



## Barriers and Motivators to early utilization of Ante Natal Care services in Chipinge South District in Zimbabwe; A Qualitative Study

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### Abstract

Zimbabwe is ranked amongst the countries with highest maternal mortality rate in the world. Lack of early Ante Natal Care (ANC) use and home deliveries by pregnant women are amongst the drivers of maternal mortality in the country. The study therefore delved on identifying barriers and motivators to early use of ANC and delivering at health facilities in Chipinge South District. A qualitative study was employed using focus group discussions, and in-depth and key informant interviews. Barriers identified included; unwanted pregnancies; long distances; and lack of transport to health facilities. Poverty, poor services at health facilities, low knowledge level on the importance of ANC and religious beliefs were also identified as barriers. Motivators to early use of ANC included fear of complications, ill health during pregnancy, awareness on the importance ANC and services offered at health facilities. The implication of these findings is to implement policies that address these barriers.

**Keywords:** Maternal mortality; Antenatal Care; Barriers; Motivators.

### 1.0 Introduction

Maternal mortality has been increasing in Zimbabwe with the country being ranked amongst the 40 countries with highest mortality rate globally, that is over 960 per 100 000 (WHO, UNICEF, UNFPA and the World Bank, 2012). Zimbabwe's maternal mortality rose from 612 deaths per 100,000 live births (ZDHS 2006/7); to 960 deaths per 100,000 live births (ZDHS 2010/11). One of the indicators of maternal mortality is the utilization of Antenatal Care (ANC) services through early booking, making sufficient visits and delivering at health facilities. United Nations (2007) has demonstrated that provided with professional health assistance from first trimester of pregnancy and when delivering, most of the maternal deaths could be easily averted. It is therefore of concern worldwide when a large number of women die from preventable conditions, diseases and complications during pregnancy and when delivering (Ronsmans et, al. 2006), yet management of these complications can reduce maternal mortality by up to 46% in the country (Munjanja 2007).

The main objective of ANC is to improve the health of the mother and the foetus. Interventions made through ANC include early advice on diet and behaviour; early detection of diseases and their prompt treatment, modifications of conditions such as down syndrome; prevention of diseases through immunisation and micro nutrient supplements; and birth and delivery preparations (Beeckman et, al. 2011; Kirk et, al. 2006; Oladokun et, al. 2010; Riskin-Mashiah et, al. (2009); Watson-Jones et, al. (2002); ZDHS 2010-11). An additional benefit of ANC is early access to Prevention of Mother To Child Transmission (PMTCT) services considering that high HIV prevalence has contributed to maternal morbidity and mortality; 46% of the maternal mortality cases in Zimbabwe are HIV related (United Nations Issue Paper Series 2013). Furthermore, early access to ANC services is vital to delivering at a health facility as there are more chances of a pregnant woman delivering at a health facility after using ANC services (ZDHS 2010-11).

Timing of visits, number of visits and place of delivery are all critical for ANC to be effective in preventing adverse pregnancy outcomes. Though evidence in Zimbabwe shows 90% attendance of ANC by women with each one of them attending at least a single visit, 19 % of women received ANC in their first trimester and the majority (40%) attended their ANC visit on their fourth and fifth month of pregnancy; yet ANC is most effective when sought between 12 to 16 weeks of gestation (ZDHS 2010-11). There is also evidence that a significant proportion of pregnant women do not meet the minimum recommended number of ANC visits; 10 % of women who had live births within the past five years did not use ANC services at all; 21% made 2 to 3 visits, and the majority (65%) made between 4 to 5 visits (ZDHS 2010-11). World Health Organization recommends a minimum of 4 visits to pregnant women who are screened for not requiring special attention, and the number of visits increases for those who require special care. Whilst delivering at a health facility reduces risks to the mother and the new born child through proper medical care and hygiene, trends show an increase of home deliveries from 23% (Bicego et, al. 2005) to 34 % (ZDHS10-11); and these deliveries take place with the assistance of family members and either trained or untrained traditional health assistants (Rossier et, al. 2014). The above data shows that a large number of women and their newly born children in Zimbabwe are at high risk of maternal morbidity and mortality due to late utilization of ANC, insufficient visits and home deliveries.

Barriers to utilization of ANC services by pregnant women in Zimbabwe are recognized in literature; and these include long distances to health facilities, lack of fees required by the health centres, lack of drugs, lack of service providers, not wanting to be alone and lack of transport (ZDHS 2010-11; Munjanja et, al. 2007). Religious factors have also promoted non- utilization of health care facilities and this is more pronounced within the Apostolic Faith Groups who believe in faith healing (Chakawa 2011). In a country where the Apostolic Faith groups constitute a significant proportion of the population, 33% of women in the country (Maguranyanga 2011); Zimbabwe is at high risk of maternal

morbidity and mortality. In an attempt to improve access to ANC services, the Ministry of Health and Child Care (MoHCC) in Zimbabwe provided Mother Waiting Shelters (MWS) to accommodate pregnant women closer to the health facilities towards the delivery dates; and the benefits of MWS are observed in literature (Gilson 1997). In addition to improving drug supplies in the health facilities and providing sexual reproductive health educational programmes through community health workers, the MoHCC withdrew user fees for delivering at primary health care facilities (United Nations Issue Paper Series 2013). Given that effort has been made to address these barriers, and that there is still an increase in home deliveries and a large number of women booking late for ANC, the study therefore explored the barriers and motivators to early ANC booking, attending sufficient ANC visits and delivering at health facilities by pregnant women in Zimbabwe.

## 2.0 Methodology

A qualitative research was conducted using Focus Group Discussions (FGDs), In-depth Interviews (IDIs) and Key Informant Interviews (KIIs) so as to have an in-depth understanding of communities' perceptions, beliefs and practices regarding early ANC visits and delivering at health facilities. Chipinge South District, being one of the rural districts, was purposively selected for the study since there are more chances of a rural child to have been born at home as compared to child born in an urban area (ZDHS 2011-12). Following that, a sample of 4 primary health facilities from a total of 9, were randomly selected and participants were recruited from the catchment areas of these facilities. To ensure geographical representation within the catchment areas of each sampled facility, participants residing in both remote and close locations from the health facilities were recruited to participate in the study.

Potential participants for the interviews and focus groups were recruited from the community with the assistance of community mobilizers. Both male and female participants who met the selection criteria were conveniently selected for participation for the IDIs and FGDs. Inclusion criteria for women into the study were as follows; (a) mothers who have delivered a baby either at health facility or outside in the last 12 months, (b) mothers who were willing to take part in the study, (c) mothers who were able to consent and were 15 years and above. For men, the inclusion criteria was as follows; (a) men who have had their partners delivering a baby either at a health facility or outside, within the last 12 months. (b) men who were willing to participate in the study, (c) men who were able to consent, (d) men who have attained the age of 15. For the reason of them being parents who were making own independent decisions, participants below the age of 18 years consented for themselves since they were regarded as emancipated minors. Key informant participants were purposively selected to take part in the study due to their professional knowledge and experience, and their positions in the community. The District Medical Officer, nursing staff, village health workers, village heads and religious leaders were selected as KII participants so as to capture a wide range of perceptions.

A total of 12 FGDs (n=12) were conducted with women and men; and these were grouped according to their sex and age; 2 FGDs for males aged 15-24, 2 FGDs for males aged 25 and above, 4 FGDs for women aged 15-24, 4 FGDs for women aged 25 and above. A further 10 IDIs were conducted with women who also met the above criteria. Selected men for FGDs were not necessarily partners of the women within the selected groups for participation in the study. The discussion was captured using a tape recorder and length of each audio file ranged from an hour and half, to an hour and forty five minutes. Six protocol trained interviewers collected data as follows; 2 moderated the discussions, the other 2 manually took notes, the remaining 2 conducted KIIs and IDIs. A total of 12 KIIs were conducted with the following; District Medical Officer (n=1), Nursing staff (n=5) and Village Heads (n=2), Church Leader (n=1) and village health workers (n=3). Data collection was stopped after conducting 12 FGDs, 12 KIIs and 10 IDIs; which was the saturation point "when the collection of new data does not shed any further light on the issue under study" (Glasser and Strauss 1967).

Following data collection, audio recorded files were concurrently transcribed and translated verbatim from the local language into English by the notetakers, and transcripts were proof read for accuracy and completeness by a different interviewer. Transcripts were then imported into NVivo 10; a qualitative software for data analysis. Data were analysed following principles of Grounded Theory (Glasser and Strauss, 1967). This was done by going through all the imported transcripts line by line using open coding to identify key points that formed codes. Constant comparison of the codes was made and changes were made upon emerging of new data. Similar codes were then merged to form categories before grouping them together to form sub-themes. The sub themes were then merged together to form themes.

Themes that emerged from the data on barriers to early booking of ANC services and delivering from health facilities were; embarrassment from unwanted pregnancies, traditional and religious beliefs, long distance from health facilities, lack of transport, low knowledge level on the importance of ANC, poverty, poor utilities at health facilities and negative attitude from the service providers. Emerging themes for motivators to early ANC booking and delivering at health facilities were; fear of complications, ill health during pregnancy, knowledge on the importance of ANC, knowledge of services offered at the health facilities including MWS, influence from family members, and health promotional activities from supporting community based organizations.

## Ethical Considerations

Participants were asked to go through the information sheets that explained the study, the voluntary nature of participation, how privacy and confidentiality were maintained, and the minimal risks associated with their participation. Questions raised by the participants were consequently responded to before signing of the consent forms. The study's protocol was approved by the local ethics body, the Medical Research Council of Zimbabwe.

## 3.0 Results

Participants noted embarrassment due to unwanted pregnancies as a barrier to ANC visits. Embarrassment was attributed to unplanned pregnancies after a woman has not used family planning pills effectively leading to an unwanted pregnancy. Participants also observed that embarrassment was more pronounced to women who got pregnant at early ages or at older ages. One of the participants noted that, "*When a young girl gets pregnant below the age of 16, she does*

not come in the open to early booking because this is unexpected of her, and this is also true to mothers who get pregnant in their 40s” (Female Participant; FGD). When probed on reasons for them getting embarrassed, participants pointed out that they were being discouraged by the nursing staff to do so as these pregnancies could expose them to high risk of complications during delivery. Participants also noted that getting pregnant at these ages would lead to referral to a higher level facility, which is undesirable to them due to costs associated with travelling and seeking services at higher level facilities unlike at the primary health care facilities that were free.

Poverty was identified as one of the factors inhibiting early ANC visits. Participants indicated that pregnant women were expected by service providers to dress properly and to have bought new sets of clothes for the unborn child. It was explained that pregnant women would therefore feel uncomfortable visiting the health centre when they cannot afford purchasing these clothes. This resulted in them failing to visit the health centre early in anticipation for raising the money for buying the new clothes. It was noted that, “...they [pregnant women] do not prepare clothes for the pregnancies, ....and are reluctant to visit the hospital because they have not bought themselves new sets of clothes to wear, and also for the future. When they talk about the future, ...they are talking about the babies’ dippers and clothes (KII; DMO). Whereas services at primary health care facilities were free, participants stated that some pregnant women delivered at home due to lack of cash required in the event that they were referred to a higher level facility. Related to economic constraints, was lack of transport fees for pregnant women to access the health care facility in time for delivery.

Low knowledge levels on the importance of early ANC visits was pointed out by participants as a hindrance to early access to ANC services. Participants opined that due to lack of knowledge pregnant women procrastinated ANC visits as they were unaware of the importance of such visits. One of the participants was of the view that, “They [pregnant women] just do not comply when asked to book early for ANC. They think it is not important to do that” (KII; Service Provider). In some instances pregnant mothers would deliver from home or on their way to clinic as a result of lack of knowledge on the ages of their pregnancies. It was mentioned that, “When experiencing some convulsions, they [pregnant mothers] would think that it is the baby turning yet they are due for delivery, and they end up delivering at home or on their way to the clinic” (Participant; male FGD).

Another barrier pointed out by participants was that pregnant women were often too busy with household chores resulting in them making less number of visits recommended for ANC. Participants explained that some pregnant women were too busy working in their fields during the rain seasons. On the onset of the rain season some pregnant women were reported to temporarily migrate into the neighbouring country, Mozambique, where they own fields. As a result of commitment to their fields these pregnant women were noted to make their first ANC visit at the fifth and sixth month of their pregnancy, and then revisit the health facility when delivering. Some were reported, however, to not visiting the health facility at all and these were noted to be delivering at home.

Long distance to health facilities was cited as another obstacle to women accessing ANC services in time. Participants indicated that pregnant women travelled long distances to health facilities either for ANC visits or for delivery. A participant explained that, “Our clients come from across the border, which is about 40 kilometres away. Some of them have delivered on their way to this facility; and when you ask them how that had happened, they tell us that they had left their homes a day before and spent the whole day walking before delivering” (KII; Service Provider). The situation is worsened by lack of transport to health institutions as there are poor roads in the area. This leaves pregnant women without any option except walking or using ox-drawn scotch carts when going for delivery. In some instances pregnant women resort to making the first ANC visit only, which they also delay, before skipping the routine ones. One of the participants stated that, “It is more practical for me to book at 7 or 8 months just before delivering since I cannot walk that long distance several times” (Participant; Female FGD). Due to fear of commitment of making sufficient visits for ANC, participants indicated that pregnant women ended up not making even a single ANC visit and would consequently deliver at home. Participants believed that when the first visit is made, pregnant women felt compelled to attend all ANC visits and that would mean that they should comply with the advice they get from the ANC visits and therefore deliver at a health facility. Furthermore, participants residing in areas where there were road networks indicated that there was poor communication networks resulting in them failing to make phone calls to request for an ambulance or to hire private transport to ferry the pregnant women to a health centre. After failing to secure transport, the pregnant woman would then deliver either at home or on her way to the health facility.

Unfavourable conditions and services at the health facilities were also highlighted as contributing to pregnant women delaying the first ANC visits. In participants’ view, some pregnant women delayed visiting the health facilities for ANC because service providers were unfriendly, which made them feel uncomfortable to either to utilize ANC and or deliver at health care facilities. Furthermore, the presence of poor utilities such as absence of water at facilities and functional Mothers’ Waiting Shelters were revealed as barriers to women delivering at health institutions. It was observed that, “When there is nowhere to stay for us here at the clinic, it means that I have to walk across those mountains to come here. This means that I cannot arrive here in time for delivery. I delivered my child on my way to this clinic. If there was somewhere to stay, I could have stayed here so that i could be closer to the clinic” (Participant; Female IDI).

Religious beliefs and traditional practices were also cited as a barrier to early use of ANC services. In participants’ opinion some pregnant women did not deliver at the health facility because they felt that it was unnecessary to do so considering that they have successfully delivered from home in the past. One of the participants pointed out that, “Some [pregnant] women say that their grandmothers have always delivered from home, and they [pregnant women] have also done the same for their earlier pregnancies; so why should they now visit the clinic this time for delivery?” (Female participant; FGD). Furthermore, it was noted that some faith based organizations including the Marange Apostolic Sect did not allow their members to seek biomedical services making it impossible for their pregnant women benefit from the early ANC visits and getting assistance from trained personnel at health centres. It was stated that, “pregnant women from these faith based churches are afraid of being punished by church leaders when seen visiting the clinic. We firstly see them pregnant, and later on we see them when they were no longer pregnant, ...so we would be expecting a

*baby,...only to hear that the baby passed away during delivery. They [pregnant women] deliver at their churches with the assistance of elderly women from within their churches” (Participant; Female FGD).*

Feeling unwell during the current pregnancy was cited as an influencing factor for pregnant women to early visit for ANC. Participants explained that pregnant women would want to seek treatment from the health facility and therefore visit the clinic early. This implies that they these women would book for ANC by default when seeking treatment. Other participants however, were of the view that pregnant women are motivated to make early ANC visits by the need to have their health monitored. Participants agreed that even in the absence of ill health, some pregnant women would want their health and that of the foetus checked, and get attended to if ever there were diseases and or potential complications. In that respect, personal health benefits motivated pregnant women to make early ANC visits.

Another factor motivating pregnant women to deliver at a health facility was fear of complications during delivery. Participants stated that pregnant women who have previous experiences of complications during delivery would want to visit the health facilities early for ANC so that they get professional assistance from service providers. A participant observed that , *“I ask myself what would happen in the event of a complication during giving birth at home” [silence] ....[Pregnant] women are afraid that the complications would lead to death” [Participant; Female FGD].* Participants viewed delivery at health facilities to be safer when compared with home deliveries; and cited an additional benefit of early access to Prevention of Mother To Child (PMTCT) services as the programme enhanced the health of both the mother and the newly born child. It was stated that, *“There are programmes such as PMTCT that take place these days,...this is what encourages pregnant women to be willing to book early so that they get treatment if they are tested HIV positive” (KII Village Health worker).*

Some participants cited promotions held by local non-governmental organizations (NGOs) within the community as influential to pregnant women’s early booking and attending sufficient ANC visits. They pointed out to promotions held by some local NGOs that provide clothing incentives for pregnant mothers who have delivered at the health facility after attending all required ANC visits. A participant opined that, *“If a pregnant mother knows that there are some material benefits to early booking, they really make effort to deliver at the health facility after having attended a minimum 6 ANC visits” (KII Village Health Worker).*

Being knowledgeable of the services being offered by health facilities was noted to be influential also to pregnant women’s decision to visit the health facility early for ANC. Participants highlighted the educational activities conducted by village health workers. It was explained that community health workers raised awareness of the services offered at health facilities, explained the potential benefits for early use of ANC services and the presence of Mothers Waiting Shelters at the local health centres. A participant thought that, *“...it is the law of this country that every pregnant mother has a right to deliver from a health facility after having been booked there at 14 weeks so that they get treated if they have any infection that could affect them and the unborn baby (Participant; Female FGD).* Additional benefits including immunization were also cited by participants as motivating pregnant women to make ANC visits and deliver at the clinic. One of the participants stated that, *“There are important medicines administered to the newly born baby by the trained service providers; and these cannot be found at home” (Participant Male; FGD).*

In addition to the influence they get from service providers, participants indicated that pregnant women were influenced by their spouses and family members to make early ANC visits, and deliver from a health facility. Family members identified included the pregnant women’s partners, in-laws and other extended family members; who have accessed sexual reproductive health from clinics, mass media and community outreach programmes. Some pregnant mothers however, were motivated to deliver at a health facility by the need to secure child birth records. A report that came up from the discussions was that it was easy to get birth records after the mother had delivered at a health facility since the necessary information would have already been captured earlier by the health institution during ANC visits.

#### 4.0 Discussion of Major Findings

Findings from this study relate to issues of poverty, low knowledge levels on importance of ANC, embarrassment due to unwanted pregnancies, long distance to health facilities, lack of transport, and too busy with other work as barriers to early ANC visits and delivery at health facilities. These outcomes confirm results from previous studies in Zimbabwe and other countries; (Munjanja 2007; ZDHS 2010-11; Tekelab and Berhanu). Other studies in Zimbabwe however, revealed that lack of fees required by the health centres, lack of drugs, lack of service providers, not wanting to be alone, and failure to get permission from partner were barriers to early ANC utilization and delivering at health facilities (Munjanja 2007; ZDHS 2011-12).

Furthermore, this study showed that pregnant women were embarrassed to attend ANC visits when they had unwanted pregnancies in the event of having pregnancies too early, too late or too close. These outcomes corroborate studies carried out in Kenya, Egypt, Turkey and Ethiopia, which found out that pregnant women were not forthcoming for early ANC booking in the event of unwanted pregnancies (Jira and Belachew 2005; Erci 2003; Youssef et. al; 2002; Biratu and Lindstrom 2006; Fekede and Gebremariam, 2007). Reasons for getting embarrassed could be that it is not socially acceptable to get pregnant at those ages and times. These results also suggest low family planning practices; UNDP (2012) noted a decline of contraceptive use in the country from 62,8% in 2005/6 to 58,5% in 2010/11; and an increase in adolescence birth where the rate rose from 96 per 1000; to 100 per 1000 for females aged between 15-19 years. This evidence suggests the need to provide family planning interventions as early, too close and too late pregnancies are also risk factors for maternal morbidity and mortality.

An anticipated result was the presence of religious factors as a barrier to use of ANC services and delivering at a health facility. These outcomes correspond with other studies that identified religious beliefs as an obstacle to accessing health care including ANC (Chakawa 2011; Gore et, al. 2014; Maguranyanga; 2011; Munjanaja et, al. 2007). This is discouraging considering that pregnant women and their children from these religious groups do not benefit at all from the services provided at the health facilities. An implication of these findings is to design interventions targeting these specific religious groups to link them to health care services specifically on the use ANC.

Factors motivating pregnant women to utilize ANC services included the need for women to have their health checked, illness with current pregnancy, fear of complications, and being knowledgeable of sexual reproductive issues. These findings were also established from previous studies (Tekelab and Berhanu 2014; ZDHS 2010-11). This suggests the need to mainstream these motivators in designing policies on improving access to ANC and averting home deliveries.

#### **Recommendations for further studies**

Further studies should focus on models of demand creation for early ANC services; and explore strategies that can be used to improve knowledge levels on the importance ANC services.

## **5.0 Conclusion**

Barriers to early utilization of ANC services by pregnant women were as follows; embarrassment due to unwanted pregnancies, long distances to health facilities, lack of transport, traditional and religious beliefs, lack of knowledge on the importance of ANC, economic factors, poor utilities and negative attitude from the service providers. These factors also contribute to insufficient ANC visits and home deliveries. Factors encouraging pregnant women to book early for ANC services included the need to have their health checked, fear of complications, ill health, knowledge on the importance of ANC, and knowledge on the services available at health facilities including MWS. Strategies to promote health education on early ANC and services offered within health facilities should be implemented, taking into consideration specific religious groups that might not be using health care facilities, so that pregnant women can access ANC services in time and use the health care facilities for delivery.

#### **Authors Contributions**

The author worked on conceptualization of the study and drafting of the manuscript. Collet Muza contributed with drafting of the manuscript and refinement of methodology and Festas Mukanangana through refinement of methodology.

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