from any form of harm, be it physical, social, economical, or spiritual; was ensured through the following measures (Brink, van der Walt and Gisela, 2006):
- The participants were informed that there will be no financial benefits from the study.
- No harm was done to the participants, either physically or emotionally. I never blamed nor judged the participants for their responses or anything else.
- Results of the study would be available to participants on request.

## **2.8 CONCLUSION**

In chapter two, the research design and research method was described in detail namely; the research design, setting, population, sampling, data collection, pre-testing, trustworthiness, data analysis procedure and ethical considerations. The next chapter will focus on the research results and literature control.

## **CHAPTER THREE**

### **RESEARCH RESULTS AND LITERATURE CONTROL**

#### **3.0 INTRODUCTION**

A detailed description of the research design and research method was provided in chapter two. The following section only summarizes the research design and research method. Individual in-depth interviews were used to explore and describe the primigravidae' health seeking practices. Interviews were conducted whilst the participants were attending antenatal clinic. The population comprised of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy. Maximum variety purposive sampling was applied. Data were saturated after conducting the tenth interview.

The results and discussions of the first research objective, which is 'to explore and describe the health seeking practices of primigravidae who started attending antenatal clinic at the level 1 MOU in their third trimester of pregnancy', are presented in chapter three.

Qualitative, descriptive, exploratory and contextual research designs were used to obtain the views of primigravidae on their health seeking practices at a level one midwives' obstetric unit in the Gauteng province.

The participants were asked one open-ended research question which was:

**'What experiences influenced you to come for your first antenatal clinic visit when you did?'**

Probes that were used were extracted from the participants' response to the research question.

The interviews were tape recorded and data were transcribed and analyzed using Tesch's eight steps of qualitative data analysis (Creswell, 1994). A full description of the data analysis steps is provided in chapter two, section 2.8. The two themes that were identified are 'Needs' and 'Delayed booking'. The theme of needs was discussed under the following sub themes: knowledge of healthy baby and healthy pregnancy, explanation of procedures, and use of technology. The theme of delayed booking was discussed under the following sub themes: unplanned and hidden pregnancies, lack of knowledge about when and where to go for antenatal care, poor quantity and quality of service provision, and personal factors. Quotes from the original transcripts were provided and literature from other authors was used as evidence to support the themes and sub themes. The themes are numbered according to the number of interview they are from and the page of the transcript. For example: 1:2 (interview number one, page number two of the transcript). Where relevant, field notes are inserted in brackets. Field notes included the participants' non-verbal cues; and the researcher's feelings about the interview.

The research results are discussed in detail as themes and sub themes. Two themes were identified which are: Needs and Delayed booking. The themes and sub themes identified in this chapter three were elaborated upon by means of literature control. Refer to table 3.1 for a summary of the themes and sub themes.

**Table 3.1** Themes and sub themes identified on what influenced primigravidae to go for their first antenatal clinic visit when they did.

<u>Themes</u>	<u>Sub Themes</u>
3.1 Needs	3.1.1 Knowledge of healthy baby and healthy pregnancy 3.1.2 Explanation of procedures 3.1.3 Use of technology
3.2 Delayed booking	3.2.1 Unplanned and hidden pregnancies 3.2.2 Lack of knowledge about when and where to go for antenatal care 3.2.3 Poor quality of service provision 3.2.4 Personal factors

### **3.1 NEEDS**

The first theme that emerged during data analysis was ‘needs’. Needs are defined as psychological features that arouses an organism to action toward a goal and the reason for the action giving purpose and direction to behaviour (Wikipedia, 2008). The needs of primigravidae were further subdivided into the following sub themes: knowledge of healthy baby and healthy pregnancy; explanation of procedures; and use of technology. Each sub theme is discussed in detail in the next sections.

#### **3.1.1 Knowledge of healthy baby and healthy pregnancy**

Primigravidae wanted to know about the health of their unborn baby and also the progress of their pregnancy and expressed this need in different ways.

Hildingsson, Waldenstrom and Radestad (2002) reported that the first aspect of midwifery care was checking the baby’s health, followed by checking the mother’s health. Teagle and Brindis, conducted a study in 1998 and found that adolescents reported concern over the health of their baby as a primary motivation to seek prenatal care.

In my research, primigravidae expressed their need for knowledge of healthy baby and healthy pregnancy as follows:

*'She told me you have to go to the clinic to check whether the baby is fine or whatever.'* (1.1)

*'I think it is important to see whether the baby is fine or not, if I have problems.'* (2.2)

*'Because I was curious to know whether my baby was in a proper condition or not.'* (3.1)

*'Actually I do need to do regular check ups to check if the baby is okay.'* (6.4)

*'I think it is important to see whether the baby is fine or not, if I have problems.'* (2.2)

*'I wanted to check if my baby is right, if my condition is right, and if there are not any complications.'* (8.1)

Literature revealed that a main thread running through the women's experience of antenatal care were their needs and wishes that concerned the health of the unborn baby, but also the health and dignity of themselves and their family (Bondas 2002).

Other primigravidae voiced their need to know not only about the pregnancy, but also about the labour. Literature revealed that during prenatal care, each woman has the opportunity to build relationships with other pregnant women, learn self care skills, get assurance about the progression of her pregnancy, and gain knowledge about pregnancy, birth and parenting (Rising, Kennedy, and Klima, 2004).

One woman expressed her need for knowledge of healthy baby, pregnancy care and labour as follows:

*'I wanted to know if my baby is okay, if I am healthy, and also to learn about antenatal care and labour.'* (4.1)

(The primigravidae's voices were filled with passion when they spoke about the concern for their baby's health).

### 3.1.1.1 Conclusion to knowledge of healthy baby and healthy pregnancy

The first response to the research question, in most interviews, was the primigravidae's need to know about their baby's health. Despite the fact that primigravidae initiate antenatal clinic attendance in their third trimester of pregnancy, they are aware of the importance of antenatal care as stated by them namely:

- Ensure normal pregnancy and good general health by education on good living habits;
- Early detection, management, and referral of complications which can be spiritual, physical, or psychological;
- Careful screening of pregnancy problems and referral where necessary;
- Physical and psychological preparation for childhood and parenthood.

Thus, the conclusion drawn to the preceding heading is that: primigravidae come to antenatal clinic to find out about theirs' and their baby's health and to learn about pregnancy and labour. Despite their identified need of knowledge of a healthy baby and a healthy pregnancy, primigravidae initiated antenatal clinic attendance at the level 1 MOU in their third trimester.

### 3.1.2 Explanation of procedures

The second need that emerged during data analysis was explanation of procedures. It is an ethical requirement that nurses explain procedures to the patients before carrying them

out. Searle (2000) confirmed this by stating that ‘The midwife explains nursing treatment, procedures and care to the patient to get the patient to cooperate with her’.

During literature control, the following literature was found to support my research findings: Kyomuhendo (2003) found that poorly understood reasons for procedures was one of the reasons explained for the unwillingness of women to deliver in health facilities. Grossmann-Kendall, Filippi, Konick and Kanhonou; (2001) found that; pregnant women complained about not being able to ask questions or obtain any explanations, and described the anguish they felt in the face of medical procedures they did not understand.

The primigravidae expressed the way procedures are not explained to them as follows:

*‘And we have some information here in our file but they didn’t explain to us what it is. Even the injection they are injecting, we don’t have an idea what it is for.’ (4.2)*

*They injected me hey! I don’t know. They were like taking my blood. I don’t know for what because they did not explain.’ (9.4)*

Primigravidae stated that even though the procedures are not being explained to them, they cannot ask anything about them. This data was supported by Marcon’s (1997) study findings which stated: ‘pregnant women in touch with health professionals are able to filter information and at the same time behave as non-participating clients, since they do not question the care offered to them even if the care is not good’.

The women expressed that they are not able to ask questions as follows:

*I feel like I have to ask but why shouldn’t they explain why are we doing this.’ (7.5)*

One primigravida sadly expressed how she felt when the procedures were not explained as follows:

*It makes me feel sad.'* (9.4)

(When the primigravidae were talking about the procedures not being explained to them, they sounded helpless).

### 3.1.2.1 Conclusion to explanation of procedures

The conclusion drawn about explanation of procedure was that primigravidae realized that the procedures were not being explained to them when they just saw things being done to them without any explanations. The procedure findings were not even communicated to them. This was realized when the primigravidae had information on their antenatal clinic cards, which they don't know what it is, or what it means. Even though the procedures were not explained, they did not ask about them

The third sub theme related to needs was use of technology.

### 3.1.3 Use of technology

The technology that was identified as a need in this study is an ultrasound scan of the pregnancy. At the MOU where I conducted my study, an ultrasound scan is not part of routine antenatal care. Only pregnant women who are presenting with problems are booked for an ultrasound. Examples of such problems are unstable fetal lie, breech presentation or multiple pregnancy. Pregnant women with preceding problems are booked for an ultrasound for Wednesdays. Should a pregnant woman present with a problem that needs urgent intervention, such as antepartum bleeding, an urgent ultrasound scan is performed at the MOU's labour ward by any doctor who is available at the health center. Antepartum haemorrhage may be an indication of placenta abruption (Sellers, 1997).

Primigravidae who had an ultrasonic scan of their pregnancy before booking for antenatal care at the MOU, enjoyed the experience of having an ultrasound of their pregnancy as they could see their fetuses. The pregnant women were attending antenatal care at private doctors. Attending antenatal care at other institutions is discussed in detail as a sub theme (3.4.2).

In 2006, Van der Zulm and Byrne conducted a study and found that: 'Women's description of ultrasonic screen image of a baby suggests it is a powerful influence on subsequent clinical and ethical decision making about the pregnancy'. In their study; Tautz, Jahn, Molokomme and Görden (2000) reported that primigravidae liked seeing their baby moving on the ultrasonic scan and also their baby's gender. Most women viewed ultrasound as being beneficial.

Primigravidae expressed their feelings about an ultrasonic scan as follows:

*'It's what we like. You can see the baby moving and know your baby's sex' (6.4)*

*'At the doctor they take you to do an ultrasound and they check that really you are pregnant.'* (7.2)

(The primigravidae had smiles all over their faces when they were talking about the ultrasonic scan).

Primigravidae recommended that ultrasonic scan of the pregnancy should be done at the midwives' obstetrical unit.

Supporting literature by Ovist, Iverson and Skajoa (2002) showed that an overwhelming majority perceived sonography as a significantly important experience (89.6%), felt more secure about the pregnancy (80.4%), and wished and expected to have a sonography for anomalies (84.3%).

The primigravidae expressed their need for an ultrasonic scan as follows:

*'Here they do sonar once a week. I think they must do sonar here before you go into labour...'* (6.5)

#### 3.1.3.1 Conclusion to use of technology

The conclusion drawn about the use of technology was that pregnant women feel that they must have an ultrasonic scan of their pregnancy done at every clinic visit. The ultrasonic scan assures the primigravidae about the wellbeing of their unborn baby, as they can see the baby moving on the screen. The women also like to find out about their unborn babies' gender, which they stated helps them with the choice of the colour of the baby's clothes to buy in preparation for the delivery. The primigravidae initiated antenatal care at the MOU in their third trimester of pregnancy, as they were attending antenatal care at places where they get an ultrasonic scan done as part of routine management (this is discussed in detail in section 3.4.2).

#### 3.1.4 Conclusion to needs

The following conclusions were drawn about the theme of needs: three different needs were identified during data collection. Firstly, the primigravidae expressed the need for knowledge of healthy baby and healthy pregnancy. The women stated that they came to the clinic to check if, and be sure that their unborn babies were fine. They elaborated on the need for knowledge of a healthy baby by saying that they needed to know if there were any complications. The women also needed to know if they were having any problems and if they were healthy. In addition, they said that they needed to learn about pregnancy care and labour.

The women expressed that they needed the procedures to be explained to them. The women said that there were procedures being done on them that were not explained. They also said that there was information written on their antenatal clinic cards that they didn't

know what it meant. The women expressed that they felt sad when the procedures were not explained to them. Despite the procedures not being explained to them, the women did not ask anything. The women said they did not ask because they felt that the health care providers should be explaining the procedures.

The other need that was identified was for the use of technology, specifically an ultrasound scan. The primigravidae knew about an ultrasound scan from their friends and some from the private doctors. The women who had a previous ultrasound scan of their pregnancy said that they needed the scan to be part of antenatal care at the MOU. Some women did not want to attend antenatal care at the MOU as an ultrasound scan was not offered routinely. The women enjoyed the experience they had of an ultrasound scan as they could see their baby moving and know their baby's gender before delivery.

## **3.2 DELAYED BOOKING**

My first research question was 'why do primigravidae initiate antenatal clinic attendance late in their pregnancy?' During the data collection, the primigravidae expressed that they delayed attending antenatal clinic for various reasons. These reasons are the sub themes to the theme of delayed booking namely; unplanned and hidden pregnancies, lack of knowledge about when and where to go for antenatal care, poor quality of health service provision, and personal factors. The first sub theme to be discussed is unplanned and hidden pregnancies.

### **3.2.1 Unplanned and hidden pregnancies**

During the interview, the primigravidae stated that they delayed initiating antenatal clinic attendance because they did not plan the pregnancy. Another reason cited was that they did not want people to find out about their pregnancy. Those who did not want people to find out that they were pregnant stayed home and did not go for antenatal care. They were scared that if the people in their communities saw them going to the antenatal clinic, they would find out about the pregnancy.

The following literature was found to support the sub theme of unplanned pregnancy: Erci (2003) and Youssef, Moubarak, Gaffar and Atta (2002) reported that unwanted and unintended pregnancies were a barrier to prenatal care services. One primigravida indicated that she did not want the pregnancy, while the other said she was hiding the pregnancy (Erci, 2003). Most women booked later in their second and third trimester and explained this in terms of the pregnancy being unwanted (Abrahams and Jewkes, 1998) and (Saliku, 2007). Magadi (2000) reported that the use of antenatal care is started later and is less frequent for unwanted and mistimed pregnancies.

The primigravidae expressed how their pregnancies were unplanned and/or hidden as follows:

*'Before I came to the clinic, I didn't want to keep the child. When I was three months I wanted to go and do an abortion.'* (5.1)

*'I didn't want anybody to know that I am pregnant so I didn't come to the clinic.'* (9.2)

Both unintended and unwanted childbearing can have negative health, social and psychological consequences. Health problems include greater chances for illness and death for both mother and child. Such childbearing has been linked with a variety of social problems, including poverty, child abuse and juvenile delinquency. In one study, unwanted children were more likely to engage in criminal behaviour, be on welfare and receive psychiatric services. In another study it was found that children who were unintended by their mothers had lower self-esteem than other intended peers 23 years later (Russo and David, 2002). When the unwanted pregnancy resulted from rape, women may not attend antenatal care. After the baby is born, they may refuse to breastfeed and may not seek postnatal care (World Health Organization, 2007). Unwanted pregnancies result in 59-60 million abortions yearly, 20 million are unsafe, accounting for 13% of maternal deaths world wide. The risk of unsafe abortions is 1 in 150 for Africa (Intersecting health risks, 2007). Factors associated with unwanted pregnancies are being

unmarried, low-income and age older than 35 years (Oklahoma state department of health, 2007).

#### 3.2.1.1 Conclusion to unplanned and hidden pregnancies

The conclusion drawn about the sub theme of unplanned and hidden pregnancies was that primigravidae did not come to seek antenatal care because: they did not plan the pregnancy and others did not want the people in their communities to know about their pregnancy.

The sub theme of lack of knowledge about when and where to go for antenatal care is discussed next.

#### 3.2.2 Lack of knowledge about when and where to go for antenatal care

The women interviewed stated that they did not know the right time to time to initiate antenatal clinic attendance. The lack of knowledge about when to initiate antenatal clinic attendance is associated with lack of experience of being pregnant.

The following literature supports the sub theme of lack of knowledge about when and where to go for antenatal care. Other problems mentioned by women was ignorance regarding the best time to book (Murira, Munjanja, Zhanda, Nystrom and Lindmark, 1997). The study by Sibeko and Moodley (2006), revealed that when women were asked about when a pregnant woman should commence antenatal care, it was found that in two of the groups, a large proportion did not know when to book, namely the '33% early bookers' and '36.4% late bookers'. Amongst the commonly cited reasons for the delay in initiating antenatal clinic was: 'still early to book' Sibeko and Moodley (2006).

The primigravidae expressed their lack of knowledge about when to initiate antenatal clinic attendance as follows:

*'I told myself I was gonna come at a later stage.'* (1.1)

*'I'm not gonna lie but I just didn't feel like coming to the clinic. I thought it was early.'*  
(9.2)

Some primigravidae indicated that they did not know where to attend antenatal clinics. Such pregnant women are amongst those who were attending antenatal care at other institutions. Attending antenatal care at other institutions is discussed in detail, as sub theme 3.4.2.

The primigravidae expressed their lack of knowledge of where to attend antenatal clinic as follows:

*'I didn't know that I must come here.'* (6.1)

*'I didn't know I should go there.'* (9.1)

As a result of the primigravidae not knowing when and where to go for antenatal care, they went to institutions such as private doctors and hospitals. Some primigravidae initially went to the private doctors to confirm their pregnancies. After confirming the pregnancy, they started attending antenatal care at those doctors. They were advised to go to the MOU, where I conducted this research. The reasons why they attended at the MOU was that private doctors they did not conduct deliveries.

In 2006, Sibeko and Moodley found that the reasons cited for the delay in initiating antenatal clinic attendance varied from 'still early to book' to the fact that they had been attending antenatal care privately. Most of the women went to private doctors for pregnancy confirmation and continued to visit them with problems during pregnancy other than complications (Abrahams and Jewkes, 1998).

The primigravidae expressed that they were attending antenatal clinic at other institutions as follows:

*'I started going through the doctors.'* (6.1)

*'I was actually going to the doctor.'* (7.1)

*'I was going to the doctor.'* (8.1)

*'Well at the first time I went to the doctor not knowing, actually I wasn't sure if I was pregnant or not.'* (10.1)

Some primigravidae did not want to attend antenatal clinic at the level one MOU because they did not trust the nursing care provided at the MOU.

Supporting literature stated that: 'Spending time searching for an alternative place to attend antenatal clinic because of fears of poor care at retreat MOU, was cited as one of the reasons for starting antenatal clinic attendance in their second and third trimester (Abrahams and Jewkes, 1998). My research study revealed that some primigravidae tried unsuccessfully to attend antenatal clinic at other institutions. In 2006, van Eijk, et al. reported that major reasons given for attending a more distant antenatal care included better perceived care (78).

The primigravidae expressed that they did not want to attend antenatal clinic at the MOU as follows:

*'Then I went to the Hospital. To be honest, I didn't want to come to this clinic.'* (2.1)

*'At first I went to hospital. I booked there because I didn't want to come here because of the bad treatment that the nurses give to other people.'* (3.1)

*'Well I thought at the doctor its more, I trust doctors more than the clinics.'* (7.2)

Some primigravidae got advice and support from their families and friend to go to the level 1 MOU for antenatal care. A study conducted in the western countries has shown that people who have a high level of social support are likely to have better health behaviours including the use of preventative health services than those who have low support (Jirojwong, Dunt and Goldsworthy; 1999).

Before being advised and motivated by their friends and family, the primigravidae stayed home and did not seek antenatal care. One primigravida was attending antenatal care at a private doctor. The doctor advised her to come to the MOU for antenatal care.

In 2003, Jimoh found that hospital workers, husbands and parents were the greatest influence on antenatal clinic attendance. In 2004, Ikamari reported that about 80% of all the respondents indicated that their husbands encouraged them to attend antenatal clinic. In contrast, in 2006 van Eijk, Bless, Odhiambo, Ayisi, Blokland, Rosen, Adazu, Slutsker and Lindblade reported that only a few husbands, mothers or mothers-in-law suggested attending antenatal care. A study by Amooti-Kagana and Nuwaha (2000) stated that amongst the factors that influenced the women's choice of delivery was influence from spouse and other relatives.

The primigravidae expressed how they were advised and motivated to attend antenatal clinic as follows:

*'My mom told me to come today.'* (1.1)

*'I have got friends that have babies. So they told me to come to the clinic.'* (1.3)

*'My mom is the one who told me to come to the clinic.'* (3.4)

*'Then my sister said that when you finish you must go.'* (10.2)

*'I was actually going to the doctor. He advised me to come and make an appointment so that they can check me and all that.'* (7.1)

*'I only came for my first visit when I did because I heard people tell me that I have to go for like: check up; I should go to the clinic.'* (9.1)

First time pregnant mothers seemed to be happy about the support they are receiving from their families and friends. When you're pregnant you need emotional support and people around you all the time (Naidu, 2007). Jirojwong, et al. (1999) stated that spouses, relatives and friends were important sources of the four principle types of support namely, emotional, instrumental, information and appraisal support.

Emotional support refers to the things that people do to make us feel loved and cared for, that bolster our sense of self-worth; such support frequently takes the form of non-tangible types of assistance, for example; talking and encouragement (John and MacArthur, 1998). An emotional support system comprises people who help you deal with the emotions you experience during a difficult time and offer you comfort (Lance Armstrong Foundation, 2007). An emotional support system may include family, friends and co-workers. Instrumental support refers to the various types of tangible help that others may provide, for example provision of transportation or money (John et al, 1998). Informational support refers to the help that others may offer through the provision of information (John et al, 1998).

Primigravidae expressed the support they received as follows:

*'My partner is very supportive, he is happy for the baby.'* (1.3)

*'I am getting emotional support from my boyfriend, cousin, mother, and at work now.'* (5.3)

### 3.2.2.1 Conclusion to lack of knowledge about when and where to go for antenatal care

The conclusion made about the sub theme of ‘lack of knowledge about when and where to go for antenatal care’ was that; primigravidae initiated antenatal clinic attendance at the level 1 MOU because they did not know the right time to initiate, or even where to go for antenatal care. As a result, the primigravidae went to private doctors for antenatal care. Some even went to hospitals that are further from their homes as compared to the level 1 MOU where I conducted this study. Eventually, the primigravidae got advice and support from their doctors, friends and families to go to the level 1 MOU for antenatal care.

### 3.2.3 Poor quality of service provision

The primigravidae reported poor quality of service provision as one of the factors that made them to come to the level 1 MOU for antenatal care in the third trimester of their pregnancy. Service provision was described in terms of communication with the health care providers, and health service delivery. The primigravidae reported that the health care providers did not communicate with them in a friendly manner. The primigravidae further reported that they heard about the poor quality of service provision before they initiated antenatal clinic attendance.

Literature to support the sub theme of poor quality of service provision by Ibnout, van der Borne and Maare (2007) reported that a higher quality of care was significantly associated with more utilization of routine antenatal care services. Perception of poor listening by staff often resulted in women deliberately deciding not to volunteer information (Abrahams and Jewkes: 1998). In a study by Mubyazi, Bloch, Kamugisha, Kitua, and Ijumba (2005), pregnant women said that poor courtesy of nurses to patients is one of the problems related to antenatal clinic service. Amongst the determinants of women’s choice of their obstetrician and gynaecologist provider were empathy and communication (Rizk, El-Zubeir, Al-Dhaheri, Al-Mansouri, and Al-Jenaibi; 2005).

The primigravidae expressed the poor quality of service provision in terms of communication as follows:

*'What do you want?' (6.2)*

This phrase was said by the health care provider in response to the primigravidae's greeting. The following quote was also said in the same context.

*'They just ask what are you waiting for. What's your problem? Is that the way to treat patients?' (7.5)*

(That was said with an angry voice of a woman who got that response on her first encounter with a health care provider on her first day in the antenatal clinic. She used her hands when she asked me if that was the right way to treat patients.)

Poor quality of service provision in terms of communication was further described by the health care providers' rudeness, scolding and judgmental attitudes.

Supporting literature by kyomuhendo, (2003) revealed that unwillingness of women to deliver in health care facilities and seek care for complications was explained by reasons such as lack of skilled staff at primary health care level, complaints of abuse, neglect and poor treatment in hospital, plus health workers' view that women are ignorant

Primigravidae who were interviewed reported rude behaviour by the health care providers as one of the reasons that kept them away from the antenatal clinic. The primigravidae reported that they heard from other people that the health care providers at the MOU can be rude. The primigravidae said that they were scared to come to the MOU, as they thought that they would also be treated rudely.

The following literature supports rudeness: Buchi, Cignacco and Luthi (2006) and McLeish (2002) reported that half of the women experienced indifference, rudeness, and racism from the health care professionals caring for them during delivery. Spiriq (2006) identified 'to receive esteem' as one of the themes in their study of needs and expectations of Tamil women attending an antenatal care department at a Swiss university hospital. Primigravidae who were interviewed said that they experienced rude behaviour from the clinic's staff, or know someone who has. The strongest predictors of dissatisfaction were women's opinions that midwives have not been supportive (Hildingson, and Radestad; 2005). 'Another woman reported rudeness from staff when her friend phoned in to check what she should do as her waters had broken.' This was found by Abrahams and Jewkes (1998) in their study of 'Health seeking practices of pregnant women in Cape Town.'

The primigravidae expressed the health care providers' rudeness as follows:

*'The nurses were rude to them' (3.1)*

*'They are so rude.'* (6.1)

*'First time I came here the person that checked me was rude.'* (8.3)

*'I heard people say thing like: nurses are so rude' (9.1)*

*'The way they talk to us, like rudely' (10.1)*

(All the women who spoke about the staff's rudeness had sad faces and sounded helpless. I used to see those faces on other patients were they are spoken to rudely.)

The primigravidae reported that the health care providers were mostly rude when the pregnant women seemed not to understand what was expected of them. In some instances, the health care providers physically abused the health care service consumers.

The following literature supports the abuse of women: Kyomuhendo. (2003) conducted a study in Uganda on low use of rural maternity services and the findings revealed that women complained of abuse by staff at health care services.

The women expressed how they heard about the physical abuse as follows:

*'If you don't open your legs, they hit your thighs.'* (1.2)

*'I heard something from my friend that if the baby doesn't come, they pinch your thighs.'*  
(7.4)

Besides the physical violence that the primigravidae reported, they also felt emotionally abused which they expressed as shouting and/ or scolding.

The following literature supported the abuse of pregnant women. In 2003, MacKeith, Chinqanga, Ahmed and Murray, found that 21% remembered someone who had treated them badly during labour, principally by shouting or scolding. Another barrier to good communication by the women interviewed was the practice of 'scolding' patients, usually in an attempt to correct aspects of their behaviour which the nursing staff perceived as deviant' (Abrahams, Jewkes, 1998).

The primigravidae expressed the emotional abuse they got from the health care providers as follows:

*'They shout at you'* (1.2)

*'They are not polite. If you ask them they just shout you know.'* (4.2)

(As she was talking about the nurses shouting, I could hear the pain in her voice, and also see it in her eyes. This is a true reflection of what is happening in the clinic.)

The primigravidae also witnessed their fellow patients being treated badly by the health care providers. The supporting literature by Beksinka, Kunene, and Mullick (2006) states that one primigravida said she witnessed her friend being treated badly. At national level, 20% of women reported that the provider shouted or scolded the patient

The primigravidae expressed how they witnessed the abuse as follows:

*'She came with the wrong piece of paper. And then you know, they shouted at her like hell.'* (10.3)

When pregnant women are treated badly during labour, they lose confidence in themselves and their ability to go through labour. Literature by Green and Baston (2003) revealed that, a sense of control is a major contributing factor to a woman's birth experience and her subsequent being. They also reported that feeling in control of staff was primarily related to being able to get comfortable, feeling treated with respect and as an individual.

Studies reveal that when women feel traumatized by bad treatment during labour they can experience distress, grief, anguish, shame and suffer from lifelong effects. Postpartum depression is related to lack of consideration for women's feelings (Tyndall, 2003).

Poor quality of service provision in terms of communication was further described by the judgmental attitude of health care providers. Montgomery (2003) reported that non-judgmental and developmentally appropriate interactions are essential to the care of pregnant adolescents. Health care providers need to be aware that not all adolescent pregnancies occur as a result of error (Montgomery; 2002). Hall and van Teijlingen (2006) found that the most important aspect of clinic care was the non-judgmental attitude of staff.

The primigravida expressed how she was blamed by the health care providers as follows:

*'She said you people you know you are impossible. You know that you must come early to the clinic. You like going to your doctors.'*(6.2)

The primigravidae were also told by their friends and family members that the judgmental behaviour of health care providers continue in the delivery room. This information was provided by the participants as one of the reasons that delayed their antenatal clinic attendance.

Literature by Jeal and Salisbury (2003) reported that the commonest reason (45%) given for difficulty attending the surgery (the doctor's private rooms) was the perception of being judged by the staff

The primigravidae expressed how they heard about people being spoken to as follows:

*'When you are about to give birth they just look at you and say they did not send you to go make the baby.'*(2.1)

When the primigravidae heard about how people are being spoken to, they did not want to come to the level 1 MOU for antenatal care. This led to primigravidae seeking antenatal care at other institutions, as described in the section of delayed booking.

The primigravidae also raised complaints also about labouring women not getting help when needed. This is also something that they heard of before they initiated antenatal clinic attendance.

The following literature provides support for poor quality of service provision: Even though women in Teso district were aware of the importance of antenatal care, they sought antenatal care late because of poor quality of services offered at local health facilities (Ikamari; 2004). Amongst the reasons given by mothers to Mwaniki, Kabiru, and Mbuqua in 2000, regarding dissatisfaction with the services offered was lack of

commitment by staff. Women's own opinion that they had too few visits was associated with dissatisfaction with medical as well as emotional aspects of care (Hildingson, Waldenstrom and Radestad; 2005).

The primigravidae expressed the poor attendance to patients screaming as follows:

*'Even when you are screaming that I'm having a baby they don't respond to you.'* (4.3)

The primigravidae raised a concern about the large number of patients attending the antenatal clinic that affects the quality of service provision. Consequently they have to arrive at the clinic very early in the morning. Additionally there are too many patients to be attended to by very few health care providers.

Literature by Skelenburg, Kyanamina, Mukelabai, Wolffers, and van Rosmalen; (2004) reports that only 54% of the 96% delivered at the clinic because of poorly staffed institutions

The primigravidae expressed overcrowding as follows:

*'It's too full. There is lots of people'* (2.1)

*'There is less nurses'* (2.1)

*'What I hear about this place is that, like it's very full'* (6.4)

My research findings revealed that primigravidae stated that the high number of patients at the health care facility leads to the health care providers not to do their work thoroughly. Literature by Mubyazi, et.al, 2005 reported that staff shortages affecting the quality of services at antenatal care clinics was mentioned as one of the major problems limiting attendance of pregnant women at antenatal care clinics.

The primigravidae expressed how the overcrowding affects the service provision as follows:

*'The nurses don't get a chance to take care of one person properly. They have to rush for the next patient' (7.4)*

The research participants suggested that there should be more staff at the level 1 MOU. Supporting literature stated that other respondents suggested more staffing (Buch, Mathambo, Ferrinho, Kolsteren, and van Lerberghe; 2003) and (Levin, Dmytraczenko, Ssenqooba, Mceuen, Mirembe, Nakakeeto, Okui and Cowley, 1999).

The primigravidae expressed their suggestions as follows:

*'They must increase the staff' (4.5)*

*'There should be more nurses' (8.3)*

*'I think we need more nurses' (9.4)*

In addition to the primigravidae expressing the shortage of staff and a large number of patients at the level 1 MOU, the primigravidae raised another issue related to quality of service provision. My research study found that the primigravidae did not want to attend the antenatal clinic at the MOU because they had heard people saying that the emergency referral system was poor. They indicated patients had to wait a long time for an ambulance to take them to the hospital. The primigravidae were scared for their unborn baby's lives. This resulted in them in trying to attend antenatal clinic at other institutions, where they have emergency obstetrical services readily available.

The following literature supports the poor availability of emergency obstetrical services: McCoy, Ashwood-Smith, Ratsma, Kemp, and Rowson (2004) did a study on Malawi's maternal mortality and found that the availability of emergency obstetric care is poor.

Lack of adequate emergency transport contributed to major factors of mortality and morbidity (King, Mhlanga, and Pinho; 2006). Pearson and Shoo (2005) reported that lack of referral facilities is one of the obstacles in providing 24 hour quality emergency obstetrical care services especially in remote and rural areas. The failure of the referral system was criticized by the women in the study on emergency obstetrical care in Bernin referral hospitals (Saizonou, Godin, Ouendo, Zerbo, and Dujardin; 2005).

The primigravida expressed her concern about the emergency referral system as follows:

*'But now from here you have to wait for an ambulance to come, go there, it's a long procedure' (3.2)*

*'By then my baby will be dead or something' (3.3)*

The primigravidae felt the quality of service provision is a determinant to where they go to seek antenatal care.

### 3.2.3.1 Conclusion to poor quality of service provision

The following conclusion was made with regards to poor quality of service provision: there are a lot of factors that affects the quality of service provision at the level 1 MOU. The primigravidae felt alienated by the way they were spoken to by the health care providers. The neglect of patients that they heard about is one of the factors that kept them away from the level 1 MOU. There was also rudeness by the health care providers towards those seeking health care. The rudeness was happening in both the antenatal and the labour ward. Some primigravidae experienced the rudeness and some witnessed it happening to their friends. Furthermore, the primigravidae felt bad when they were blamed for seeking health care at other institutions. The primigravidae were also not pleased when they heard that pregnant women are being blamed for being pregnant. Another factor that affected the quality of service provision is overcrowding of the antenatal clinic by the patients whereas there is inadequate staff to render health care. The

primigravidae suggested that the staff at the antenatal clinic should be increased. The poor availability of the emergency referral system got the primigravidae scared that something might go wrong with their pregnancies while they are waiting for the ambulance, should they need emergency referral to higher levels of health care. The quality of service provision is a crucial determinant of where primigravidae go to seek antenatal care.

### **3.2.4 Personal factors**

During the interviews, primigravidae raised some concerns about their personal factors that kept them away from seeking antenatal care at the level 1 midwives obstetrical unit. The personal factors that were identified are smoking cigarette, drinking alcohol and lack of transport and money.

There were some primigravidae who used to smoke or drink alcohol. They were scared to go for antenatal care because they believed that when health care providers find out about their habits, they would shout at them.

The following literature supports how smoking and drinking alcohol can delay seeking antenatal care: Despite the risk associated with smoking, the number of pregnant women who smoke until delivery remains high (Grangé, Vayssier, Borgne, Ouazana, Huiller, Valensi, Peiffer, Aubin, Renon, and Thomas; 2005). Smoking during pregnancy (95%) was one of the factors associated with non-attendance of antenatal check ups in primiparae (Fabian, Radestad, Waldenström; 2004). Some of the primigravidae used to smoke and/ or drink before pregnancy. Smoking during pregnancy was one of the factors associated with non-attendance of antenatal check-ups in primiparae (Fabian, Radestad 2004). Chambers, Hughes, Meltzer, Wahlgren, Kassem, Larson, Filey, and Hovell (2005) found that 43% of pregnant Latinos reported some alcohol use in the three month prior to recognition of the current pregnancy.

The primigravidae expressed their habits as follows:

*'I used to smoke. I used to drink alcohol' (1.1)*

*'I used to smoke and drink. Now I don't do it anymore' (9.1)*

One primigravida continued smoking during pregnancy. Literature by Lendahls, Öhman, Liljestrand, and Håkansson; (2002) reported that women who still smoked at their first visit to the antenatal clinic often had an established smoking pattern

The primigravida expressed how she has not quit their habits as follows:

*'I haven't quit' (1.2)*

Continuation of smoking during pregnancy is one of the reasons that the primigravida delayed initiation of antenatal clinic attendance.

The other identified personal factor that delayed initiation of antenatal clinic attendance was lack of transport and money. As such, the primigravidae commenced attending antenatal clinics in the third trimester as they could not afford a taxi fare. Additionally participants reported that the level 1 MOU is far from their homes.

The following literature supports lack of transport and money as a factor that can delay initiation of antenatal clinic attendance: Magadi (2000) reported in a study on frequency and timing of antenatal care in Kenya that long distance to the nearest antenatal care facility are an obstacle to attending antenatal clinic. With regards to barriers to public prenatal care, adolescents were more likely to identify system related barriers, for example: lack of transport (Teagle and Brindis; 1998). Gharoro and Iqbafe (2000) attributed late booking to financial constraints in their study on antenatal care. Sibeko and Moodley (2006) reported that 1.7% of pregnant women had either not booked or booked late because of financial reasons. Limited financial resources were cited reasons for non use of antenatal care services (Adamu and Salihu, 2002).

The primigravidae expressed their lack of transport and money as follows:

*'I don't have transport' (6.3)*

*'I did not have money to come to the clinic.' (9.2)*

(This woman (9.4) spoke with a very sad voice and she held herself from crying. I could see she was hurting. She said the situation was resolved.)

This brings me to the end of the discussion of the sub theme of personal factors.

#### 3.2.4.1 Conclusion personal factors

The following conclusion was made about personal factors: one primigravida used to smoke tobacco but quit before starting antenatal care. The other primigravida said that she was still smoking as it is not easy for her to quit. It was also difficult for primigravidae to access the level 1 MOU's antenatal clinic as it is far from their homes. Two factors that made it difficult for the women to go to the clinic was lack of transport and money.

#### 3.2.5 Conclusion to delayed booking

The following conclusion was drawn about the theme of delayed booking. The primigravidae did not want come to seek antenatal care because: they did not plan the pregnancy and others did not want the people in their communities to know about their pregnancy. This led to the primigravidae delaying initiation of antenatal clinic attendance at the level 1 MOU.

The other factor that delayed initiation of antenatal care at the level 1 MOU was that the primigravidae did not know the right time to initiate, or even where to go for antenatal care. As a result, the primigravidae went to private doctors for antenatal care. Some even

went to hospitals that are further from their homes as compared to the level 1 MOU where I conducted this study. Eventually, the primigravidae got advice and support from their doctors, friends and families to go to the level 1 MOU for antenatal care.

Poor quality of health service provision at the level 1 MOU was another factor mentioned that delayed initiation of antenatal clinic attendance at the level 1 MOU by the primigravidae. The primigravidae mentioned different factors that affect the quality of service provision at the level 1 MOU. The primigravidae felt alienated by the way they were spoken to by the health care providers. The neglect of patients that they heard about is one of the factors that kept them away from the level 1 MOU. There was also rudeness by the health care providers towards those seeking health care. The rudeness was happening in both the antenatal and the labour ward. Some primigravidae experienced the rudeness and some witnessed it happening to their friends. Furthermore, the primigravidae felt bad when they were blamed for seeking health care at other institutions. The primigravidae were also not pleased when they heard that pregnant women are being blamed for being pregnant. Another factor that affected the quality of service provision is overcrowding of the antenatal clinic by the patients whereas there is inadequate staff to render health care. The primigravidae suggested that the staff at the antenatal clinic should be increased. The poor availability of the emergency referral system got the primigravidae scared that something might go wrong with their pregnancies while they are waiting for the ambulance, should they need emergency referral to higher levels of health care. The quality of service provision is a crucial determinant of where primigravidae go to seek antenatal care.

Personal factors such as smoking and lack of transport and money were mentioned to have led to delayed initiation of antenatal clinic attendance at the level 1 MOU by the primigravidae. One primigravida used to smoke tobacco but quit before starting antenatal care. The other primigravida said that she was still smoking as it is not easy for her to quit. It was also difficult for primigravidae to access the level 1 MOU's antenatal clinic as it is far from their homes. The geographical location of the level 1 MOU and the lack

of transport and money by the primigravidae led the primigravidae to delay initiation of antenatal clinic attendance at the level 1 MOU.

### **3.3 CONCLUSION**

Chapter three discussed the research results and literature supporting these results. The next chapter discusses the conclusion, recommendations and limitations of this study.

## **CHAPTER FOUR**

### **CONCLUSION, LIMITATIONS AND RECOMMENDATIONS**

#### **4.0 INTRODUCTION**

The research results for health seeking practices amongst primigravidae were discussed in chapter three. Those results were obtained through data analysis by Tesch's eight steps of data analysis. Chapter four discusses the conclusion, the limitations and recommendations which are aimed at encouraging the primigravidae to initiate antenatal care in their first trimester.

#### **4.1 CONCLUSION**

The conclusion drawn in my study will be discussed in relation to the health belief model (HBM). The HBM is the conceptual framework that guided my research (refer to section 1.8.2.1 for a detailed description of the HBM). I used a tabular form to demonstrate application of the HBM to my study. The following conclusions were drawn about my study:

##### **4.1.1 Conclusion to the need for knowledge of healthy baby and healthy pregnancy in relation to the HBM**

Primigravidae expressed the need for knowledge of healthy baby and healthy pregnancy. The women said they came to the clinic to check if, and be sure that their unborn babies were fine. They elaborated on the need for knowledge of a healthy baby by saying that they needed to know if there any complications. The women also needed to know if they were any problems, if they were healthy. In addition, they said that they needed to learn

about pregnancy care and labour. Application of the HBM to the need for knowledge of healthy baby and healthy pregnancy is illustrated in table 4.1.

**Table 4.1** Application of the HBM to the needs for knowledge of healthy baby and healthy pregnancy

<u>Concept</u>	<u>Application</u>
1. Perceived susceptibility	The primigravidae believed that their unborn babies and their pregnancies may be at risk of developing complications.
2. Perceived severity	The primigravidae believed that the risk of developing complications was significant enough for them to try to avoid complications.
3. Perceived benefits	Primigravidae believed that if they attended antenatal clinic they would know if their unborn babies are well and that their pregnancies are progressing without complications.
4. Perceived barriers	Non attendance of antenatal clinic was a barrier to the primigravidae having knowledge about the health of their unborn babies and that of their pregnancies.
5. Self-efficacy	Primigravidae went to the MOU for antenatal clinic attendance.

#### **4.1.2 Conclusion to the need for explanation of procedures in relation to the HBM**

The women stated that they needed the procedures to be explained to them as procedures were being done on them but were not explained to them. They also said that information was recorded on their antenatal clinic cards but that they did not know what it meant. The women expressed that they felt sad when the procedures were not explained to them. Despite the procedures not being explained to them, the women did not ask the reasons for this non-explanation. The women said they did not ask because they felt that the

health care providers should be explaining the procedures. The application of the HBM to the need for explanation of procedures is described in table 4.2.

**Table 4.2** Application of the HBM to the need for explanation of procedures

<b><u>Concept</u></b>	<b><u>Application</u></b>
1. Perceived susceptibility	The primigravidae believed that they should be provided with explanations for the procedures that are performed on them.
2. Perceived severity	The women said that as the procedures were not explained to them, they did not know what it was that was being done, or recorded on their antenatal clinical cards.
3. Perceived benefits	The women believed that it would be better for them to know and understand the procedures, than not to know at all.
4. Perceived barriers	Primigravidae believed that they could not ask about the procedures as the nurses were supposed to explain the procedures to them.

#### **4.1.3 Conclusion to the need for use of technology in relation to the HBM**

Regarding the need for the use of technology, specifically an ultrasound scan, primigravidae knew about an ultrasound scan from their friends, and some from the private doctors. The women who had had an ultrasound scan of their pregnancy done before said that they needed the scan to be part of antenatal care at the MOU. Some women did not want to attend antenatal care at the MOU as an ultrasound scan was not offered routinely. The women loved the experience they had of an ultrasound scan as they could see their baby moving and know their baby's gender before delivery. Table 4.3 describes application of the HBM to the need for use of technology.

**Table 4.3** Application of the HBM to the need for use of technology

<b><u>Concept</u></b>	<b><u>Application</u></b>
1. Perceived susceptibility	The women believed that they needed an ultrasound scan of their pregnancy.
2. Perceived severity	The women believed that if they did not get an ultrasound scan of their pregnancy they would not be assured about the condition of their unborn babies.
3. Perceived benefits	The women believed that if they had an ultrasound scan of their pregnancy, they would know their baby's gender before they were born.
4. Perceived barriers	Primigravidae knew that an ultrasound scan was not offered at the MOU.
5. Cues to action	Primigravidae had heard that private doctors did ultrasound scans on pregnant women.
6. Self-efficacy	The women were going to private doctors for an ultrasound scan of their pregnancies.

#### **4.1.4 Conclusion to unplanned and hidden pregnancies in relation to the HBM**

Unplanned and hidden pregnancies were some of the factors that delayed initiation of antenatal clinic attendance. One primigravida said that she did not want to keep the pregnancy at first. She delayed seeking antenatal care as she was thinking about terminating the pregnancy. One woman was a scholar who did not want people to find out about her pregnancy. This woman delayed antenatal clinic attendance as she thought that, when people saw her going to the clinic they would find out about her pregnancy. Application of the HBM to unwanted and hidden pregnancies is described in table 4.7.

**Table 4.4** Application of the HBM to unplanned and hidden pregnancies

<b><u>Concept</u></b>	<b><u>Application</u></b>
4. Perceived barriers	Primigravidae did plan the pregnancy so they delayed seeking antenatal care.

#### **4.1.5 Conclusion to lack of knowledge about where and when to go for antenatal care in relation to the HBM**

The primigravidae said that they did not know when they should start going for antenatal care. Some felt that it was still early for them to initiate antenatal clinic attendance. The women just told themselves that they were going to start antenatal clinic attendance at a later stage. Other women said they did not know where they were supposed to go for antenatal care. Lack of knowledge about when and where to go for antenatal care led to the primigravidae attending antenatal clinic at other institutions. Most women were attending antenatal care at private doctors. Some of the women who were attending antenatal care at the private doctors first went there to confirm their pregnancy. Afterwards, they attended antenatal care at the doctors until they came to the MOU. Other women were attending antenatal care at the hospital. Some primigravidae said that they did not want to come for antenatal care at the MOU. These women stated that they trusted the doctors more than they did the health care providers at the MOU. Primigravidae were encouraged by their family members, friends and their doctors to initiate antenatal clinic at the level one midwives' obstetrical unit. Some primigravidae had emotional support from their families, friends and colleagues. These women were happy and welcomed the support they were getting. Application of the HBM to lack of knowledge about when and where to go for antenatal care is described in table 4.5.

**Table 4.5** Application of the HBM to lack of knowledge about when and where to go for antenatal care

<u>Concept</u>	<u>Application</u>
1. Perceived susceptibility	Primigravidae believed that they may develop pregnancy related complications.
2. Perceived severity	The women believed the risk for developing pregnancy complications was significant enough for them to avoid it.
3. Perceived benefits	The women believed that they needed the best antenatal care available in order to avoid pregnancy related complications.
4. Perceived barriers	Primigravidae did not know when or where they should have gone to for antenatal care.
5. Cues to action	Primigravidae were advised and motivated by their friends and family to initiate antenatal clinic attendance at the level 1 MOU.
6. Self-efficacy	The women took action by attending antenatal clinic at the level 1 MOU.

#### **4.1.6 Conclusion to poor quality of service provision in relation to the HBM**

Poor quality of service provision was identified as one of the factors that delayed antenatal clinic attendance. The women said that the quality of service provision at the MOU was very poor. They mentioned that the nurses communicated badly with patients. The women did not feel welcome at the health centre. The women also said that the health care providers did not speak politely to them. Primigravidae heard that when women are in labour screaming for help, the health care providers did not respond to them. Hearing about this made the women not to want to come to the MOU for antenatal care.

The primigravidae said that they had heard from their friends and family that the nurses are rude. The women said that the nurses spoke to them rudely and explained this

rudeness as being both physical and emotional. The women said that the nurses would shout at them as well as other patients. In the labour ward at the MOU, the women said that the nurses pinch the women if they seemed to be uncooperative. Consequently, due to the rudeness of nurses, primigravidae did not want to go to the MOU for antenatal care.

Health care providers had a judgmental attitude towards the pregnant women. The women said that the health care providers blamed them for attending antenatal care at the private doctors. This comment made the primigravidae feel bad about what they did. The primigravidae heard that when women go into labour, the nurses in the labour ward would tell them that they did not send them to go make babies. Primigravidae did not want to come to the MOU for antenatal care because they thought they would also receive the same poor quality of service provision.

In addition, the primigravidae were not satisfied with the emergency referral system and the number of pregnant women that come to the level 1 MOU for antenatal care. One pregnant woman was scared for both her life and that of her unborn baby. She was wondering what would happen to her, should she need emergency referral to the hospital. She had heard about someone who had waited too long for an ambulance from the MOU. The primigravida said it would be better for her to attend antenatal care at an institution which had emergency obstetrical service readily available. That way she would be assured that should she need emergency intervention, it would be implemented immediately.

The primigravidae also felt that the MOU was overcrowded, which required them to wake up early in the morning to beat the long queues. The problem with overcrowding was that there were not enough health care providers to manage the high number of service consumers. The women said that the health care providers did not do their jobs properly because of the long queues. Apparently the health care providers did a rushed job just to make the queues move faster. The women reported that the private doctors examined them thoroughly, which they thought should be done at the MOU. The

recommendation made by the primigravidae was that the staff numbers should be increased to overcome this problem of overcrowding. Table 4.6 describes the application of the HBM to poor quality of service provision.

**Table 4.6** Application of the HBM to poor quality of service provision.

<u>Concept</u>	<u>Application</u>
1. Perceived barriers	Pregnant women believed that the poor quality of service provision was a barrier to their antenatal clinic attendance, which they had to overcome.
2. Self-efficacy	Primigravidae attended antenatal care, despite the quality of health service provision at the level 1 MOU being poor.

#### **4.1.7 Conclusion to personal factors in relation to the HBM**

Primigravidae had a concern about their bad habit of using substances. Some women were smokers and others drank alcohol. These women who had bad habits were afraid to come to the MOU for antenatal care. The women feared that the nurses would scold them if they found out about their bad habits. One primigravida said that she was still smoking even though she was pregnant.

Lack of money made the primigravidae initiate antenatal clinic attendance late in their pregnancies. The women did not have money for transport fare to the MOU. These women lived further from the MOU. Some women did not have transport at their homes to take them to the MOU. The women who did not have transport or money to get to the MOU said it was too far for them to walk to the MOU. Application of the HBM to personal factors is described in table 4.7.

**Table 4.7** Application of the HBM to personal factors

<b><u>Concept</u></b>	<b><u>Application</u></b>
1. Perceived susceptibility	Primigravidae believed that they were at risk of developing pregnancy related problems related to smoking whilst pregnant.
2. Perceived severity	The women believed that the complications of smoking during pregnancy were significant enough for them to take action.
3. Perceived benefits	Primigravidae believed that attending antenatal clinic would help with the detection of complications of smoking in pregnancy.
4. Perceived barriers	Primigravidae believe that they could not go to the MOU for antenatal care as they did not have transport to go to the MOU.
5. Self-efficacy	The primigravidae took action by initiating antenatal clinic attendance at the MOU late in their pregnancies.

From the conclusions recommendations were made to encourage primigravidae to initiate antenatal care in their first trimester. The recommendations are discussed in section 4.4. The limitations to this study are discussed in the next section.

## **4.2 LIMITATIONS**

The following limitations were encountered in the study:

- The participants were hesitant to stay for the interview after their antenatal check-up. The women said that they needed to go home as they have been in the clinic for more than two hours. The researcher overcame this limitation by assuring the participants that they only had to stay for an hour. Other interviews were conducted while the women were still waiting to be attended to.

- During the interviews some primigravidae wanted to speak their home languages. The researcher humbly asked them to speak strictly English. One primigravida was clarified on the word ‘pinch’, she could not remember this word so she said it in Sesotho. Some of the meaning may have been lost in translation.
- Some primigravidae were speaking either fast or softly and this was going to make the audio-tapes not unclear. The researcher overcame this limitation by asking the participants to adjust the tone of voice and speed at which they spoke, and the tape recorder was placed nearer to the participants.
- The results of this research can only be generalized to other settings and populations that are similar to the one described in my study. This is because the sample size is only ten participants.

### **4.3 RECOMMENDATIONS**

The first objective of my study was to explore and describe the health seeking practices of primigravidae who started attending antenatal clinic in their third trimester of pregnancy. This objective was achieved in chapter three of research results as follows: my research provided a detailed description of the health seeking practices of primigravidae at the level 1 midwives obstetrical unit in the Gauteng province of South Africa. The second objective of my study was to make recommendations with the intention of encouraging primigravidae to initiate antenatal care in their first trimester. The second objective is addressed in this section.

Recommendations are made according to those arising out of the study, for nursing practice; research and education.

#### **4.3.1 Recommendations that arise out of the study**

The recommendations arising out of this study are provided in table 4.8.

**Table 4.8** Recommendations arising out of this study

<u>Issue</u>	<u>Recommendation(s)</u>
<p>1. The need for knowledge of healthy baby and healthy pregnancy</p>	<p>1.1 Posters about pregnancy education must be pasted at places where the community can see and read them. Such places are street poles, schools, community centers, and shopping complexes. This will increase the women’s knowledge about pregnancy issues before they actually fall pregnant. The posters may address issues such as:</p> <ul style="list-style-type: none"> <li>• Signs of pregnancy.</li> <li>• The importance of antenatal clinic attendance and when to initiate antenatal clinic attendance.</li> <li>• Signs of fetal wellbeing. Such signs are fetal movements and increase in fundal height.</li> <li>• Danger signs in pregnancy that should be reported to the health care facility. Such signs are decreased fetal movements, vaginal bleeding, severe abdominal pains, severe headache, blurred vision and water draining from the vagina.</li> </ul>
<p>2. Need for explanation of procedures</p>	<p>2.1 The health care providers should be encouraged to explain the procedures to the patients before doing them.</p> <p>2.2 There should be frequent in-service training for the staff members. The topics discussed should include the importance of ethical nursing practice, which incorporates the need for explanation of procedures to health care consumers.</p>

**Table 4.8 continues on the next page**

**Table 4.8 continued**

<b><u>Issue</u></b>	<b><u>Recommendation(s)</u></b>
3. Need for a pregnancy ultrasound scan	<p>3.1 Pregnant women must be notified that an ultrasound scan is not offered to pregnant women, unless if there is a health need for it. Notices can be displayed in the antenatal clinic notifying the pregnant women about this matter.</p> <p>3.2 Pregnant women should be advised of places where they can go for an ultrasound scan. For example, they can go to some private doctors and they should be notified of the cost of the ultrasound scans.</p>
4. Unplanned and hidden pregnancies	<p>7.1 Women who come to the health center for any consultation must be advised about the family planning services that are available at the health center. This is to prevent unwanted pregnancies,</p> <p>7.2 Female victims of sexual abuse should be offered emergency post-coital contraceptives,</p> <p>7.3 The team that provides outreach programs for the health center can provide school care nursing on some days of the week or month. The aim will be, amongst others, to educate scholars about the types and the importance of family planning services and where the services are available,</p> <p>7.4 Pregnant women who do not wish to keep their pregnancies should be advised about available services to terminate the pregnancy safely if they are less than 22 weeks pregnant. The women should be referred to the services available to support such women, for example psycho-social services.</p>

**Table 4.8 continues on the next page**

**Table 4.8 continued**

<b><u>Issue</u></b>	<b><u>Recommendation(s)</u></b>
5. Lack of knowledge about when and where to go for antenatal care	5.1 Information posters can be pasted on the walls in other departments of the health center to provide information about pregnancy to female patients. Information on the posters can include: <ul style="list-style-type: none"><li>• Signs of pregnancy,</li><li>• The best time to initiate antenatal care,</li><li>• Places that offer antenatal care.</li></ul>
6. Poor quality of service provision	6.1 The health center should hire more staff, to minimize the work load for each staff and promote a pleasant, safe work environment, 6.2 The health center should initiate programmes to increase job satisfaction. A reward system should be initiated for certain categories, for example, best nurse of the month. This will minimize the resignation rate of staff, thus the clinic will have sufficient staff. 6.3 Debriefing sessions should be arranged for the health care providers, where they may talk about workplace stressors. This should motivate them to work, 6.4 A complaints box or book should be available at the clinic's entrance so that all people who come into the clinic are aware of it and may submit their written complaints, anonymously, 6.5 Patient's rights charter should be displayed on the clinic's walls and the patients should be made aware of the grievance procedure. The complaints and steps taken to resolve them should be addressed in the clinic's annual general meetings, so that the community can know that they are being taken into consideration.

**Table 4.8 continues on the next page**

**Table 4.8 continued**

<u>Issue</u>	<u>Recommendation</u>
	<p>6.5 Pregnant women should be advised to attend antenatal clinic at the clinics nearest to their residential area. This ensures effective use of other health centers and prevention of overcrowding at only one health center.</p> <p>6.6 The health center should arrange to have their own emergency medical vehicle(s) available for referrals to hospitals.</p>
7. Personal factors	<p>7.1 Pregnant women should be referred to social services for advice and assistance.</p> <p>7.2 The health centre should initiate campaigns to discourage the use of harmful substances during pregnancy,</p> <p>7.3 Posters should be pasted on the clinic walls, community service centers, and shopping complexes about the dangers of substance use in pregnancy,</p> <p>7.4 The health center can initiate a support group for women who are having problems stopping the use of harmful substances during pregnancy.</p>

The second recommendations made are for nursing practice, research, nursing education. The recommendations are made with the intention of encouraging the primigravidae to initiate antenatal clinic attendance in their first trimester.

**4.3.2 Recommendations for nursing practice**

- Nurses should provide pregnant women with explanations for all the procedures they perform on them. This will make pregnant women understand the care that they receive and encourage their friends and families to come to the antenatal clinic.

- When providing antenatal care, the nurses should take their time to examine the pregnancy thoroughly and allow interaction with the pregnant women. This will make the woman feel respected.

#### **4.3.3 Recommendations for research**

- On strategies required to encourage antenatal clinic attendance by pregnant women.
- At the level 1 MOU to determine the effect of large numbers of patients on the quality of providing health care and on the health care providers.
- At the level 1 MOU to determine the reasons for staff turn over.
- On how women perceive the use of contraceptives.

#### **4.3.4 Recommendations for nursing education**

- Nursing education curricula should emphasize the importance of providing holistic nursing care for patients.

### **4.4 SUMMARY**

This study is good because the question, aim and objectives of the study were achieved. From the results, recommendations to encourage primigravidae to initiate antenatal care in their first trimester were formulated. The earlier the pregnant women attend at an antenatal clinic, the earlier any problems may be detected. Consequently, early detection of complications should result in lower maternal morbidity and mortality rates of.

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HEALTH SEEKING PRACTICES AMONGST PRIMIGRAVIDAE IN THE  
GAUTENG PROVINCE, SOUTH AFRICA

**PARTICIPANT'S INFORMATION SHEET**

Dear \_\_\_\_\_  
(Participant)

I am Mosibudi Lucia Mohale, a registered nurse and midwife currently studying for a Masters degree in Nursing Science at the University of the Witwatersrand. I am conducting a research study into the above topic and would like to invite you to participate in the study.

The appropriate authorities at the Department of Health, University of the Witwatersrand and the clinic where the study will be conducted have approved the study and its procedures. The purpose of the study is to explore and describe the reasons for you as a primigravida to start attending antenatal clinic when you did, with the aim of making recommendations that can encourage women to start antenatal clinic attendance within the first three months of their pregnancy.

The study involves you being interviewed on a face-to-face basis by me. The interview will be tape-recorded with your consent. A maximum time limit of 1hour is scheduled per interview. All the information obtained during the interview will be treated with confidentiality and no unauthorized persons will gain access to it. The data collected will be destroyed once the study is completed and the research report has been written. There are no risks involved and your participation will not influence your antenatal clinic check-ups.

Participation is voluntary and you can withdraw from the study without penalty at any time. Feel free to ask questions about the study at any time. Confidentiality is ensured and your real identity will not be disclosed in the research report and the results will be made available to you on request. There are no financial benefits or payments for participating, but the study will help improve timeous antenatal clinic attendance.

For further information and/or queries, contact me on 0847455979.

Thank you

Yours faithfully

Mosibudi Lucia Mohale

HEALTH SEEKING PRACTICES AMONGST PRIMIGRAVIDAE IN THE  
GAUTENG PROVINCE, SOUTH AFRICA

**PARTICIPANTS' CONSENT FORM**

I \_\_\_\_\_ have read and understood the contents of the information sheet and thus give voluntary consent to participate in the study. I have had an opportunity to ask questions and these had been answered to my satisfaction. I understand that I may withdraw from the study at any point without penalty and that there is no remuneration for participating.

\_\_\_\_\_  
Participant's signature and date

I, Mosibudi Lucia Mohale, have explained this study to the above participant and have sought her understanding for informed consent.

\_\_\_\_\_  
Researcher's signature and date

HEALTH SEEKING PRACTICES AMONGST PRIMIGRAVIDAE IN THE  
GAUTENG PROVINCE, SOUTH AFRICA

**PARTICIPANT'S AUDIO-TAPING CONSENT FORM**

Please tick or cross 'YES' or 'NO' where applicable:

I/We, the undersigned, hereby grant permission to \_\_\_\_\_ to  
make use of the audio-tapes Yes/No during interviews involving myself for the following  
purposes:

- Only for listening by the researcher and/or supervisor Yes/No
- For permission as an assessment and teaching aid to approved professionals and  
students in this institution Yes/No
- For research purpose where such research is being conducted by one or more  
approved professional persons Yes/No
- For extraction of material for publication in a recognized professional journal or  
approved dissertation or thesis Yes/No

This informed consent is duly signed by me on (date) \_\_\_\_\_

at (place) \_\_\_\_\_

Signature \_\_\_\_\_

HEALTH SEEKING PRACTICES AMONGST PRIMIGRAVIDAE IN THE  
GAUTENG PROVINCE, SOUTH AFRICA

**INTERVIEW QUESTION**

What experiences influenced you to for your first antenatal visit when you did?

HEALTH SEEKING PRACTICES AMONGST PRIMIGRAVIDAE IN THE  
GAUTENG PROVINCE, SOUTH AFRICA

University of the Witwatersrand  
Department of Nursing Education  
Faculty of Health Sciences  
7 York Road, Parktown, 2193  
Johannesburg

---

The Nursing service manager  
Alexandra Health Centre and University Clinic  
33 Arkwright Avenue  
Bergvlei, 2090

Dear \_\_\_\_\_

Re: Research at a level 1 Midwives Obstetrical Unit in the Gauteng Province.

I am a Master of Science (nursing) student at the faculty of Health Sciences, University of the Witwatersrand, who is required as part of my course to conduct a clinical research project under supervision. The title of my research is 'Health seeking practices amongst primigravidae'.

I intend to collect the study data by interviewing an estimated number of eight participants individually, taking at least 1hour per interview. One open-ended question: 'what experiences influenced you to go for your first antenatal visit when you did?' will be asked. The participants will be given information letters about the study and are required to give a written consent for participating. All interviews will be tape-recorded.

The participants will be assured of anonymity, privacy, confidentiality and the right to withdraw from the study anytime they wish to without penalty.

Antenatal care is of great importance amongst all pregnant women as the pregnant women's health care needs are assessed and met during their antenatal clinic attendance. Primigravidae are selected for use in this study as they are considered to be a high risk group because: every first labour is a trial of labour, they are at increased of developing hypertensive disorders of pregnancy, and their inexperience about pregnancy leads us to emphasize more on health education practices such as antenatal exercises. You are assured that the institution's name and clients who will be involved in this study will not be disclosed in the research report.

I hereby apply for permission to undertake the research at your Midwives Obstetrical Unit once my research proposal has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand. A copy of the final research report will be made available to you if so requested.

Yours sincerely

\_\_\_\_\_ (Signature)

Mosibudi Lucia Mohale

*TRANSCRIBED INDIVIDUAL IN-DEPTH INTERVIEW WITH A PRIMIGRAVIDA.  
INTERVIEW NUMBER THREE*

**KEYS:**

I-Interviewer

P-Participant

I: Could you please tell me what experiences influenced you to come for your first antenatal clinic visit when you did?

P: Because I was curious to know whether my baby was in a proper condition or not. So I had to go and check.

I: What about the baby's condition?

P: Whether the baby is fine or not, cause this is my first time. So I needed to be sure (*sitting vary still*).

I: Baby being fine or not, what do you mean (*probing with hands*)?

P: In a proper condition. Like whether my baby is sitting in a right way. That is what I wanted to know.

I: At how many months did you come to book at this clinic?

P: At this clinic came at my 4<sup>th</sup> month. They started checking me when I was 5 months pregnant.

I: Before you came here, what was happening? Why didn't you come here earlier on?

P: At 1<sup>st</sup> I went to the hospital. I booked there because I didn't want to come here because of the treatment that the nurses give to other people. So I was scared that maybe they were going to be rude to me and stuff like that. So I went to the hospital. I booked there, took my blood tests, everything I did there. 2<sup>nd</sup> time I went back for check-up they referred me saying the department of health says they must refer me to the nearest clinic that I stay to. They will only take us to the hospital if we have complications. That's when they will take us to hospital but furthermore they will take us to the clinic. So I came here and they said I must come back for the next appointment and I did. And I took my blood tests again (*speaks softly, with a same tone*).

I: Can you just elaborate on the treatment from nurses?

- P: I've got 2 sisters. 1 delivered in this clinic and she told me about the treatment when she was here. They were not treated clearly. The nurses were rude to them and when you deliver, after delivery if you are fine you go home (*speaks softly and sounds worried*). Unlike in the hospital after delivery you just stay there for a day or so. So I didn't want to deliver and go home. Cause I don't know if I'm going to be fit enough or strong enough to go home. So I need to stay at the clinic for some few hours (*this is what happens*), or a night if I can.
- I: So this sister who delivered at the hospital...
- P: (*she interrupts*) she delivered in this clinic and came home afterwards. The other delivered at the hospital which she stayed there for 1 day.
- I: Why did she stay there for one day?
- P: Cause she was waiting for the doctor to come and check if the baby was fine.
- I: What is the difference between treatment at Alex clinic and at the hospital?
- P: There is a big difference there. Here maybe they get that you have a problem and they have to rush you to hospital for an operation, its going to take too long for you to be there (*speaks with hands*). But if you are there they just move you to the operation room. But now from here you have to wait for an ambulance to come, go there, it's a long procedure. At least there it's easy (*sounds reassured*).
- I: From what you say, you didn't want to come here because they discharge you early and it takes time to get to the hospital.
- P: It's going to take time. If I'm in hospital it takes maybe 15 minutes to move from me to the operation room from labour room. But from here to the hospital, its gonna take 2 or 3 hours (*sometimes it does*) and my baby will be dead or something (*looks concerned*).
- I: Dead from what?
- P: If maybe there is a complication. I can't let anything happen to him. I'm scared. But anyway...(*lifts shoulders silently*).
- I: We have rules on how to transfer patients to hospital. I f I call the ambulance and tell them it's a priority 1, they try to get here earlier.
- P: I don't think they will come earlier cause this ambulances, we don't have too much ambulances. What if you call an ambulance, they are all on duty. What is going to happen (*with a concerned look*)? Am I supposed to wait for an hour or 2 for the ambulance to come? What is going to happen to my baby and who is going to be responsible for my baby's death? You or the ambulance (*sounds angry*)?

I: None of us.

P: Then you see (*using hands*)! That's what I'm scared of. I don't want that thing to happen. Either maybe if you can find doctors who will operate from this clinic. Maybe that will be okay.

I: The reason why we send patients to hospital is because we offer services at different levels. We refer to different hospitals.

P: Now I want to know, what if you refer me to Edenvale and they want to refer me to Johannesburg? That is a long procedure because also in Edenvale if they can't give you further treatment they refer you to Johannesburg (*quickly leans forward*). So it's better if you just go to Johannesburg. At least you will be safe. And you know that your baby will be fine.

I: We only refer to Edenvale during specific hours and the doctors there can refer to Johannesburg. So you are going to get the necessary services in either hospital.

P: (*lifts shoulders in silence*)

I: Is there anything you need to say or ask?

P: No. Nothing else.

I: Do you need health care during pregnancy?

P: Yes. Because I don't have experience. This is my 1<sup>st</sup> baby. I need to know what's wrong, what's right. I can say my baby is kicking (*raises shoulders*). Now that I'm going to the clinic I know that my baby must kick everyday. If I wasn't going to the clinic I wouldn't know that. And if I came to the clinic at 7 months there is a possibility that I may go into labour at 7 months. So I need to go earlier than that to avoid of me not coming to the clinic and the baby might die. Sometimes my baby will die and I won't know because I will be staying at home.

I: According to you, what experiences do people who have kids have that you don't have?

P: People who has kids they do know that the baby has to kick everyday, that they have to go to the clinic and book earlier. They know that during their 7<sup>th</sup> month of pregnancy they can go into labour. Even the 6<sup>th</sup> month you can go into labour but the baby might not live. And they also know what stuff to bring to the labour ward, what they need to eat. But if I don't go there I don't know what I must eat. I just eat everything, drink any medicine. Now that I come to the clinic I know I don't have to take any medicine that I used to take before I was pregnant.

I: Where does coming to the clinic put you compared to someone who has children?

P: I cannot say we are at the same level. We do have the same experience now even though we have not been to the labour ward. But according to knowledge, I won't say we are on the same level. But people have 2 or 3 kids but still I don't know whether its being stubborn or what, you stand with her in a queue and the nurses will say go to the toilet I need your urine. The lady will just stand there (*sounds and looks annoyed*) but you who doesn't have kids will go and get urine. She will just stand there until the nurses scream at her. I won't say we are in the same level of knowledge. No. Maybe it's because of we don't understand the reason why, but the education that they give us is on the same level. She knows more about how does the baby come, how it feels being in labour, I don't know that. That's the difference between the 2 of us.

I: Are there any money or transport issues that affect your coming to the clinic?

P: No. I won't say they are because the minute you decide to make a baby you know that you have to go to the clinic. So the reason of us giving to the nurses that we don't have money for transport, I mean you just go to Alex clinic and they refer you to your nearest clinic where you don't need money for transport or transport to travel. You just go. It's nearer to you. I don't see the money for transport to the clinics being the issue for us not to book earlier. I heard one woman say to me, why are you here so earlier? I said I have to know if my baby is fine or not. She said to me 'but you will go many times'. I said I only go there once a month. I don't see that as an issue not to book because I have to go there, it's a long procedure. Going up and down. That's why I am saying we don't understand things the same. The one who has kids will not go to the clinic to book earlier. Because of the money or they say it's a long procedure. They go there when they are 3 or 4 weeks to go to deliver. That's not an issue. They are just stubborn to go and book (*speaks with hands*).

I: So, for you transport and money...

P: (*she interrupts*) that's not an issue. It doesn't affect my coming to the clinic.

I: Any relationships at home with family and partner that affects your coming to the clinic?

P: No. My mom is the one who told me to come to the clinic. At first, I've got friends. Friends can influence you badly. So they (*friends*) said to me even if you are 5 or 6 months you can book. So I went home and told my mom and she said 'you are going to do it my way. I'm telling you, you have to go there before 4 months because we don't know whether the baby's condition is fine or not'. So I came because I don't want to regret myself tomorrow. If anything happens to my baby my friends won't be there. Only my mom will be there. And the baby's father. So if both of them (*her mother and the baby's father*) are telling me to go there, I will go.

I: Can I say you have a strong support system at home?

P: Yes. I have a strong support system and a good one. So if they say I should do so, I do. Because at the end of the day they are the ones who are going to be there for me. Not my friends or anyone else.

I: Did you have any idea about the clinic's booking system before you came here?

P: No. I didn't. I just heard a little. I knew that I was going to come here and they were gonna take my blood. But that I have to go every now and then, that I have to check, I didn't know that.

I: When is every now and then?

P: Like when I go after a month. I didn't know I was gonna go there after a month. I thought I was gonna go there once and then after 2 months. It's what I thought. It's not too often. I just thought I was gonna go after 2 months.

I: Anything else you can tell me?

P: No. There is nothing... *(Suddenly)* I need to know, at 1<sup>st</sup> I went to take blood at the hospital. I went to take my blood without counseling. They then called me to come take the results. They didn't counsel me actually. She just told me 'can you please tell me what you know about HIV?' I just told her what I know and she said to me 'no, you don't need any counseling. Then she gave me the stick that shows whether you are HIV positive or not. And said 'do you know what that means?' I said no, then she told me what it meant. Are they allowed to just take your blood and counsel you later or should they counsel you then take your blood and counsel again?

I: As I know, the right thing is to be counseled, you ask questions, they take your blood, counsel again before giving the results, and counsel again. But it can be more, depending on the situation. They will assess you after giving you the positive results and if the need arise; they might need to counsel again, or even tell you about available support groups for HIV positive people. Does this answer you?

P: I think you did.

I: Anything you would like to tell me?

P: No.

I: How was your reaction when you found out you were pregnant?

P: At first I was scared and I was happy. I thought of my mom. I'm not married. What is she going to say (*worried*)? Is she going to be happy? I thought about her. I wanted to get my first born when I was married. So unfortunately it happened now and I'm not married. I was happy because the baby's father was happy. But I thought a lot about my mother.

I: Did that emotional moment affect your coming to the clinic?

P: No. It didn't affect me in any way. It was just a moment thing then I was fine afterwards.

I: Did you disclose?

P: I didn't tell my mom. I told myself she was gonna see through me. I just kept quiet until she said to me there is something wrong (*giggling*) and I said no. Then she started seeing my tummy grow and said 'I told you there was something so go to the clinic and book now.'

I: What do you think would have happened if your mother found out earlier, if you had told her when you found out?

P: She would have told me to go to the clinic straight away.

I: Is there anything else?

P: No.

I: I don't have any more questions. Thank you.

*TRANSCRIBED INDIVIDUAL IN-DEPTH INTERVIEW WITH A PRIMIGRAVIDA.  
INTERVIEW NUMBER FOUR*

**KEYS:**

I-Interviewer

P-Participant

I: Please tell me what experiences influenced you to come for your first antenatal clinic visit when you did?

P: I wanted to know if my baby is okay. If I'm healthy and also to learn about antenatal care and labour.

I: When did you find out that you were pregnant? How many months pregnant were you?

P: I found out when I was 2 months pregnant.

I: From that time when you found out that you were pregnant until the time that you decided to come to the clinic, what was keeping you from coming to the clinic?

P: I came to the clinic when I was 1 month pregnant to do a pregnancy test and the sister advised me to come to book for antenatal care when I was 3 months pregnant (*I witnessed this information being given to other pregnant women*). I came here when I was 3 months pregnant and they gave me a date to come back when I was 5 months pregnant

I: So you came when you were 5 months pregnant.

P: Yes.

I: So the only reason why you came at 3 months was because you were told so?

P: Yes (*she speaks softly*).

I: According to you, is it important for a pregnant woman to attend antenatal clinic?

P: Yes.

I: Why is it important?

P: Because you have to know the state of your baby, if your baby is living, the condition of the baby and if maybe to find out if you don't have disease.

I: Did you have any idea what was going to happen when you came to book?

P: No.

I: No one ever told you about anything?

P: Yes.

I: Did the nurse patient relationship influence your decision to come to the clinic?

P: No. But the nurses here are not polite. They are not polite. Because the 1<sup>st</sup> day you don't know what to do. If you ask them they just shout you know (*looks and sounds upset*).

I: What else?

P: The treatment here, you know, because I started coming to the clinic in February but I don't know my date of delivery and another thing, every time I was asking, they took our blood group test but we don't know our blood group until you showed us that this is our blood group. Most of us didn't know that it was our blood group. And we have some information here in our file but they didn't explain to us what it is. Even the injection they are injecting we don't have an idea what it is for (*worried and sad*).

I: Did you ever ask why are they doing those things to you?

P: There is no time to ask because they are rude (*raises voice*).

I: They are rude in what way?

P: They are shouting 'why are you standing there?' When you come to the consulting room the 1<sup>st</sup> thing they just shout at you 'why are you standing? Why are you not taking off your jacket?' And it's our 1<sup>st</sup> time we don't know what to do. They have to explain to us; okay you have to do this and that. Like the 1<sup>st</sup> time when they are weighing us we didn't know that we have to take off our jackets because no one explained to us that we have to take our jackets off. They were just shouting at us (*upset*).

I: Did you have the information about the nurses shouting at you before you came to the clinic?

P: No. Before I came to the clinic I only heard that at labour ward the treatment is not good. But about the antenatal clinic I never heard anything.

I: Treatment is not good in the labour ward, in what way?

P: Err... (*Silence*)

I: What is it that you heard?

P: The nurses they don't pay attention to you (*hesitation*).

I: Okay. Go on (*using hands*).

P: And then your baby can fall down while they are not checking you. Even when you are screaming that I'm having a baby they don't respond to you (*sad*).

I: Go on.

P: You can have the baby on the floor. That is why I am not going to have my baby here.

I: Where are you going to have your baby?

P: Pretoria.

I: Do you live there?

P: My parents live there.

I: So you are going to your parents to have your baby there?

P: Yes.

I: Okay. When you say nurses don't pay attention to you, can you elaborate on that?

P: When you are asking them to help you they just ignore you or shout at you.

I: Did you hear what help this people will be asking for?

P: If maybe you are calling them saying your baby is here, they don't help you. You just scream and cry and no one helps you.

I: And all this things, you heard from people?

P: Yes. Two weeks back I was listening to the radio. They were talking about labour and a girl from Alex called. She said she had a baby at this clinic. They didn't wash or wipe the baby. They just told her to go home with the baby.

I: How did all that information make you feel?

P: Scared.

I: Scared in what way?

P: I'm scared that what if all these things happen to me. Am I going to lose my baby?

I: Is that all you are scared of?

P: Yes. Or maybe... I'm scared of losing the baby. Or maybe my baby will...*(hesitant)*  
Somehow, if my baby felt what if he is not going to be okay? What if this is going to affect her physically or mentally?

I: You are right to be worried and I don't know what to say to comfort you. I hope none of those things happen to you.

P: Okay. Thanks.

I: Where do you stay?

P: It's far but not very far.

I: Did it affect the time that you came to the clinic for your first visit?

P: No.

I: Do you have any money issues that affect you coming to the clinic?

P: No.

I: Any questions?

P: No. My friend delivered her baby without the sister's assistance last year January.

I: What did she say happened?

P: She was calling the sister they were just ignoring her and she delivered the baby on her own without assistance and then they came and shouted at her. They told her to clean the floor. After that she didn't rest. They just told her to take a bath and she was weak at that time.

I: So you heard this before you were pregnant?

P: Yes.

I: Did it affect your coming to the clinic?

P: It affected only the labour.

I: So coming to the antenatal clinic is fine for you?

P: It was fine before I came here.

I: Now that you came?

P: Now that I came next time I don't think I will come here. Maybe I will go somewhere else.

I: What makes you say that?

P: Because they don't explain to us the information they write in our files. (*silence*)

I: Yes...

P: Another thing, there was a lady who was coming together with us to the antenatal clinic; she had a baby last Monday. She told us 2 babies fell on the floor when the mothers were delivering (*this happens*) the babies without assistance.

I: How does that make you feel?

P: Very scared.

I: I don't know what happened, but things like that happen in the labour ward. So I won't disagree with you. Now what do you think about the treatment that you are getting in the antenatal clinic?

P: The treatment is good but the nurses' attitude, they are not polite to us. They forget that we are also human (*sounds upset*). Maybe it's because they are old, I don't know.

I: What do you think about the number of nurses that are working at the antenatal clinic?

P: There are not enough nurses because Alex is overcrowded.

I: Does the nurses not being enough affect their work?

P: Yes. I think so. It affects their work. Maybe they are working too much without rest, that is why they are so rude. I think they must increase the staff. Another thing, at our 1<sup>st</sup> antenatal visit, I was shocked by how the doctor examined me. She just opened my legs and looked at my vagina.

I: What else happened?

P: And just checked my urine (*lifts shoulders*).

I: What do you think about that?

P: I asked him is my baby okay? And she said yes the baby is okay. And then I asked her if I'm finished and she said 'yes you can go'.

I: How did you feel about that?

P: Almost... I was shocked and helpless (*shakes head*). I was consulting another doctor. He is the one that is helping me.

I: Why are you seeing this other doctor?

P: Because here at the clinic the doctor doesn't check you properly. Two minutes in the consulting room. Maybe I was in the consulting room for 1 minute.

I: What do you think made the doctor check you so quickly?

P: Maybe because she is a professional doctor under government...(*silence*)

I: What do professional doctors under government do?

P: I think she has attitude. She doesn't like people.

I: How do you mean?

P: Or maybe she chose the wrong career, I don't know.

I: Anything else that you can tell me?

P: I think that doctor must have time for people or she must do her work.

I: Do her work how?

P: She must check people properly.

I: As a pregnant woman, do you need to be cared for by the health workers.

P: Yes.

I: Why?

P: Because they are the ones who know how to handle a patient. If I need advice I can go to them and ask them.

I: While you were here, did you ever feel that you needed advice?

P: Yes (*nods head*).

I: Did you ask?

P: Yes I did... (*silence*)

I: What happened when you asked?

P: I did get the information (*nods head*). It was helpful.

I: Anything else?

P: No.

I: I have no more questions. Thank you.