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RESEARCH

# Potential barriers to focused antenatal care utilisation by HIV-positive pregnant women in Swaziland

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**Background:** Maternal mortality and human immunodeficiency virus (HIV) continue to be major challenges to the Kingdom of Swaziland. In the past, the government introduced focused antenatal care and integrated it with national strategies to reduce maternal mortality and the mother-to-child transmission of HIV. It was anticipated that individualised and integrated principles guiding the focused antenatal care model would enhance the quality of care received by pregnant women, consequently leading to high utilisation of the antenatal care services, a low rate of mother-to-child transmission of HIV and better pregnancy outcomes.
**Method:** The study used a qualitative, descriptive and exploratory design, with individual semi-structured, face-to-face interviews. A total of 18 interviews were conducted with 18 HIV-positive pregnant women who attended at least two antenatal care visits at a regional referral hospital.
**Results:** Seven potential barriers emerged from the thematic comparative content analysis of the participants' descriptions. These were long waiting hours, poor equipment, nonadherence by the nurses with the working hours, fragmented care, lack of privacy, the length of time spent with health professionals, and inadequate health education.
**Conclusion:** It is essential for healthcare providers to understand and address the factors which are viewed by HIV-positive pregnant women as being potential barriers to the use of focused antenatal care.

**Keywords:** focused antenatal care, HIV-positive women, potential barriers to antenatal care utilisation

## Introduction

Maternal mortality and human immunodeficiency virus (HIV) continue to be major challenges in Swaziland. The 2011 report of the Ministry of Health showed that 41% of pregnant women attending antenatal care were HIV-positive and 25% of maternal deaths were due to HIV-related infection.[1] Compliance with antenatal care activities has been associated with reduced pregnancy complications and improved pregnancy outcomes.[2] Multiple opportunities are offered to pregnant mothers attending antenatal care including the provision of information on pregnancy-related complications and the risks relating to labour and delivery, and promotion of natural delivery with the assistance of a skilled healthcare provider.[3] In addition, antenatal care is an entry point for the prevention of mother-to-child transmission of HIV, and can facilitate women's future utilisation of healthcare services.[4]

In the past, the Swaziland government introduced focused antenatal care and integrated it into national strategies to reduce maternal mortality and to prevent mother-to-child transmission of HIV.[1] Focused antenatal care is an integrated and individualised approach to antenatal care in which the quality of visits over the quantity of visits is emphasised.[5] It was anticipated that the individualised and integrated principles guiding focused antenatal care model would enhance the quality of care received by pregnant women, consequently resulting in high utilisation of the antenatal care services, a low mother-to-child transmission of HIV rate and better pregnancy outcomes.[6] However, HIV-related stigma and discrimination, and other individual factors, may positively or negatively influence the decisions of HIV-positive pregnant women to use available antenatal care services. This study explored and described the views of HIV-positive pregnant women on potential barriers to focused antenatal care utilisation at a regional referral hospital in Swaziland.

## Research methodology

### *Design*

A qualitative, descriptive and exploratory design, utilising individual, semi-structured, face-to-face interviews, was used in the study.

### *Setting*

The study took place at a public referral hospital in Swaziland. The hospital has a bed capacity of 350 and serves an estimated population of 350 000.

### *Sampling and sample*

Participants were drawn from the hospital antenatal care attendance register. Purposive sampling was used to select HIV-positive pregnant women aged at least 18 years, who had presented for at least one antenatal care visit during the course of their current pregnancy, and who were willing to be interviewed. Eighteen women who met the above criteria were interviewed. The number was determined by data saturation. All 18 women were educated, 11 were employed, and their ages ranged from 19–36 years.

### *Data collection*

Semi-structured, individual, face-to-face interviews were used to collect the study data. The interviews which the concepts were conducted by the researchers between September and October 2014, and carried out in English. The central question asked was: "What do you view as barriers to the utilisation of antenatal care as a HIV-positive pregnant woman?". Probing questions were used, when appropriate, to enhance the richness of the data. Field notes were employed to capture the body language and facial expression of the interviewees. Each interview lasted approximately 45 minutes. The interviews were digitally recorded, checked for quality and transcribed. The key findings were discussed within 24 hours.

### *Data analysis*

Data analysis was guided by the thematic comparative content analysis method, described by Creswell.[7] After assimilating the data, the researchers developed a coding scheme in which the concepts and themes were labelled, categorised and summarised, followed by charting, which involved rearranging the data into themes. The themes which emerged were organised and interpreted to determine relationships between the codes to aid easy presentation.

### *Scientific rigour*

Scientific rigour was achieved through the application of strategies described in Creswell.[7] Dependability was ensured by giving the raw data to an independent coder. Credibility was secured through prolonged engagement, the neutrality of the researchers during the interviews, member checking, the careful handling of emotional expressions, and the reflexibility and triangulation of the data, using independent coding and peer evaluation. Conformity was achieved by keeping an appropriate emotional distance between the researchers and informants to avoid the findings being influenced. Data were coded and recoded several times, and compared with the themes identified by the independent coder.

### *Ethical considerations*

The study received ethical approval from the research and ethics committees of the University of South Africa (HSHDC/204/2013) and the Ministry of Health of the Kingdom of Swaziland (MH/599C/FWA 000 15267/IRB 00000 9688). In addition, the researchers adhered to ethical research principles that relate to human subjects.[8]

## Results

Seven themes emerged as potential barriers to focused antenatal care service utilisation by HIV-positive pregnant women. These were long waiting hours, poor equipment, nonadherence by the nurses to the working hours, fragmented care, lack of privacy, the length of time spent with nurses and inadequate health education.

### *Theme 1: Long waiting hours*

"Waiting hours" refers to the time spent by clients in the facility before they received the care they sought. This time was viewed as being too long by all 18 participants: "The time I spent waiting to be attended by a nurse was too long. Sometimes you have to go back to work, and this delay affects you psychologically as you have to think of what to tell your boss and colleagues when you get back to work".

### *Theme 2: Poor equipment*

Some participants were concerned about the status of the equipment, especially the CD4 count machine. They believed that this equipment was not always functional: "The only part I don't like is the CD4 machine which is always out of order. This makes us not know how healthy and strong we are".

### *Theme 3: Nonadherence by healthcare workers to the working hours*

Participants reported that healthcare workers at the antenatal clinic did not adhere to the official working hours. This nonadherence led to delays in accessing the required care, as well as adding to the time spent waiting: "The clinic has enough nurses, but a major problem is the time they arrived at the clinic. The clinic is scheduled to start at 8h00, but you will find that some clinic staff start working at around 10h00. Thus, late arrivals cause delays in the delivery of antenatal care".

### *Theme 4: Fragmented care*

This theme referred to lack of integration of the antenatal care services with the follow-up care and treatment for HIV-related conditions. Although the antenatal care appointments were aligned with the follow-up care provided for HIV, the arrangement did not translate into integration of care. All 18 participants reported that the provision of care was still fragmented: "It is not good. I wish everything was done in one single room, and one can go straight home. But you have to go through different rooms before you are done".

Others viewed this fragmentation as demanding and unfair: "It is not comfortable. This going in and out from all these rooms (pause). It is just too much for us, and they forget that some of us are very weak because of our (HIV) status".

### *Theme 5: Lack of privacy*

Lack of privacy was associated with writing patients' HIV status on the antenatal care appointment cards, as well as the fragmentation of services. Some of the respondents were concerned that the nurses would disclose their status to community members: "You know what, this endless moving from one room to another exposes you to a lot of nurses, which means that at the end of the day your status is known by everybody in the hospital because of this process. The worst part is that we live with some of them in the same areas, and they will go and tell people whom you don't want to know about your status".

Others questioned the extent to which confidentiality was observed in the context of fragmentation: "Are they going to ensure any confidentiality in the treatment process? Currently, there is none. Yet we (HIV-positive pregnant women) are also humans, and have equal rights to those who are HIV negative".

### *Theme 6: The length of time spent with nurses*

Participants were of the view that healthcare professionals, i.e. nurses, were very slow in providing care. They wondered if this was because of a requirement to follow given protocol or because of the incompetence of the nurses: "I cannot say that the hospital is short staffed, but what I noticed is the way they perform their duties (pause). They are slow. I do not know if they (the nurses) are responsible for this slow pace, or it is because of protocol that they have to follow".

Others were more concerned about the slow pace of delivery than the long waiting hours: "I am not so much concerned about the waiting time because there are many people who use this hospital. My main problem is the slow pace in delivering the care".

### *Theme 7: Inadequate health education*

Inadequate health education pertains to the provision of information on pregnancy and HIV-related issues: "The nurses gave me some information, but it was not detailed. I did not receive enough information on HIV". Others did not remember receiving any information: "I can't remember being offered any health education. I am just using my experience. I followed the basic precautions". All 18 women viewed the inadequacy of health education as a potential barrier to the future utilisation of antenatal care services.

## Discussion

This study sought to understand potential barriers to focused antenatal care utilisation by HIV-positive pregnant women. The findings add to the understanding of potential barriers in this regard. Women' decisions as to whether or not to use maternal

health services were influenced by several factors, often classified as user related, provider or policy related, and user and provider interaction related.[8] In this study, the provider-related factors emerged as potential barriers to the utilisation of focused antenatal care by HIV-positive pregnant women; specifically long waiting hours, poor equipment, nonadherence by nurses with the working hours, fragmented care, lack of privacy, the length of time spent with the nurses, and inadequate health education.

The potential role of these factors in inhibiting the utilisation of antenatal care by pregnant women has been reported in previous studies. Long waiting hours, poor basic equipment and health providers' behaviour were identified as barriers to maternal health service utilisation in qualitative studies conducted in two informal settlements in Nairobi,[9] in a small village in northern India,[10] in Tanzania[11] and in Cambodia.[12] Lack of privacy as a barrier to antenatal care services utilisation was documented in studies conducted in southern Malawi,[13] Northern Ireland[14] and Colombia.[15]

The concern expressed by participants regarding the length of time taken by health professionals to provide antenatal care is also documented in the literature. It was shown in a study conducted in Tanzania that the provision of antenatal care through the focused antenatal care model increases the time that health professionals spend with pregnant women when providing antenatal care services.[16] This potential barrier should also be viewed within the context of poor equipment and staffing, as reported by the participants in this study. The participants' views on inadequate health education as a barrier to focused antenatal care utilisation highlight the importance of the quality of health education in the future utilisation of antenatal care services by HIV-positive pregnant women. The quality of health education provided to pregnant women has also been linked to hospital delivery in studies conducted in Chandigarh[17] and Colombia.[15]

Finally, the findings of this study increase the understanding of the role played by consumers' actual experiences on the future utilisation of focused antenatal care in the context of HIV-positive pregnant women. Consumers' experience of care is a component of the quality-of-care model, which explains why they access services, access them late, or suffer avoidable adverse outcomes despite timely presentation. According to the model, it is argued that users' actual experiences of care influence their future utilisation of health services.[18]

## Conclusion

It is essential for healthcare providers to understand and address the factors which are viewed by HIV-positive pregnant women as being potential barriers to the use of focused antenatal care. Consumers' cumulative experiences of care play a significant role in influencing their future decision on whether or not to use the available health services. Interventions aimed at enhancing the utilisation of antenatal care must include the perspectives of HIV-positive pregnant women. The potential barriers which emerged in this study could easily be avoided through organisational interventions. Policy-makers should support the implementation of focused antenatal care facilitated by adequate human resources. For example, the length of time spent with nurses and the lack of provision of adequate health education could be addressed through in-service training and the capacity building of healthcare providers.

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*Conflict of interest* – There was no conflict of interest to declare with respect to this study.

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