UTILISATION OF ANTENATAL CARE SERVICES IN RURAL PRIMARY HEALTH CARE FACILITIES IN MUTASA DISTRICT, ZIMBABWE

BY:

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Declaration

I, Tatenda Mukhalela (17008637) declare that this mini-dissertation entitled, "**Utilisation of antenatal care services in rural primary health care facilities in Mutasa District, Zimbabwe"** is my own work and it has never been submitted to any university by anyone else and all the sources used have been acknowledged in references and have been quoted throughout the academic paper.

Signature……

Tatenda Mukhalela

Dedication

This research project is dedicated to my parents, John and Elizabeth Mukhalela together with my husband, Brian Chido Damba and my siblings for their support and encouragement throughout this course.

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Abstract

The high maternal mortality ratio is caused by various factors, including avoidable complications which can be reduced by attendance to antenatal care visits. The utilisation of antenatal care has been low in rural areas, especially in Africa. The purpose of this study was to explore the utilisation of antenatal care in Mutasa District of Zimbabwe. This study used a qualitative study approach, adopting the descriptive, explorative design that presented an active image of the research participants' reality and capture live experiences. Participants of the study were pregnant women and women with children under the age of one. The participant were sampled using purposive and snow-ball sampling techniques. In-depth interviews were conducted. The participants were interviewed in their native language, Shona. The main question was: *Can you explain in your own words how you use antenatal care services from the primary health care facility?* The researcher clarified questions which the participant failed to understand. The researcher wrote down all responses and used a tape recorder to capture the responses. The researcher analysed data using thematic content analysis where themes and sub-themes were discussed. The main theme was low uptake of antenatal care in rural primary health care facilities. From the main theme there were factors influencing and perceptions of women on uptake of antenatal care services in primary health care facilities. Trustworthiness was ensured through credibility, dependability, transferability and conformability. Permission from the relevant authorities, such as the University of Venda Higher Degrees Committee, the Provincial Medical Director and the District Administrator was sought before conducting this study. Informed consent was also sought before interviewing the participants. The study concluded that socio-demography of participants affected antenatal care attendance. These are age, level of education, low income, high parity and distance to facility. Other hindering factors to utilization of antenatal care were lack of knowledge, religion and acceptability of antenatal care by the women in rural primary health care facilities. Findings will be disseminated through a research report and published in relevant accredited journals with the help of the supervisors. The study recommended that the Ministry of Health and Child Care of Zimbabwe review Antenatal Care policies to ensure friendliness and to increase awareness through health education and continuous dissemination of antenatal care information.

Keywords; **antenatal care, martenal mortality rate, pregnant women, utilisation**

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List of acronyms

WHO	:	World Health Organisation
UNICEF	:	United Nations Children's Fund
UNFPA	:	United Nations Fund for Population Activities
CIA	:	Central Intelligence Agency
MDG	:	Millennium Development Goals
UN	:	United Nations
HIV	:	Human Immunodeficiency Virus
MOHCC	:	Ministry Of Health and Child Care
TB	:	Tuberculosis

CHAPTER 1

OVERVIEW OF THE STUDY

1.1. Introduction and Background

Antenatal care grew over a period of more than a century. The trend shifted progressively from in-patient to out-patient form of care that is currently taking place in the 21st century. It was a rather late development to introduce this special care for women in developing countries (UNICEF, WHO, UNFPA and World Bank, 2010). This type of care is defined as intermediation by health care givers to curb maternal and infant mortality. It is also planned intervention of medical supervision of pregnant women directed towards making pregnancy a safe and satisfying experience until birth occurs (Amna, 2015). Antenatal care is concerned mainly with the prevention of complications as well as early diagnosis of diseases in pregnant women, such as malaria or diabetes, hence it is vital for women to initiate it early. Antenatal care also ventures into the treatment of general medical and pregnancy associated disorders (Phelphs, 2012).

Early antenatal care attendance is when a pregnant woman registers with a health care provider from the onset of pregnancy up to 12 weeks and late attendance (above the 12 week period). All pregnant women are urged to initiate antenatal care within the first 3 months of pregnancy (Phelphs, 2012). It is very vital as far as maternal health care and mortality is concerned. The high maternal mortality ratio is caused by avoidable complications which occur during pregnancy and can be noticed during ante-natal care visits. Diseases such as haemorrhage, malaria, anaemia and hypertension in pregnancy can cause morbidity if not discovered early (Lule, Ooman, Epp, Huntington, Ramanad, Rosenb, 2005). Antenatal care is a combined effort at improving the prevention of maternal mortality by allowing pregnant mothers to engage with their service providers in the discussion of matters concerning them and their young ones, in order to identify any complications and gain advice on healthy behavior during pregnancy (Lule et al, 2005).

Munjanja, Nystrom, Nyandoro and Magwali (2007) examined the three avoidable delays; namely, (1) delay in seeking care from a primary health care provider, (2) delay in reaching a primary health care provider once a person has decided to do so and (3) delay in accessing health care. These delays were found to have an effect on the overall maternal mortality rate (Munjanja et al,

2007). Thus the World Health Organisation (WHO) encourages health providers in all countries to make sure that all pregnant women in the locality can access the antenatal care services by means of organizing the services and scheduling all appropriate clinic attendances (WHO, 2014). WHO goes on to recommend that a pregnant woman should have 4 or more visits per gestational period. The first visit can be as soon as a woman misses her period up to 12 weeks, for booking. The second visit can be from 24 to 26 weeks, the third at 32 weeks and the fourth at 36 to 38 weeks. From the first visit the pregnant mother receives health education and disease prevention in terms of immunisation against tetanus, malaria, hookworms and anaemia. (WHO, 2016).

In Zimbabwe, 4 to 6 visits per pregnancy are recommended. The first visit is for booking at less than 12 weeks, which comprises of weight and height checking; blood pressure checking, HIV testing and blood group tests. Every woman is given an antenatal care number which will be used for all the visits and treatment is given for tetanus, malaria, syphilis and Tuberculosis if a pregnant woman is found to be infected with the diseases (Ministry of Health Zimbabwe, 2016). It also includes health education on pregnancy from conception up to birth and even up to postnatal period. All the visits have all these components, except at 32 weeks, where all the pregnant women have to test for HIV for the second time. There is a skilled health nurse at every primary health care center to assist the pregnant mothers and also provide antenatal care services (MoHZ, 2016). The WHO guidelines 2016 are used in the antenatal care booking register to make sure every woman has received appropriate care on every visit.

Maternal mortality ratio was recorded at 610 deaths per 100 000 in Zimbabwe in the year 2014 (WHO, 2014). In the year 2015 it dropped to 443 per 100 000 (CIA World Fact Book, 2016). Furthermore, the utilisation of antenatal care was very low before the introduction of the waiting mothers' homes in the rural areas. These are infrastructure constructed for the purpose of accommodation, serving pregnant mothers who have reached full term gestation period awaiting labor or with complications that need to be monitored by a professional health care provider. This was initiated as a strategy to reduce maternal mortality and it was a successful intervention, reducing maternal mortality to 443 per 100 000 in 2015. It also increased the utilisation of ante-natal care, pregnant women who live too far away from the rural clinics and hospitals have been utilising the homes but maternal mortality is still high (MoHZ, 2016).

WHO discovered that in2008 rural women were not attending antenatal care regularly, mainly because they had not yet grasped its importance. Rural clinics are usually under-resourced, and this discourages pregnant mothers from visiting the clinics. Health facilities have to be fully equipped with professionals to assist and give proper quality care, and they also need to be

properly developed (WHO, 2008). This will reduce maternal mortality, as mothers will be satisfied with the care. In most rural areas women only make one visit to the clinic for antenatal care, just to get the card and during labor to utilise the waiting mothers' shelter (WHO, 2008).

Pregnant women do not pay for any services rendered to them during pregnancy and when giving birth at government clinics. However, the country's economic state has affected the provision of the services in the health care centers. Thus there are shortages of equipment, drugs and skilled health workers have affected the health of the country at large, affecting mostly the pregnant women in the rural areas (UN, 2013).

The United Nations has confirmed that a rate of above 500 per 100 000 is a very high number for mortality and Zimbabwe is still far from reaching the target of under 71 deaths per 100 000, as recommended in the sustainable development goals (UN, 2013). In 2016 Zimbabwe's maternal mortality increased from 443 to 570 per 100 000 live births (CIA World Fact Book, 2016). Therefore there is still a gap to be filled to reduce maternal mortality in Zimbabwe. The present researcher aims at determining the utilisation of antenatal care in rural primary health care. Without the utilisation of ante-natal care during pregnancy, maternal mortality may continue to rise.

1.2. Statement of the Problem

In 2014 maternal mortality was recorded at 614 per 100 000 live births. Due to the successful implementation of the waiting mother's shelters in rural primary health care clinics, it dropped to 443 per 100 000 live births in 2015. In 2016 it rose to 570 per 100 000 and it is still rising (CIA World Fact Book, 2016). Recently, the Ministry of Health and Child Care of Zimbabwe reported 124 maternal deaths from January up to May 2017 and Manicaland districts had the most deaths (Chronicles Newspaper Zimbabwe, 2017). Maternal mortality in Manicaland was last recorded at 505 per 100 000, constituting the most deaths in the whole country (Ministry of Health Zimbabwe, 2016).

The present researcher observed whilst on an internship that antenatal care services are available in Mutasa District free of charge in all clinics, both public and private. However, utilisation was low. Out of the recorded 5760 who gave birth in the year 2016, ninety three percent (which is 5357 women) utilised the waiting mothers' shelter before delivery. Out of the total recorded, forty percent (2304 women) attended four or more visits. The low utilisation of antenatal care contributes to low detection of complications in pregnancies causing high maternal mortality rates.

However, despite the utilisation of antenatal care mostly in the last trimester, women are still dying, posing a threat to the future of the district. Hence maternal mortality remains very high in Manicaland.

1.3. Rationale of the Study

The researcher was motivated by her interest in the health and wellbeing of pregnant women, which is not often regarded as important in Africa. Rural communities are usually neglected, yet they are the most disadvantaged due to the economic crisis of the country. Studies done by Ye, et al (2010), Ren (2011), Onasoga, et al (2012), Shivam and Ye (2014) and Das, et al (2018) on the utilisation of antenatal care in other countries have been done quantitatively. However, this study will use a qualitative approach. Based on the present researcher's findings, there are no known studies on the utilisation of antenatal care in Mutasa district in Zimbabwe.

1.4. Significance of the Study

The health care providers may benefit through findings by understanding the knowledge of factors that influence the utilisation of antenatal care, in order to propose the new interventions that may increase attendance of antenatal care and/or maintenance of attendance. Health practitioners may also gain knowledge on the perceptions of pregnant women on antenatal care, giving them insight into the issues they might not have known.

Policy makers may use the information when formulating policies on antenatal care, including new strategies for increasing antenatal care attendance. This may contribute in the reduction of maternal mortality in the near future. The study findings may also be used to review and evaluate the implementation of antenatal care utilisation in rural areas.

Other researchers may use the study findings and recommendations to investigate further on antenatal care utilisation.

1.5. Aim of the Study

The main aim of this study was to explore the utilisation of antenatal care services by rural women in Mutasa District, Zimbabwe.

1.6. Objectives

The objectives that guided the study were:

1. To identify the factors influencing the utilisation of ante-natal care by women in rural primary health care facilities in Mutasa District, Zimbabwe.

2. To identify the women's perceptions on utilisation of antenatal care in rural primary health care facilities in Mutasa District, Zimbabwe.

1.7. Definition of Terms

Antenatal care: It is the intermediations done by health care givers to curb maternal and infant mortality by means of a planned intervention of medical supervision for pregnant women directed towards making pregnancy a safe and satisfying experience until birth occurs (WHO, 2016). In this study it will be defined as care that is given to a pregnant woman before 12 weeks of pregnancy to full term by a health care provider or professional.

Maternal mortality: The death of a woman during pregnancy, during birth, after 42 days of termination of pregnancy, irrespective of duration of pregnancy, from any cause related to the pregnancy or the management of the pregnancy, but not from accident or incidental causes (Ronsmans and Graham, 2006). In this study it will be known as the death of a woman due to pregnancy, termination of pregnancy and not by accident.

Primary Health Care: It is essential health care, based on hands-on, scientifically sound and socially acceptable methods and technology made totally accessible to individuals and families in communities through their full involvement and at a cost that the community and country can afford to maintain at all stages of their development in the spirit of self-confidence and self – willpower (WHO Alma-Atta, 1978). In this study it will be known as comprehensive care that is affordable, accessible, available and acceptable to the community.

Maternal waiting homes/ waiting mothers' shelter: A setting where pregnant women can be housed during the final weeks of their pregnancy near a hospital or clinic with essential obstetric facilities (WHO, 2016) In this study it shall be addressed as infrastructure constructed for the purpose of accommodation, serving pregnant mothers who have reached full term gestation period awaiting labor or with complications that need to be monitored by a professional health care provider.

Utilisation: The action of making practical and effective use of a service (Babitsch, Goh and von Langerke, 2012). In this study it will be addressed as the correct use or effective use of a health care service throughout the study.

Woman: A woman is a female human being (Collins English Dictionary, 2012). In this study a woman will be described as female in childbearing age and in this case one who is pregnant or having children less than one year of age.

Outline of chapters

In this study, the outline of chapters is as follows:

Chapter 1: Overview of the Study

Chapter 2: Literature Review

Chapter 3: Research Methodology

Chapter 4: Presentation and discussion of the findings

Chapter 5: Summary, Conclusions and Recommendations

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

The previous chapter described the overview of the study which is the introduction and background. It also outlined the problem statement, significance, rationale and objectives of the study. This section presents the available and reviewed literature related to the provision of ante-natal care services and utilisation of the services by women in rural primary health care. It will start by giving an overview of ante-natal care and its provision. The literature will identify and describe the factors influencing the utilisation of ante-natal care by mothers. These are socio-demographic, knowledge of mothers on antenatal care and service accessibility. The last section will provide a conceptual framework that will guide this study.

2.2. Overview and provision of Antenatal Care

Antenatal care is the care given to a pregnant woman at the onset of pregnancy up to the time of delivery, which is essential as it helps eliminate health complications throughout the pregnancy. It consists of the intermediations done by health care givers to curb maternal mortality and it involves planned intervention of medical supervision of pregnant women directed towards making pregnancy a safe and satisfying experience until birth occurs. (Phelphs, 2012). Antenatal care is concerned mainly with the prevention of complications and early diagnosis of diseases in pregnant women, such as malaria or diabetes. Antenatal care also ventures into the treatment of general medical and pregnancy-associated disorders (Amna, 2015).

The World Health Organization standards for antenatal care recommends that for every pregnant woman there should be four or more antenatal visits per pregnancy being assessed by a skilled health attendant. For women whose pregnancies have been found to have complications, more antenatal visits are recommended. The first visit should be within the first 12 weeks after conception as soon as signs and symptoms of pregnancy start to show. The second visit should be from 24 weeks up to 26 weeks of pregnancy, the third visit must be from 28 weeks to 36 weeks (preferably at 32 weeks) and the last visit should be from 36 weeks up to delivery (WHO, 2016).

Antenatal care provides pregnant women with health education, which is important, so that mothers can prepare for birth, knowing what to eat (nutrition education) and what to protect the

baby from (education on malaria, TB and HIV). Mothers should also be fully equipped with knowledge on what they need to do in order to prevent complications and maternal mortality (UNICEF, WHO, UNFPA and World Bank, 2010).

Many complications can be averted by attending antenatal care visits. The act of screening for HIV, malaria, tetanus immunisation and screening for worms is very important, as it helps discover complications and conditions that can affect the baby. These conditions include stillbirth, abortion, low birth-weight and neonatal tetanus (Ronsmans and Graham, 2006, Klipgat, 2009). Sub-Saharan Africa faces challenges in adhering to World Health Organization standards and health ministries are failing to integrate the standards into what the community receiving health care needs. Furthermore, African countries need to look into the resources they have and what the country needs, to identify the possible way of giving women the best antenatal care services (Centenary, 2010).

The World Health Organization (2016) is of the view that quality antenatal care services should have all the seven components. If one is not being done then the service is not of quality. The elements of quality antenatal care are, urine testing, blood testing, provision of supplements, measuring blood pressure, provision of tetanus injections, provision of intestinal parasite drugs and health education regarding pregnancy, warning signs and nutrition or disease education. Without these dimensions of antenatal care, according to the standard, there is no quality antenatal care being offered (WHO, 2016). These are technical aspects of antenatal care which can be further seen through the studies done in most African developing countries. In the study to determine quality of antenatal care and childbirth by Duysburgh, Zhang, Ye, Williams, Masawe, Sie, Williams, Mpembeni, Luokanova and Temmerman (2013) in Ghana, Tanzania and Burkina Faso, it was found that some technical aspects which provide quality antenatal care were not being followed. In Tanzania Duysburgh et al, (2013) found that counselling and laboratory examinations of the pregnant mothers were poor, as well as history taking. The counselling of pregnant mothers on danger signs, such as fever, vaginal bleeding, swelling of face or feet and convulsions, were not given by health practitioners. In Burkina Faso it was found that they had no testing kits for HIV and they also did not have essential drugs as well as laboratory supplies. In Ghana antiretroviral drugs were not available, hindering the utilization of the services by women because the provision was poor (Duysburgh et al, 2013).

Boller, Wyss, Mtasiwa and Tanner (2003) also looked at the technical aspects in their study to compare the quality of antenatal care in public and private hospitals in Tanzania. They focused on the assessment of history of the pregnant mothers, the diagnostic approach, Blood Pressure

measurement, urine tests, hemoglobin tests, provision of prophylactic drugs such as iron and physical examination. It was found that public hospitals' technical attributes were much better than in public hospitals, though quality was not satisfactory (Boller, et al, 2003). Therefore it is not possible to have quality antenatal care without the essential needs that should be provided by the health facilities. Fagbamigde and Idemudia (2015), in their study to assess the quality of Focused Ante-Natal Care in Nigeria, found that the most widely provided services were iron supplements and blood pressure. Receipt of good quality antenatal care was present in women who initiated the care earlier in their pregnancy and had four visits with a skilled health attendant (Fagbamigde and Idemudia, 2015).

Antenatal care provision is affected by availability of infrastructure, which is a necessity in providing good quality antenatal care. Rural communities are usually disadvantaged in regards to access to health care facilities. Insufficient infrastructure delays the quality of care negatively, therefore delaying the utilisation of care. Without infrastructure, service providers cannot give the quality care needed. A good clinic infrastructure should have water and sanitation, and should practice safe hygiene (Armar-Kleumuse, 2006). Without water, a clinic is not allowed to offer services and if it does not offer them, women's utilisation of antenatal care is decreased. In South Africa, it was affirmed that in rural areas infrastructure is poor in terms of diagnostic equipment that is supposed to be used to administer quality care. Infrastructure weaknesses cause poor quality of care and hinders the utilisation of care by rural women (Armar-Kleumuse, 2006).

2.2.1. Utilisation of Antenatal Care by Women

Utilisation of antenatal care services is affected by various factors, such as the socio-demographic factors. These include education of mothers, age of mothers and economic status. Knowledge of antenatal and accessibility of antenatal care will be discussed. Utilisation of antenatal care has always been a problem in both developed and developing countries, especially in rural areas. In rural Nepal it was reported that only 45% of women had their first antenatal visit after three months and 28% did not attend at all. The women attended antenatal care late for the first visit, particularly after 12 weeks (Neupane and Doku, 2012). In Japan 58% attended antenatal care in the second trimester, which means that they visited antenatal care clinics late, too (Ye, Yoshida, Harun-Or-Rashid and Sakamoto, 2010). Ren (2011) also found out the same in China where rural women were attending for the first visit in the second and third trimester (Ren, 2011). In a study to compare antenatal care attendance in rural and urban areas of Vietnam it was found that rural

women initiate antenatal care later than urban women, who initiate it at the onset of pregnancy. It was concluded that this was due to lack of awareness in the rural areas (Tran et al, 2011).

In African countries utilisation of antenatal care has also been shown to be a problem in rural areas, with Nigeria facing challenges in availability of health care staff. The shortage of twenty-four hour care services for women has resulted in many of rural Nigerian women having to go to traditional birth attendants for antenatal care. The women were disadvantaged when they seek antenatal care at local clinics, where only one nurse attends to the whole village and they get the chance to be seen late (Babalola and Fatusi, 2009). Gaede and Versteeg (2011) found that South Africa had the same problem too, on the shortage of health care nurses in the rural areas. It was also found that the areas where the greatest health care needs are found would be having the smallest share of resources. Lack of equipment and drugs affects the provision of the care (Gaede and Versteeg, 2011).

Uganda also faced a shortage of skilled staff in the rural areas, which had a negative effect on the utilization of antenatal care by rural women. Having a skilled attendant who knows the procedures to be followed on a woman attending antenatal care is a necessity and it helps in providing quality care. On the other hand, unskilled health attendants only increase maternal mortality rates because of the gap in knowledge (Centenary, 2010). In Zimbabwe shortage of nurses has also been found to be hindering the utilization of antenatal care. Rural clinics have at least two qualified nurses who attends to a lot of patients on a daily basis (Makate and Makate, 2017).

2.2.2. Socio-demographic factors

Education is by far the most important aspect in seeking health care. Studies have shown that uneducated women received less antenatal care than educated women. Joshi, Torvaldsen, Hodgson and Hayen (2014) conducted a study to find out the factors affecting the use and quality of antenatal care in rural Nepal and found that educated women (who had a tertiary education qualification) sought care more than uneducated women (Joshi, et al, 2014). Openshaw, et al (2011) conducted a comparison study between women in Birmingham and South Africa, which led to the discovery of lower attendance in women who have a low education status. Birmingham women, who attended more, had a higher education status (Openshaw, et al, 2011). In a study conducted in San Antonio, the same result was found, that a high education status affects the

utilization of antenatal care. Sixty percent of the women in San Antonio attended early antenatal care and it was attributed to the high education status (Sunil, 2010).

The age of the women also affect their need to get care. Older women get care more than the younger women, as shown by Joshi, et al, (2014). More women, due to their older age, know they are at risk, especially after the third child. Therefore they seek care more than the younger women. Furthermore, young women attend more care during their first pregnancy, and reduce utilisation of antenatal care during the second and third pregnancies, when there are no apparent complications in the first one (Joshi, et al, 2014). Tariku (2010) found that as the age of the women in Ethiopia increased through parity, the utilisation of care decreased and planned pregnancies increased antenatal care attendance (Tariku, 2010). This is attributed to low resources, time management and negative perceptions towards pregnancy. High parity comes with perceptions that all subsequent pregnancies will not have the same complications as the first one (Ali, et al, 2010). In Tanzania, a study which investigated factors associated with antenatal care services visits found out that the younger women had higher odds of attending than older women. It concluded that the women who were older were not attending as much as the younger women (Shivam, and Yea, 2014). Bayu, Adefris, Amano and Abuhay (2015) also concluded that Ethiopian women in the age 15 to 19 years were more likely to attend antenatal care visits than those from 35 and upwards which supports the findings of this study (Bayu, et al, 2015).

However, Das, Kanakamedala and Mummadi (2018) conducted a study in Telangana, India on the factors associated with utilisation of antenatal care services among rural women and found out that the higher the parity the more antenatal care visits are attended. The women in Telangana who had more than two children were attending more than those with less than 2 children. This is due to the risk that is attributed by being older. This study also revealed that the higher socio-economic status of the women in Telangana who were in the study area contributed to the high attendance of antenatal care in the clinics. Women of 25 years and younger were found to be attending less (Das, et al, 2018). This study is also in relation to a study which was done in India whereby women with a high parity were found to be attending antenatal care services more than young women with less children. It was also found out that these women also attended earlier due to the previous complications they had in pregnancies (Meshram, et al, 2014).

Sunil (2010) concluded that women who were married initiated antenatal care less, whilst a study by Gross, et al (2012) concluded that there was no relationship between being married and the utilisation of antenatal care, mainly because the pregnancies were planned (Gross, et al, 2012).

Economic hardships also reduces the likelihood of antenatal care services utilisation among women in rural areas and those with no jobs. Studies have confirmed that women who earn a salary or who have working partners are most likely to attend antenatal care services than those who do not have any working member in their family. (Haque and Haque, 2014). Das, Kanakamedala and Mummadi, (2018) supports the findings of this study with the conclusion that high socio economic status has an effect on the utilisation of antenatal care. This study concluded that women in rural and low socio- economic background did not use antenatal care services but those who have high socio-economic backgrounds found it easier to access antenatal care services at any time.

Rural areas are mostly poverty stricken making it difficult for people to access health care as it is not always free. Antenatal care services are now free in most parts of Africa but they get affected by shortages of equipment and drugs to sustain the health services provided. This shortage leads to lack of utilisation of most health services since most people would have to buy medicine and pay for health care services if there is such a shortage (Das, et al, 2018).

In a study of the determinants of maternal services in rural India, it was found that there is a relationship between low income and utilisation of care. Mothers who were from low income families did not make time to go for antenatal care services, compared to those with high income (Mbai, 2015). Joshi, et al, (2014) also reached the same conclusion. Women who were from poor families had low utilisation of antenatal care. On the other hand, rich women were at an advantage; care is accessible and affordable for them (Joshi, et al, 2014). Sunil (2010) found that a higher income makes it easy for the utilisation of antenatal care (Sunil, 2010). In a study to determine the role of community-level factors of prenatal care utilisation in Zimbabwe, it was found out that health expenditures prevented women to seek antenatal care. Pregnant women were affected by the cost of health care which comes with economic hardships that they are facing. Although health care for pregnant women is free, other illnesses that are not associated with pregnancy will need financial assistance (Makate and Makate, 2017).

Religion is one of the factors to utilisation of antenatal care services. It can either uplift health care uptake or degrade it where the individual's belief can be strengthened by church values to the extent that an individual can no longer see the importance of health care provision when sick. However, all religious groups have their different views on health and health care issues. Some promote health care acceptance with faith as a building block and some disregard it on the basis that faith heals on its own (Benjamins, 2005).

In Zimbabwe, Maguranyanga (2011) found out that among all the ultra- conservative Apostolic churches in the country, mostly in rural areas, religious teachings, doctrine and regulations of the church are mostly stressing on faith healing and total adherence to church orders, beliefs and practices. This always have an effect on the uptake of health care. Most of the religious groups are of the view that seeking spiritual counselling and faith healing should precede the use of medications. Women who are affiliated with such religious groups mostly follow the teachings and orders of the church as they are (Maguranyanga, 2011). Makate and Makate (2017) also concluded that religious composition of the community has a great influence on uptake of antenatal care. The religious teachings that pregnant women are given in their different religious background affected their need to seek health care mostly in a bad way (Makate and Makate, 2017).

Onasoga, et al (2012) concluded that religion had a significant association with antenatal care attendance. Those women in religious background attended less for antenatal care. Solanke, Oladosu, Akinlo and Olanisebe, (2015) conducted a study to find out whether religion has an effect on maternal health care services utilisation in Nigeria by use of the demographic and health survey data. The study concluded that Muslim women were attending less. This was attributed by the belief that sickness is a spiritual cause and can be treated spiritually (Solanke, et al, 2015).

Some diseases were classified into those that need spiritual healing and those that needed medical attention. Therefore their faith and belief decided for them when to seek health care and when not to reducing the attendance of women to antenatal care. The women would decide first whether going for antenatal care requires medical attention or spiritual. The attendance of antenatal care is also disturbed by the belief that some sicknesses are a result of the wrath of the Supreme Being as a punishment of sin, disobedience or lifestyle (Solanke, B L, et al, 2015).

However, according to Das, et al, (2018) religion had no role in the utilisation of antenatal care. In their study amongst Hindus and Muslims concluded that the women in those religions attended antenatal care which was mostly attributed to the high socio-economic status of the women. The results were attributed to the belief that the Muslims and Hindus have. They distinguish between diseases that are of the spirit and those that need health care attention. Pregnancy is seen as an important process that needs health care attention and therefore most of the women in these religious backgrounds attend antenatal care services and childbirth at the clinics (Das, et al, 2018).

2.2.3. Knowledge of women on Antenatal care

Knowledge of antenatal care is very important for women. Pregnant women should know everything from the initial visit, which is from onset to 12 weeks; second visit, from 24 weeks to 26 weeks; third, from 32 weeks and the fourth, from 36 weeks. Pregnant mothers should also understand that if complications are found during any of the 4 visits, then more visits are needed, to ensure the safety of both mother and child (WHO, 2016). Mothers also need to know what to eat during pregnancy and exercises to be done to ensure the safety of both mother and the child, in order to prevent complications.

Ye, Yoshida, Harun-Or-Rashid and Sakamoto (2010) found that Japanese women who did not have any knowledge on antenatal care did not receive care but those who knew what it is and all the benefits it brings were able to get care. Therefore knowledge plays a vital role in utilization of antenatal care services in urban or rural areas. However, in rural areas knowledge of antenatal services is not always available for the women (Ye, et al, 2010). Women in Malasyia did not know the importance of seeking antenatal care hence the utilisation was very poor (Rosliza and Muhamad, 2011).

Lack of understanding of the importance of antenatal care decreases utilisation. Pregnant women who have knowledge on antenatal care have a changed behavior (Ndidi and Oseremen, 2010). They will know why it is important and it increases utilisation of the services. They will also understand how it helps in the wellbeing of the baby and why it is important to have 4 or more visits. This is very important, and all women should know that (Mbai, 2015). Women in rural areas also lack knowledge on antenatal care and why it is important to visit a health care provider. Furthermore, they do not utilise the services provided for them (Hossain, 2010). In Uganda it was found that lack of knowledge was hindering women in utilising antenatal services, though the women needed to be taught on the importance of antenatal care to increase utilisation (Matua, 2004).

Between 2004 and 2005 in Zimbabwe more women went for antenatal care in the last visit. Most of the pregnant women had their initial visit in the second or third trimester. It shows that there was no knowledge of why the visits are done and why it is important to visit the clinic in the first trimester (UNICEF, WHO, UNFPA and World Bank, 2010). This shows that having an education on why antenatal care is important increases utilisation and when there is no knowledge there will not be a high utilisation of services (Singh and Khare, 2001). The Ministry of Health and Child Care of Zimbabwe found that adolescent pregnant mothers have little knowledge on antenatal care, as they are not taught about these health issues at school (MoHZ, 2007).

On the other hand, a study which was done in India showed that women had enough knowledge of antenatal care hence they attended more because they understood the importance of attending the antenatal care visits. These women were from rural areas in India but they were given enough education to promote their attendance (Das, et al, 2018).

2.2.4. Accessibility of antenatal care

Antenatal care should be accessible to everyone. It should also be accessible for all age groups – the young women and the older women; all races; the rich and poor, and the educated or uneducated. No one should be denied of the antenatal services, as attested by Kluge (2006). Every pregnant woman has a right to their visits at any clinic within their reach, and the health providers should not discriminate or deny care to the ones who would seek it. Pregnant mothers cannot utilise care that is inaccessible to them and there are so many issues associated with inaccessible care (Kluge, 2006). The structure of rural areas is different from urban areas, where the distribution of households is different from urban areas. Accessibility of antenatal care is also affected by the stigma and beliefs of the people in the community. Lack of confidentiality from skilled staff has been found to hinder antenatal care utilisation, and these experiences make the utilisation of antenatal care hard (Joshi et al, 2014). In rural Nepal, women who lived more than 2 kilometers from a primary health care clinic utilised care less and resorted to traditional methods. Most of them ended up consulting traditional birth attendants, rather than a skilled service provider (Neupane and Doku, 2012). Long distances to clinics also affected rural Nigerian women, and utilisation of antenatal care decreased (Fagbamigde and Idemudia, 2015).

Gross et al (2012) believe that women in rural areas attended antenatal care less, as a result of poor accessibility of antenatal care services in terms of long distances to the health centers which Ye, et al (2010) and Onasoga et al (2012) also concurred. The distance to antenatal care facility, availability of the transport and cost of the transport hindered women to seek antenatal care earlier (Gross et al, 2012: Ye et al, 2010: Onasoga et al, 2012). In rural Zimbabwe households are dispersed and a public clinic is placed where it is believed to be central. However, most pregnant mothers walk 5 kilometers or more to the clinics and they do not go for antenatal visits regularly due to the long distance. Amna, (2015) revealed that 72% of the women who booked late for antenatal care services had challenges of distance to the health care facilities. The clinics were too far away and the women always booked very late. Some booked and never went back for other visits meaning most of the women will have only one visit to antenatal care. Distance has been found to hinder the uptake of the antenatal care services (Amna, 2015).

Rural South Sudan women were also discouraged by the accessibility of antenatal care services. The long distances were aggravated by sparsely distributed population settlements and the semi – nomadic lifestyle of the people increased the distance to the health care facility. Some of the nearby clinics did not offer antenatal care services forcing the women not to attend as the clinics that were offering antenatal care services were very far away from their villages. This was a barrier to utilisation of antenatal care services in the rural women (Wilunda, Putoto and Takahashi, 2017).

However, in Zambia distance was never found to be a determining factor in the uptake of antenatal care services. It was found that knowledgeable women were attending regardless of the distance. Women in rural Zambia were given enough awareness and education on the importance of antenatal care. This provided the conclusion that knowledge and awareness of the importance of antenatal care were far much important in the uptake of antenatal care services since the women did not care about the distance that they have to walk but the protection and health of their pregnancies. Prevention of complications was far much important to the rural women than the distance they had to walk to get antenatal care (Kyei, et al, 2012).

2.2.5. Acceptability of antenatal care

Cultural issues such as language discourage some women from accessing antenatal care early and regularly, especially in the rural areas. When pregnant women attend antenatal clinics they want to communicate in a language they understand and they do not want to encounter problems when discussing matters relating to their pregnancy (Shaffer, 2002). The study done in Oyo-State in Nigerian local women revealed that communication barrier also affects utilisation of antenatal care in that area. This has been reported by several studies that women from a culturally and linguistically diverse (CALD) background in other cultures are less likely to access maternal and other health care services provided by health facilities due to language barrier (Ogundairo and Jegede, 2016).

The perceived attitude of staff also has a significant effect on attendance of pregnant mothers for antenatal care. If staff members have a bad attitude towards patients, the pregnant women may never wish to go again for care, to avoid that attitude (Shaffer, 2002). Hispanic women living in the US did not return for antenatal appointments because they felt staff were too harsh or simply reluctant to answer their questions (Tandon, 2005). A study that was conducted in Malawi, on the patient-provider relationship and antenatal care utilisation at two referral hospitals, revealed that pregnant women were not attending the services as a result of the attitude of nurses at the

hospitals. Pregnant women revealed that the nurses at the hospitals were always shouting and yelling at the clients. This prevented the women from going again to seek antenatal care services reducing the uptake of antenatal care amongst the women (Roberts, et al, 2015).

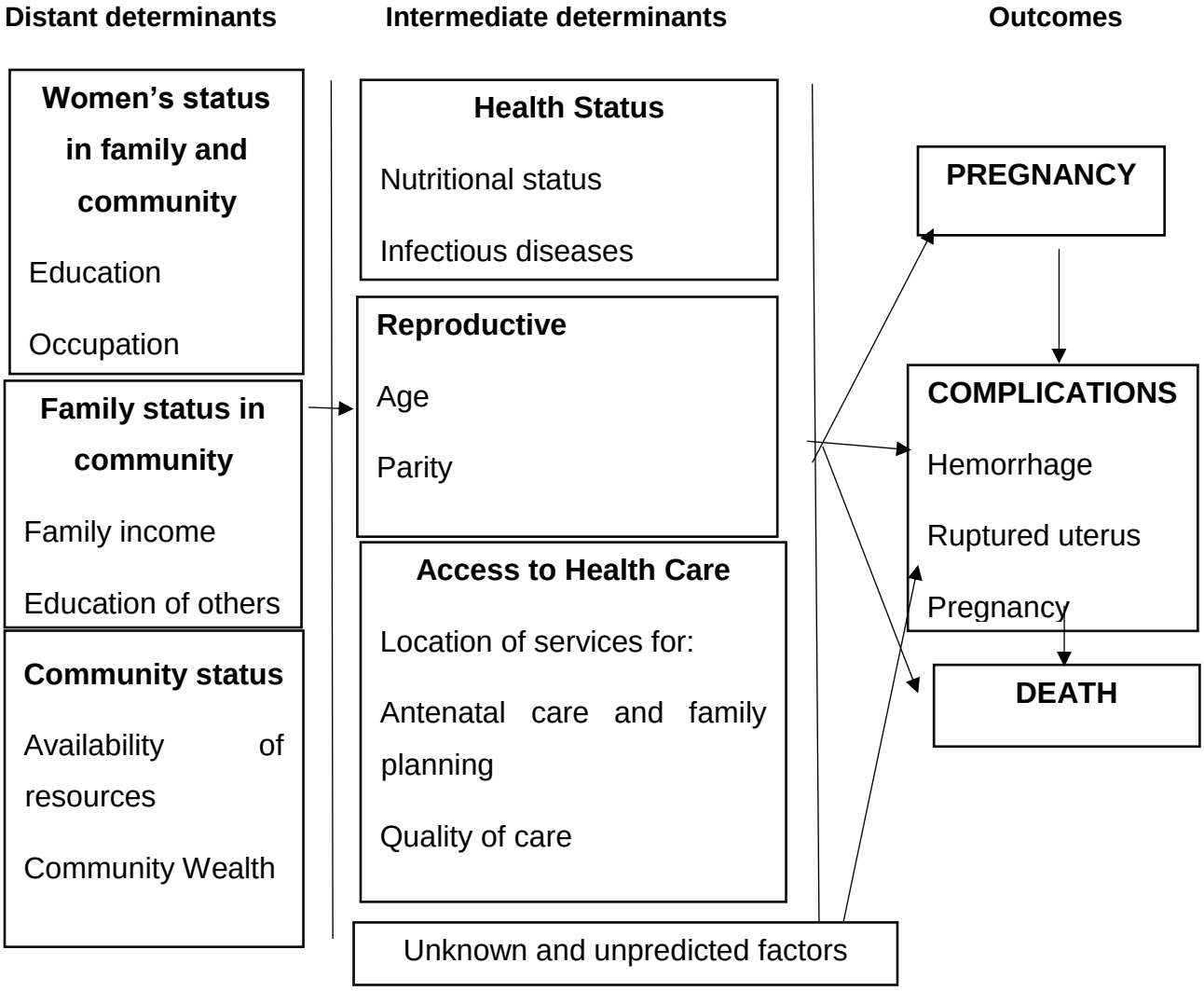
Solarin and Black (2012) conducted a study on women's antenatal care booking experience which revealed that a large proportion of pregnant women attend ANC late and the reasons given was the delay by health care workers in the provision of care and 40% of them were not booked in the first visit they were told to come back in another day ending up registering in the third trimester (Solarin and Black, 2012). Morgan, Tetui, Karanura, Ekirapa – Kiracho and Goerge (2017) found out that rural women were not attending antenatal care due to the rudeness and abusive behavior of the nurses providing antenatal care services. The women in the study area found the nurses to be rude to them and it reduced their antenatal care uptake. The study concluded that the attitude of the nurses is a determining factor in the uptake of antenatal services by the women in rural areas (Morgan, et al, 2016).

Ogundairo and Jegede, (2016) also conducted a study in the Oyo-State of Nigeria and found out that the attitude of the health care providers as perceived by the women was a determining factor in the uptake of antenatal care. The women had reduced antenatal care attendance due to the perceived attitudes of the health care providers (Ogundairo and Jegede, 2016). In a study to determine barriers to early utilisation of antenatal care services in Chipinge District of Zimbabwe, it was found out that pregnant women delayed registering due to the negative attitudes of the staff at the clinics (Gore, Muza and Mukanangana, 2014).

The gender of consulting staff has also been found to be a problem in some countries where pregnant mothers may not prefer to be seen by a male doctor or nurse due to their different cultural backgrounds. Tsianakas (2002) studied Islamic women living in Australia and found that the vision of being given an ultrasound services by a male doctor, rather than a female, caused them to cancel antenatal appointments. It was against their cultural background to be seen by a male who is not their husband (Tsianakas, 2002). These cultural misunderstandings may be considered disrespectful, as viewed by the women from various ethnic groups, and may create feelings of frustration, making the pregnant mothers fail to utilise antenatal care.

2.3. Conceptual Framework

This study adopted the concept from McCarthy and Maine (2002), which focuses on determinants of maternal mortality applicable to developing countries.



Source: McCarthy and Maine (2002)

Figure 1: Conceptual Framework

The concept of this study is based on the belief that there are elements that hinder the utilisation of antenatal care. These include women's status in community, looking at education, occupation and income status. Education level influences how they access health care and the knowledge they have on their health. If one does not know anything about the importance of seeking care, the utilisation of that care is limited. Women's income status influences their utilisation of antenatal care. Family status and income also act as an influence. As a result, poor women in the rural

areas may not utilise care because of the costs involved in accessing the care. Furthermore, clinics are too far away, and for a pregnant woman walking five kilometers to seek health care can be daunting. Shortages of near clinics and staff in the clinics may also discourage rural women from seeking health care. However they can also be discouraged by their nutritional status and presence of infectious diseases (McCarthy and Maine, 2002).

Age, parity and marital status are reproductive matters that may also influence the utilisation of antenatal care. As a person gets older and have more children, they might attend antenatal care less because they might think that they will never have any complications in the future if they have been having uncomplicated deliveries. Age and parity go hand in hand, in such a way that young women might also access care less when they are still young, for fear of stigmatisation by the community. The location of the health care services has to be accessible in order to get all the services and information regarding those services (McCarthy and Maine, 2002).

Women have to be knowledgeable about the importance of antenatal care, in order to have a clear view why they have to go there and why it is needed. These factors may lead to a complicated pregnancy, resulting in hemorrhage, pregnancy induced hypertension and ruptured uterus, just to mention a few. In some instances it may cause death (McCarthy and Maine, 2002).

This conceptual framework was used to guide the study in terms of the development of themes in data analysis, and to guide the researcher on the anticipated results. The framework was also used as a guide to present the results of the study.

2.4. Summary of Chapter

This chapter presented the available and reviewed literature related to the provision of ante-natal care services and utilisation of the services by women in rural primary health care. The literature identified and described the factors influencing the utilisation of ante-natal care by mothers. These were socio-demographic, knowledge of mothers on antenatal care and service accessibility. A conceptual framework that guided this study was also described.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

The previous chapter discussed the available and reviewed literature related to the study. This section describes the research design of the study, the study setting, population sample and sampling method. It will then describe the data collection instrument and method, data analysis method and ethical considerations. Lastly it will discuss the dissemination of the study findings.

3.2. Design of the Study

This study adopted the qualitative, descriptive and explorative research design. Qualitative research refers to the inductive, complete and procedure- oriented methods used to understand, interpret, define and improve a theory on a phenomenon or setting. It is a methodical, particular approach used to describe life experiences in the end give them meaning (Grove, Gray and Sutherland, 2016). The researcher used qualitative research, in order to generate an in-depth account that will present an active image of the research participants' reality and capture live experiences using the descriptive explorative study design.

Descriptive research refers to research that takes its main objective as the correct representation of the appearances of the people in study (Marshall, 2015). Exploratory research is the examination conducted to increase new insights, come up with new ideas and/or increase knowledge of a phenomenon (Grove, Grey and Sutherland, 2016). The researcher used the descriptive explorative study design, in order to investigate the utilisation of antenatal care and be able to collect data on real experiences of women in the rural areas.

3.3. Study Setting

This study was carried out in Zimbabwe in Manicaland (figure 2). The province which consists of a total population of 1 752 698 and an area of 36 459 square kilometers of which 83 % are rural areas (Zimbabwe Population Census, 2012). The study setting was in Mutasa District (green in color on map below), which has a population of 168 747 with 89 199 females. Mutasa has 43 health facilities offering health care services. Government clinics offer health services free of charge. The area is hot and endemic to malaria, giving reason for antenatal care utilisation, to

prevent malaria in pregnancies. Most of its primary health care clinics are situated more than 5 km from households. Thus pregnant women walk for long distances to reach health care. (Zimbabwe Population Census, 2012). The study was conducted at Sakupwanya and Mutasa Clinics residential catchment area.

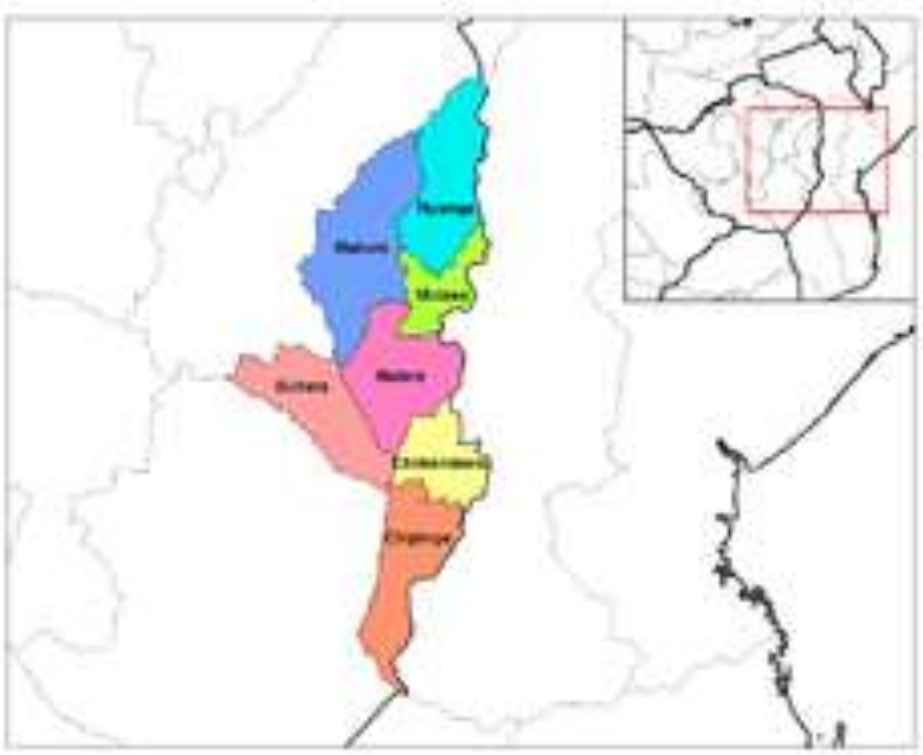


Figure 2: map showing Mutasa district, Zimbabwe.

3.4. Population and Sampling Procedure

Population is the inclusion of all the components that meet certain criteria for inclusion in a study (Grove, Grey and Sutherland, 2016). The target population comprised of all the pregnant women in the study area and childbearing women with children under 1 year. Purposive non-probability sampling was used for the study because it provides rich information for in-depth study and uses available and willing participants in the target group. Snow-ball sampling was also used to get the participants who were not utilising antenatal care services.

A sample is a subset of participants to be part of the research study, representing the total population (Grove, Grey and Sutherland, 2016). Two clinics were sampled purposively, to meet

the purpose of this study. The size of the sample for participants was controlled by saturation of information, which is determined when repetition of previously collected data starts to happen. Thus, there was no specific number of participants sampled (Streubert Speziale and Carpenter, 2011). A total number of 15 to 20 participants was anticipated but 11 participants were interviewed by the researcher.

3.4.1. Inclusion criteria

- Women who were pregnant.
- Women who had children under 1 year.
- Women who were pregnant but not attending antenatal care visits.

3.5. Data Collection methods

After the ethical clearance and permission had been sought from relevant authorities, the researcher conducted in-depth interviews from August 2018 to October 2018 during the day with the women. They gave consent prior to participating in the study. Narrative data from participants were recorded on a voice recorder and notes on socio-demographic data, such as age, marital status and education level, were jotted down in a notebook, as well as some of the responses from the participants. The researcher personally collected the data. The purpose of the study was explained to all the participants before they respond using the information sheet. The researcher did not manage to get assistance from the health care workers in getting the participants since there was a delay in response from the Ministry of health Manicaland province. The participants were interviewed in their homes. Each interview lasted +/- 40 minutes. The researcher used the questions on the interview guide (appendix 5). The researcher first sought participants' approval through visits in their homes then agreed on dates and times of the interviews. The participants chose when they wanted to be interviewed and the researcher conducted the interviews at those agreed dates and times. Finally, the participants were interviewed in their native language, Shona.

3.6. Data Collection instrument

The researcher made use of an interview guide to conduct the in-depth interviews in order to gain the bulk of the knowledge on the participants being studied. By using interviews, the researcher

wanted to include even the illiterate participants and to remove any difficulties of misunderstanding questions which eliminated any missing data from the responses. The interview guide had one opening question. Then the researcher probed further.

3.7. Data Analysis method

The researcher made use of the proposed steps in data analysis by Tesch, to transcribe and record data (De Vos, Strydom, Fouche and Delport, 2011). These are as follows:

(1) Familiarising with data: listening to the tape recorder, reading the transcriptions and making notes of ideas that come to mind.

(2) Generating codes: the researcher transcribed data and generated codes to represent the data.

(3) Searching for themes: the researcher then started arranging the similar topics into groups of unique topics and what does not fall under the two was put aside.

(4) Reviewing the themes: the researcher then started reducing the large topics into sub themes.

(5) Defining themes and sub-themes: The researcher then chose the titles of each section and arranged data alphabetically.

(6) Producing of report: presentation of final themes and sub-themes.

3.8. Trustworthiness

Trustworthiness is defined as the creation of validity and reliability of qualitative research. Qualitative research is trustworthy when it truthfully symbolises the experiences of the study participants (Streubert Speziale and Carpenter, 2011). The researcher achieved trustworthy by means of credibility, transferability, dependability and conformability.

3.8.1. Credibility

Credibility is demonstrated when participants are able to recognise the described research findings as their own experiences (De Vos, Strydom, Fouche and Delport, 2011). To ensure credibility, the researcher had prolonged engagements with the participants, spending time being orientated to the area of study before conducting the interviews. The researcher established a rapport with the participants, had a prolonged engagement and met with them at agreed times

and places. The researcher also used an independent coder to code the themes that emerged from the interviews.

3.8.2. Transferability

Transferability refers to the chance of the study findings having meaning to others in similar situations. It is when study findings of the research can fit into other situations similar to the described findings (Streubert Speziale and Carpenter, 2011). The researcher ensured transferability through exposing the study to colleagues for positive criticism and shared the findings with other women who were not be participating in the study. The supervisors were responsible for examining the results, analysis, and recommendations of the study.

3.8.3. Dependability

Dependability shows the consistency of the findings of the study, obtained through credibility, which is when participants are able to recognise the described research findings as their own experiences (Streubert Speziale and Carpenter, 2011). To ensure dependability, the researcher had the research findings audited by external experts which were done through the research supervisor. The research findings were subjected to examination by the Department of Public Health, University Higher Degrees Committee and the Research Institute, to ensure consistency. The findings were also disseminated to the participants who were able to recognise the described findings as their own.

3.8.4. Confirmability

Confirmability is when study findings have both credibility and transferability, meaning the findings can fit in another similar situation and participants are able to see the findings as their own experiences. The evidence and thought processes of the study must give another researcher the same assumptions as in the research context (De Vos, Strydom, Fouche and Delport, 2011). Conformability was reached through transferability, dependability and credibility, as well as through conducting an intensive literature review, to verify whether literature supports the findings or not.

3.9. Ethical Considerations

The researcher started by seeking permission from the relevant authorities, such as the University of Venda Higher Degrees Committee. The ethical clearance was obtained through application to the Research Ethics Committee at the University of Venda Research and Innovation Centre (annexure 1). The researcher also sought permission from the District Administrator of Mutasa and the village chiefs before conducting the study.

3.9.1. Informed Consent

The researcher sought informed consent before interviewing the participants. All the information relevant to the study was given to the participants through use of information sheet before they agreed to be part of the study. The information sheet was provided in English and the researcher explained in Shona to the participants. All participants were able to read and understand English and they were all Shona speaking.

3.8.2. Self-determination

The participants were given authority to either be part of the study or not, after reading the consent form, meaning they were allowed to quit at any time even after signing consent form. They were not forced to continue by the researcher. Voluntary participation was encouraged.

3.8.3. Confidentiality

Participants' names were kept confidential, meaning that the researcher did not use participants' real names when conducting the interviews. Furthermore, there were no names of participants on the tape recordings, transcription or notes. The researcher identified participants as participant 1, 2 and so on. Notes and recordings were kept in a locked safe place, in order to promote confidentiality.

3.8.4. Freedom from exploitation

The researcher ensured that no harm was done on participants, by making sure that interviews were done in a safe environment chosen by participants themselves. Furthermore, the information that the participants provided was not used against them.

3.10. Dissemination of Study Findings

Findings of this study will be disseminated through University of Venda in the form of a research report. The findings will also be submitted to the District Administrators office and the participants through community gartherings. The findings of this study will also be published in relevant journals with the help of the supervisors.

3.11. Summary of Chapter

This chapter described the research design of the study, the study setting, population sample and sampling method. It also described the data collection instrument, data analysis method, trustworthiness and ethical considerations. Lastly, it discussed the dissemination of the study findings.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1. Introduction

The previous chapter presented the research methodology which was used in this study. This chapter presents the findings of the study and a discussion of the results. It presents the data analysis according to themes and sub-themes to reflect the experiences of the participants and place the findings of the study into a proper perspective in relation to the relevant literature. The main aim of the study was to explore the utilisation of antenatal care services by rural women in Mutasa District, Zimbabwe.

The specific objectives of the study were to:

1. Identify the factors influencing the uptake of ante-natal care by women in rural primary health care facilities in Mutasa District, Zimbabwe.
2. Identify women's perceptions of antenatal care utilization in rural primary health care facilities in Mutasa District, Zimbabwe.

4.2. Presentation of findings

In-depth interviews were conducted on a total of 11 participants. The interviews lasted for +/- 40 minutes. Participants were interviewed in their homes, where they felt comfortable and safe. All the participants were sourced from the communities having sampled the clinics which had low utilisation of antenatal care; namely, Sakupwanya Clinic and Mutasa Clinic. Five participants were from the Mutasa Clinic Area and six were from Sakupwanya.

4.2.1. Participants' socio-demographic information

All participants were females aged from 20 to 43 years, most being younger than 30. Age is seen as a contributory factor to utilisation of antenatal care. Due to lack of awareness and education, young women may attend less, whereas older women may attend more due to complications that arise with multiple pregnancies. All participants had formal education ranging from form 2 as the lowest, to a tertiary degree, as the highest level. Most studies revealed that formal education affects the utilisation of antenatal care. Thus women who were not formally educated or had little formal education lacked proper understanding of antenatal care and its importance during

pregnancy. In terms of occupation, only 2 participants had some form of employment and 9 were unemployed. Lack of employment contributes to lack of utilisation of antenatal care in cases where health care needs financial assistance. All the participants were married. The average number of children for the participants was 3, and 5 of the participants were pregnant at the time of the interviews. This made them key participants in the study. Women with more children tend to attend less regularly if the previous pregnancies had no complications. Six participants had children under 1 year of age. The average distance to the facility for participants was 3 kilometers, with the longest being 5 kilometers away and the shortest being just a kilometer away. Most participants lived 4 to 5 kilometers away from the primary health care facility. All participants' walked to the nearest clinic. The distance to the facility affects the women's utilisation, such that it discourages them from seeking health care. Distance and lack of employment correlate, whereby women who live far away from the clinics need transport to attend antenatal care visits, which they cannot afford due to unemployment. Summary of the characteristics of the participants is shown in Table 4.1 below.

Table 4.1. Socio - Demographic information of participants

Characteristic	Category	Frequency	Percentage (%)
Age	20 - 30	6	54.55
	31 - 40	4	36.36
	41 – 50	1	9.09
Highest level of education	Form 1 to 6	7	63.64
	Degree	4	36.36
Occupation	Employed	2	18.19
	Unemployed	9	81.81
Marital status	Married	11	100
Parity	1 to 2 children	4	36.36
	3 to 4 children	6	54.55
	5 and above	1	9.09
Distance to facility	1 to 2 km	4	36.36
	3 to 4 km	5	45.45
	5 km and above	2	18.19
Transport used	On foot	11	100

This study found that most participants were young mothers aged 20 to 30 (54.55%). One participant was over 40 years. This shows that young women do not attend antenatal care, which contradicts with findings by Joshi, et al, (2014), who found that more women know they are at risk, due to their age, especially after the third child. As a result, they seek care more than the younger women. Young women were found to be attending antenatal care more during their first pregnancy. They then reduced their attendance throughout the second and third pregnancies, when there were no apparent complications in the first pregnancy (Joshi, et al, 2014).

Women with a tertiary education are more likely to attend antenatal care visits than those with just a secondary education, as seen from the results. Many participants had a lower level of education of under form 6 and were thus not attending antenatal care services. Joshi, Torvaldsen, Hodgson and Hayen (2014) found that educated women who had a tertiary education sought care more than uneducated women (Joshi, et al, 2014). Openshaw, et al (2011) also found that there is lower attendance among women from low education background in South Africa, as compared to the educated women in Birmingham (Openshaw, et al, 2011). In San Antonio, the same result was found, that a high education status affects the utilisation of antenatal care. Sixty percent of the women in San Antonio attended early and it was attributed to the high education status (Sunil, 2010).

Most participants in the study had no occupation. This is attributable to low income which is found to be a predisposing factor to utilisation of antenatal care. Mbai, (2015) found that there is an inverse relationship between income and utilisation of care. Mothers who were from low income families did not make time to go for antenatal care services as much as the ones with high income did (Mbai, 2015). Joshi, et al, (2014) concurred. The women who were from poor families had low utilisation of antenatal care. (Joshi, et al, 2014). Sunil (2010) also concluded that a higher income makes it easy for women to utilise of antenatal care (Sunil, 2010).

The participants were all married. This concurres with Sunil (2010), who concluded that women who were married initiated antenatal care less than women who were not married. However, Gross, et al (2012) found that there was no relationship between being married and the utilisation of antenatal care (Gross, et al, 2012).

The current study found that most participants had 3 to 4 children, which correlates with the findings that utilisation of antenatal care is affected by parity. Tariku (2010) found that as the age of the women in Ethiopia increases through parity, utilisation of care decreases and also found out that planned pregnancies increases antenatal care attendance (Tariku, 2010). Ali, et al, (2010)

concluded that high parity comes with perceptions that all succeeding pregnancies will have no complications as the first one (Ali, et al, 2010).

Most participants lived 3 to 4 kilometers away from the health care facility. Neupane and Doku, (2012) found that women who lived more than 2 kilometers from a primary health care clinic utilised care less and they resorted to traditional methods. Most of them ended up consulting traditional birth attendants, rather than a skilled western service provider (Neupane and Doku, 2012). Long distances to clinics also affected rural Nigerian women. Thus, the utilisation of antenatal care decreased (Fagbamigde and Idemudia, 2015). These results correlates with the findings of the current study.

Gross, et al (2012) also concluded that women in rural areas attended less antenatal care as a result of poor accessibility of antenatal care services in terms of long distances to the health centers. Ye, et al (2010) and Onasoga, et al (2012) also concluded that the distance to the antenatal care facility, availability of transport and the cost of the transport hindered women from seeking antenatal care earlier (Gross, et al, 2012; Ye, et al, 2010 and Onasoga, et al, 2012).

4.3. Presentation and Discussion of the findings from participants

The main focus of the study was to explore the utilisation of antenatal care services by rural women in Mutasa District, Manicaland. Table 4.2 below shows the themes and sub-themes that emerged from the raw data of the participants. These findings were collected from the pregnant women who were not attending antenatal care at the time of the study and those who had children who were less than 1 year of age and lived in Mutasa District. The women were residing in catchment areas under the Sakupwanya and Mutasa health facilities. The participants indicated the reasons that made them unable to attend antenatal care. The main theme from the results was:

Low uptake of antenatal care in rural primary health care facilities.

Two other themes emerged from the data with sub-themes (Table 4.2). The themes are as follows:

1. Factors that influence the utilisation of ante-natal care by women in rural primary health care facilities
2. Perceptions of the women on antenatal care utilisation in rural primary health care facilities.

Appropriate quotes from raw data and literature to substantiate the themes are discussed.

4.3.1. Main theme: Low utilisation of antenatal care in rural primary health care facilities

Antenatal care utilisation is low in Zimbabwe especially in the rural areas. It has been associated with several factors, which varied from each rural area. The Ministry of Health and Child Care (MOHCC) of Zimbabwe, after discovering the low utilisation of antenatal care in rural areas, developed the waiting mothers' shelter as an initiative to increase antenatal care attendance. Several studies have been conducted in the rural primary health care settings of Zimbabwe over the years. Different reasons for low utilisation of antenatal care have emerged.

From the studies conducted in Zimbabwean rural facilities, several factors emerged, such as socio-economic and socio-demographic factors, women's knowledge of antenatal care, accessibility and acceptability of antenatal care. Low utilisation of antenatal care was directly linked to these factors. The economic background of women reduces their antenatal care use. Other influences are socio-demographic factors like age, education and marital status.

Maguranyanga (2011) found that religion was among the important factors affecting the use of antenatal care. This is because certain churches did not allow the use of health care services. Religion made health care unacceptable to the rural women and communities. In Chipinge district of Zimbabwe, it was found that pregnant women had perceived negative attitudes from health care providers. The perceived negative attitudes prevented the pregnant women from attending antenatal care services (Gore, Muza and Mukanangana, 2014).

Makate and Makate (2017) discovered the community-level factors that were associated with low utilisation of antenatal care in Zimbabwean communities. These were contraceptive prevalence, religious composition, density of nurses, health expenditure and availability of government hospitals (Makate and Makate, 2017).

Table 4.2. Themes and sub-themes of the ante-natal care utilisation in rural primary health care facilities in Mutasa District, Zimbabwe

Main theme	Theme	Sub-themes
4.3.1. Low utilisation of antenatal care in rural primary health care facilities	**4.3.2**.Factors influencing antenatal care utilisation in the rural primary health care facilities	**4.3.2.1**.Knowledge Lack of understanding of importance antenatal care
		4.3.2.2. Affordability Economic status, Low income
		4.3.2.3. Accessibility Distance to facility
	4.3.3.Perceptions of women on utilisation of antenatal care services in primary health care facilities	**4.3.3.1**.Acceptability due to age
		4.3.3.2.Acceptability due to religion
		4.3.3.3.Preferred gender of health care provider
		4.3.3.4.Perceptions on attitude of health care providers
		4.3.3.5. Communication and interaction with health care providers

4.3.2. Theme 1: Factors influencing antenatal care utilisation in the rural primary health care facilities

Antenatal care utilisation is influenced by many factors. The study found that participants were able to share their views on the low uptake of antenatal care services as per their experiences. Lack of knowledge on antenatal care importance prevented women from attending antenatal care visits. Furthermore, pregnant women lacked knowledge on why it was important to attend antenatal care services. Participants also revealed that attending antenatal visits requires financial assistance.

The women did not attend these services because of the economic hardships they were faced with. They believed antenatal care needed to be affordable in order for them to attend. Participants

also indicated that antenatal care was not accessible. This is because money and time were required to reach the primary health care facility. The distance to the facility was unbearably long for them and it would need financial assistance which was possible due to the financial difficulties. These were the main factors that influenced the utilisation of antenatal care services.

Under this theme the following sub-themes emerged:

1. Knowledge – lack of understanding of the importance of antenatal care visits
2. Affordability – economic status, low income
3. Accessibility – distance to facility

4.3.2.1. *Sub-theme 1: Knowledge - Lack of understanding of the importance of antenatal care visits*

Knowledge and understanding of antenatal care has proved to be a vital determinant of antenatal care attendance. If women do not know why it is important, their visits are most likely to decrease. This study found that women had no knowledge of the importance of antenatal care. This is because most participants presented a lack of knowledge on the importance of antenatal care attendance. However, some participants showed that they have some knowledge on antenatal care but they did not know why it is important. Some women had no knowledge on antenatal care at all. Others did not want to know anything about antenatal care and its importance in the growth of the baby. Below are some of the responses from participants when they were asked if they knew about antenatal care and its importance.

> *"Iiiiii I don't know anything about on what you asked." (Participant 2)*

This participant continued and added the following:

> *"Ummmm firstly I don't really know much about the antenatal care services you asked me about. Secondly, when I get pregnant…ummmm you have seen my grandmother, whom I live with..eeeeh she does everything for me..all the checking and what not. " (Participant 2)*

Another participant responded as follows:

> *"I don't use the services at all. "(Participant 3)*

Some participants were aware of the services and what they are for but lacked an understanding of the importance of the services,as all of them did not attend them. The responses are as follows:

"Aaaah . these services I know about them but I just don't take time to understand them. I have never had the time to do that." (Participant 5)

"I have heard of those services and I know about them. A friend of mine goes to attend them at the clinic. At my church we are not allowed to do so; so I don't really know much about them. (Participant 6)

"I know you have to attend 4 or more visits. though I don't attend them anymore." (Participant 9)

"I don't know much about them. I only know it's for pregnancy." (Participant 11)

One participant reported that she did not know anything until the 5th pregnancy. The response is provided below:

"As old as I am now….I….I gave birth to my children…ah...I got to know some things about pregnancy and birth on my 5th child." (Participant 1)

Knowledge about antenatal care is vital in the uptake of antenatal care services. These findings correlates with the study which was conducted in Japan which found that Japanese women without any knowledge about antenatal care did not receive care. However, those who knew what it is and the benefits it brings were able to get care (Ye, et al, 2010). Therefore knowledge about antenatal care is a determining factor in the uptake of antenatal care amongst women in the rural areas. The study also revealed that in rural areas knowledge about antenatal services is not always available for the women. This was due to the shortages of health care providers in the rural clinics, whereby one or two nurses would be providing health care for a greater catchment area whereby all the services had to be given to the whole community. Some of the services were not being provided to the full capacity; hence those who attended antenatal care were not

provided with the full package of the services, resulting in some doubts and change of perceptions towards the services. Most of the rural women would go and not get attended hence it reduced their need motivation to go for the services as they were not being provided with the services at full capacity (Ye, et al, 2010).

Another supporting study in Malaysia concluded that women in rural areas did not know the importance of seeking antenatal care; hence, the utilisation was very poor. Rural women were not getting enough awareness on antenatal care matters. Furthermore, the importance of the development of the baby was not instilled in them; hence, they were not attending regularly (Rosliza and Muhamad, 2011). In addition, lack of understanding of the importance of antenatal care decreases its utilization. Pregnant women who have some knowledge about antenatal care can have changed behavior (Ndidi and Oseremen, 2010). Mbai, (2015) concurres with the study findings by stating that women who have some knowledge about antenatal care will know why it is important. This increases the utilisation of the services. They will also understand how it helps in the wellbeing of the baby and why it is important to have four or more visits therefore women have to be taught about antenatal care and its importance, in order to achieve the highest level of utilisation (Mbai, 2015).

The study findings also correlates with Hossain, (2010) who concluded that women in rural areas lack knowledge about antenatal care and why it is important to visit a health care provider; hence, they do not use the services provided for them (Hossain, 2010). The same was found among Ugandan women, that lack of knowledge was hindering women from utilising antenatal services (Matua, 2004). All these studies have the same findings regarding the lack of knowledge and understanding of rural women, which is a determinant of utilising antenatal care. The findings show a strong relationship between lack of knowledge and uptake of antenatal care by women in the rural areas.

On the other hand, a study which was conducted in India showed that women had adequate knowledge about antenatal care; hence, they attended more often because they understood the importance of antenatal care visits. These women were from rural areas in India but they were given enough education to promote their attendance (Das, et al, 2018).

4.3.2.2. *Sub-theme 2: Affordability - Economic status, Low income*

This study found that most participants were affected by economic hardships. The majority of the participants did not have any form of employment but were educated. Only two participants had

formal employment. Financial variability is one of the most important determinant of the uptake of antenatal care services in rural women, especially if both the woman and the man are unemployed. Low income has been found to be a pre-disposing factor in the uptake of antenatal care in this study. Most of the participants had no form of employment. The data showed that participants linked their low income status with their low uptake of antenatal care. Below is a response from one participant:

> *"As I said it is too far for me to go and me and my husband do not have jobs so there is no money to spend on transport to take me to the clinic for my visits. Money is not easy to find in this country, let alone in the rural area. It is hard. Again it is too much of a distance for a pregnant woman and I can no longer go for visits. I will only go for delivery." (Participant 5)*

Below is another response from a participant:

> *"…I could go to another clinic but it would be too far away. It is in the next village; so it's a long distance and I don't think I would have money to go there, considering the economic hardship in the country." (Participant 3)*

Participants also revealed that it is a waste of time and resources to attend the antenatal visits under the current economic situation in the country.

> *"You see…the clinic is too far away and I walk there for immunizations; now imagine going for checkups with pregnancy at such a distance. It is a waste of time for me plus I have never had a problem in any of my pregnancies. I don't have any problem with the medicine that grandmother gives for the pregnancies. It saves me a lot of time. I give birth at home with the help of grandma and it works for me." (Participant 2)*

> *"Plus it is just a waste of time for me to go up and down when I should be taking care of my family and looking for part time jobs. I would rather look for a job than walk 4 km just to get checkups for a pregnancy" (Participant 5)*

"It's just a waste of time to go and come back without being attended..sometimes the clinic will be flooded with people. It's stressing sometimes." (Participant 9)

Economic hardships reduce the likelihood of utilising antenatal care services by women in rural areas and those with no jobs. It is clear that a low economic status is greatly associated with lower levels of attendance, meaning that those women with low income do not attend as much as those with high incomes. Studies have confirmed that women who earn a salary or who have working partners are more likely to attend antenatal care services than those who do not have any working member in their family (Haque and Haque, 2014).

Das, Kanakamedala and Mummadi, (2018) concur with the findings of this study, that a high socio- economic status has an effect on the utilisation of antenatal care services. This study concluded that women from rural and low socio-economic background did not use antenatal care services. However, those from high socio-economic backgrounds found it easier to access antenatal care services. Rural areas are mostly poverty-stricken, making it difficult for people to access health care, as it is not always free. Antenatal care services are now free in most parts of Africa. However, they are affected by shortages of equipment and drugs to sustain the health services provided. This shortage leads to poor utilisation of most health services, as most people would have to buy medicine and pay for health care services if there is such a shortage (Das, et al, 2018).

In a study on the determinants of maternal services in rural India, it was found that there is a direct relationship between income and utilisation of care. As a result, mothers from low income families did not make time to go for antenatal care services and all the maternal care services, compared to those with high income. When the income is low, there is a high chance that the women will not receive all the health care services due to lack of money (Mbai, 2015). This finding correlates with the finding of the current study. Joshi, et al, (2014) also reached the same conclusion that women from poor family backgrounds had a low utilization of antenatal care.

On the other hand, rich women were at an advantage. This is because care is accessible and affordable for them (Joshi, et al, 2014). Sunil (2010) found that a higher income makes it easy for women to utilise antenatal care (Sunil, 2010). Therefore, low economic status affects uptake of antenatal care services among rural primary health care women.

4.3.2.3. *Sub-theme 3: Accessibility - distance to the facility*

Participants also shared their views regarding the accessibility of antenatal care services at the rural primary health care facilities. Participants mentioned accessibility as a contributory factor to the uptake of antenatal care. Participants were of the view that the health facilities are too far away from where they live, and this made it difficult for them to travel such long distances with a pregnancy. In rural Zimbabwe households are dispersed and a public clinic is placed where it is believed to be central. However, most pregnant mothers walk 5 kilometers or more to the clinics but they do not go for antenatal visits regularly due to the long distances.

The study shows that distance to the facility is a contributory factor to the uptake of antenatal care services in rural primary health care facilities.

Below are some of the responses from the participants.

> *"You see…the clinic is too far away and I walk there for immunizations. Now imagine going for checkups with pregnancy at such a distance..It is a waste of time for me plus I have never had a problem in any of my pregnancies. I don't see any problem with the medicine the grandmothers are giving me for the pregnancies. It saves me time. I give birth at home with the help of grandmas and it works for me." (Participant 2)*

> *"As I said, it is too far for me and my husband is unemployed, so there is no money to spend on transport, to take me to clinic for my visits. Money is not easy to find in this country let alone in the rural area. It is hard. Again it is a long distance for a pregnant woman and I can no longer go for visits. I will only go for delivery." (Participant 5)*

> *"…The clinic is too far away. When you are heavily pregnant, you cannot walk long distances anymore. (Participant 9)*

Many studies have shown that distance plays a role in the uptake of a health care services. In rural areas, the structure is different from what is in urban areas, where the distribution of

households is scattered, making it difficult to access a health care center. Rural residences are mostly associated with low utilisation of health care services. People who live in rural areas are most likely to attend fewer health care services provided. In rural Nepal, women who lived more than 2 kilometers from the primary health care clinic utilised care less and resorted to traditional methods. Most of them ended up consulting traditional birth attendants, rather than a skilled service provider (Neupane and Doku, 2012).

In the current study, the average distance was 3 kilometers from the clinic. Some participants walked 4 and 5 kilometers to the clinic and they responded that it was too long for someone who is pregnant. The distance itself prevented them from seeking antenatal care services and most of the participants preferred to go for immunisations and birth, rather than go when they were still pregnant. Amna, (2015) revealed that 72% of the women who booked late for antenatal care services had challenges of distance to the health care facilities. The clinics were too far away and the women always booked very late. Some booked and never went back for other visits, meaning that most women only have one visit to the antenatal care center. Distance has thus been found to hinder the uptake of antenatal care services (Amna, 2015).

Rural South Sudan women were also discouraged by the accessibility of antenatal care services. The long distances were aggravated by sparsely distributed population settlements and the semi – nomadic lifestyles of the people, which increased the distance to the health care facility. In addition, some of the nearby clinics did not offer antenatal care services, forcing the women not to attend the services, as the clinics that were offering antenatal care services were too far away from their villages. This was a barrier to the utilization of antenatal care services for the rural women (Wilunda, Putoto and Takahashi, 2017). Long distances to clinics also affected rural Nigerian women, and the utilisation of antenatal care also decreased (Fagbamigde and Idemudia, 2015).

Gross et al (2012) believe that women in rural areas who attended antenatal care are very little, as a result of poor accessibility of antenatal care services in terms of long distances to the health centers. This correlates with the findings of the current study. Ye, et al (2010) and Onasoga et al (2012) also concurred regarding accessibility of antenatal care being a determining factor in the uptake of antenatal care services. The distance to antenatal care facility, availability of the transport and cost of the transport hindered women from seeking antenatal care earlier (Gross et al, 2012: Ye et al, 2010: Onasoga et al, 2012).

However, in Zambia distance was not found to be a determining factor in the uptake of antenatal care services. It was found that knowledgeable women were attending regardless of the distance. Furthermore, women in rural Zambia were given enough awareness and education on the importance of antenatal care. This shows that knowledge and awareness of the importance of antenatal care were much important in the uptake of antenatal care services as the women did not care much about the distance that they had to walk but about the protection and health of their pregnancies. Prevention of complications was far more important to the rural women than the distance they had to walk to get antenatal care (Kyei, et al, 2012).

4.3.3. Theme 2: Perceptions of women on the utilisation of antenatal care services in primary health care facilities

Under this theme, the acceptability of antenatal care services category theme emerged. The study revealed that participants had different perceptions regarding the utilisation of antenatal care services. Acceptance of the antenatal care services is very important in the utilisation of the antenatal care services, hence, the women were able to share their views on their perceptions towards receiving antenatal care. Participants in the current study indicated that acceptance of antenatal care services has an effect on the utilisation of antenatal care. Thus women who did not accept the services provided and how they were provided did not seek antenatal care services at the clinics. The categories that were brought up under acceptability were age and religion. Preferred gender of health care providers, perceived attitudes of health care providers were other reasons for low utilisation of antenatal care. Communication and interaction with health care providers also emerged from the results. These were raised as issues which were hindering the women from utilising antenatal care. The views are discussed and described below.

4.3.3.1. *Sub-theme 1: Acceptability due to Age*

Participants indicated that age was also a factor in the utilisation of antenatal care services in rural primary health care facilities. The age of a woman at the time of her pregnancy is seen as an important factor which influences the utilisation of antenatal care services. Mostly, women aged 35 and above attend antenatal care more because of the complications that are assumed to arise when they become pregnant at that age (Shivam and Ye, 2014). Pregnancies that occur at that age range are considered a danger to both the mother and the child. Many birth defects such as Down's syndrome can occur. Therefore, women aged 30 or older are encouraged to

attend early for antenatal care services. The study also showed that women older than 40 are not willing to attend antenatal care due to the embarrassment they feel and the stigma surrounding being pregnant at 40 and above. This embarrassment makes them unwilling to attend antenatal care. The following is the respond from a participant.

> *" …eeeeh the young mothers would be laughing at me saying I am too old to be giving birth..it is embarrassing. I ended up not going for antenatal visits, I only went for the birth of my boy. I just told myself that as long as I have registered my pregnancy I will just go for delivery and that's what I did." (Participant 4)*

This response from the current study correlates with Joshi, Torvaldsen, Hodgson and Hayen (2014) who found that age affects the use and quality of antenatal care in rural Nepal. The study also showed that women reduce their utilisation of antenatal care services during the second and third pregnancies proving that high parity reduces utilisation of antenatal care. Most participants in rural Nepal reported that anticipated complications were less after the first pregnancy and therefore they reduced their visits to antenatal care services (Joshi, et al, 2014). In Tanzania, a study which investigated the factors associated with antenatal care services visits found that younger women had higher odds of attending antenatal care than older women. It concluded that older women do not attend antenatal care as much as younger women (Shivam, and Yea, 2014).

Tariku (2010) also found that as the age of the women in Ethiopia increased through parity, the utilization of care decreased and planned pregnancies increased antenatal care attendance. This means the decrease in antenatal care is attributable to unplanned pregnancies that happen mostly in older women. The study concluded that a high number of births comes with perceptions that all subsequent pregnancies will not have the same complications as the first one; hence the older women did not attend antenatal care as much as they did during their first pregnancies (Tariku, 2010).

Ali, et al, (2010) found that perceptions of pregnancy, such as fear of embarrassment reduces antenatal care attendance. This correlates with the finding of this study. Older women are more prone to embarrassment at the clinics for being pregnant at an old age than the younger women (Ali, et al, 2010). Bayu, Adefris, Amano and Abuhay (2015) also concluded that Ethiopian women aged 15 to 19 years were more likely to attend antenatal care visits than those from 35 years and upwards. This correlates with the findings of this study (Bayu, et al, 2015).

However, Das, Kanakamedala and Mummadi's (2018) study in Telangana, India on the factors associated with the utilisation of antenatal care services among rural women found that the higher the number of births, the more antenatal care visits are attended. Women in Telangana who had more than two children were attending antenatal care more than those with less than 2 children. This is due to the risk that is attributed to age. The current study also revealed that the higher socio-economic status of the participants in Telangana contributed to the high attendance of antenatal care. Younger women aged 25 years and younger were found to be attending less antenatal care (Das, et al, 2018).

The current study correlates with a study which was conducted in India whereby women with more births were found to be attending antenatal care services more than young women with less children. It was also found that these women also attended antenatal care earlier due to the previous complications they had in their pregnancies (Meshram, et al, 2014).

4.3.3.2. *Sub-theme 2: Acceptability due to Religion*

The majority of participants shared their views on religion as a reason for not attending antenatal care services at the clinics. Most participants were from church denominations which do not allow attendance of clinics whether, they are sick or not. Participants revealed their churches' names during the interviews. It was found that most of them were from one church. Most of these participants were from the Sakupwanya area. Participants revealed that their faith is more important than antenatal care and they cannot disobey church orders for earthly things. However, some had tried to disobey church orders but, forcing them to stop attending antenatal care services at the clinics. The participants cited religion as a reason for not attending antenatal care visits. Some of the responses are as follows:

> *"as I said the last time when you came, I was born in Johane Marange Church and I got married there, so all this clinic talk or going to seek health care we don't know much about it as a congregation because our church does not allow it. As it is, we don't visit the clinic at all." (Participant 1)*

"No. I don't use antenatal care services at all because of religion. At my church we believe faith heals everything. When my pregnancy is due I will give birth under attendance of church women assigned to my spiritual needs." (Participant 6)

"I don't use antenatal care services at all. My belief in God is strong. He is the provider of all services immunization and everything. I mean everything." (Participant 8)

"God governs everything, according to my church; so we don't use clinic services of any sort. "(Participant 10)

I grew up in this church and I have never needed health care from a clinic.. Anointed water from church is the key to everything in the life that we live as the Johane Maranges (the church). (Participant 11)

Another participant added a retraction of what would happen if they defied church orders and the experience she went through after defying church orders

"Haaaa… we used to just sit and relax and wait for the varapi (church health attendants) to help us. As I said, the church does not allow for any checkup of any sort. We just give birth at church, we don't use any medication during pregnancy or for any illness. It's not allowed but with my 5th child I went just to see what happens there. Somehow it helps because my boy is healthy and he is the only healthy child I have. Four died and the last one seems retarded or something...he is not ok but I cannot take him to the clinic now. When I went I was breaking the law of the church, I had to be reprimanded." (Participant 1)

The participant also explained what happens when one defies the rules and attends antenatal care services.

Haaaaaa, you can get thrown out of church. You will no longer be able to attend with other members. But as for me, I got reprimanded because I asked for

forgiveness and begged to return again as a born-again person. It's not allowed at all; it is against church protocol, everything is put before God. If you take any medicine you are already unclean; so if you ask for forgiveness, you get cleansed again and you can join the congregation. "(Participant 1)

Another participants responded as follows:

"Yoooh. You can get kicked out from our church but if you ask for forgiveness, you will be reprimanded and serve your time in the church to be holly again." (Participant 6)

One participant indicated that antenatal care services are important and that defying church rules is better than losing the children. This participant had lost four of her children.

"But for me, I will always sneak out and go because I have seen the importance of antenatal care so I take the children I am left with to the clinic every now and then." (Participant 1)

This study reveals that most participants do not attend antenatal care services due to their faith, beliefs and church orders. They followed a certain way of living, according to church doctrines. The doctrines do not allow use of medicines or attendance to clinics for any ailments. The study also shows that most women are afraid of what will happen if they defied the church rules. Some participants were adamant that faith is the way to go on everything and would not attend any antenatal care services at the clinics.

According to their belief, antenatal care is provided by the holy church and spiritual beings in the church. Therefore, acceptance of any services outside the church vicinity is a sin. The antenatal care services provider in the church was identified as the 'Varapi' by the participants. They are the ones who give all health care services amongst the church members. Studies have shown that religion is one of the social institutions that shape individual and community health behavior through the influence it has on congregants' lifestyle, worldviews and motivation.

Religion can uplift health care uptake or degrade it as shown in the current study. The individual's belief can be strengthened through church values, to the extent that an individual no longer sees the importance of health care provision when sick. However, all religious groups have their different views on health and health care issues. Some promote health care acceptance, with faith as a building block, while some disregard it on the basis that faith alone heals (Benjamins, 2005).

In Zimbabwe, Maguranyanga (2011) found that among all the ultra-conservative Apostolic churches in the country, religious teachings, doctrine and regulations of the church mostly stress faith healing and total adherence to church orders, beliefs and practices. This always has an effect on the uptake of health care. Furthermore, most of the religious groups are of the view that seeking spiritual counselling and faith healing should precede the use of medications. As a result, women who are affiliated with such religious group mostly follow the teachings and orders of the church to the letter (Maguranyanga, 2011).

A certain church found in Mutasa District, as found by Maguranyanga (2011), forbids church members from using any modern medicine and health care, even among pregnant women. The use of modern medical services is seen as exhorting man above God and it is classified as being 'worldly' or 'of the devil'. Once a pregnant woman seeks health care during pregnancy, they are considered to be of the devil. The use of modern health is also seen as a sign of weak faith, and to have strong faith all pregnant women have to be sent to the church clinics or healing centers. These offer their own antenatal care services. Once a pregnant woman presents complications during pregnancy they are considered as one with sin or one who has committed adultery, and they are forced to confess (Maguranyanga, 2011). Another study was conducted in Chipinge district on the role of community-level factors on prenatal care utilisation in Zimbabwe. The study found that religious composition has a way of influencing pregnant women regarding whether to seek health care or not (Makate and Makate, 2017).

The findings of the current study correlates with Maguranyanga (2011). The women in the current study were not receiving antenatal care services as a result of the church orders that govern them. Most of the participants' reason for not attending antenatal care was religious belief. One participant tried to defy church rules after four of her children had died during child birth at the church clinic. She disobeyed church rules and was punished. Most of the women had grown up in this church environment and were content with the rules that they had to follow when they are pregnant. It is evident that those who grew up in the church, following the church rules, had no reason to accept antenatal care as an option or to even accept its importance in the healthy growth of the child (Maguranyanga, 2011).

Onasoga, et al (2012) concluded that religion had a significant association with antenatal care attendance. Thus, women with religious background attended less antenatal care. Solanke, Oladosu, Akinlo and Olanisebe, (2015) conducted a study to find out whether religion has an effect on maternal health care services utilisation in Nigeria. The researchers used demographic and health survey data. The study concluded that Muslim women were attending less antenatal

care. This was attributed to the belief that sickness is a spiritual cause and can be treated spiritually (Solanke, et al, 2015).

Some diseases were classified into those that need spiritual healing and those that needed medical attention. Therefore, their faith and belief decided for them when to seek health care and when not to; thus reducing the women's use of antenatal care. The women would decide first whether going for antenatal care required medical attention or spiritual intervention. The attendance of antenatal care is also influenced by the belief that some sicknesses are a result of the wrath of the Supreme Being as a punishment for sin, disobedience or lifestyle (Solanke, B L, et al, 2015).

However, according to Das, et al, (2018) religion had no role in the utilisation of antenatal care. In their study amongst Hindus and Muslims, these researchers concluded that the women in those religions attended antenatal care. This was mostly attributed to the high socio-economic status of the women. The results were attributed to the belief that the Muslims and Hindus have. They distinguish between diseases that are of the spirit and those that need health care attention. Pregnancy is seen as an important process that needs health care attention and therefore most of the women from these religious backgrounds attend antenatal care services and childbirth at the clinics. This study contradicts with the current findings (Das, et al, 2018).

4.3.3.3. *Sub-theme 3: Preferred gender of health care providers*

Participants were of the view that the gender of the presiding health attendant makes it difficult for them to utilise antenatal care. Male health attendants or nurses were not preferred by some participants with regard to antenatal care services. Participants valued their privacy and pointed out that it was a disgrace in their culture to receive antenatal care from someone of the opposite gender.

> *"ummmmmm I don't go there because my husband discourages me from going. You see the culture I am married to is different from mine. There is a male nurse at the clinic and though there is also a female nurse. the fact that there is a male nurse is the reason why I don't go. My husband says being seen by a male nurse is more like cheating." (Participant 3)*

Participant explained their perception about the gender of the attendant providing health care, as explained by the husband. The partner had an influence on the decision taken by the women regarding attending antenatal care services. Participant goes on to say:

> *"Imagine you are wearing a dress and you have to open up so that they can feel the baby inside the womb, so everything is naked and the nurse sees you even if you have your panties on. It is weird, don't you think? My husband says if you go and get touched by that man you have already cheated. I understand where he is coming from though." (Participant 3)*

This study revealed that if the barrier of gender were to be removed. more women would attend antenatal care services. This is based on the response of a participant, after being asked if they would increase uptake of antenatal care services provided change of gender of health care providers.

> *"I would attend antenatal care because the barrier would have been removed. They should put only female nurses in the clinic. Imagine now you want to give birth and there is a male nurse, given my husband's concept of cheating, I would be cheating already in the labour ward. I don't blame some men for disputing that antenatal care is just about health and nothing else." (Participant 3)*

The gender of the consulting staff has been found to be a problem in some countries, mostly in the rural areas, where pregnant mothers may not prefer to be seen by a male doctor or nurse, due to their cultural backgrounds. Participants revealed that the culture where you marry into has an effect on health-seeking behavior. It prevents seeking health care from a male nurse, showing that if one does, so they will be seen as adulterous. Therefore, women in such cultures cannot seek health care where there is a male health practitioner. The study found that if there was a female nurse providing antenatal care, they would attend antenatal care more, which means that a male nurse is seen as a barrier to the utilisation of antenatal care.

The findings of the current study correlates with Tsianakas (2002) who studied Islamic women living in Australia and found that the vision of being given ultrasound services by a male doctor, rather than a female, caused them to cancel antenatal appointments. It was against their cultural background to be seen by a male who is not their husband. This is a result of the procedures in antenatal care, whereby if a nurse has to perform a palpation, there is need to remove the clothes

covering the stomach, and uncovering the stomach is seen as disobedience to the culture of the women. Only the husbands of the women are allowed to see or touch their stomachs (Tsianakas, 2002).

These cultural misunderstandings may be considered disrespectful, as viewed by the women from various ethnic groups, and may create feelings of frustration, making the pregnant mothers fail to utilize antenatal care.

4.3.3.4. *Sub-theme 4: Perceptions on attitudes of health care providers*

The attitude of health care workers, as perceived by the pregnant women, has much influence when it comes to the acceptance of antenatal care services by pregnant women in most countries. It has a direct influence on the satisfaction of clients and is often viewed as a measure of the quality of health care provided. Participants were of the view that the nurses' attitudes prevent them from attending antenatal care services. The way the services were provided was not favorable for the participants.

One participant described their experiences with nurses as a reason why they do not attend antenatal care services anymore:

> *"My first visit was late and at first I got scolded for coming late but I did not care I wanted my baby to survive. I got discouraged from going again but I ended up going for all the visits that I was supposed to get, because of the time I had left in my pregnancy. The nurses would scold you if you were late, they said I was supposed to come within the first 3 months to register and I was already 4 months pregnant. But the rest of the visits I was never late, despite the distance which is tiresome." (Participant 1)*

Another participant responded as follows:

> *"I faced some challenges during my last pregnancy. Like I said I am 43 years old now. I have this young boy I gave birth to in my early 40s. so upon going to the clinic to register my pregnancy, the problem I faced was that the nurses, were concerned about my age and were rude, I decided not to go anymore for checkups. I only went once and I got scolded and asked why I was getting pregnant at my*

age. They said I am too old and past the age of conceiving and I am putting myself at risk." (Participant 4)

The participant added the following:

"I am a BP patient as well, so they said a lot of things. The pregnancy just happened at that age, it was not planned, so the way they talked to me about it, I did not like it at all, although I understood their concern. So, I stopped going because it was belittling, there would be young women there and I was already embarrassed, so I could not let myself be embarrassed again and again and I stopped going." (Participant 4)

Another participant shared the following views on their encounter with nurses at the clinic:

"…My first experience with the nurses was that they were not welcoming and the fact that when you are late they don't attend to you. They make you wait but you would have come from far. They also complain that we come smelling…haaaa what do you expect from someone who has walked a long distance to get to the clinic. Or should we rather bath when we arrive? They should be considerate…we all sweat. "(Participant 9)

The study revealed that the nurses' attitudes in the rural primary health care facilities was not favorable to the women attending antenatal care. This had an influence on their uptake of antenatal care services. Therefore, the attitude of the nurses reduced antenatal care attendance of women in the rural areas of Mutasa District. Participants did not like the way they were treated at the rural clinics. They described the attitude as unwelcoming or rude. Participants also revealed that they acknowledged the reasons why the nurses shouted at them, such as late attendance and putting themselves in danger, for example, being pregnant at over 40years. However, the way the concerns were delivered was not favorable to them; they preferred kindness and proper exchange of words between client and health provider. Yelling and rudeness were not favorable to them.

If staff members have a bad attitude towards patients, the pregnant women may never wish to go there again for care, to avoid that attitude. Good attitudes are associated with an increase in

the utilisation of antenatal care (Shaffer, 2002). The study findings correlates with the findings of the study on Hispanic women living in the US. They were found to stop attending antenatal services because they felt staff were too harsh or simply reluctant to answer their questions (Tandon, 2005).

A study conducted in Malawi, on the patient-provider relationship and antenatal care utilisation at two referral hospitals, revealed that pregnant women did not attend antenatal care services as a result of the attitude of nurses at the hospitals. The pregnant women revealed that the nurses at the hospitals were always shouting and yelling at the clients. This discouraged the women from going again to seek antenatal care services reducing the uptake of antenatal care amongst the women (Roberts, et al, 2015).

Solarin and Black (2012) conducted a study on women's antenatal care booking experiences, which revealed that a large number of pregnant women attend antenatal care late. The reason given was the delay by health care workers in providing care and 40% of them were not booked in the first visit but were told to come back another day, ending up registering in the third trimester (Solarin and Black, 2012).

Morgan, Tetui, Karanura, Ekirapa – Kiracho and Goerge (2017) found that rural women were not attending antenatal care due to the rudeness and abusive behavior from the nurses providing the services. The participants found the nurses to be rude to them; this reduced their antenatal care uptake. The study concluded that the attitude of the nurses is a determining factor in the uptake of antenatal services by women in rural areas (Morgan, et al, 2016).

Ogundairo and Jegede, (2016) conducted a study in the Oyo-State of Nigeria and found that the attitude of the health care providers as perceived by the women, was a determining factor in the uptake of antenatal care. Antenatal care attendance was low due to the perceived attitudes of the health care providers (Ogundairo and Jegede, 2016).

4.3.3.5. *Sub-theme 5: Communication and interaction with health care providers*

Communication barriers were also found to hinder the utilisation of antenatal care in rural women. Health providers and clients can only understand each other when communication is in one language. Change in language can distort communication and prevent the client from receiving health care. Participants in the current study were of the view that communication during the visits

was distorted due to a lack of understanding between the health care provider and the clients in terms of the language. Mutasa District is an area of the Manyika people, a Shona Dialect. One participant responded as follows:

> *"I do attend the services but not always. I got transferred from Chipinge to Mutasa district and it's a hustle to adapt to the changes in language. Here they speak differently to the way I am used to; so I am always misunderstood and I also do not get to understand what the nurses are saying sometimes. So I have stopped going for a while..I am learning to speak and understand Manyika, so that there are no misunderstandings the next time I will go for checkups." (Participant 7)*

The study revealed that language can act as a barrier to the utilisation of antenatal care. The uptake of antenatal care declines when service providers and clients are not in full understanding of each other. This is because language discourage some women from accessing antenatal care early and regularly, especially in the rural areas. When pregnant women attend antenatal clinics, they want to communicate in a language they understand and they do not want to encounter problems when discussing matters relating to their pregnancy (Shaffer, 2002).

Participants from different Shona dialects (Ndau- speaking) had some difficulties accessing antenatal care because there was always a communication barrier between the client and health provider. The study area comprises of Manyika-speaking people, which is entirely different from the Ndau, Zezuru and Karanga. A person from a Ndau-speaking area can barely understand the Manyika type of Shona and it would take some time to practice it. It was thus hard for participants to fully access antenatal health care services due to the communication barrier.

The study conducted in Oyo-State in Nigerian local women revealed that communication barrier also affects the utilization of antenatal care in that area. This has been reported by several studies, that women from a culturally and linguistically diverse (CALD) background in some cultures are less likely to access maternal and other health care services provided by health facilities due to language barriers (Ogundairo and Jegede, 2016).

4.4. Summary of chapter

This chapter analysed data collected from the participants. The findings were analysed and discussed. Different themes and sub - themes were identified and linked with the participants' responses during in depth interviews. The main theme was low uptake of antenatal care in rural primary health care facilities, followed by the following themes:

1. The influencing factors on antenatal care utilisation in rural primary health care
2. Perceptions of women on the utilisation of antenatal care services in primary health care facilities

The first theme had the following sub-themes:

1. Knowledge – lack of understanding of antenatal care importance
2. Affordability – Economic status, low income
3. Accessibility - distance to facility

The second theme had the following sub-themes:

1. Acceptability due to age
2. Religion
3. Preferred gender of health care providers
4. Perceived attitude of health care providers
5. Communication and interaction with health care providers

These themes and sub-themes were analysed and discussed in the context of the literature in general.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The previous chapter presented the analysis and discussion of the data collected from the participants. The different themes and sub-themes were identified and linked with the participants' responses recorded during the in-depth interviews. This chapter presents the summary of all the chapters and findings of the study. The recommendations are also presented based on the study findings. The strengths and limitations of the study are also discussed.

5.2. Conclusions from the study

The main aim of the study was to explore the utilisation of antenatal care in rural primary health care facilities in Mutasa District, using two purposively sampled clinics which had low utilisation of antenatal care in the district. The study had two objectives, which were:

1. Identify the factors influencing the utilisation of ante-natal care by women in rural primary health care facilities in Mutasa District, Zimbabwe.
2. Identify the women's perceptions on the utilisation of antenatal care in rural primary health care facilities in Mutasa District, Zimbabwe.

A qualitative, explorative and descriptive study design was employed, with the target population being the women of childbearing age who were not attending antenatal care services in the rural areas of Sakupwanya and Mutasa Clinics catchment. Purposive sampling was used to sample participants. The researcher interviewed 11 participants based on data saturation. An interview guide was used with socio-demographic indicators and one opening question, whereby the researcher probed further during the interviews. The themes and sub-themes which emerged from the data were discussed using supporting literature. The findings of the study were as follows:

1. Factors influencing the utilisation of ante-natal care by women in rural primary health care facilities in Mutasa District, Zimbabwe.

Socio – demographic factors

It was found that young women were not attending antenatal care services at the clinics. Most participants were aged 20 to 30 years and were not attending antenatal care services at all. A lower level of education was greatly associated with low utilisation. Furthermore, lack of jobs affected the utilisation of antenatal care by pregnant women due to lack of income to finance their health care. Pregnant women had no money for transportation, as they lived 4 to 5 kilometers away from the health care facility due to lack of income caused by unemployment. Parity (number of children) also affected utilisation of antenatal care. Women with more than two children were not utilising antenatal care services.

Knowledge

Pregnant women in the rural primary health care facilities lacked the knowledge about the importance of antenatal care attendance. Women were given no knowledge due to lack of health care practitioners. The lack of knowledge on antenatal care directly influenced the need to seek antenatal care services from the rural primary health care facilities.

Affordability factors

Most pregnant women and their spouses were unemployed. The economic hardships due to lack of income influenced their uptake of antenatal care in a negative way. Low income directly affected the use of antenatal care by the women in rural primary health care facilities.

Accessibility factors

Distance to health facility had a negative impact on the utilisation of antenatal care. Women in the rural areas lived 4 to 5 km away from the health care center and that meant higher transport costs, which is not attainable due to the low economic status. The long distance to the clinic discouraged them from attending antenatal care services.

2. Women's perceptions on the utilisation of antenatal care in rural primary health care facilities in Mutasa District, Zimbabwe.

Acceptability of antenatal care was found to be associated with age. Thus, pregnant women who were older did not attend antenatal care services due to the embarrassment they went through and the stigma as a result of being pregnant and be over 40 years.

Religion also has a direct influence on antenatal care attendance. The majority of the women were affiliated to a religion that does not allow attendance of health care facilities. Pregnant women followed religious faith and church orders, thus reducing antenatal care attendance.

The gender of staff at the clinics was not acceptable to some women from strong cultural backgrounds. Male nurses were not preferred, hence reducing uptake of the antenatal care services.

The attitude of nurses providing antenatal care services was preventing women from attending visits at the clinic. Rudeness, yelling and a rude way of delivering concerns in clients were seen to be unfavorable.

There were visible disparities in communication and interaction between health care providers and pregnant women seeking antenatal care. The language used at the clinic was a barrier in communication. There was no understanding between Ndau and the Manyika Shona dialects. The study area comprises of Manyika speaking people which is the Shona that was used in conducting the interviews. And some participants spoke Ndau from Chipinge area.

5.3. Strengths and limitations of the study

Strengths

The study focused on purposively selected participants in selected rural areas. The participants were from the catchment area of the selected rural clinics, with low attendance of antenatal care based on the statistical data. Participants were women who were not attending antenatal care at all, making them key respondents and knowledgeable about the study topic. The study was fully described to give the readers a choice to generalize study findings or not.

Limitations

Other rural areas and clinics were not included in this study due to time constraints of the requirements to complete the degree in Public Health. Thus, it is not clear whether participants gave true information in their responses though the researcher ensured that the aim of the study was fully explained and participants were aware that the aim of the research was to improve antenatal care attendance in the rural areas, so that they were free to give honest answers. The study findings of this study cannot be generalised to the entire district, as the study conducted among participants from two rural health facilities who were purposively sampled.

5.4. Recommendations

Based on the conclusions made the following recommendations were suggested:

1. The Ministry of Health and Child Care of Zimbabwe (MOHCC) should review the policies for antenatal care, to strengthen health programs to ensure that they are friendly and focused. The policies should include strategies to empower communities to overcome obstacles to reach antenatal care in terms of its accessibility. Antenatal care policies should be reviewed to promote evidence based guidelines and standards of antenatal care to strengthen the quality of the services provided in the rural clinics.
2. Church health leaders can be included in antenatal health services policies, to accommodate religious beliefs. Health awareness can be provided to religious communities and include the church health representatives in health education. They can be taught about antenatal care, its importance and how to prevent danger signs in pregnancy through the use of the chiefs and village health care workers.
3. The study recommends the use of village health care workers, to identify pregnant women who cannot access the health care facility in terms of distance. Strategies can be put in place in order to give these women the care, regardless of how far they live from the clinic. Village health care workers can be the mediators between health care providers and the clients. Village health care workers can be taught on how to provide antenatal care services and to do follow up visits to pregnant women who miss their review dates.
4. The MOHCC should increase awareness of antenatal care through health education in communities on antenatal care and its importance. There should be a continuous dissemination of information on antenatal care to rural communities to ensure enough knowledge of antenatal care. Village health care workers can be used to disseminate antenatal care information. Health education should target the whole communities, including the males, to increase support to pregnant mothers.
5. The MOHCC should increase rural health care management, by increasing the emotional intelligence of staff through the provision of quality motivation, to make their work more interesting. Strategies can also be put in place to increase nursing staff in rural areas and review salaries for health care workers. There is also required adequate supervision and monitoring of rural clinics, which can enhance the morale of health care workers to reduce bad attitudes towards clients.
6. The study recommends the use of peer discussions amongst pregnant women, to enhance knowledge and educate them on antenatal care as a collective. Village health

care workers can spearhead the initiative. The peer groups can be divided according to the age groups of the women. This initiative can work as encouragement to attend antenatal care.

7. The study also recommends the use of focus group discussions for further study on antenatal care. Further research can use observations of the clinics as well as the nurses' views of factors influencing antenatal care, to get a bigger picture. Finally, there is need for further research, to compare the factors affecting attendance of antenatal care in the rural clinics against urban clinics by using in-depth interviews or focus group discussions.

5.5. Summary of chapters

Chapter	Description
Chapter 1	This chapter provided references to the whole study by presenting an overview of the study, to introduce the topic, purpose and objectives of the study. The purpose of this study was to explore the utilisation of antenatal care in rural primary health care facilities in Mutasa District. It also outlines the statement of the problem, significance and rationale for the study. The terms that were used throughout the study were defined and an outline of all chapters was given to guide the reader.
Chapter 2	This chapter contains a description of reviewed data-based literature that was relevant to the study. It outlines the overview and provision of antenatal care together with its utilisation with reference to the objectives stated in the previous chapter. The focus of the literature was on the factors influencing antenatal care uptake and the perceptions of women on antenatal care uptake. A conceptual framework to guide the study is also described.
Chapter 3	This chapter describes the research methodology used in the study, which includes the design, study setting, sampling, data collection and an analysis methods. The study adopted the qualitative, descriptive and explorative design. Purposive and snow-ball sampling was used to sample participants. Data was collected using face to face in-depth interviews and analysed using thematic analysis. Measures of trustworthiness and ethical considerations are also discussed.

Chapter 4	This chapter focuses on the research findings and discussion in themes that developed during data analysis. The findings are answers to the objectives: 1. Identify the factors influencing the utilisation of ante-natal care by women in rural primary health care facilities in Mutasa District, Zimbabwe. 2. Identify the women's perceptions on the utilisation of antenatal care in rural primary health care facilities in Mutasa District, Zimbabwe. The objectives were met during data collecting. One major theme emerged, namely the low uptake of antenatal care in rural primary health care facilities, followed by the following themes: 1. The influencing factors on antenatal care utilisation in rural primary health care 2. Perceptions of women on utilisation of antenatal care services in primary health care facilities Literature control was done to support the findings of the study through a discussion.
Chapter 5	This chapter focuses on the conclusions and recommendations of the study. It also provides the strengths and limitations of the study, as well as the summary of all the chapters.

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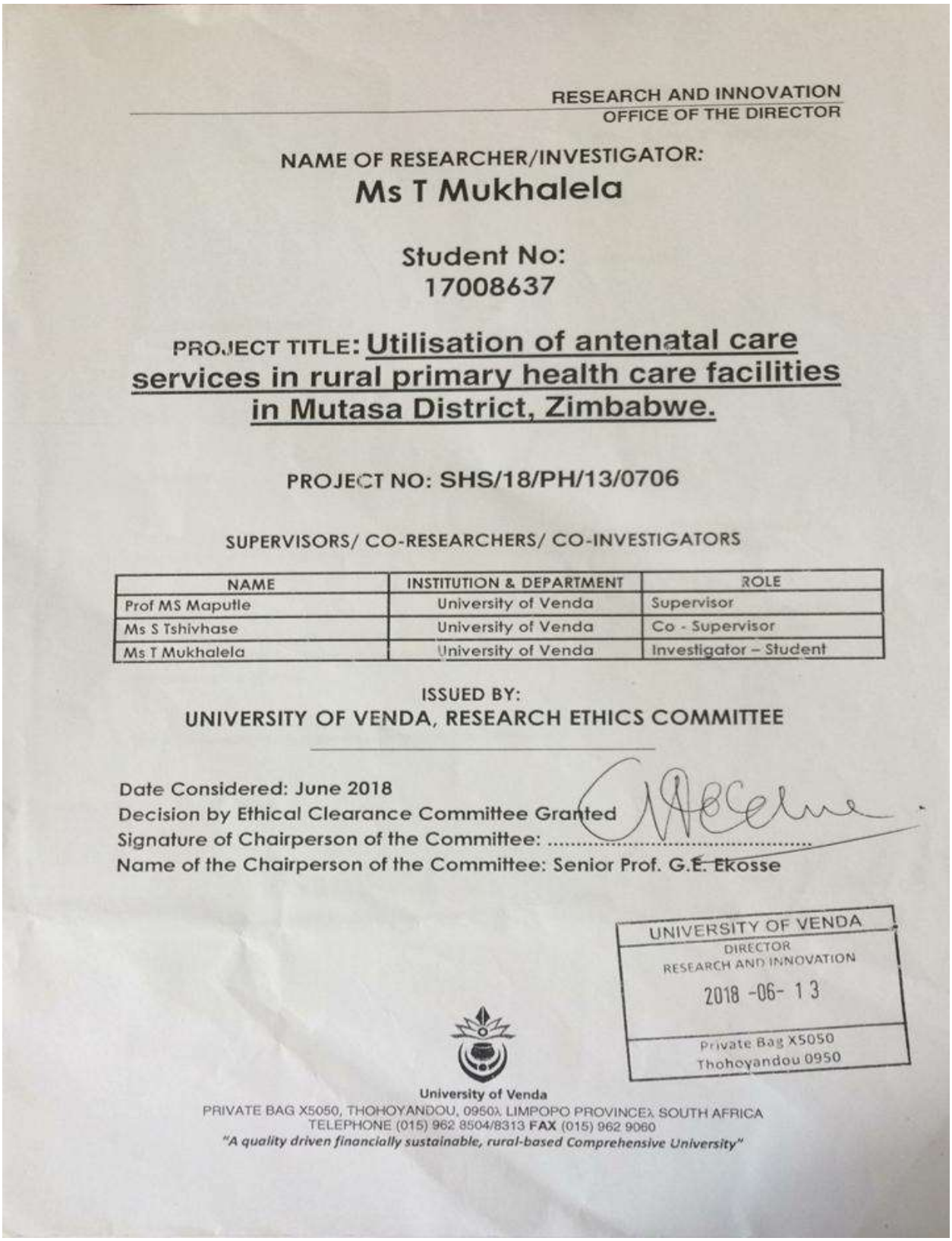
Annexure 1: Ethical Clearance certificate



RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms T Mukhalela

Student No:
17008637

PROJECT TITLE: **Utilisation of antenatal care services in rural primary health care facilities in Mutasa District, Zimbabwe.**

PROJECT NO: SHS/18/PH/13/0706

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MS Maputle	University of Venda	Supervisor
Ms S Tshivhase	University of Venda	Co - Supervisor
Ms T Mukhalela	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: June 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2018 -06- 13
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

Annexure 2: Permission letter to the District administrator of Mutasa

Bonda Primary School

P. O. Bonda

Bonda

The District Administrator

Mutasa District

P Bag J7113

Mutasa

REQUEST FOR PERMISSION TO CONDUCT STUDY

Dear sir/ madam

I am a qualified health services manager and currently a public health student at the University of Venda in the school of health sciences. I am carrying out a research with the title “Utilisation of Antenatal Care Services in Rural Primary Health Care Facilities in Mutasa District”, under the supervision of Prof M S Maputle and Miss S E Tshivhase from the University of Venda in South Africa. The purpose of this study is to explore the utilisation of antenatal care in the district. In-depth interviews will be conducted and audio taped. The results of this study will help policy makers to formulate policies on antenatal care, including new strategies for increasing antenatal care attendance, which may later reduce maternal mortality in the near future. The study findings may also be used to review and evaluate the implementation of antenatal care utilisation in rural areas.

For more information please contact the researcher on +263 776 026 705 (ZIM) OR +27 612 628 933

Thank you in advance.

Yours

Mukhalela T

…….. ……..

Signature Date

Annexure 3: Permission letter to the Chief of Mutasa District

Bonda Primary School

P. O. Bonda

Bonda

CHIEF OF MUTASA

REQUEST FOR PERMISSION TO CONDUCT STUDY IN YOUR COMMUNITY

Dear sir/ madam

I am a qualified health services manager and currently a public health student at the University of Venda in the school of health sciences. I am carrying out a research with the title “Utilisation of Antenatal Care Services in Rural Primary Health Care Facilities in Mutasa District”, under the supervision of Prof M S Maputle and Miss S E Tshivhase from the University of Venda in South Africa. The purpose of this study is to explore the utilisation of antenatal care in the district. In-depth interviews will be conducted and audio taped. The results of this study will help policy makers to formulate policies on antenatal care, including new strategies for increasing antenatal care attendance, which may later reduce maternal mortality in the near future. The study findings may also be used to review and evaluate the implementation of antenatal care utilisation in rural areas.

For more information please contact the researcher on +263 776 026 705 (ZIM) OR +27 612 628 933

Thank you in advance.

Yours

Mukhalela T

…….. ……..
Signature Date

Annexure 4: Permission letter from the District Administrator of Mutasa

Ministry of Local Government, Public Works And National Housing

Correspondence should not be addressed to individuals

Telephone: 028-2561/2228
Telefax: 028-2228

ZIMBABWE

Office of the District Administrator
(Mutasa)
P Bag J7113
Mutare

REF:

16 August 2018

To Whom It May Concern

PERMISSION TO CARRY OUT A RESEARCH IN MUTASA DISTRICT – MUKHALELA TATENDA ID 63-1472362B13

The above matter is relevant.

The above named is a student at University of Venda and studying for a Masters in Public Health. As per the degree requirements, the student must do a project which requires a research. To this end the office has granted Ms Mukhalela permission to carry out her research in the district under the title 'Utilization of antenatal care services in rural primary health care facilities in Mutasa District'

May you please render her all the necessary support.

Your cooperation towards this issue is highly appreciated.

DISTRICT ADMINISTRATOR
Local Government, Rural and Urban Development
MUTASA
Private Bag J7113, Mutare

C Mudawariwo
FOR DISTRICT ADMINISTRATOR-MUTASA

Annexure 5: Interview guide

Age……

Highest education level……..

Occupation…….

Parity……..

Distance to facility…….

Transport used……..

Utilisation of antenatal care

Can you explain in your own words how you use antenatal care services from the primary health care facility?

Annexure 6: Information sheet and consent form

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

Appendix B

LETTER OF INFORMATION

Title of the Research Study : Utilisation of Antenatal care services in rural primary health care facilities in Mutasa District, Zimbabwe.

Principal Investigator/s/ researcher : Tatenda Mukhalela, Master of Public Health

Co-Investigator/s/supervisor/s : M S Maputle, RN, BA (Cur), M.Cur and D.Cur.

S E Tshivhase, RN, BA (Cur), BA (Cur) (Hons) and Master of Public Health.

Brief Introduction and Purpose of the Study: The high maternal mortality ratio is caused by various factors, including avoidable complications which occur during pregnancy, some of which can be noticed during antenatal care visits. The utilisation of antenatal care has been low in rural areas, especially in Africa. To explore the utilisation of antenatal care services by rural women in Mutasa District, Zimbabwe.

Outline of the Procedures : The researcher will be conducting interviews using one central question and recording conversations as well as meeting of participants in Mutasa district. Participants are expected to participate voluntarily.

Risks or Discomforts to the Participant: no risks are anticipated.

Benefits: The researcher will benefit from the participants in order to finish the masters degree and publish. The participants may benefit when the research has been published, their plights might be heard.

Reason/s why the Participant May Be Withdrawn from the Study: There will not be any adverse consequences if the participant wishes to withdraw from the study. Participants can withdraw if they no longer wish to be part of the study.

Remuneration: There will not be any monetary payment to participants for participating in this study.

Costs of the Study: Participants will not cover any of the study costs. The researcher will fund the study.

Confidentiality: Participants' names will be kept confidential, meaning that the researcher will not use participants' real names when conducting the interviews. Furthermore, there will be no names of participants on the tapes, transcription or notes. Notes and recordings will be kept in a locked safe place, in order to promote confidentiality.

Research-related Injury: There are no research-related injuries anticipated. The researcher will withdraw from any interview if the participant feels they want to withdraw from the study.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher +2761 262 8933, my supervisors Prof Maputle M S +2784 602 2063 and Tshivhase S E +2782 441 5959 or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Tatenda Mukhalela, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.

- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
.....	.....	.....	.....

Tatenda Mukhalela herewith confirm that the above participant has been fully

Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Tatenda Mukhalela Date……. Signature……

Full Name of Witness (If applicable)

……. Date ……. Signature……

Full Name of Legal Guardian (If applicable)

…….. Date…… Signature……..

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

References:

Department of Health: 2004. *Ethics in Health Research: Principles, Structures and Processes*

http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/

Department of Health. 2006. *South African Good Clinical Practice Guidelines*. 2nd Ed. Available at: http://www.nhrec.org.za/?page_id=14

Annexure 7: Transcripted data from a participant

Data translated from Shona to English to demonstrate the factors influencing and perceptions of women on antenatal care uptake in rural primary health care facilities in Mutasa District.

Key: Researcher = R Participant = P

R – Good afternoon

P – Afternoon

R - I am back regarding what we talked about the last time I was here to ask for your permission to do an interview recording with you. Like I said when I came, I am from University of Venda doing a research on Utilisation of antenatal care services in rural primary health care facilities in Mutasa District. As we discussed last time I was here your name is to be kept confidential, it will not appear on this recording since you have agreed to be recorded. If you want us to stop this recording at any minute I will stop it and if you want to be excluded from the research at any moment you are free to say so. I will not force you to continue or keep on recording if you feel you don't want your voice to be heard by anyone. You are free to withdraw at any time of the interview.

P – Ok. I read the paper and you explained so I understand. Thank you for coming again as planned.

R – You are welcome.

P – as I said the last time when you came, I was born in Johane Marange Church and I got married again there so all this clinic talk or going to seek health care we don't know much about it as a congregation because in our church it is not allowed. As it is we don't visit the clinic at all.

R – Oh, ok.

P – As old as I am now….I….i gave birth to my children…ah...i got to know some things about pregnancy and birth on my 5th child. Four of my children are dead and I gave birth to them with the help of the Varapi (HEALTH ATTENDANTS from church). My other child is not normal, I gave birth again at the varapi.

R – Ok

P – So this one the 5th one, my only normal child, I took him for checkups when I was pregnant.

R – Okay. So you have attended antenatal care before now?

P – Yes. As I have said I went with my 5th pregnancy. The last one I have now I did not go at all.

R – Okay. How old are you mam?

P – I am 37 years old.

R - So as you have said you went only once and on this baby you have now you have never gone for checkups at all, can you share your reasons with me?

P - Haaaa… we used to just sit and relax and wait for the varapi to help us. As I said the church does not allow us to go for any checkup of any sort. We just give birth at church, we don't use any medication during pregnancy or for any illness. It's not allowed at church to seek medical care but with my 5th child I went just to see what happens there. Somehow it helps because my boy is healthy and he is the only healthy child I have. Four died and the last one seems retarded or something...he is not ok but I cannot take him to the clinic now. When I went I was breaking the law of church, I had to be reprimanded.

R – Ok

P - And when I went I got to know a lot of things like immunizing babies so I took my boy for all that when he was still young. We were also taught that you should give birth in a clean environment and issues about prolonged labor that it is possible to happen. I think that is what made my 6th child to be abnormal.

R – Mmmm ok. If I may ask, how far have you gone with school? Which level did you manage to reach?

P - At school I finished form 4

R - Alright, ok. Do you have any form of employment?

P - Aaaaaah I don't... I just plough in my garden at home for food.

R - Alright. Does your husband work?

P - My husband…for now is not working. The situation in Zimbabwe has made it difficult for him to go back to work so he is at home, he does piece jobs sometimes.

R – So you gave birth to 6 children and you only have 2 that are alive, how do you view the causes of death in the four who died in relation to antenatal care services utilization?

P – Previously before I went to receive antenatal care services with my 5th child I didn't know anything. I followed church protocol. I used to say "a child is like a brick if it crushes you can always make another. It was how we were taught at church. God gives and God takes if He sees it fit. I had no education on the importance of checking for baby health during pregnancy. I give birth and the babies don't breathe. The 3rd one took a first breathe but died shortly after. If I am to link what I was taught when I went to the clinic with my fifth child to what happened to my 4 children I know it was lack of care during pregnancy... the kicking of a baby you can feel but the other aspects you need health care and church birth attendants (varapi) will just give you salted water and some natural herbs which I am sure are never tested and proven to work or not. And my children. The ones who died…they never received immunisations at all. Those injections I think helped my 5th child because I took him for all of them just to see the difference I was tired of holding dead babies. Maybe if I had gone to the antenatal care I would have all my babies with me.

R – Ok. What happens at church if you decide to defy the rules and go to the clinic?

P – Haaaaaa you can get thrown out of church. You will no longer be able to attend with other members but for me I got reprimanded because I asked for forgiveness and begged to return again as a born again person. It's not allowed at all to go its church protocol, everything is put under God. If you take any medicine you are already unclean so if you ask for forgiveness you get cleansed again and you can join the congregation. But for me I will always sneak out and go because I have seen the importance of going so I take the children I am left with to the clinic from now and then.

R - How far is the clinic where you go to for antenatal care services and immunisations of the babies?

P – We walk 3 and half kilometers.

R - Which transport do you use?

P – We walk on foot. As hard as things are nowadays we just walk.

R – Alright. So when you said you went for antenatal care services on the 5th child, can you describe the services you got from the clinic?

P – My first visit was late and at first I got scolded for coming late but I did not care I wanted my baby to survive. At first I got discouraged to go again but I ended up going for all the visits that I was supposed to get provided the time I had left to go with the pregnancy. The nurses will scold

you if you are late, they said I was supposed to come within the first 3 months for registering and I was already 4 months. But all the rest of the visits I was never late despite the distance which is tiresome.

R – Ok. How do you view the knowledge that you were given at the clinic for antenatal care? Do you think it helps as you have been taught about some of the things during your 5th pregnancy?

P – Yes. The knowledge helps. Like now I have 4 dead children and one who is not normal. Some of the things that happen are avoidable. I could have avoided death of the children earlier.

R – You talked about the varapi-church birth attendants who help you give birth. Are they trained health attendants?

P – I don't know if they are trained or not but they are just older women in the church who just help women of the church in deliveries and pregnancies. They just tell us to come and notify them if we ever get pregnant and even towards delivery we go and camp at their homes instead of going to the clinics.

R – Ok

P – So we just go and camp at one house but when I went for antenatal care with my 5th child I was taught that at the church birth attendants sometimes we might get infected just from the materials they use to help us give birth. The materials should be sterile, so at church who will sterilize it and who knows how to sterilize? We might end up sick or end up with dead babies just as I did because we are not sure if the utensils are changed after being used once or it can be used on another person especially razor blades so mmmmm I learnt a lot and I also learnt that it's important to register so you can protect your baby from diseases like HIV – you can be put on medication early and protect your child. At the church attendants there is nothing like that you just come, give birth and go.

R – So as you have said you are acknowledging that when you went for antenatal care services you were helped a lot?

P – Yes, it helped me a lot. If I had gone early I would have all my children. The last one I take for health checkups though I did not go for antenatal care services when I was pregnant with him.

R – Alright

P – Now I take the children for immunisations and I don't care if I get caught and be chased away from church. I feel my children need health care. And future children if I am going to have more I will attend antenatal care.

R – Is there anything you want to add that can improve uptake of antenatal care services in the rural areas?

P – Aaaah...I would like to add this: I thank you for coming here to talk about this. Maybe it will help us and other women to understand the importance of going for antenatal care visits. I found out late that they are important maybe if I had gone my babies would all be here alive.

R – Ok. Thank you so much