

# **EXPERIENCES OF PREGNANT WOMEN FROM A RURAL COMMUNITY REGARDING ANTENATAL CARE SERVICES IN ETHEKWINI DISTRICT, KWAZULU- NATAL**

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Durban University of Technology

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## Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student

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Date

Approved for final submission

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# **Abstract**

## **Introduction and background**

According to the Declaration of Alma-Ata, maternal and child health care forms an integral component of primary health care. In line with this, the South African national government legislated free maternal and child healthcare services in the public sectors to ensure accessibility and availability of basic health care services to the community of South Africa. However, poor access and utilization of antenatal care services in rural areas continues and contributes to high maternal mortality and morbidity rates and untoward pregnancy outcomes.

## **Aim**

The aim of this study was to explore the experiences of pregnant women from the KwaMkhizwana rural area regarding antenatal care services in order to identify the factors affecting effective provision of and access to the antenatal care services.

## **Method**

A qualitative, explorative, descriptive research design, which was guided by Rosenstock's Health Belief Model, was used to conduct the study. Data were collected by conducting semi-structured interviews with 15 participants who were purposively sampled between February and March 2016 and was analysed using Tesch's method of data analysis. The sample size was determined by data saturation that was reached after ten interviews were conducted. A total of five additional interviews were conducted to confirm saturation of data.

## **Findings**

There were five major themes and several sub-themes that emerged from the interviews. The major themes included: 1) availability and accessibility of

antenatal care services; 2) established practices by the health post staff to reduce the number of clients; management and administration of the health posts; 3) access to health information by pregnant women; 4) communication between the pregnant women and the health post staff; and 5) socio-cultural taboos and beliefs of the community in the area.

## **Conclusion and recommendations**

The information gathered from the participants with regard to their experiences affirms that challenges still exist in this rural community regarding access to health care services, particularly antenatal care services. Recommendations pertaining to policy development, institutional management, practice, and research were made. Some of these recommendations included that several policies that are currently non-existent should be developed in order to promote accessibility of antenatal care service at primary health care level, more primary health care training schools should be established to increase the number of primary health care trained nurses, short courses for training of clinic supervisors should be conducted and that further research studies looking at ANC service accessibility especially in rural areas, focusing on health care workers and management experiences be conducted.

## *Dedication*

*I dedicate this dissertation with humble gratitude to my loving husband Mduduzi Khambule, my two daughters Aphíwe, and Esethu, my sons Skhumbuzo, Thula and Kito, my granddaughter Wiza, my mother, my two sisters and brother. Your continued support, encouragement, unconditional love and unceasing prayers have contributed a lot to my success. You are the pillars of my strength and the source of my blessings.*

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- My role model Dr Dudu Sokhela for her encouragement and support.
- Mrs S. Mthembu my neighbour for helping me.

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## **Glossary of Terms**

### **Antenatal Care (ANC)**

Antenatal means the health care that is rendered to pregnant woman throughout pregnancy until child birth, aimed at detecting those problems already existing or those that can develop in the pregnant woman and her baby (Pattinson 2007:5).

### **Gravity**

Gravity is defined as the total number of pregnancies, regardless of duration or outcome (Goolsby and Grubbs 2011:568).

### **Maternal death**

Maternal death is the death of a woman while pregnant or within 42 days of termination pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (World Health Organization [WHO] 2014:5).

### **Maternal mortality ratio**

According to the World Health Organization (WHO), maternal mortality ratio is the number of maternal deaths in a given period per 100 000 women of reproductive age during the same period (WHO 2010:15).

### **Midwife**

Midwife means a licensed health care practitioner who is registered with the South African Nursing Council (SANC). He/she has completed a recognized education and training programme to nurture, assist and treat the client, who can be a woman, a neonate or a family, in the process of promoting a healthy pregnancy, labour and post-partum period (SANC 2001).

**Parity**

Parity is the number of pregnancies resulting in live births together with all stillbirths (Douglas, Nicol and Robertson 2005:212).

**Primary Health Care**

According to the WHO (1978:15), primary health care (PHC) means essential health care based on practical, scientifically sound and socially accepted methods and technology, universally accessible to all in the community through their full participation at an affordable cost and geared towards self-reliance and self-determination.

## List of Acronyms

| <b>Acronym</b> | <b>Full term</b>   |
|----------------|--|
| AIDS           | Acquired immune deficiency syndrome                              |
| ANC            | Antenatal care   |
| ART            | Antiretroviral therapy   |
| BANC           | Basic antenatal care   |
| CEE            | Central and Eastern Europe                                       |
| CHCs           | Community health centres   |
| CIS            | Commonwealth of Independent States                               |
| DHS            | District health system   |
| DUT            | Durban University of Technology                                  |
| EAP            | Employee Assistance Programme                                    |
| HB             | Haemoglobin  |
| HIV            | Human immunodeficiency virus                                     |
| HPCSA          | Health Professions Council of South Africa                       |
| ICN            | International Council of Nurses                                  |
| KZN            | KwaZulu-Natal  |
| KZNPA          | KwaZulu-Natal Provincial Administration                          |
| MDGs           | Millennium Development Goals                                     |
| MMR            | Maternal mortality rate  |
| MOU            | Midwife obstetric unit   |
| NCCEMD         | National Committee on Confidential Enquiries into Maternal Death |
| NSDA           | Negotiated Service Delivery Agreement                            |
| PHC            | Primary health care  |
| PMTCT          | Prevention of mother-to-child-transmission                       |
| RH             | Rhesus factor  |
| RPR            | Rapid plasma reagent test  |
| RSA            | Republic of South Africa   |
| SANC           | South African Nursing Council                                    |
| TBA            | Traditional Birth Attendants                                     |



| <b>Acronym</b> | <b>Full term</b>               |
|----------------|--------------------------------|
| UNICEF         | United Nations Children's Fund |
| UNFPA          | United Nations Population Fund |
| WHO            | World Health Organization      |

## Chapter Outline

| CHAPTER   | TITLE   | CONTENTS   |
|-----------|---|--|
| Chapter 1 | Overview of the study.  | Focuses on the background behind health care services in South Africa, highlighting the different approaches and strategies undertaken to improve discrepancies in access to health care services and gives a description of the research problem, aims and the significance of the study in order to highlight the need and importance of conducting the current study. |
| Chapter 2 | Literature review.  | Review, analyse and summarize related and existing literature with respect to ANC service accessibility focusing in rural communities.   |
| Chapter 3 | Research methodology.   | Focuses on research design, sampling process, data collection and analysis as well as ethical considerations and describes how the HBM was used as a theoretical framework that guided the study.  |
| Chapter 4 | Presentation of results   | Presents the study findings arising from analysis of data  |
| Chapter 5 | Discussion of results.  | Discussion of the findings of the study in relation to the research question. Literature is used to further clarify findings.  |
| Chapter 6 | Summary of findings, conclusions, limitations and recommendations of the study. | Discussion of the summary of findings, conclusions, limitations and recommendations of this study.   |

# **CHAPTER 1 : OVERVIEW OF THE STUDY**

## **1.1 INTRODUCTION**

Chapter 1 focuses on the background behind health care services in South Africa, highlighting the different approaches and strategies undertaken to improve discrepancies in access to health care services caused by inequalities and inequities in health care distribution during the previous years. The chapter also gives a description of the research problem, aims and the significance of the study in order to highlight the need and importance of conducting the current study.

## **1.2 BACKGROUND**

Attendance of maternal health care services before, during pregnancy and after the birth of a child enhances maternal and infant health (Abou-Zahr and Wardlaw 2003:1). Antenatal care (ANC) is usually an entry point for most women for provision of multiple interventions and programmes, aiming to reduce maternal and perinatal mortality rate in South Africa (Republic of South Africa 2008:22). The South African National Department of Health recognizes ANC service utilization and access as one of the strategies to reduce maternal and perinatal mortality rates (Pattinson 2007:7).

Prior to 1994, South Africa had a highly fragmented and bureaucratic health care system with 14 separate departments to look after the health of the different racial groups, the four homelands and six 'self-governing' territories (Harrison 2010:4). There were multiple ministries and departments based on race (tricameral system) and ethnicity (homeland governments) (Harrison 2010: 4). According to Hassim, Heywood and Berger (2007:9), this led to great inequalities in access to health services due to lack of infrastructure, lack of equity in resource allocation, lack of transport and lack of service affordability.

This resulted in high morbidity and mortality rates among the vulnerable groups such as those living in rural areas.

Hassim *et al.* (2007:12) noted that before 1994 most pregnant women had to pay for ANC services and hence could not afford to attend these services. Harrison (2010:1) observed that the challenge facing the South African government was to design a comprehensive programme to redress social and economic injustices, eradicate poverty, reduce morbidity and mortality, and promote greater control by communities and individuals over all aspects of their lives. This led to the introduction of new health policies and laws as contained in the White Paper for transformation of the health sector in South Africa (Republic of South Africa 1997). The main aim of the White Paper was to correct the ills of the health systems. In 1994, the ANC National Health Plan introduced the District Health System (DHS) approach to restructure the health system and to deliver health care according to the PHC approach (Republic of South Africa 1995). The WHO views the DHS as a vehicle for the delivery of an integrated health care (WHO 1996:32). According to Tarimo (1991:4), the DHS based on PHC is a more or less self-contained segment of the national health system. It comprises of a well-defined population living within a clearly delineated administrative and geographic area and includes all the relevant health care activities in the area. Therefore, after 1994, more PHC clinics, mobile health care clinics, health posts and health care centres were built to provide basic health care services such as promotive, preventive and curative health care services, at first contact and closer to the communities (Hassim *et al.* 2007:19-21). In spite of all these efforts by the Department of health, maternal death kept on increasing and thus it became a health challenge.

In 1997, maternal death became a notifiable condition in order to analyse the causes of maternal deaths so that strategies to avoid these deaths could be identified and instituted (Pattinson 2007:6). This gave rise to the birth of the Policy Management Guidelines for Common Causes of Maternal Deaths to be implemented in clinics; community health centres (CHCs) and hospitals (Republic of South Africa 2001:12). Furthermore, section 4(3)(a)

of the National Health Act 61 of 2003, mandated public clinics and CHCs to provide free health care services to all pregnant women (Republic of South Africa 2005: 18).

In South Africa, maternity care forms an integral component of PHC services and is provided as a free service to pregnant women (Republic of South Africa 2007:7). One of the general measures to prevent maternal deaths is to ensure that all pregnant women receive ANC before 20 weeks of pregnancy (WHO 2010:3). This concurs with the recommendations by Pattinson (2007:7) that effective ANC in South Africa can make a major contribution in improving the health of the pregnant women, saving lives, and also significantly improving the health and survival of the women and their unborn babies. Pattinson (2007:5) defines ANC as the care of pregnant women in the months and weeks before the birth of their babies, aiming to detect pregnancy related problems and to monitor progress of pregnancy to optimize maternal and foetal health. This is supported by Fraser and Cooper (2009:16) who highlight that ANC includes screening for pregnancy problems, assessment of pregnancy risks, and management of problems that may arise during the antenatal period and preparation of the women for labour, delivery and post-partum period.

According to Pattinson (2007:7), ANC services are particularly important in the rural and poorer communities because the percentage of pregnant women that need special care (high-risk pregnant women), is greater than 25%. Pattinson further proposes that the Basic Antenatal Care (BANC) approach should replace the traditional approach to ANC service provision. Pattinson (2007:i) argues that in the traditional approach there was no scientific basis for the way ANC was performed or for what was included in each visit. He advocates that the BANC approach be adopted stating that it is a scientific goal oriented approach, which aims to bring together all resources and to facilitate their use, focusing on the number, timing and content of each antenatal visit. The BANC approach facilitates effective provision of ANC at the correct level of care by identifying those pregnant

women who are suitable for BANC, and those that require specialized services at the higher level of care (Pattinson 2007:8).

The National Department of Health (Republic of South Africa 2007:19), encourages booking of pregnant women for ANC as soon as pregnancy is detected, even as early as 4 or 5 weeks' gestation in order to achieve the best possible maternal outcome. According to National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD) the percentage of avoidable factors responsible for maternal deaths is higher at primary than secondary and tertiary levels of health care (NCCEMD 2011:32). This is confirmed in tenth interim Saving Mothers report (NCCEMD, 2013:11) where it is highlighted that the trend of Maternal Mortality Rate (MMR) has increased by 10,9 from 2005 to 2012, in the Community Health Care Centres (CHC). The committee also highlighted that inaccessibility of ANC services carries approximately four times the increased risk of maternal death compared with the general pregnant population. Moodley, Pattinson, Fawcus, Schoon, Moran and Shweni (2014:3), argue that the South African government tried to simplify all the interventions that are effective during the ANC period at a primary level of care by changing those that are not effective in improving access to maternal health care services, but with very little impact on high maternal mortality rates. While ANC service utilization increased to 94%, in urban areas after 1994 Republic of South Africa 2005:61) there was still underutilization of these services in the rural areas which led to overcrowding and long waiting times in urban areas and a considerable rise in maternal death rates. This concurs with the Fifth Saving Mothers' Report, which indicates that maternal mortality rates increased during the 2008-2010 triennium compared to any of the previous years (NCCEMD 2012: xii).

### 1.3 RESEARCH PROBLEM STATEMENT

The province of KwaZulu-Natal (KZN) has been identified as the province with the highest number of maternal deaths in South Africa (NCCEMD 2012:28). Almost all the Saving Mothers' Reports to date highlight non-attendance of ANC as one of the major contributory causes of maternal deaths and advocate for early and regular attendance of ANC (NCCEMD 2012:32). Therefore, access to maternal health care services that are affordable and of high quality is fundamental to the survival of pregnant women (Hoque, Hoque and Kader 2008:12).

The National Department of Health (Republic of South Africa 2001:7) emphasises that the Antenatal care services are said to be accessible if they are available seven days a week for 24 hours a day and 365 days a year, as well as closer to the pregnant women. According to the PHC norms and standards, service access is measured by the proportion of people living within 5 kilometres or 30 minutes' walk to a clinic that attend the PHC clinic (Republic of South Africa 2001:7). However, access to health care depends on access to health care workers to provide the services or attend to the clients (Hassim *et al.* 2007:26).

The majority of the Black and the Coloured population group in South African households rely on the public sectors for health services (Republic of South Africa 2011:75). However, the South African health system is facing a challenge of inappropriate production and deployment of human resources for health professionals in rural areas (Republic of South Africa 2010a:5), thus adversely influencing access to health care services for the communities in these areas. The Republic of South Africa (2010a:7) attribute this to poor human resource for health planning and absence of staffing norms and standards for health care facilities in South Africa. The National Department of Health (Republic of South Africa 2010b:16) attest to this where it states that in the South Africa, while 43.6% of the population lives in rural areas they are only served by 12% of the doctors and 19% of the nurses practising. According to the Republic of South Africa (2011:22),

the lack of professionals in rural areas is affected by a number of factors such as funding, historical deficiencies of health care services, no additional benefits for working in inhospitable settings, safety concerns and lack of social infrastructure. Oyolola, Elung'ata and Muindi 2015:80) attest to this and state that this has resulted in rural areas where ANC services are a challenge, skilled midwives are replaced by traditional birth attenders without proper skills,

During situational analysis conducted at KwaMkhizwana rural community, the researcher noted a scarcity of health care services in this area. This aroused the interest of the researcher concerning how and where the women from this area accessed ANC services and led to the intention of assessing the experiences of the pregnant women regarding ANC services in the KwaMkhizwana rural area.

#### **1.4 RESEARCH AIM**

The aim of the study was to explore the experiences of pregnant women from KwaMkhizwana rural area, in eThekweni district regarding ANC services.

#### **1.5 RESEARCH QUESTION**

The study aimed to answer the following question:

- What were the experiences of the pregnant women from KwaMkhizwana area regarding ANC services?

#### **1.6 SIGNIFICANCE OF THE STUDY**

Exploring the experiences of pregnant women regarding ANC services would enable identification of factors affecting provision of and access to ANC services. This would facilitate consideration of health care users' needs when planning health care services and promote community engagement and participation. The findings from the study could be used to



make the South African government aware of successes and challenges regarding ANC services in rural areas and to make recommendations regarding aspects of ANC services that require attention with the potential of having these considered when new policies, guidelines and strategies to improve and optimize service delivery are being developed. The results of the study could not only benefit KwaMkhizwana rural area but other rural communities that are in a similar situation as KwaMkhizwana rural area in and around eThekweni district and throughout the country.

## **1.7 SUMMARY OF THE CHAPTER**

Chapter 1 covered the introduction of the study. The history of inequalities in distribution of medical health care services and its effect between rural and urban areas were explored. The South African Government strategies and approaches to improve accessibility and equity in distribution of health services were presented. This chapter also covered the aims, research question, significance of the study and the problem statement.

## **CHAPTER 2 : LITERATURE REVIEW**

### **2.1 INTRODUCTION**

Chapter 2 aims to review, analyse and summarize literature in regards to ANC services provision and accessibility most especially in rural communities globally and in African and South African context. The literature reviewed in this chapter includes reports on maternal deaths and several peer and non-peer reviewed articles, on maternal and child health issues especially concerning ANC services provision.

### **2.2 STRATEGIES USED TO SEARCH FOR RELEVANT LITERATURE**

Several keywords were decided upon before engaging in the search. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that core elements and arguments could be highlighted. Beel, Kobialka, Schimdt and Engeser (2011:465) emphasize that mind maps are well suited to structure document collections because the structure of the mind map is similar to an outline used to draft documents. The creation of a mind map to aid in the formulation of keywords helped to identify key search terms. Identifying keywords for the subject before initiating any literature search ensured that correct results were obtained. The keywords and phrases that were used as search terms included ANC service access to health care facilities, maternal outcomes, maternal, newborn, child and women's health outcomes and rural utilization of health care facilities. Each of the search terms were initially used individually, and then combined using Boolean operators AND, OR and NOT which are widely used to expand or delimit the search (Polit and Beck 2012:99). The resources that were available for the literature search were books and journals, which included both hardcopy and electronic databases. Electronic databases included:

- EBSCOhost search engine focusing on nursing journals.
- The Cumulative Index of Nursing & Allied Health Literature (CINAHL).
- Medical literature online (MEDLINE).
- PubMed Public/Publisher Medline database.

The Durban University of Technology's (DUT's) library resources including the institutional repository inter-library loan system were used for literature search. The latter enabled the researcher to obtain documentary and electronic information, and data only available from other academic institutions and organizations to which the DUT library is affiliated. The archives, databases and websites of other local and international sources of information, such as reputable research institutions and organizations included the WHO, South African Nursing Council (SANC) Statistics South Africa (Stats SA), and the South African Department of Health were consulted in the mission of obtaining a multi-perspective approach to the research topic.

### **2.3 GLOBAL CONTEXT REGARDING ANTENATAL CARE COVERAGE**

According to the WHO (2013:5), all pregnant women should have four routine ANC visits, with the first visit starting as soon as pregnancy is confirmed, second visit at six months, the third at eight months and the final at eight months. Globally 70% of women attend ANC at least once in pregnancy, thus giving an opportunity to provide a broader range of health activities (WHO 2013:7). Currently, about 71% of women attend ANC at least once in well-developed countries (WHO 2013:1). According to Oyolola, *et al.* (2015:67), inequities in ANC service persist internationally with service users from vulnerable population groups continuing to express that services are not accessible because they do not meet their expectations. The majority of the pregnant women receiving care from skilled workers in East Asia and the Pacific are high, up to 90% (UNICEF 2009:6). Victora, Matijasevich, Silveira, Santos, Barros and Barros (2004:34), state that in Brazil racial group inequalities in access to ANC

services exist. These authors also discovered that 98% of white women in the public and private sectors attend ANC in the first trimester. According to Oyolola *et al.* (2015:33), 79% of the ANC consultations in Sub Saharan countries is by a skilled midwife.

The WHO (2013:27) state that Maternal mortality rates (MMR) differ between countries and is higher in the developing countries compared with the developed countries. According to the WHO (2013:19-27) estimates, in the year 2000 South Africa's MMR was 230, compared to the world average MMR of 400. The middle-income countries like Ukraine (37) China (56) Cuba (33) and Thailand (44) achieved a lower MMR in the year 2000. According to the WHO (2013:24), globally an estimated number of 289 000 women died during pregnancy and childbirth worldwide in 2013 due to lack of access to skilled works and emergency care.

According to the WHO (2013:11-13), in developing countries as a whole, the number of births attended by a skilled health professional has increased by more than a quarter, from 42% to 53% over the decade. From 1990 to 2000, the percentage of births attended by a medical professional in Asia rose to 35%. Data on skilled attendants at delivery is available for only 74 per cent of live births in the developing world. The report from the WHO (2010:16) indicated that delivery care has improved significantly in all regions though not all countries have shared equally in improvements.

## **2.4 ANC COVERAGE IN SUB-SAHARAN AFRICAN COUNTRIES**

The lack of access to maternal health care services remains a challenge for many Africans, while complications of pregnancy continue to threaten the lives and well-being of pregnant women in the region (Oyolola *et al.* 2015:45). In some parts of Africa, such as Western Africa, a woman's lifetime risk of death from pregnancy is said to be amongst the highest in the world. According to the WHO (2014:13-21), in Chad the risk of a woman dying during pregnancy or childbirth is 1 in 14, which is higher than that of other countries. Even in a relatively prosperous country like Nigeria,

the maternal mortality rate is estimated at 14% (40 000). The Sub-Saharan African region accounted for 62% (179 000) of global deaths, followed by Southern Asia at 285 (69 000) due to shortage of skilled workers including doctors and an inadequate number of PHC clinics. In sub-Saharan Africa 69% of pregnant women have at least one ANC visit, more than in South Asia, at 51%. In Africa, 80% of women in the richest quintile have access to more than three or more ANC visits. In sub-Saharan Africa where maternal mortality is highest, the numbers on skilled attendance on delivery are very low.

## **2.5 ANC COVERAGE IN SOUTH AFRICA**

The South African government's effort to extend ANC services has been largely successful as a result; the percentage of pregnant women who attend ANC at least once has increased to 97-100% (Beksinska, Mullick, Kunene and Mosery 2012: 294). Despite the high percentage of ANC coverage, MMR remains high. This is evidenced by NCCEMD (2012:28) which states that, in most provinces in South Africa there have been a high number of maternal deaths. The current level of MMR in South Africa is 625 per 100 000 live births, which is above the Millennium Development Goal (MDG) target of reducing maternal death by 38 per 100 000 live births by 2015.

According to Hoque *et al.* (2008: 66) as evident in Northern KZN, 9% of pregnant women book for an ANC visit in their first trimester and 67% in the second and third trimester of pregnancy. Mxoli (2007:31) attest to this when highlighting that most pregnant women attend ANC clinic but at a later stage or advanced stage of pregnancy. Mxoli (2007:31) further state that, such delays contribute to a quarter of avoidable causes of maternal deaths in South Africa. Myer and Harrison (2003:268) found that most women from rural areas attend ANC late in pregnancy and at times, they fail to go for return visits.

## **2.6 ANC COVERAGE IN KZN**

The KZN Province is the second largest and most populous province in South Africa. According to the District Health Information System (DHIS) (2013:32) and evident in the census for 2011 (Stats SA 2013:15), the population of the KZN province is 10 703 920, accounting for 21.4% of the total South African population. The population statistics also indicate that approximately 70% of the population in KZN is below the age of 35 years, which is a childbearing age (Stats SA 2013:22). According to NCCEMD (2013:9), maternal age and maternal death are interrelated because teenagers are at a high risk of developing complications of hypertension in pregnancy and non-pregnancy related infections are also high between the age of 25 and 40 years. In KZN, approximately 54% of the population live in rural areas and 10% of the population live in underdeveloped informal settlements which, as a result of under development and non-availability of essential resources necessary to maintain health, have significant health and service delivery implications (Department of Rural Development and Land Reform 2011:10).

According to the NCCEMD (2013:7-8), five major causes of maternal deaths, which include: pregnancy related HIV and AIDS, hypertension, obstetric haemorrhage, pregnancy related sepsis and pre-existing maternal diseases prevail in South Africa. According to this committee, KZN Province is constantly leading in high MMR as compared to all other provinces mainly due to non-pregnancy related sepsis, which is 15% above the national range. The Western Cape and Free State have the lowest percentage of MMR which falls below 15% of the national range. The NCCEMD (2013:12) further state that, in 2012, the Free State Province reported 2 maternal deaths due to haemorrhage, as compared to 17 in 2011. This followed after the Free State Province had deployed several strategies to reduce maternal deaths. The District Clinician Specialist Teams (DCST) had to be established in order to deal with these problems at the community level (National Department of health 2010a:9).

In a study carried out in the rural health district of Hlabisa in KZN, women identified several reasons that prevented them from seeking ANC in time such as: accessibility, being unsure that one is pregnant, waiting for foetus to move and not seeing any benefits of attending ANC (Hoque *et al.* 2008:12).

## **2.7 STRATEGIES FOR DECREASING THE MATERNAL MORTALITY AT PHC LEVEL IN SOUTH AFRICA**

Provision of accessible ANC services in rural communities has been a challenge in most countries, hence, section 27(1) in Chapter 2 of the Constitution of South Africa declares access to health care as a human right (Republic of South Africa 2004:12). ANC is a pregnancy related service, which is a component of maternal health service that is necessary for all women during pregnancy to reduce preventable maternal mortality and morbidity.

Hoque *et al.* (2008:66d) proposed that ANC visits should be used and be conducted more effectively since they are an important point of contact between the health care facilities and pregnant women. Effective ANC service as highlighted by the National Department of Health (Republic of South Africa 2008:7), is defined in terms of its accessibility to the women who need it. According to the WHO (2013:23), universal health care for all means that all people obtain the health care services that they need without suffering any kind of hardship. According to Mxoli (2007:3-4), accessibility can be achieved by improving transport and communication between facilities and health care centres for easy referral from one centre to another. The referral system for pregnant women with high-risk conditions in South Africa has been reviewed. The emphasis in the referral guidelines is that ambulances for obstetric emergencies should be available and should respond within an hour of having been called (Republic of South Africa 2004:12) and that in remote areas an ambulance should be stationed at each facility where deliveries are conducted. The recommendation by the national department of health is for all facilities where road infrastructure do

not allow uninterrupted provision of ambulance and other transport facilities to consider building maternity waiting homes/ rooms previously referred to as mothers' lounge so that women can await labour in these facilities when they are at term (Republic of South Africa 2010a:13-14).

Primary healthcare re-engineering focuses on the use of community health workers as part of the DCST. AN outreach team consisting of a community oriented trained family doctors, PHC trained nurses and midwives should be used to improve access to health care services (Republic of South Africa 2010b:1). The PHC clinics should be within walking distance and provide free integrated ANC services (Republic of South Africa 2001:3). The PHC approach is designed as the foundation of the health system for promoting healthy lifestyle and preventing diseases (Republic of South Africa: 2010:12).

The South African health system is facing the challenge of quadruple burden of diseases of which one is the high maternal mortality ratio. This could be responsible for the decrease in life expectancy of the people of South Africa as demonstrated by information released from Stats South Africa (Republic of South Africa 2010a:15). The South African Department of Health committed itself to improving the health status of the people of South Africa, by identifying four strategic outputs, in order to contribute to the government vision of a long and healthy life for all (Republic of South Africa 2010b:4). One of the four strategic outputs which the health sectors are expected to focus on is output number 2, from National Service Delivery Agreement which aims at decreasing maternal and child mortality to 100 per 100 000 live births (Republic of South Africa 2010b:4). This can be achieved through the implementation of PHC re-engineering (PHC three streams) and a fundamental referral system to responsive support systems of hospitals (Republic of South Africa 2010b: 6).



## **2.8 THE SIGNIFICANCE OF THE FIRST ANC CLINIC VISIT AT PHC LEVEL**

Appropriate and timely ANC plays an important role in providing maternal and child health. It aims to detect and treat existing health problems and to screen for complications such as eclampsia, anaemia, syphilis and hypertension as well as other problems that may develop during pregnancy. The ANC visit also afford the health care workers an opportunity to provide vital health information to women and girls regarding lifestyle risks and to offer social support, counselling on nutrition, self-care and for developing a birth and emergency plan (Pattinson 2007:41). The initial visit to the antenatal clinic should, ideally, be the first meeting with the health care provider to confirm pregnancy occurring preferably during the first 12 weeks of pregnancy (Pattinson 2007:6). At the end of the first visit, it should be clear whether the woman qualifies for BANC or needs special assessment (Pattinson 2007:8). Approximately 25% of pregnant women at the end of their first visit will not qualify for the BANC and will need special care in higher health care facilities (Pattison 2007: 10).

Table 2.1 highlights several conditions occurring during pregnancy, which according to Pattinson (2007:5) can be successfully detected and treated during ANC and their effect on pregnancy if not treated.

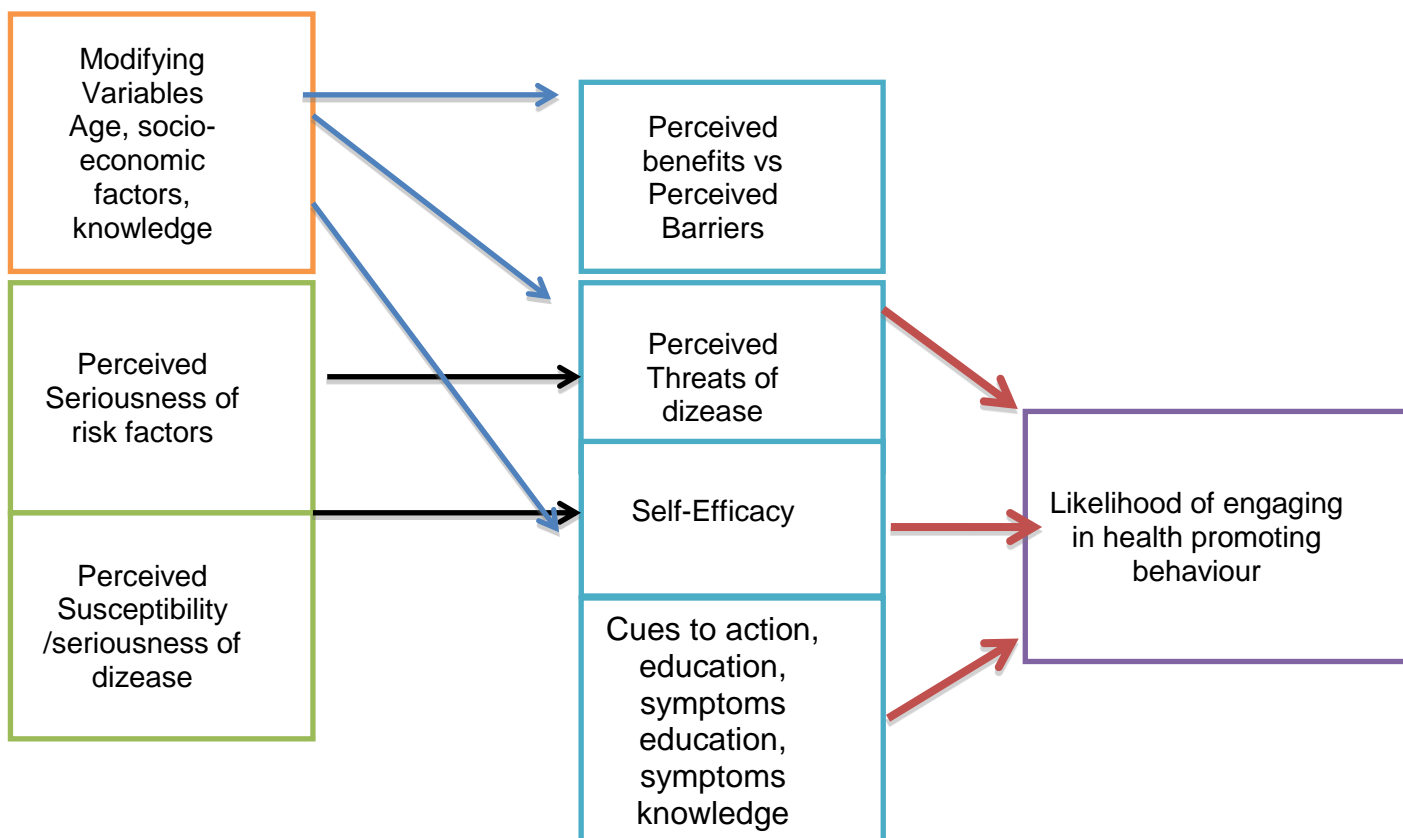
**Table 2.1: Common conditions occurring during pregnancy**

| <b>Maternal condition</b>   | <b>Effect on pregnancy</b>   |
|---|--|
| Anaemia.  | More likely to bleed, smaller babies.  |
| Hypertension and pre-eclampsia.   | Convulsions, haemorrhage, maternal deaths, foetus / neonatal deaths.         |
| Medical diseases for example, diabetes mellitus, epilepsy, heart disease. | Maternal death, foetal/neonatal death.                                       |
| HIV complications.  | Maternal death, pre-term birth, growth impaired babies, HIV infected babies. |
| Chronic infections for example, tuberculosis (TB).                        | Maternal death, foetus/neonatal death.                                       |
| Urinary tract infections.   | Maternal kidney infection, pre-term labour, foetus/neonatal death.           |
| Vaginitis and other sexually transmitted infections.                      | Pre-term labour, foetus / neonatal death.                                    |
| Malnutrition.   | Small babies.  |
| Poor foetal growth.   | Foetus / neonatal death.   |
| Post-maturity.  | Meconium aspiration, foetus / neonatal death.                                |
| Congenital infections.  | Foetus / neonatal death.   |
| Twins, triplets.  | Pre-term labour, foetus / neonatal death.                                    |
| Abnormal foetal lie.  | Ruptured uterus, foetus / neonatal death.                                    |
| Congenital abnormalities.   | Foetus/neonatal death.   |
| Rhesus isoimmunisation.   | Anaemic neonate, foetus / neonatal death.                                    |

## **2.9 THE THEORETICAL FRAMEWORK USED TO GUIDE THE STUDY**

The Health Belief Model (HBM) was used to guide the study. The origins of the HBM is described by Rosenstock (1974: 328-335). Later on Glanz, Rimer and Lerman (2002) produced work on the application of this model. Glanz *et al.* (2002:32) clarify that the HBM is not their original work but was developed by a group of social psychologists in the United States of America in 1950 to provide the framework for understanding why some people take specific action to avoid illness, whereas others fail to protect themselves. When the model was developed both public and private sectors were concerned that people were reluctant to be screened for TB, to have a Pap smear, to be immunized or to take preventive measures that were either free or available at nominal cost (Rosenstock 1974: 328). The model was designed to predict which people would or would not use

preventive measures and to suggest intervention that might reduce clients' reluctance to access health care (Rosenstock1974: 328). The underlying concept of the original HBM is that health behaviour is determined by personal beliefs or perception about a disease or strategies available to decrease its occurrence (Rosenstock1974: 328). Perceptions are modified by other variables such as culture, educational levels, past experiences, skills and motivation (Rosenstock1974: 328). This is a framework for indicating peoples' health related behaviours such as healthcare use and compliance with medical treatment. How the HBM was used to guide the current study is described in detail in Chapter 3 and outlined in Figure 2.1.



**Figure 2.1: The Health Belief Model (Glanz, Rimer and Lerman 2002: 52)**

## **2.10 CHAPTER SUMMARY**

This chapter surveyed ANC coverage globally, ANC coverage in Africa, ANC coverage in South Africa as well as in KZN province. The impact of ANC coverage in maternal death rate internationally was discussed. It also covered ending maternal mortality and morbidity through effective antenatal service provision and the significance of first antenatal visit.

## **CHAPTER 3 : RESEARCH METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter focuses on research design, sampling process, data collection and analysis as well as ethical considerations. The chapter also includes a description of how the HBM was used as a theoretical framework that guided the study.

### **3.2 RESEARCH DESIGN**

According to De Vos, Fouche and Delpont (2011:143), a research design focuses on the end product and all the steps in the process to achieve the anticipated outcome. Polit and Beck (2012:764) concur with De Vos, Fouche and Delpont (2011) that a research design is the overall plan for addressing a research question, including specifications for enhancing the study's integrity. A qualitative, exploratory, descriptive, contextual research design was used to conduct the study. Polit and Beck (2012: 763) describe qualitative research as the investigation of the phenomena typically in an in-depth and holistic fashion, through the collection of rich narrative material, using a flexible research design. The qualitative design enabled the researcher to find out what the people in the study thought and felt about ANC services and what the significance of the signs and symbols in the settings could be (Henning 2004: 75).

#### **3.2.1 Qualitative research**

The qualitative design enabled the researcher to gather information through in-depth semi-structured individual interview in rural areas where ANC services are a challenge. Creswell (2014:4) describes qualitative research as an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The semi-structured interviews allowed participants to tell their own stories about their experiences regarding ANC services. According to Hennink, Hutter and

Bailey (2011:9), qualitative researchers study people in their natural settings to identify how their experiences and behaviour are shaped by the context of their lives, such as the social, economic, cultural or physical context in which they live. The strength of qualitative research is its ability to provide descriptions of how people experience a given research issue and to provide information about the 'human' side of an issue (Grove, Burns and Gray 2013:271). The qualitative design enabled the researcher to explore experiences of pregnant women regarding ANC services at KwaMkhizwana to provide answers to the research question 'What are the experiences of pregnant women regarding ANC services, from a rural community at KwaMkhizwana area?' Researchers who use a qualitative approach adopt a person-centred and holistic perspective to understand human experiences without focusing on specific concepts. The original context of the experience communicates unique and rich knowledge and insight, which can be generated in depth to represent a lively picture of the participants' reality and social context (Grove *et al.* 2013: 271).

### **3.2.2 Exploratory research**

According to Polit and Beck (2012:727), exploratory research is a study that explores the dimensions of a phenomenon. A study of this nature is designed to increase the knowledge of a particular field of study (Grove *et al.* 2013:694). In this current study, the exploratory research enabled the researcher to explore and understand experiences of pregnant women regarding ANC services at KwaMkhizwana.

### **3.2.3 Descriptive research**

Descriptive research provides an in-depth description of participants' experiences in a narrative type description (Grove *et al.* 2013:233). A descriptive qualitative research design is a non-experimental research design used to collect data in a form of in-depth interviews. Streubert and Carpenter (2007:341) state that descriptive research describes and documents the behaviour, events, beliefs, characteristics, attitudes,

structures and process that occur in a phenomenon. In the current study, the descriptive research design was used to gather information in a form of in-depth semi-structured interviews, for the purpose of exploring the participants' experiences regarding ANC service access.

#### **3.2.4 Contextual research**

Contextual research is an ideographic method of research in the sense that it is uniquely descriptive within the context of the individual setting. This study was contextual because interviews took place in one of the two mobile health posts in the area where pregnant women regularly attended ANC services. Interviews were scheduled for the day, time and place that best suited the study participants. De Vos *et al.* (2011:326) are of the view that human behaviour can be influenced in many ways by the environment or setting in which data collection take place. Therefore, this study was a contextual study in order to enhance articulation of the participants' views about their experiences regarding ANC services at KwaMkhizwana.

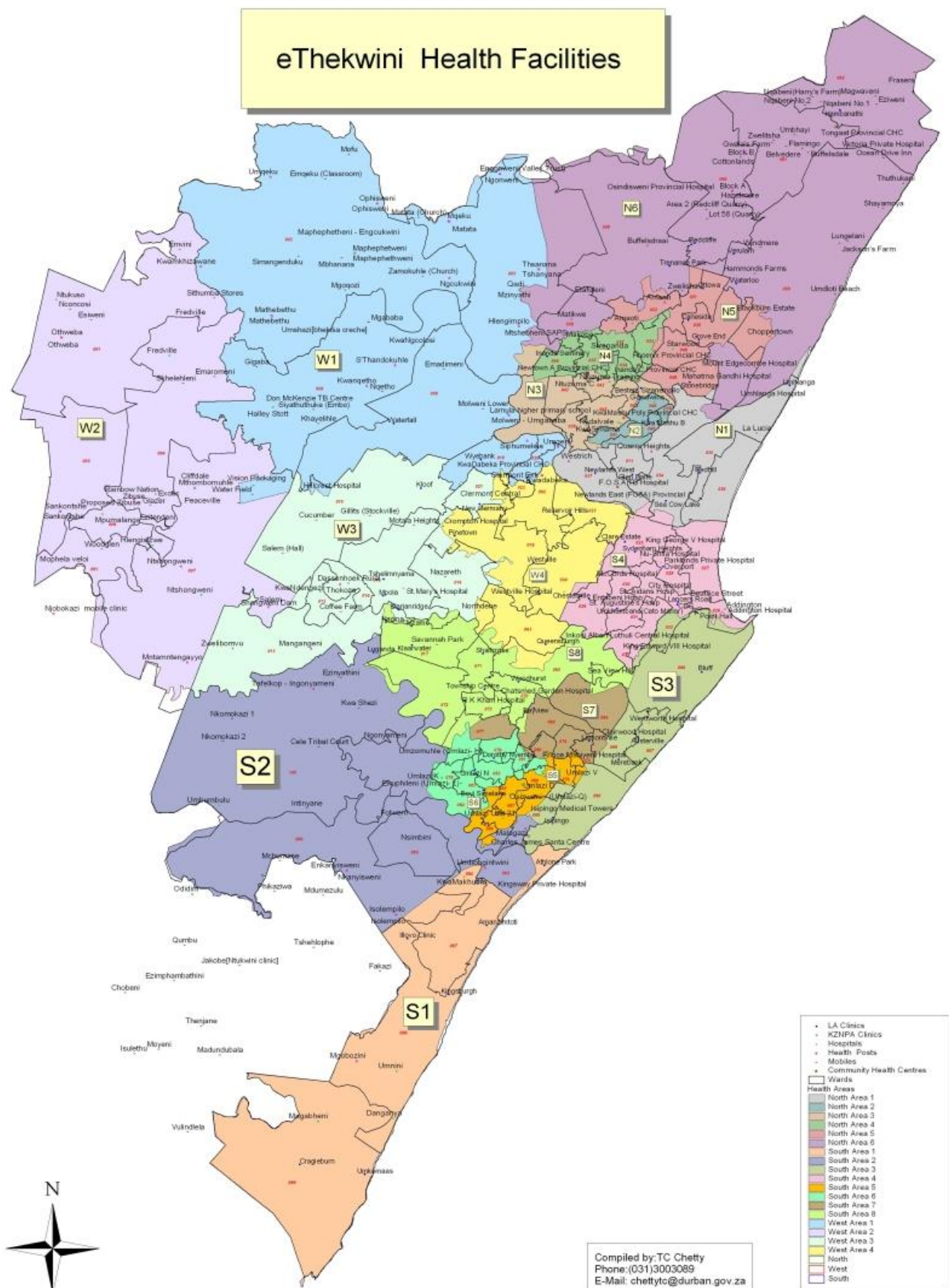
### **3.3 STUDY AREA**

This study was conducted at KwaMkhizwana tribal authority, a rural area in eThekweni district in KZN. EThekweni District is divided into three sub-districts for functional purposes, the south, the west and the north sub-districts. The sub-districts are further divided into wards with a total of 103 wards all under the control of eThekweni local authority. The number of wards within each sub-district differs based on the population size and density. In the rural areas within the sub-districts, the wards are further divided into tribal authorities that are governed by traditional monarchs (the chiefs and *izinduna*) as well as political leaders. Further demarcation of the areas include division of sub-districts into PHC service areas which is done mainly for distribution, management and monitoring of health care services shared between KZNPA and eThekweni Health Municipality ( Figure 3.1).

KwaMkhizwana area is situated in the West sub-district, in Ward 2, which is one of the six wards in the western sub-district and is part of PHC area 1. The area is situated halfway between Durban and Pietermaritzburg, and comprises of seven tribal areas Mlahlanja, Umqeku, Qhodela, Imbubu, Dangwini, and Amapofu. The total number of households at KwaMkhizwana is 629. The estimated total population is 8 000 (Geographic Information System 2011:12). The West sub-district is the most densely populated area in eThekweni district. West sub district consists of two CHCs and two district hospitals, which are R.K. Khan and St. Mary's. Facilities in this area are not equitably distributed, (eThekweni District Health Plan 2015/2016:19-20).

The researcher gathered from the traditional leaders in the area during situational analysis that the health care services at KwaMkhizwana area include a mobile clinic and two health posts, managed parallel by eThekweni Municipality Health Unit and KZN Provincial Administration (KZNPA). The two health posts operate once a week for 3 to 4 hours. They provide ANC services to non-complicated cases, and complicated cases are either referred to uMsunduzi PHC clinic 15 km away from the area. ANC deliveries are conducted by either Hlengisizwe CHC which is situated 20km from the area, St. Mary's Hospital, which is situated 56 km away or R.K Khan Hospital.





**Figure 3.1: Map of eThekweni Sub-district (KZN Department of Health 2009:23)**

### **3.4 HOW THE HEALTH BELIEF MODEL WAS USED TO GUIDE THE STUDY**

The HBM attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of the individuals. In the current study the experiences of the pregnant women with ANC services could influence how the women perceived and attended ANC services in the area.

According to Rosenstock (1974:328), the HBM is based on three assumptions:

- It assumes that a person will take a health related action if that person feels that a negative health condition can be avoided.
- It also assumes that a person will take action if that person has a positive expectation that by taking a recommended action, negative health condition will be avoided.
- It further assumes that a person takes a health related action if the person believes that she/ he can successfully take the recommended action.

The HBM has six constructs which represent the perceived threats and net benefits. These are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues of action and self-efficacy.

#### **3.4.1 Perceived susceptibility**

Perceived susceptibility, also called perceived vulnerability, refers to one's perception of the risk or the chances of contracting a health disease or condition and includes estimates of resusceptibility and susceptibility to illness in general (Rosenstock 1974:328). A person's perception is that personal action will have an impact towards one's health. Rosenstock (1974:328) further states that persons need to understand how their action affects their health. This requires that there should be activities that increase their perception of their own vulnerability to certain conditions. In this study, pregnant women perceived themselves at risk of developing pregnancy related complications.

### **3.4.2 Perceived severity**

This refers to one's own opinion of how serious a condition is and what the consequences are. According to Rosenstock (1974:330) when a person recognizes that she/he is susceptible to getting a certain problem or condition, it does not motivate her to take necessary action until she realizes that serious physical, psychological and social implications will come out. This study established whether or not pregnant women realized the consequences of not attending ANC early and regularly.

### **3.4.3 Perceived benefits**

A person needs to believe that by taking a certain action, it will assist her/him avoid or prevent a problem from occurring. It is this belief which gives them confidence to take action because they are sure of the results (Rosenstock 1974:332). It was established in this study whether or not attending ANC was perceived as a strategy to prevent complications of pregnancy hence protect their unborn babies.

### **3.4.4 Perceived barriers**

There could be several barriers that can affect people's decision making to take particular actions, such as costs, duration, complexity of the desired behaviour and accessibility to services that would support the action taking (Rosenstock 1974:335). In this study, barriers that affect the appropriate and timely utilization of ANC services were identified. Ways to reduce such barriers were explored.

### **3.4.5 Cues of action**

The required action will benefit them and knowing how to deal with the expected barriers. According to Rosenstock (1974:13), it requires motivation to have the desire to comply with the prescribed action or treatment. People should have a concern about health matters and be willing to seek and accept health care and engage in positive health activities. In this study level of awareness and knowledge regarding ANC services were established.

### 3.4.6 Self-efficacy

Self-efficacy refers to the strength of an individual's belief in their own ability to respond to novel or difficult situations and to deal with any associated obstacles or setbacks (Peltzer 2000:39). This is confidence in one's ability to take action based on adequate knowledge, guidance and understanding on where to get what. One should feel that she/he is capable of taking the necessary action correctly because it is that confidence that would motivate her/him to take action. In this study it was further established if pregnant women attended ANC because they knew even before they fell pregnant about availability of such services within the area. Corrective actions regarding untoward experiences towards ANC services were also determined.

Table 3.1 outlines the application of the Health Promotion Model in the current study.

**Table 3.1: Application of Health Belief Model in the current study**

| Concept                         | Definition  | Application  |
|---------------------------------|---|--|
| <b>Perceived susceptibility</b> | One's opinion of chances of getting a condition.  | Pregnant women believe they may be at risk of developing complications of pregnancy.   |
| <b>Perceived severity</b>       | One's opinion of how serious a condition and its consequences are.                          | Pregnant women believe the consequences of not attending ANC early could be detrimental to the maternal and child health.  |
| <b>Perceived benefits</b>       | One's belief in the efficacy of the advised action to reduce risk or seriousness of impact. | Pregnant women believe that the recommended action of attending ANC early would benefit both the mother and baby, by allowing early detection and treatment of diseases. |
| <b>Perceived barriers</b>       | One's opinion of the tangible and psychological costs of the advised action.                | Pregnant women identify their personal barriers and explore ways to eliminate such barriers.   |
| <b>Cues to action</b>           | Strategies to activate 'readiness'.   | Cues of action in the form of reminders are explored.  |
| <b>Self-efficacy</b>            | Confidence in one's ability to take action.   | Guidance on where to get more information/ help.   |

### **3.5 CODEBOOK FOR DATA DEFINITION**

The health posts and the study participants were assigned codes in order to ensure confidentiality. The two health posts are referred to as health post A and B and the participants were assigned numbers as follows, participant A1 meaning the first participant from health post A. The PHC clinic that was repeatedly mentioned by the participants during the interviews is referred to as clinic C

### **3.6 SAMPLING PROCESS**

#### **3.6.1 Identification of the study sites**

Purposive sampling method was used to select the health care clinics that were included in the study. According to Polit and Beck (2012:739), purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgment about which ones will be most informative. The study was conducted in the health care facilities that provide ANC services within KwaMkhizwana rural area.

#### *Inclusion criteria*

- Only the health care clinics that provided ANC services were included and therefore the two health posts that provide health care services in the area were included.

#### *Exclusion criteria*

- The health care clinics that were not providing ANC services were excluded and therefore the mobile clinic that is providing health care services in the area was excluded.

### **3.6.2 Sampling of pregnant women**

The population is the entire set of individuals or objects having some common characteristics (Polit and Beck 2012:738). The target population in the current study was pregnant women who were 18 years old or above, living in the KwaMkhizwana area and were willing to participate in the study. Sampling is the process of selecting a portion of the population to represent the entire population when conducting a study (Polit and Beck 2012:742). The purposive sampling method was used to select eligible pregnant women as they visit the clinic for ANC. The sample size was determined by data saturation. Data saturation occurs when additional sampling provides no new information, only redundancy of previously collected data (Grove, Burns and Gray 2013:371). A further 2-5 interview can be conducted after reaching data saturation to confirm data saturation.

#### *Inclusion criterion*

- All the pregnant women who were 18 years old or above, living in the KwaMkhizwana area and were willing to participate in the study were included

#### *Exclusion criterion*

- All the other women were excluded.

### **3.7 PRE-TESTING OF DATA COLLECTION TOOL**

Grove *et al.* (2013:343) clarify that pre-testing assists in assessing the feasibility and acceptability of the design, its procedure, analysis sample size and makes it easy to conduct the study. In the current study, pre-testing of data collection tool was conducted in one health post in eThekweni district by conducting semi structured interviews with three pregnant women in order to detect any errors and flaws in the data collection tool and procedures. There were no errors and flaws that were identified during pre-testing and therefore no adjustments were made regarding data collection tool and method. The

health post, participants and the findings obtained from the pre-testing were not included within the major research findings.

### **3.8 DATA COLLECTION METHOD**

Data collection is the gathering of information to address a research problem (Polit and Beck 2012:724). Semi-structured in-depth interviews were conducted with the pregnant women. The interviews were guided by an interview guide which consisted of one grand tour question followed by five probing questions which were used to ensure in-depth, rich gathering of information (Appendix 6a and 6b). The interviews were conducted in isiZulu which is the local language in the area. All translation from English to isiZulu and reverse translation from isiZulu to English was done by a qualified language translator (Appendix 2). All the interviews were conducted by the researcher in a consultation room in the health post or in any of the study settings depending on the choice of the participants and lasted for 30 to 45 minutes. Although the researcher was a professional nurse her presence in the interview did not have any influence on the information gathered because she had no particular relationship with the participants and had never worked at KwaMkhizwana health clinics. The interviews took place in one of the two mobile health posts in the area and were scheduled for the day, time and place that best suited the study participants. Responses were recorded on an audiotape and field notes were taken to record non-verbal cues and to substantiate the recorded information. Interviews were conducted until data became saturated.

### **3.9 DATA ANALYSIS**

The aim of data analysis is to organize, provide structure to, and elicit meaning from data. Data analysis was run simultaneously with data collection to determine direction for further data collection in relation to data saturation. The transcribed data was analysed using Tesch's eight steps of data analysis (Creswell 2014:186) his included:

- Data transcription of the tape-recorded information: Listened and re-listened to audiotape until data was clearly understood and known.

- Transcribed word for word response.
- Transcribed information was written in isiZulu and translated into English.
- Read and reread the transcribed interviews to get the meaning of the transcription.
- Grouped together related topics or codes that emerged and wrote these codes next to appropriate segments of the text.
- Clustered codes into categories and created major themes and sub-themes.
- Any other topic or codes that emerged were also written next to appropriate segments of the text.
- Grouped together the related topics and emerging list of categories.
- Preliminary analysis of data by assembling data that belonged to each category from themes that emerged.

### **3.10 TRUSTWORTHINESS AND RESEARCH RIGOR**

Research rigor is defined as a commitment to excellence through use of discipline, reliable and adherence to detail and strict accuracy (Burns and Grove 2009: 720). Ethical rigor is the identification of ethical implications related to the study (Burns and Grove 2009:611). The researcher observed all the correct processes of obtaining consent, data gathering and results presentation and analysis to ensure ethical rigor to ensure trustworthiness. Babbie and Mouton (2001:276) describe trustworthiness as the extent to which a research study is worth paying attention to, worth taking note of and the extent to which others are convinced that the findings are to be trusted. Lincoln and Guba (1985:289) suggest four criteria for developing the trustworthiness of a qualitative inquiry, namely, credibility, dependability, confirmability and transferability. The authors later identified a fifth criterion which is authenticity.



### **3.10.1 Credibility**

Credibility refers to confidence in the truth of the data and interpretation of them (Lincoln and Guba 1985:263). The researcher ensured credibility of data by developing a sense of trust with the participants throughout the data collection process by the manner in which the researcher presented herself during all the contact sessions with the participants and by not giving false information and false promises to the participants. All interviews were recorded and field notes were taken during interviews, using direct quotations and narratives by the study participants.

### **3.10.2 Dependability**

According to Lincoln and Guba (1985:324), dependability refers to stability of data over time and through various conditions. The researcher used the interview guide in order to ensure that the same grand tour question was asked for all the participants. The probing questions were asked based on the information given by the participants.

### **3.10.3 Confirmability**

Confirmability is the potential for congruence between two or more independent people regarding the accuracy of data, relevance and meaning (Lincoln and Guba 1985:156). The researcher developed and maintained an audit trail to ensure confirmability of data by reporting and describing the entire research process and ensuring that data was securely stored for availability should the need arise. On-going documentation was ensured regarding the researcher's decisions about data analysis, collection and process. Documentation from the audit trail included the recorded information on the tape recorder and the field notes about the process of data collection. A large amount of data was included in the written report, to show objectivity and neutrality of the data.

#### **3.10.4 Transferability**

Lincoln and Guba (1985:232) refer to transferability as generalizability of data, the extent to which the findings can be transferred to have applicability in other settings or groups. There are several aspects of the proposed study such as size of the study (KwaMkhizwana area only) participants included (pregnant women only) and demographics of the participants (all Africans) that could make it difficult to generalize the study findings to other parts of the country, but it might be transferred to other rural communities. However, the researcher attempted to ensure transferability of the results of the study by providing a description of the research setting and research processes, which will also confirm the authenticity of the study, making it possible to build on these findings when performing further research.

#### **3.10.5 Authenticity**

Authenticity means the extent to which the qualitative researcher fairly and faithfully shows a range of different realities in the collection, analysis, and interpretation of data (Polit and Beck 2012:720). Authenticity was ensured by collecting data in proposed areas and adhering to the inclusion and exclusion criteria when sampling the study participants. The data was collected using the designed interview guide through semi-structured interviews. The pre-testing of data collection tools to detect flaws and errors was done. Data analysis and interpretation was guided by Tesch's eight steps.

### **3.11 ETHICAL CONSIDERATIONS**

To protect the rights of the institution, the research was reviewed by the Faculty of Health Sciences Research and Higher Degrees Committee. Thereafter, ethical clearance of the research proposal was granted (Appendix 1a) by DUT Institutional Research Ethics Committee (IREC 133/15).

To access the municipal sites a letter requesting permission from eThekweni Municipality Head of Health Department (Appendix 2a) was written with the research proposal attached, and a letter of approval letter was received from

the eThekweni Municipality Health Department was received (Appendix 2b). The researcher signed an acknowledgement letter of research conditions regarding conduct of the study on Municipal property (Appendix 2c). The study was also discussed with the facility managers. This was done to ensure that the study proposal met all the ethical standards before commencing the study.

Ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit and Beck 2012:727). To ensure that ethical issues were taken into consideration, various steps were followed by the researcher such as respect of person, participant's informed consent, beneficence and justice.

#### **3.11.1 Respect of person**

The protection of the right of the participants was considered as a priority in this study. The study participants were clearly informed about the purpose of the study, possible risks and benefits, procedures to be followed and that their responses would remain completely confidential (Appendix 3a) in a language they understood. Participants were volunteers and were informed that they could refuse to participate or withdraw at any time without explanation.

This ensured that their right to self-determination and full disclosure remained protected. The participant's rights, interest and wishes were considered first when choices were made. All interviews were scheduled for a date, time and place that best suited the study participants. A quiet consultation room which provided privacy with no interruptions was used for interviews.

#### **3.11.2 Participants' informed consent**

Informed consent is an ethical principle that requires researchers to obtain the voluntary participation of subjects, after informing them of possible risks and benefits (Polit and Beck 2012:730). Informed consent is a major ethical issue meaning that a participant knowingly, voluntarily and intelligently and in a clear

and manifest way gives his or her consent to study participation. A consent form is a written agreement signed by a study participant and a researcher concerning the terms and conditions of voluntary participation in a study (Polit and Beck 2012: 723).

The participants were provided with all the details of the study and were given an opportunity to ask questions before they signed informed consent forms as a confirmation that they were provided with the relevant information and that they were participating voluntarily (Appendix 4a). The participants were reassured of their privacy and confidentiality of the data collected. The participants were reassured that the information collected was accessible to the researcher only. The interview guides (Appendix 5a) completed interview schedules, recorded information and the signed consent forms were assigned codes and kept separately thus making it impossible to link them to one another and also to ensure confidentiality.

### **3.11.3 Beneficence**

Beneficence is a fundamental ethical principle that seeks to maximize benefits for study participants (Polit and Beck 2012:720). Beneficence means participants must not be subjected to unnecessary risks of harm or discomfort. The study participants were informed about the possible risks and benefits of the study reassuring the participants that the study was not subjected to any harmful effect (Appendix 3a).

### **3.11.4 Justice**

Justice was maintained because participants who chose to decline participation at any stage of the research were allowed to do so without incurring any negative consequences whatsoever. Participants were informed that there was no reward that would be given for participating in the study nor threats of penalty that would be charged for failing to participate in the study (see Appendix 3a).

### **3.12 CHAPTER SUMMARY**

This chapter outlined the research design, study area, the sampling process, pre-testing of the data collection tool, trustworthiness, ethical consideration and all the phases undertaken during data collection and analysis.

## CHAPTER 4 : PRESENTATION OF RESULTS

### 4.1 INTRODUCTION

This chapter presents the study findings arising from analysis of data that were gathered from in-depth semi structured interviews conducted to explore experiences of pregnant women regarding ANC services at KwaMkhizwana rural area.

### 4.2 SAMPLE REALIZATION

Data were collected from the pregnant women using one-on-one semi-structured interviews between February and March 2016. Two Health Posts (referred to as Health Post A and Health Post B throughout this document) were used as study sites to gather data from pregnant women. Saturation of data was reached after four interviews in Health Post A and after five interviews in Health Post B. Three extra interviews were conducted in both Health Posts to confirm data saturation. In total, seven interviews were conducted in Health Post A and eight in Health Post B which resulted in a grand total of 15 interviews for the entire study. A summary of sample realization is presented in Table 4.1.

**Table 4.1: Sample realization for the current study**

|   | <b>Health Post A</b> | <b>Health Post B</b> | <b>Total</b> |
|---|----------------------|----------------------|--------------|
| Number of interviews at data saturation         | 5                    | 4                    | 9            |
| Number of interviews to confirm data saturation | 3                    | 3                    | 6            |
| <b>Total no. of interviews conducted</b>        | <b>8</b>             | <b>7</b>             | <b>15</b>    |

### 4.3 DEMOGRAPHIC DATA

All participants were African black females between the age of 19 and 42 years. A total of nine participants were single and four were married. The level of education of the participants ranged from Grade 2 to Grade 10. Parity

ranged from 0-5 and gravidity from 0-7 pregnancies. One woman had a set of twins, two had miscarriages, four had stillbirths and two had neonatal deaths. A total of 11 participants were unemployed, and four were employed. Out of the eleven participants who were unemployed, four were still at school. Table 4.2 presents the demographic, obstetric and social data for the study participants.

**Table 4.2: Table 4.2 Demographic data of participants**

| Health Post    | HEALTH POST: A |    |    |    |    |    |    |    | HEALTH POST: B |    |    |    |    |    |    |
|----------------|----------------|----|----|----|----|----|----|----|----------------|----|----|----|----|----|----|
| Participant    | A1             | A2 | A3 | A4 | A5 | A6 | A7 | A8 | B1             | B2 | B3 | B4 | B5 | B6 | B7 |
| Age            | 37             | 29 | 30 | 27 | 42 | 19 | 36 | 33 | 32             | 20 | 26 | 19 | 20 | 19 | 19 |
| Race           | b              | b  | b  | b  | b  | b  | b  | b  | b              | b  | b  | b  | b  | b  | b  |
| Marital status | s              | s  | s  | m  | s  | s  | s  | s  | m              | m  | s  | m  | s  | s  | s  |
| Grade          | 2              | 10 | 4  | 7  | 9  | 2  | 8  | 9  | 4              | 9  | 8  | 8  | 10 | 8  | 9  |
| Parity         | 1              | 2  | 2  | 3  | 5  | 1  | 4  | 2  | 1              | 1  | 1  | 0  | 0  | 0  | 0  |
| Gravid         | 2              | 3  | 3  | 4  | 5  | 2  | 7  | 3  | 2              | 2  | 2  | 1  | 1  | 1  | 1  |
| Miscarriage    | 0              | 1  | 0  | 0  | 0  | 0  | 2  | 0  | 0              | 0  | 0  | 0  | 0  | 0  | 0  |
| Still birth    | 0              | 0  | 0  | 2  | 2  | 0  | 1  | 0  | 0              | 0  | 1  | 0  | 0  | 0  | 0  |
| Neonatal death | 1              | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0              | 0  | 0  | 0  | 0  | 0  | 0  |
| Twins          | 0              | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 0              | 0  | 0  | 0  | 0  | 0  | 0  |
| Employment     | y              | n  | n  | y  | n  | n  | n  | y  | y              | n  | n  | n  | n  | n  | n  |
| Schooling      | n              | n  | n  | n  | n  | y  | n  | n  | n              | y  | n  | n  | n  | y  | y  |

Key: b = Black s = single m = married y = yes n = no



#### 4.4 THEMES AND SUB-THEMES THAT EMERGED FROM THE INTERVIEW DISCUSSIONS

A total of five major themes and several sub themes emerged from the interviews with pregnant women. The major themes were:

- Availability and accessibility of ANC services.
- Established practices by the health post staff to reduce the number of clients in the health posts.
- Management and administration of the health posts.
- Access to health information by pregnant women and communication with the health post staff.
- Socio-cultural taboos and beliefs of community from the area.

Table 4.3 presents the major themes and sub-themes that emerged from the interviews.

**Table 4.3: Themes and sub-themes that emerged from the interviews**

| Theme no | Major themes  | Sub-themes   |
|----------|---|--|
| 1        | Availability and accessibility of ANC service.  | <ul style="list-style-type: none"> <li>• Absence of a fixed PHC clinic in the area.</li> <li>• Inadequate services offered at the health posts.</li> <li>• Health posts operating days and times.</li> <li>• Lack of transport to the health posts.</li> </ul>                                   |
| 2        | Established practices by the health post staff to reduce the number of clients in the health posts. | <ul style="list-style-type: none"> <li>• Not all clients accepted at the health post</li> <li>• Early closure of the health posts.</li> <li>• Clients sent home before receiving health care services.</li> </ul>  |
| 3        | Management and administration of the health posts.  | <ul style="list-style-type: none"> <li>• Closure of health the health posts even during days when they are expected to open.</li> <li>• Clients refused access to clinic-by-clinic staff.</li> <li>• Lack of necessary resources.</li> </ul>   |
| 4        | Access to health information by pregnant women and communication with the health post staff.        | <ul style="list-style-type: none"> <li>• Knowledge about when to start attending for antenatal care.</li> <li>• Awareness about services rendered in the health post.</li> <li>• First and subsequent visits expectations.</li> </ul>  |
| 5        | Socio-cultural taboos and beliefs of community from the area.                                       | <ul style="list-style-type: none"> <li>• Exposure to spiritual attacks associated with witchcraft.</li> <li>• Culturally accepted practices in the area</li> <li>• Use of traditional medication and traditional birth attendance.</li> <li>• Fear of rejection by family and school.</li> </ul> |

## **4.5 MAJOR THEME 1: AVAILABILITY AND ACCESSIBILITY OF ANC SERVICES**

The majority of pregnant women commented on the poor availability and accessibility of ANC services and indicated that they had to attend ANC services outside the area. This was evident in the following statements by participants:

*“....The majority of pregnant women from this area attend ANC clinic at clinic C because the clinics in the area do not accept pregnant women and even for sick people they only operate once a week and are here for a very limited time.”* (Participant A1).

*“....With my first baby I attended clinic at a different clinic because I had a relative who lived near that clinic. I could not attend here because the clinics in this area do not attend to the pregnant women.”* (Participant B6)

*“....I first started ANC at in one local Hospital because that is where I want to give birth because there is no clinic or hospital around here where I can deliver my baby or attend clinic.”* (Participant A2).

According to the participants the poor availability and accessibility of health care services were mainly caused by not having a fixed clinic in the area, the number of days and times during which the health posts were operating, and unavailability of transport for the pregnant women to get to the clinics.

### **4.5.1 Sub theme 1.1: Absence of a fixed PHC clinic in the area**

The participants reported that the problem was compounded by the fact that there was no fixed PHC clinic in the area but the three health posts that were not functioning as effective as the PHC clinics in the neighbourhood. This was expressed in the following comments by the participants:

*“....We are very unfortunate here that we do not have a proper clinic, other areas have big clinics that are open every day and night they do not have*

*problems they are able to attend for ANC and even give birth there.”* (Participant B6).

*“....The real truth is we do not have the clinic in this area, the clinics that we have are closed most of the time even when they are open they are as good as not there you hardly get any help, it is either they cannot attend to your problem, you must go to a big clinic or hospital or they do not have this or that so you can’t call that a clinic.”* (Participant B5).

*“....Shame, the nurses try but everything happens in a rush. By the time they come and set up soon they need to pack up and leave and usually just a few of them and we are already shouting and complaining and sometimes reporting them to our traditional leaders. I really feel sorry for them. They really try their best. Perhaps it would have been better if it was just a proper clinic.”* (Participant A6).

#### **4.5.2 Sub theme 1.2: Inadequate services offered at the health posts**

The participants commented that some health care services were not available at the health posts at KwaMkhizwana area which indicated that the health post were not offering comprehensive package of health care services. An example of this was the following comments from the participants:

*“....The first day I came to start ANC clinic I was told that they don’t do first ANC, and I was advised to go and start ANC somewhere else.”* (Participant B4).

*“....I do not even bother to go to the health posts for ANC because I know they do not attend to the pregnant women even if you go there in labour they will send you away.....I only came today because I have flu.”* (Participant A7).

*“....Our clinics are very small with very limited services, otherwise for most services you need to go somewhere else like to clinic C which is much bigger, it is just that it is far and they also attend to their local patients before attending to us.”* (Participant B1).

#### **4.5.3 Sub-theme 1.3: Clinic operating days and times**

The majority of participants reported that it is very difficult for them to attend the clinic because the two health posts available in the area are open once a week and the health posts are closed during public holidays and weekends. This was revealed in the following quotations by the participants:

*“....The problem is that this clinic opens once a week, and we cannot wait for them if one is really sick, because sometimes they don’t open at all, like in December last year.”* (Participant B1).

*“....The clinic only opens on Mondays every week from 10h30 up until they finish seeing patients, they have chosen to see on that day and send others back home to be seen on the following Monday.”* (Participant A3).

*“....The health post opens only on Wednesday but sometimes they do not open at all and don’t even communicate to the clients beforehand.”* (Participant A6).

*“....If you can double check you will discover that the majority of working pregnant women attend ANC clinic at clinic C and in other clinics because there is no clinic on weekends here yet the majority of us are working and weekends are the only times that we are available to attend.”* (Participant A5).

The majority of participants were not happy about the operating times stating that both health posts operate for few hours on days when they are open. The participants also indicated that the nurses usually arrived very late to open the clinic and left very early. According to the participants, this reduced the number of hours during which they could get assistance from the clinics. This is revealed in the following quotations:

*“....This clinic opens once a week for few hours and this means that we should seek health services even if we are not sick (faking to be sick) so that we can keep our medicines at home to use them when we get sick.”* (Participant B3).

*“....We arrive very early and wait for them and after a few hours even before they have seen all of us they start packing their stuff and leave stating that they still have to travel.” (Participant A7).*

*“....This clinic is useless because it does not meet our needs, it is better not to have a clinic than to have a clinic once a week and for just a few hours, it is just a joke.....(raising her voice).” (Participant B5).*

#### **4.5.4 Sub-theme 1.4: Transport to reach other health care institution**

The majority of participants commented that they had to travel long distances to get to other health institutions where they could access health care services. They indicated that they had problems with transport. The majority of them had to use public transport which mainly consisted of buses and taxis. The public transport was only available during certain times of the day and expensive as sometimes they needed to take more than two taxis to get to the nearby PHC services, private doctors or hospitals. The transport was mostly available in the mornings and afternoons to transport the working community to their workplaces. There was barely any transport during off pick hours, during the night and public holidays and weekends. Most of the participants said that they had to relocate to urban areas during advanced pregnancy so that they could be nearer to hospital. The following excerpts highlight the views of the participants in this regard:

*“....This clinic is too far and there is no transport available. I walked in order to come here.” (Participant B3).*

*“....There is no ambulance available, and some pregnant women deliver at home by traditional birth attendance.” (Participant A4).*

*“....It is better to book your own transport or relocate nearer to hospital where you are going to give birth, than to rely on an ambulance.” (Participant A3).*

*“....Transport is mainly for the people going to work, so during the day there is no transport even if you finish early at the clinic you must either walk home or else wait till the afternoon when there is transport again.” (Participant B4).*

*“....I lost three pregnancies one child was a stillborn and two miscarriages all because of the problem of transport. I could not attend the clinic and when I was bleeding I had no transport to go to hospital and delivered at home.” (Participant A7).*

#### **4.6 MAJOR THEME 2: ESTABLISHED PRACTICES TO REDUCE THE NUMBER OF CLIENTS IN THE HEALTH POSTS**

The participants commented about several practices that were practiced by the staff in the health posts in order to limit/reduce the number of clients. These included not accepting all clients that present in the health posts, early closure of the health posts, and sending the clients home before receiving health care services.

##### **4.6.1 Sub-theme 2.1: Not all clients are accepted at the health posts**

The majority of participants indicated that not all clients were accepted in the health posts. The clinic staffs were using the number system where they will have a specific number of pre-numbered cards to issue to the clients as they arrive in the health posts. No more clients were accepted in the health posts once these numbered cards were finished. The rest of the clients had to go home and come back on the following week or go to other clinics which are far away from the area irrespective of what their problems were. The pre-numbered cards were distributed by the security guard who did not have the skill or expertise to consider the nature or severity of the problem that the clients were presenting with. All that he/she considered was first come first served. This was evident in the following statements by the participants:

*“....The first day I came to start ANC clinic I was told by the security guard that the numbers were finish therefore I should go to clinic C. I tried to explain my situation but he would not listen.” (Participant A1).*

*“....On my third visit I came to the clinic I was experiencing some lower abdominal pains. I was sent back home because the numbers were finish.” I eventually delivered the baby at home.” (Participant A4).*

#### **4.6.2 Sub-theme 2.2: Early closure of the health posts**

Some participants indicated that the health posts in the area did not have fixed hours of operation. Sometimes the staff will close the health posts once the clients that they found already queuing at the gate of the clinic were issued with numbers, no matter how few these clients were. The staff would tell the clients who arrived late that they as clinic staff are not expected to wait for the clients but instead it was the clients that should come early and wait for them by the clinic gate. This was evidenced in the following statements by participants:

*“....We don't know what time does the clinic open and close, as a result we wait to see the vehicle. We know that if the vehicle is there, they are also there, and if we don't see the vehicle it means they are not there.” (Participant B5).*

*“....On the day of the clinic we have to be here early and wait because when the nurses come they will attend to those who are here and then leave even if it's early.” (Participant A4).*

*“....The first day I came to start the clinic, I came a bit late, and the clinic was closed and was told the nurses left early because there were very few clients at the clinic that day because of the cold weather.” (Participant A3).*

#### **4.6.3 Sub-theme 2.3: Clients sent home before receiving health service**

The majority of participants reported that in spite of limited days and hours of operation, they find that there are some days when the health posts will not open even when they were expected to open and such messages will not be communicated to clients early.

The majority of participants said that sometimes when they arrive at the health post they find it closed. There are times where they had to go back home having not been attended to, or sometimes not offered the full service that they required. This is revealed in the following quotations:

*“....I was sent back home because there was only one nurse who was on duty on that day.”* (Participant B5).

*“....I came for pregnancy test but I was also vomiting. They give me glucose for the vomiting and asked me to come back on the following Monday for the pregnancy test because they were short staffed.”* (Participant A3).

*“.....The first day I came to start ANC I was told they do not do first ANC I must go to other clinics.”* (Participant A1). *“....On the first day I came to start ANC clinic, the clinic did not open, we waited until late and no one came.”* (Participant B3).

*“....The first day I came to start ANC, the nurses sent me back home because they did not have maternity cards and asked me to come back on the following week, on the following week I found the clinic closed, and I had to go to clinic C.”* (Participant A2).

*“....Sometimes this clinic does not open for days when it should be open, like in December.”* (Participant B2).

*“....What is bad is that we do not know before-hand that the clinic will not open, you put aside everything and come and join the queue, only to find that you waste your time because no one comes until you decide to go home very frustrating.....”* (Participant B3).



#### **4.7 MAJOR THEME 3: MANAGEMENT AND ADMINISTRATION OF THE HEALTH POSTS**

The participants raised their concerns about how the health posts were managed and administered. They verbalized that sometimes the health posts were closed during the days when they were expected to be open and that more often than not a number of clients who presented at the health posts were not accepted. They highlighted the issue of inadequate supplies of human and material resources as being the major cause of most of these problems and attributed them to poor management and administration of the health posts. This was evident in the following excerpts by one of the participants:

*“....You know Ma’am, I think the problem is with the leaders of these clinics, they do not plan and manage them well you can see from many problems that we face. Today is shortage of staff tomorrow is shortage of medication or something else. It is like there is no one responsible or no one cares....”*  
(Participant A3).

##### **4.7.1 Sub-theme 3.1: Clients refused access by the health post staff**

The majority of participants commented that sometimes they would be denied to enter the health post gate by the security guard who will tell them that the numbers were finished. This was revealed in the following quotations by the participants:

*“....I was told by the security guard that I must leave because the numbers were finish. He did not even allow me an opportunity to go and explain to the clinic sister what my problem was.”* (Participant A1).

*“....The second time I came to the clinic I found the gate closed and I was denied access by the gate keeper who was a security guard.”* (Participant A2).

#### **4.7.2 Sub-theme 3.2: Inadequate supplies of human and material resources**

Most participants indicated that they did not start ANC immediately after pregnancy had been confirmed due to lack of maternity cards and other resources for basic screening tests such as haemoglobin, HIV and or Rhesus factor screening kits. They would be advised to come back another day or be referred to another PHC clinic for investigations and management. This problem of lack of material resources was evident in the following statements by participants:

*“....Some medication was not available and I was told to come back on the following Wednesday in case they have got it.” (Participant B1).*

*“....After confirming my pregnancy, the nurse told me to come back on Monday because there were no maternity cards at the clinic.” (Participant A5).*

*“On the first day I started ANC clinic I was told to go to clinic C for haemoglobin testing because they did not have the haemoglobin machine.” (Participant A3).*

*“....Sometimes, I understand and feel sorry for the nurses, there is just a few of them and we are so many, it is really unfair. Really something need to be done about this, perhaps you can help us talk to the government to put more nurses in the clinics.” (Participant B1).*

#### **4.8 MAJOR THEME 4: ACCESS TO HEALTH INFORMATION BY PREGNANT WOMEN AND COMMUNICATION BETWEEN THEM AND THE HEALTH POST STAFF**

The majority of participants stated that there was no health information that was given to patients in groups or individually in either health posts. Some participants indicated that nurses were always in a hurry to finish; as a result they did not spend enough time examining them properly. According to the

study participants, clients were treated symptomatically most of the time and were not given instructions on how and when to take the medication.

*“....The nurses don't give health talks in this clinic.”* (Participant B4).

*“The nurses did not examine me they just gave me the medication which I did not have an idea how to use it.”* (Participant B1).

*“....I came to this clinic complaining of draining water from my private part, they told me I having ruptured membranes, so I must to go to clinic C. I was so worried because I did not know what they were talking about; I thought they meant my baby was dead.”* (Participant A3).

#### **4.8.1 Sub-theme 4.1: Awareness about services rendered**

According to National Department of Health, all PHC clinics should provide the full package of health care services in order to ensure comprehensive service availability at PHC level. The majority of the participants were not aware about where to attend ANC when they are pregnant, because they did not know where to get such services. They assumed that the clinic can only provide other services but not ANC services. This is evidenced in the following statements by participants:

*“....When I came here to start ANC clinic I was eight months pregnant and the nurses told me to go and start clinic in hospital because I delivered my first and second babies by caesarean section. I did not understand, why I should go to hospital, I was not sick and not going to deliver soon I was only eight months pregnant.”* (Participant A2).

*“....I know that I have to come to this clinic only if I'm sick otherwise.....”* (Participant A1).

*“....I did know if ANC services were available in this clinic, I was told by my neighbour because she also attended ANC clinic in this clinic.”* (Participant B5).

*“....I don’t know anything about this clinic, what I know is that it opens on Monday only.”* (Participant A2).

#### **4.8.2 Sub-theme 4.2: Expectations regarding first and subsequent visits**

Most participants did not know when to start ANC clinic and what to expect during first and subsequent visits. This was evidenced in the following statements:

*“....I did not have an idea of when to start the clinic, I came here because I was not feeling well and the nurses asked me to start the clinic.”* (Participant B2).

*“....My first day at the clinic was the same as the second and third visits, and I did not do anything about that because I did not know the difference.”* (Participant A1).

*“.....On my first ANC visit I was screened for pregnancy, and after that advised to go and start ANC clinic at clinic C.”* (Participant B3).

*“....On the second visit I was just turned back home because there were no numbers, and when I came back the following week I was seen by an Enrolled nurse who gave me another return date, without even touching me.”* (Participant B2). *“....I came to the clinic because I was sick and the nurses told me I was nine months pregnant and I need to start clinic immediately and they asked me to come back on Wednesday.”* (Participant B2).

*“.....I knew I was pregnant but I wanted to start ANC clinic at six months because I was well and all was fine with me and the pregnancy.”* (Participant B2).

#### **4.9 MAJOR THEME 5: SOCIO-CULTURAL TABOOS AND BELIEFS OF COMMUNITY FROM THE AREA**

Some of the participants indicated that some cultural beliefs influence the decision to disclose and to seek ANC in several ways. Most women reported that they should wait until they had missed some more months of periods before disclosing or confirming a pregnancy hence for the first three months the women should not be seen in any public areas.

They also reported that according to African culture falling pregnant before marriage is taboo. This was revealed in the following quotations:

*“....I don’t want to attend clinic with teenagers, because they will laugh at me.”*  
(Participant B1).

*“....I was tested for virginity now I don’t want people to see me like pregnant therefore I will hide my pregnancy and even delay starting ANC so that they don’t see me.”* (Participant B4).

*“....I am ashamed of being pregnant and I don’t want people to see me in public.”* (Participant B4).

*“...The reason I did not start ANC early was that culturally I had to wait until I missed four months before confirming the pregnancy because early confirmation could result to negative spiritual implications to unborn baby.”*  
(Participant B3).

##### **4.9.1 Sub-theme 5.1: Exposure to spiritual attacks associated with witchcraft**

Some pregnant women delay to start ANC deliberately because they perceived that they are vulnerable (especially during first trimester) to spiritual attacks associated with witchcraft that can lead to destruction of pregnancy. In this context, early disclosure can expose them to spiritual attacks. This was revealed in the following quotations:

*“....I don’t want people to know that I’m pregnant because I’m afraid of bewitchment.” (Participant A1).*

*“....I started ANC clinic when I was six months pregnant because I was afraid of spiritual attacks.” (Participant A3).*

*“....It is not safe to go out and mix with other people during the first three months of pregnancy, because during that time we are more vulnerable to spiritual attacks that can affect your unborn baby.” (Participant B5).*

*“....Culturally pregnant women are very weak and vulnerable to spiritual attacks hence they should be protected against evil spirits. With my first pregnancy I had a miscarriage because I declared pregnancy early by attending the community gathering.” (Participant B4).*

#### **4.9.2 Sub-theme 5.2: Use of traditional medicines and traditional birth attendance**

The majority of women perceived pregnancy as a natural healthy state and not a disease therefore they saw no reason to visit the clinic. This is evidenced in the following statements:

*“....I do not understand why I should come to the clinic every month to attend ANC clinic, even if I’m not sick.” (Participant B2).*

*“....I don’t belief in attending ANC because pregnancy is a natural healthy state, and we should just allow nature to take it cause.” (Participant B3).*

*“....We rely on the women who are traditional birth attendants. They use traditional medicines for induction and precipitation of labour with no complications.” (Participant A1).*

#### **4.9.3 Sub-theme 5.3: Fear of rejection from family or community**

Some participants also indicated that early disclosure can lead to rejection or discrimination in the community and at school, especially for school age girls, hence they delay starting ANC. This was evidenced in the following quotations:

*“....I am afraid I don’t want my teachers and the learners from school to know.”*  
(Participant A4).

*“....I was afraid of being rejected by my family; hence I decided to hide my pregnancy.”* (Participant B2).

*“....I did not know how to deal with the situation because I knew the boy will not have money to pay for the damages therefore I had to hide my pregnancy or opt for abortion.”* (Participant A2).

#### **4.10 CHAPTER SUMMARY**

In this chapter the results and findings of data analysis were presented and supported by verbatim statements by the participants. The themes and sub-themes that emerged from the analysis of information gathered from the study participants were outlined. These will be discussed in the next chapter in order to create meaning regarding the experiences of the pregnant women regarding ANC services at KwaMkhizwana area.

## **CHAPTER 5 : DISCUSSION OF RESULTS**

### **5.1 INTRODUCTION**

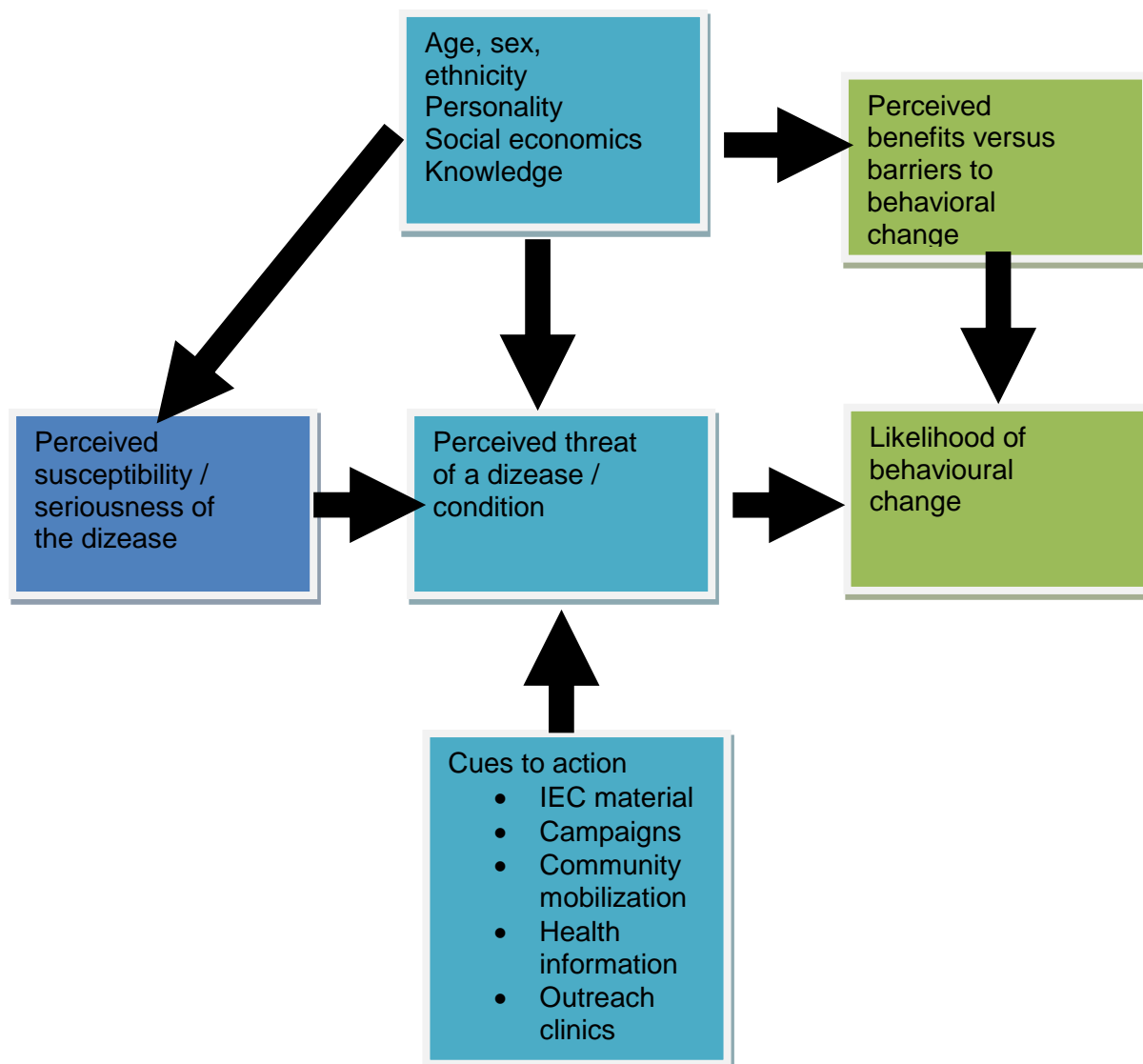
The previous chapter presented the results of the study. The intention of this chapter is to discuss the findings of the study in relation to the research question which was: “What were the experiences of the pregnant women from KwaMkhizwana area regarding ANC services?” Literature is used to further clarify findings that emerged from data analysis and to support the discussion.

### **5.2 DISCUSSION OF THE STUDY FINDINGS**

The discussion of results is based on the Health Belief Model as the model that was used to guide the study. The Health Belief Model describes a range of health behaviour that can be predicted based on certain determinants which include: perceived susceptibility, perceived benefits, perceived barriers/threats, cues to action / modifying factors and self-efficacy. The discussion focuses mainly on individual perceptions, modifying factors and likelihood of action all of which were originally presented by Rosenstock (1974). According to Rosenstock (1974:328-332) the health behaviour (likelihood of action) is determined by personal beliefs or perceptions (individual perceptions) about the disease and the strategies available to decrease its occurrence and the perceptions are influenced by a whole range of intrapersonal factors and other variables (modifying factors). Figure 5.1 illustrates the application of the model in discussion of results from the current study.



## INDIVIDUAL PERCEPTIONS MODIFYING FACTORS LIKELIHOOD OF ACTION



**Figure 5.1: Application of the Health Belief Model (Stretcher and Rosenstock 1997: 333)**

### 5.2.1 Individual perceptions

The individual perceptions could be perceived susceptibility, perceived severity, perceived benefits and/or perceived barriers/threats (Stretcher and Rosenstock 1997:31).

#### 5.2.1.1 Perceived susceptibility

Perceived susceptibility refers to one's chances of getting a condition (Glanz, *et al.* 2002:32). A person's perception that a health problem is personally relevant will contribute to taking the required action by the individual (Glanz *et al.* 2002:40). An individual requires understanding how the health problem or issue will affect them as they should acknowledge that they are at risk of getting the health problem. This requires that there should be activities that increase an individual's perception of their own vulnerability. In this study, it was revealed that pregnant women do not comprehend the consequences of attending ANC late hence the majority booked for ANC late, including those with previous pregnancies. In this study the lack of knowledge of pregnant women with regard to ANC attendance before they fall pregnant was established. The majority of the pregnant women had little perception of the threats of pregnancy complications and severity. However, a few of them acknowledge the importance of ANC and did attend even though they booked late with some making the effort to go outside the community area to access ANC service.

#### *Access to health information by pregnant women and communication between them and the health post staff*

In this study most of the participants stated that they had no information about ANC services before they became pregnant. Most participants revealed that no ANC information was offered to them either through health education or counselling. According to Ndyomugyeniyi, Numa, and Magnussen (1998:234), pregnant women with inadequate knowledge of maternal and child health are likely not to utilize ANC services. Nndidi and Oseremen (2010:49) also found that ignorance on the importance of ANC and misconceptions were the major reasons for poor ANC service use. More studies have shown that adequate knowledge of ANC has a positive and statistical significant effect on ANC use (Paredes *et al.* 2005; Nisar and White 2003; Gore, Muza and Mukanangana 2014).

#### 5.2.1.2 Perceived severity

According to the Health Belief Model, perceived severity are the complications of pregnancy related conditions such as hypertension leading to eclampsia and HIV infection. These complications happen if they were not identified and treated early during ANC hence perceived severity of disease complications could be a modifying factor on the likelihood of pregnant women complying with the policy of ANC attendance utilisation of ANC. The majority of the pregnant women in this study had little knowledge of pregnancy complications and severity that can be identified and prevented by attending ANC hence they saw no reason for attending ANC. Most of the participants revealed that they perceived pregnancy as a natural process which should have no complications at all, hence they preferred to use natural remedies or traditional medicines from western medicines to facilitate the natural processes of labour and delivery conducted by traditional birth attendants.

Individual perception has been found to have a negative impact on the maternal service utilization. Individual perceptions such as women's attitude towards pregnancy where pregnancy is generally considered normal life processes and not associated with health problems or complications, can lead to lack of ANC service utilization. Ndidi and Oseremen (2010:49) attests to this stating that the participants out of ignorance on the benefits of ANC believed that it was not beneficial to start ANC early unless they were sick. The participants perceived antenatal health care services as curative rather than preventive services.

#### 5.2.1.3 Perceived benefits

Most participants reported that they were unaware of the benefits of using ANC. The perceived barriers outweighed perceived benefits due to lack of awareness of the benefits of ANC utilization. The participants reported that they had never seen any pregnant women coming for ANC service in the health posts; hence they assumed that such services were not available.

Some highlighted that some screening tests were not performed due to lack of necessary resources so they had to go to other clinics or hospitals in order to get such services. Shortage of medication was also highlighted as another challenge that was verbalized by the majority of the participants. In the study conducted by Gross, Alba, Glass, Schellenberg and Obrist (2012:24) it was revealed that the attendance of early ANC is further jeopardized by the fact that health facilities lack required equipment and supplies at all times and on the other hand health professionals were not friendly. Unavailability of ANC services such as being sent home without receiving services owing to insufficient staff, lack of drugs and no clinic cards, was verbalized as one of the barriers to ANC service attendance (Gross *et al.* 2012:6). These were some of the issues that discouraged the pregnant women to attend ANC services in the current study.

In most cases, the clients make their choice of health care institution based on the quality of services rendered by such institutions. The services are in terms of material resources, obstetric emergency, laboratory services, ambulance services in host of others as well as the availability and friendly attitudes of health care professionals.

#### 5.2.1.4 Perceived barriers / threats

An individual's choice of behavioural options depends on choice of beliefs and barriers. Therefore, a cost benefit analysis allows an individual to evaluate the outcome expectations and assess whether the expected benefit of behaviour outweighs the perceived expenditure incurred by engaging in the behaviour. Compliance with recommended health seeking behaviour is impeded to the extent that perceived barriers outweigh perceived benefits that would results from engaging in the health behaviour (Rosenstock 1974:67). In the current study the majority of participants reported that according to their traditional and cultural belief they were required to wait until they had missed several menstrual periods before disclosing or confirming a pregnancy. In South Africa, some of the beliefs are that for the first three months the pregnant

women should not be seen in any public areas or disclose how far pregnant they are. It is perceived that they are vulnerable (especially during first trimester), to spiritual attacks associated with witchcraft that can lead to destruction of pregnancy. Edgard-Marius, Charles, Jacques, Justine, Virginie, Ibrahim and Laurent (2015:5) attest to this where the authors highlight that cultural beliefs influenced pregnant women's habits to the extent that they felt that when pregnancy was too young, it is advisable to hide it to the mystical forces that could affect it. In this context, early disclosure can expose them to spiritual attacks; hence this belief restricted early ANC attendance. Similarly to this, Mathole, Lindmark, Majoko and Ahlberg (2004:67) found that the early period of pregnancy was the most vulnerable time to witchcraft associated with fears. A study conducted in Malawi by Chiwaula (2011:692) also demonstrated that cultural beliefs and misconceptions negatively influence utilisation of ANC. A pregnant woman would choose not to go to the clinic if she sees no benefit in doing so, but instead more risks due to cultural beliefs.

### **5.2.2 Modifying factors**

According to the Health Belief Model, the perceived threat could be a modifying factor as well as having a direct impact on the likelihood of pregnant women complying with the policy of ANC attendance. The pregnant women perceived many barriers that prevent them from attending ANC such as demographic variables, ANC service unavailability and accessibility. This was also discovered by Tshabalala (2012:63) that 31% of the pregnant women identified barriers that prevent them to start ANC during first trimester of pregnancy, such as clinic availability hours (open times), limited resources, transport problems, nurses attitudes and fear of disclosing pregnancy early.

Stretcher and Rosenstock (1994:62) state that several factors such as age, sex, ethnicity, personality, social economics and knowledge are responsible for modifying behaviour.

#### 5.2.2.1 Demographic variables

The demographic variables in the current study included: age, level of education, marital status and parity. This concurs to the findings by Abosse, Woldie and Ololo (2010:75) that discovered that maternal age, husband's attitude, family size, maternal education, and perceived morbidity were major predictors of antenatal care service utilization.

##### *Age*

In this study it was discovered that maternal age had no serious impact on ANC utilization, because both young and old women had different perceptions regarding pregnancy and ANC use. In this study it was found that older women did not want to attend ANC together with teenagers and again teenagers also did not want to attend ANC with older women due to fear of embarrassment on both sides. Similar findings were reported by Magadi, Agwanda and Obare (2006:232) that young people do not want to attend ANC with elderly women, probably they fear embracement. Magadi *et al.* (2006:1315) also found little or no variation between timing of ANC and age of pregnant mother. In a study conducted in Turkey it was demonstrated that teenage mothers were statistically less likely to use ANC services (Ciceklioglu 2005:688). Similarly, Abosse *et al.* (2010:75) attest that maternal age is a factor in the utilization of ANC services. These authors discovered that mothers who are in the age group of 25–29 years were less likely to utilize ANC service than those 35 years and older. This is contrary to the study done in Nigeria (Simkhada, Teijlingen, Porter and Simkhada 2008:234) where it was discovered that, young women book early for ANC because they have more information about modern health care from reading. Whereas older women tend to believe that modern health care is not necessary due to experience and accumulated knowledge from previous pregnancies. This confirms that age has no influence in attending ANC service.

### *Level of education*

Studies have shown that maternal education has an influence on ANC utilization. Similarly, in the current study, it was demonstrated that women with higher education level attended ANC more frequently than those with lower education level. The study conducted in Nepal also demonstrated that women with higher education were more likely to attend ANC than those with lower education. This was also attested to by Magadi, Madize and Rodrigues (2000:559) who found that both maternal and paternal education positively influence ANC utilization. In line with this, Abosse *et al.* (2010:82) discovered that mothers with primary educational level are more likely to attend ANC than women who are unable to read and write. Women's education status is highly influential to ANC utilization due to motivation and empowerment by knowledge they have on modern health care (Gore, Muza and Mukanangana 2014:14). Poor education, according to Openshaw, Hlelekazi and Pretlove, (2011:3) tended to lead to decreased knowledge of problems affecting pregnancy among women in Pretoria, resulting in poorer use of ANC service.

### *Marital status*

In the current study, it was determined that unmarried and young women are not likely to attend ANC, because they fear possible stigma and rejection by the community associated to pregnancy out of wedlock. According to Mathole *et al.* (2004:58), women who booked late for ANC visit they delay to seek care for reasons such as pregnancy out of marriage, which is culturally a taboo. In contrary to this Sunil *et al.* (2010:138) discovered that the highest percentage of antenatal care use is reported among the women who are never married than married women. According to Sunil *et al.* (2010:138) married women need to get permission to attend antenatal care service from their partners which could potentially delayed them commencing ANC.. In the study the researcher found no influence on marital status about ANC service utilization which was similar to the findings by Gross *et al.* (2012:4) that there

was no significant association between marital status and ANC early or late booking.

### *Parity*

Tshabalala (2012:650) reports that no differences existed between multigravidas and primigravidas on the time they start ANC, the current study discovered that both women with multiple parity and no parity book late for ANC due to unavailability of such services in the area. Most authors discovered that higher parity is a barrier to adequate use of ANC in developing countries (Magadi *et al.* 2000; Overbosch 2004; Sagna and Sunil 2012; Simkhada *et al.* 2008). Although, the perceived lower risk associated with births of higher order may explain the greater odds of inadequate visits among multiparous women, higher parity women may not feel the need to use antenatal services, due to their accumulated pregnancy experiences and knowledge of the birthing process (Sagna and Sunil 2012:417). Adewoye, Musa, Atoyebi and Babatunde 2013:54) argue that pregnant women with no experience of previous utilization of ANC for the pregnancy preceding the current, are nearly sixteen times more likely to book lately than those who had previous experience of ANC due to lack of awareness regarding importance of early ANC booking.

#### 5.2.2.2 ANC service unavailability and accessibility

Access to ANC is important in helping to modify women's risk behaviour and promote positive health practices. In the current study several factors were discovered to be responsible for unavailability and poor accessibility of ANC services. These included: absence of a fixed PHC clinic in the area, health post operating hours, staff attitudes, the use of a numbering system, poor management and administration of health posts, inadequate services offered at the health posts, distance of health facility and lack of transport.



### *Absence of a fixed PHC clinic in the area*

Participants reported that the problem was compounded by the fact that there was no fixed PHC clinic in the area except the three health posts that were not functioning as effectively as the PHC clinics in the neighbourhood. This finding is supported by Hassim, Heywood and Berger (2007:19) stating that there is still a great need to increase accessibility of ANC services to public in rural areas despite all that has been done to improve access to health care.

### *Health posts operating hours*

Qian, Smith, Huang, Zhang, Haung and Garner (2007:110) and Iyaniwura and Yussuf (2009:23) agree that inconvenience clinic opening hours can be a barrier to ANC service use among young and working females. In the current study, the majority of participants reported two major issues regarding service availability such as: the uncertainty of healthcare provider availability and the inconvenience and limited facility working hours. Several participants highlighted that the health posts operating times were very limited and inconvenient for them. The majority of participants verbalized that sometimes they had to seek ANC services in private sector.

Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need (Alli, Maharaj and Vawda 2012:71). These authors highlighted that, more than often, some clinics do not post their hours of service, or do not serve clients during certain hours when they are supposed to be open. The health providers discourage clients from coming in the afternoons and often do not provide services to women who are only able to attend in the afternoons. All these habits have a negative effect on accessibility and utilization of ANC services. The participants raised their concerns that according to the traditional leaders and other Government officials in the area health care services in these health posts are meant to be available at least five days a week for eight hours a day.

### *Staff attitudes/ Use of numbering system*

The attitude of health personnel is a significant determinant of patients' service utilization (Nwaeze 2013:22) and satisfaction. The good provider-patient relationships are therapeutic and have been described as the single most important component of good medical practice. Not only because it identifies problems quickly and clearly, but it also defines expectation and helps establish trust between the clinician and patient. Staff morale and attitudes are factors that have been revealed as being influential to ANC utilisation in this study. In this study, the majority of participants highlighted having been ill treated by some of the staff working in the health posts. Nwaeze (2013:33) discovered that some women did not seek health care services anymore after being mistreated by health professionals in the health institutions which concurs with that staff attitudes are amongst the determinants of maternal health care utilization. In this study, the majority of participants reported that the numbering system was used to limit the number of patients to be seen on that day. The numbers are distributed on arrival to the clinic at the gate by the security guard, who will then turn the patients away once numbers allocated for the day were finished. In the study conducted by Sibiya (2009:150), the results revealed that a numbering system was used to control queues where patients were given numbers on arrival since at times patients jumped the queue. Fomundam and Herrmann (2007:154) explained that the patients were turned away once the numbers are finished or when the waiting room is full and this implies denying access to health care services.

### *Poor management and administration of health posts: Inadequate services offered at the health posts*

The participants commented that some health care services were not available at the health posts in KwaMkhizwana area, which indicated that the health posts were not offering a comprehensive package of health care services. The participants raised their concerns about poor or no supervision

and support of health posts by management. It has been suggested that clinic supervisors can help to improve quality of care in clinics by providing both administrative and technical support (Gore *et al.* 2004:72). The participants in the current study verbalized that sometimes the health posts were closed during the days when they were expected to be open and that more often than not a number of clients who presented at the health posts were not accepted. This is due to poor facility supervisory visits or lack of facility based manager. They highlighted the issue of inadequate supplies of human and material resources as being the major cause of most of these problems and attributed them to poor management and administration of the health posts. The issue of high rate of absenteeism was also highlighted as being due to high staff turnover and abuse of sick leave by staff. Shortages of staff lead to patient longer waiting times, thus reducing client satisfaction with the health service.

#### *Distance of health post*

In this study, it was discovered that participants were not attending ANC due to location (there is no transport to take them to the clinic) and the far distance of the health post from their residential areas. This led them not to attend the clinics for ANC services. Magadi *et al.* (2000:223) concur with this when stating that an increase in distance to the nearest health care facilities is associated with fewer ANC visits. Abosse *et al.* (2010:79) discovered that mothers who are residing within a nearer walking distance (less than an hour) from a health facility were about 4 times more likely to utilize antenatal care than those residing farther (greater than 2 hours). Gabrysch and Campbell (2009:45) argue that distance to health services hinders ANC service utilization, as many pregnant women prefer not to attempt reaching a facility, since walking many kilometres is difficult where transport is not available.

### *Lack of transport*

Lack of transport was highlighted by the majority of participants as another challenge that they were experiencing in this study. Transport challenges included travelling to the health posts or other clinics to attend routine ANC and to hospital in cases of emergency. The participants experienced challenges with regards to public transport to health posts as well as lack of ambulance services. According to the participants almost all the time especially during the night the ambulance took a very long time to arrive to take the pregnant women in labour to the hospital. This resulted to a high number of home deliveries conducted by traditional birth attendants and with some babies born before arrival to hospital. Similarly to the findings by Sibiya (2009:165), transport in the current study was identified as one of the challenges experienced by participants. The participants in the current study stated that it took a very long time for an ambulance to arrive at the clinic to take the client to hospital in cases of emergency. Most authors agree that physical accessibility and acceptability of ANC services remains a significant challenge to health care service delivery in developing countries with several factors impeding on accessibility of ANC services (Tawiah, 2011; Magadi *et al.* 2003; Anarfi and Ahideke, 2006). These include distance to health services, lack of available transportation, high transportation costs, poor road conditions and uneven distribution of health care facilities their health all of which increase travel time and the difficulty in accessing health service facilities. According to Karasaridis, Zauyamakando and Vermaak (2004:26) the difference between the expected time and the actual time for ambulances to arrive at the facilities in KZN was 99 minutes, which was 40 minutes more than that of the national average. In this study, it was also discovered that the majority of participants are not attending ANC due to lack of transport. Similarly, to the study conducted in Zimbabwe by Mathole *et al.* (2004:102) it was revealed that transport costs, poor road conditions and difficulties in crossing big rivers were barriers to utilization of ANC.

According to the Health Belief Model, the perceived threat could be a modifying factor as well as having a direct impact on the likelihood of pregnant women complying with the policy of ANC attendance. A previous study suggests that the quality of care shapes women's decision to use ANC (Gabrysch and Campbell 2009:34). The finding that the availability of better quality services is a significant predictor of inadequate use of ANC in rural areas, if unexpected, is plausible and similar to Kyei, Campbell and Gabrysch (2012:48). Previous literature suggests that women are more likely to have adequate visits, due to good quality service of ANC (Gage and Guirlène Calixte 2006:283). Sagna and Sunil (2012:418) state that the provision of ANC health facilities with better technical quality of care has an impact on service utilization.

#### 5.2.2.3 Cues of action as modifying factors

Stretcher and Rosenstock (1997:33) describe the cues of actions as the events, people or things that move people to change their behavior. The current study identified health post staff as people that could potentially influence the change of behavior for the pregnant women in this rural community by providing maternal health information education material and coordinating events such as awareness campaigns, outreach clinics and other community door-to-door mobilization strategies. The findings of the current study highlighted that the health post staff in the community provided none of these activities to them. Raising community awareness through health information sharing and distribution of information, and communication materials, would possibly motivate the pregnant women to attend ANC. According to Tshabalala's (2012:75) study findings suggested that health education, community mobilizations, campaigns, outreach clinics and provision of Information education and communication materials in different local languages would motivate pregnant women to utilize ANC services early. According to Gore *et al.* (2014:32), being knowledgeable of the services offered by health facilities is influential to pregnant women's decision to visit the health facilities. Improving knowledge for women of childbearing ages,

spouses, families and communities would have a large impact on improving ANC service utilization. Several barriers to ANC utilization were verbalized by the majority of pregnant women hence dealing with verbalized perceived barriers and threats would also encourage them to utilize ANC services early.

### **5.2.3 Likelihood of action: Self-efficacy**

Stretcher and Rosenstock (1997:62) describe self-efficacy as the belief in one's own ability to do something and that people do not try to do something new unless they think they can do it. If someone believes a new idea is useful (perceived benefit) but does not think she/he is capable of doing it (perceive barrier) chances are that it will not be tried (Stretcher and Rosenstock 1997:34). This was evident from the comments of the participants who stated that although they were aware that they needed to attend ANC, they anticipated various challenges, which they thought they were not going to be able to deal with, so they decided not to attend for ANC in the local health posts. Other participants decided on their own or from the information gathered from other community members to find another health facility where they could attend for ANC or to still continue and attend the local health post despite their fears simply because of the perceived benefit attached to attending ANC. It was having the knowledge (Tshabalala 2012:77) that attending for ANC is important that motivated them to ensure that they attended for ANC.

## **5.3 CHAPTER SUMMARY**

In this chapter, the findings of the current study were discussed guided by the Health Belief Model and based on individual perceptions, modifying factors and likelihood of action all of which were originally presented by Stretcher and Rosenstock (1997:34) in their application of the model. A detailed summary of the current study is presented in the next chapter.

## **CHAPTER 6 : SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY**

### **6.1 INTRODUCTION**

This chapter discusses the summary of findings, conclusions, and limitations and recommendations of this study.

### **6.2 FINDINGS**

The findings from this study revealed that there are still barriers in ANC service access leading to poor service utilization, in spite of every effort made to ensure access to health care services.

### **6.3 CONCLUSIONS**

The information gathered from the participants with regard to their experiences affirms that challenges still exist in this rural community regarding access to health care services in particular antenatal care services.

### **6.4 LIMITATIONS OF THE STUDY FINDINGS**

Due to the nature of the study, the qualitative research method, the study findings cannot be generalized to the entire province or country. However, they could be locally generalized for the eThekweni district, KwaMkhizwana rural area. Another limitation was the fact that the participants were pregnant women living at the KwaMkhizwana rural area.

## **6.5 RECOMMENDATIONS**

The following recommendations are made with special reference to policy development and implementation, institutional management and practice, nursing education and further research.

### **6.5.1 Policy development and implementation**

Despite a number of policies that have been developed to improve maternal mortality, challenges still exist. Based on the findings of the study recommendations are made that the department of health should consider the development and implementation of the policies listed below which could be implemented at PHC level in order to promote and improve ANC service accessibility.

- Development of policy on adequate resource allocation and management, strategies to provide efficient services with limited resources through partnership support.
- Development of policy on client satisfaction (customer service).
- Development of policy on community oriented PHC.
- Community orientation programme on Patients' Rights Charter, Bato Pele principles and service standards and on how to lodge complaints.
- Development of policy on quality service provision and sustainability through mentorship and adequate supervision.
- Development of policies and strategies on service marketing.
- Development of policies to address public health issues.
- Development of policy on employee satisfaction and wellness programmes.
- Development of policy on regular employee skills audit, development and training (capacity building).
- Development of strategies to encourage and reward good practices.
- Development of policy on regular scheduled clinic supervisory support visits by senior management.



### **6.5.2 Institutional management and practice**

The PHC services are provided by PHC specialised nurses using management protocols as guidance, hence such protocols need to be simplified and be user friendly. Based on the findings of the current study the following recommendations are highlighted focusing on institutional management and practices:

- Institutional protocols and standard operating procedures that are aligned to national policies and guidelines should be developed and audited for implementation on a regular basis.
- Regular coaching and mentorship of staff on the use of stipulated guidelines should be conducted.
- Regular scheduled clinic supportive supervision should be conducted.
- Unannounced clinic audits / assessment by quality assurance team should be conducted.
- Developing institutional customer centred vision statement.
- Services provided and clinic-operating hours should be posted and known by the community.
- Co-ordination of open day event, which involved all other stakeholders.
- Conducts client satisfaction survey, write a report and draw a quality improvement plan annually.
- Facility should monitor client-waiting time twice a year, write a report and the quality improvement plan.
- All facilities should have facility-based managers to improve clinic governance and management.
- Strategies to improve availability of medicines and supplies.

### **6.5.3 Nursing education**

Although the curriculum transformation has been finalized and is being implemented in most academic institutions, there is still a challenge due to the increase in disease burden and a growing population as well as decentralization of services to PHCs. In South Africa PHC is a nurse driven

programme where nurses rely on hence more PHC trained and multi-skilled and well-experienced nurses are needed to deliver affordable, efficient, comprehensive and integrated community oriented PHC services. More PHC training schools are needed as the demand for PHC trained nurses is increasing. Short courses trainings for clinic supervisors on supervisory skills should also be conducted at a management level. This requirement becomes true and essential from the findings by Marquez *et al.* (2002:1) that most clinic managers often lack skills and authority to manage and address service delivery challenges.

#### **6.5.4 Further research**

The researcher recommends that further research studies be conducted in other districts and provinces looking at ANC service accessibility especially in rural areas, focusing on Health care workers and management experiences.

### **6.6 FINAL CONCLUSION AND REMARKS**

The importance and benefits of ANC utilization based on its availability cannot be underestimated on impact it has on reduction of maternal deaths. This depends mainly on ANC service availability and accessibility, which was discussed in detail in Chapter 2.

## References

Abosse, Z., Woldie, M. and Ololo, S. 2010. Factors influencing antenatal care service utilization in Hadiya Zone. *Ethiopian Journal of Health Sciences*, 20(2): 75-82.

Abou-Zahr, C. and Wardlaw, T. 2003. *Antenatal care in developing countries: promises, achievements and missed opportunities: an analysis of trends, levels and differentials, 1990-2001*. Geneva: World Health Organization.

Adewoye, K.R., Musa, I.O., Atoyebi, O.A. and Babatunde, O.A. 2013. Knowledge and utilization of antenatal care services by women of childbearing age in Llorin-East Local Government Area, North Central Nigeria. *International Journal of Science and Technology*, 3(3) 188 – 193 ISSN 2224-3577.

Alli, F., Maharaj, P. and Vawda, Y. 2012. Interpersonal Relations between Health care workers and young clients. Barriers to accessing Sexual and Reproductive Health care. Durban: South Africa.

Anarfi, J.K. and Ahiadeke, C. 2006. Improving the health of children among the urban poor in the city of Accra, Ghana. Accra: Institute of Statistical, Social and Economic Research.

Babbie, E. and Mouton, J. 2001. *How to succeed in your master's and doctoral studies: a South African guide and resource book*. Pretoria: Van Schaik.

Beel, R., Kobialka, S., Schimdt, M. and Engeser, M. 2011. Direct experimental evidence for an enamine radical cation in SOMO catalysis. *Chemical Communications*, 47(11): 3293-3295.

Beksinska, M., Mullick, S., Kunene, B. and Mosery, N. 2012. *Maternal care: antenatal, peri and postnatal*. Health Systems Trust. (Online). Available: [www.hst.org.za/uploads/files/chap18\\_06.pdf](http://www.hst.org.za/uploads/files/chap18_06.pdf) (Accessed on 12 November 2015).

Burns, N. and Grove, S.K. 2009. *The practice of nursing research appraisal, synthesis, and generation of evidence*. 5<sup>th</sup> ed. St Louis, MO: Saunders Elsevier.

Ciceklioglu, M. 2005. Factors associated with the utilization and content of prenatal care in a western urban district of Turkey. *International Journal for Quality in Health Care*, 17(6): 533-539.

Chiwaula, C. 2011. Lack of knowledge of proper timing to initiate antenatal care, cultural beliefs and unplanned pregnancies were the major factors contributing to late initiation on ANC.

Creswell, J. 2014. *Research design*. Thousand Oaks, CA: Sage.

De Vos, A.S., Fouche, C.B. and Delport, C.S.L. 2011. *Research at grass roots*. 7<sup>th</sup> ed. Pretoria: Van Schaik.

Douglas, G., Nicol, F. and Robertson, C. 2005. *Macleod's clinical examination*. 11<sup>th</sup> Edition. Philadelphia, PA: Elsevier.

Edgard-Marius, O. Charles, S.J. Jacques, S. Justine, G.C., Virginie, M.A., Ibrahim, M.A. and Laurent, O.T. 2015. Determinants of low antenatal care services utilization during the first trimester of pregnancy in Southern Benin Rural Setting. *Universal Journal of Public Health*, 3(5): 220-2015.

Fomundam, S. and Herrmann, J. 2007. A survey of queuing theory applications in health care. *Institute for Systems Research Technical Report*, 24:1-22.

Fraser, D.M. and Cooper, M.A. Eds. 2009. *Myles textbook for midwives*. 15<sup>th</sup> ed. Edinburgh: Churchill Livingstone.

Gabrysch, S. and Campbell, O. 2009. Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy Childbirth*, 9(1): 9-34.

Gage, A. and Guirlène Calixte, M. 2006. Effects of the physical accessibility of maternal health services on their use in rural Haiti. *Population Studies*, 60(3): 271-288.

Glanz, K. Rimer, B. and Lewis F.M. eds 2002. *Health behaviour and health education theory, research and practice*. 3<sup>rd</sup> ed. San Francisco, CA: Jossey-Bass.

Goolsby, M.J. and Grubbs, L. 2011. *Advanced assessment: interpreting findings and differential diagnosis*. 2<sup>nd</sup> ed. Philadelphia, PA: F. A. Davis Company.

Gore, O.T., Muza, C. and Mukanangana, F. 2014. Barriers and Motivators to early utilization of Antenatal Care services in Chipinge South District in Zimbabwe: *Global Journal of Biology, Agriculture and Health Sciences*, 3(4): 116-121.

Gross, K., Alba, S., Glass, T.R., Schellenberg, J.A. and Obrist, B. 2012. Timing of antenatal care for adolescent and adult pregnant women in south-eastern Tanzania. *BMC Pregnancy and Childbirth*, 12 (16):1-12.

Grove, S.K., Burns, N. and Gray, J.R. 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7<sup>th</sup> ed. St Louis, MO: Elsevier.

Harrison, D. 2010. An overview of health and health care in South Africa 1994-2010: priorities, progress and prospects for new gains. Discussion document. National Health Leaders' Retreat, Muldersdrift, January 24-26.

Hassim, A., Heywood, M. and Berger, J. 2007. *Health and democracy: a guide to human rights, health law and policy in post-apartheid South Africa*. Cape Town: SiberInk.

Henning, E. 2004. *Finding your way in qualitative research*. Pretoria: Van Shaik.

Hennink, M., Hutter, I. and Bailey, A. 2011. *Qualitative research methods*. Thousand Oaks, CA: Sage.

Hoque, M., Hoque, E. and Kader, S.B. 2008. Audit of antenatal care in a rural district of KwaZulu-Natal, South Africa. *South African Family Practice*, 50(3): 66c-66d.

Karasaridis, A. Zauyamakando, T. and Vermaak, K. 2004. *The national primary health care facilities survey 2003: KwaZulu-Natal*. Durban: Durban: Health Systems Trust.

KwaZulu-Natal (KZN) Department of Health. 2009. *Policy and guidelines for integrated antenatal and postnatal care at district hospital community health care centre and clinic level*. Pietermaritzburg: Department of Health.

KwaZulu-Natal (KZN) Department of Health. *EThekweni District Health Plan 2015-2016*. Pietermaritzburg: Department of Health.

KwaZulu-Natal (KZN) Department of Geography. 2011. *Geographic Information System*. Pietermaritzburg: Department of Geography.

Kyei, N., Campbell, O. and Gabrysch, S. 2012. The influence of distance and level of service provision on antenatal care use in rural Zambia. *PLoS ONE*, 7(10): e46475.

Lincoln, Y. and Guba, E. 1985. *Naturalistic inquiry*. London: Sage.

Magadi, M. Madize, N. and Rodrigues, R. 2000. Frequency and timing of antenatal care in Kenya: explaining the variations between women of different communities. *Social Science & Medicine*, 51(4): 551-561.

Magadi, M., Zulu, E. and Brocherhoff, M. 2003. The inequality of maternal health care in urban sub-Saharan Africa in the 1990s. *Population Studies*, 57(3): 153-176.

Magadi, M.A., Agwanda, O.A. and Obare, F.O. 2006. A comparative analysis of the use of maternal health care services between teenagers and older mothers in Sub Saharan Africa: *Social Science and Medicine*, 64 (2007): 13311-1325.

Mashego, T.A.B. and Peltzer, K. 2005. Community perception of quality of primary health care services in a rural area of Limpopo Province, South Africa: *Curationis*, 28(2): 13-21.

Mathole, T. Lindmark, G. Majoko, F. and Ahlberg, B. 2004. A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. *Midwifery*, 20(2): 122-132.

Moodley, J., Pattinson, R., Fawcus, S., Schoon, M., Moran, N. and Shweni, P. 2014. The confidential enquiry into maternal deaths in South Africa: a case study. *BJOG*, 121(Suppl. 4): 53-60.

Mxoli, W.N. 2007. Women's perception of antenatal care rendered by midwives. Master's dissertation. Nelson Mandela Metropolitan University, Port Elizabeth.

Myer, L. and Harrison, A. 2003. Why do women seek antenatal care late? Perspectives from rural South Africa, in *Journal of Midwifery and Woman's Health*, 48(4): 268-272.

National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD) 2013. *Saving mothers 2011-2012: Tenth interim report on Confidential Enquiries into maternal deaths in South Africa*. Pretoria: Department of Health.

National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD) 2012. *Saving mothers 2008-2010: fifth report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Department of Health.

National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD). 2006. *Saving mothers 2002-2004: third report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Department of Health.

National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD) 2001. *Saving mothers: policy and management guidelines for common causes of maternal deaths*. Pretoria: Department of Health.

National Committee on Confidential Enquiry into Causes of Maternal Deaths (NCCEMD). 2001. *Saving mothers 1999-2001: second report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Department of Health.



National Department of Health: See Republic of South Africa National Department of Health

Ndidi, E.P. and Oseremen, I.G. 2010. Reasons given by pregnant women for late initiation of antenatal care in the Niger Delta, Nigeria. *Ghana Medical Journal*, 44 (2): 47- 51.

Ndyomugyenyei, R., Numa, S. and Magnussen, P. 1998. The use of formal and informal services for antenatal and malaria treatment in rural Uganda. *Health Policy and Planning*, 13(1): 94-102.

Nizar, N. and White, F. 2003. Factors affecting utilization of antenatal care among reproductive age group women (15-49 years) in an urban squatter settlement of Karachi. *Journal of the Pakistan Medical Association*, 53(2): 47-53.

Nwaeze, I.L., Enabor, O.O., Oluwasola, T.A.O. and Aimakhu, C.O. 2013. Perception and satisfaction with quality of antenatal care services among pregnant women at the University College Hospital, Ibadan, Nigeria. *Annals of Ibadan Postgraduate Medicine*, 11(1): 22-28.

Openshaw, R.M., Hlelekazi, N.B. and Pretlove, S. 2011. An evaluation of the timing and use of healthcare during pregnancy in Birmingham, UK and Pretoria, South Africa. *International Scholarly Research Network Obstetrics and Gynaecology*, 2011: 1-6.

Overbosch, G. 2004. Determinants of antenatal care use in Ghana. *Journal of African Economies*, 13(2): 277-301.

Oyolola, M., Elung'ata, P. and Muindi, K. 2015. Understanding the factors affecting the use of traditional birth attendants in Nairobi informal settlements: 2000-2012. *International Journal of Maternal and Child Health*, 3(2): 80-90.

Paredes, I., Hidalgo, L., Chendraui, P., Palma, J. and Eugenio, J. 2005. Factors associated with inadequate prenatal care in Ecuadorian women. *International Journal of Gynaecology and obstetrics*, 88(2): 168-172.

Pattinson, R.C. 2007. *Basic antenatal care handbook*. Pretoria: University of Pretoria.

Pelzer, K. 2000. Factors affecting condom use among junior secondary school pupils in South Africa. *Health SA Gesondheid*, 5(2): 37-44.

Polit, D.F. and Beck, C.T 2012. *Nursing research: generating and assessing evidence for nursing practice*. 9<sup>th</sup> ed. Philadelphia, PA: Lippincott Williams and Wilkins.

Qian, X., Smith, H., Huang, W., Zhang, J., Haung, Y. and Garner, P. 2007. Promoting contraceptive use among unmarried female migrants in one of factory in Shanghai. *BMC. Health Sciences Research*, 77 (7).

Republic of South Africa. Census. 2013. *Statistics for South Africa*. Pretoria: Government Printer.

Republic of South Africa. 2011. *Demographic Information Survey*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 1995. *The district health system*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 1997. *White paper for the transformation of health system in South Africa*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2005. *National Health Plan for South Africa*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2007. *South Africa millennium development goals: mid-term report*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2009. *Guidelines for maternity care in South Africa*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2010a. *Negotiated service delivery agreement*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2010b. *The Primary Health Care Package for South Africa-A set norms and standards*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health. 2011. *Human resources for health South Africa: RHR Strategy 2012/3-2016/17*. Pretoria: Government Printer.

Republic of South Africa. National Department of Health 2011. *District information system*. Pretoria: Government Printer.

Republic of South Africa. National Department of Justice. 1996. *Constitution of South Africa*. Pretoria: Government printer.

Republic of South Africa. National Department of Rural Development and Land Reform. 2011. *Simplified spatial development framework guidelines*. Pretoria: Government Printer.

Republic of South Africa. General Household Survey. 2011. *Statistics for South Africa*. Pretoria: Government Printer.

Republic of South Africa. 2005. *Nursing Act 33 of 2005*. Pretoria: Government Printer.

Rosenstock, I.M. 1974. Historical origins of the health belief model. *Health Education Monographs*, 2(4): 328-335.

Sagna, M. and Sunil, T. 2012. Effects of individual and neighbourhood factors on maternal care in Cambodia. *Health & Place*, 18(2): 415-423.

Sibiya, M.N. and Gwele, N.S. 2009. An analysis of the meaning of integrated primary health care from the KwaZulu-Natal primary health care context. *Curationis*, 32(2): 31-37.

Simkhada, B., Teijlingen, E., Porter, M. and Simkhada, P. 2008. Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. *Journal of Advanced Nursing*, 61(3): 244-260.

South African Nursing Council (SANC). 2001. Scope of practice of the nurse and midwife (first draft). Circular 5/2001.

Stretcher, V. Rosenstock, I. M. 1994. The Health Belief Model. *Health Behaviour and Health Education: Theory, Research and Practice*.

Streubert, H.J. and Carpenter, D.R. 2007. *Qualitative research in nursing: advancing the humanistic imperative*. 4<sup>th</sup> ed. Philadelphia, PA: Lippincott, Williams and Wilkins.

Sunil, T.S., Spears, W.D., Hook, L., Castillo, J. and Torres, C. 2010. Initiation of and barriers to prenatal care use among low- income women in San Antonio, Texas. *Maternal and Child Health Journal*, 14 (1): 133-140.

Tarimo, E. 1991. Towards a healthy district: organizing and managing district health systems based on primary health care. Geneva: WHO.

Tawiah, E.O. 2011. Maternal health care in five sub-Saharan African countries. *African Population Studies*, 25(1):1-25.

Tesch, R. 1992. *Qualitative research: analysis types and software tools*. New York: Falmer.

Tshabalala, M. 2012. Utilization of antenatal care (ANC) and prevention of mother-to-child transmission of HIV (PMTCT) services in east Ekurhuleni sub-district, Gauteng Province, South Africa. Master's thesis. University of South Africa, Pretoria.

United Nations Children's Fund (UNICEF). 2009. Monitoring the situation of children and women. Progress for children, a report card for maternal mortality. South Africa: The United Nations Children's Fund.

Victora, C. G., Matijasevich, A., Silveira, M., Santos, I., Barros, A. J. and Barros, F. C. 2004. Socio-economic and ethnic group inequalities in antenatal care in public and private sector in Brazil. *Health Policy Plan*, 25(4): 253-261.

World Health Organization (WHO), UNICEF, UNFPA and the World Bank. 2010. *Trends in maternal mortality 1990-2010: WHO, UNICEF, UNFPA and The World Bank estimates*. Geneva: WHO.

World Health Organization (WHO), UNICEF, UNFPA, World Bank and the United Nations Population Division. 2014. *Trends in maternal mortality 1990-2013: estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. Geneva: WHO.

World Health Organization. (WHO). 1978. Primary health care. *Report of the international conference on primary health care*. Alma-Ata, USSR, 6-12 September 1978. Geneva: WHO.

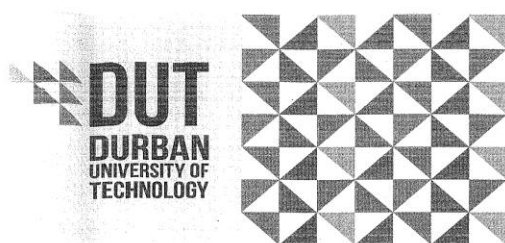
World Health Organization (WHO). 1996. *Integration of health care service delivery*. Geneva: WHO.

World Health Organization (WHO). 2003. *Pregnancy childbirth, postpartum and newborn care: a guide for essential practice*. Geneva: WHO.

World Health Organization (WHO). 2013. *World health statistics*. Geneva: WHO.

# Appendices

## Appendix 1a: University ethics clearance certificate



Institutional Research Ethics Committee  
Faculty of Health Sciences  
Room MS 49, Mansfield School Site  
Gate 8, Ritson Campus  
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900

Fax: 031 373 2407

Email: lavishad@dut.ac.za

[http://www.dut.ac.za/research/institutional\\_research\\_ethics](http://www.dut.ac.za/research/institutional_research_ethics)

[www.dut.ac.za](http://www.dut.ac.za)

20 November 2015

IREC Reference Number: **REC 133/15**

Ms N Z B Khambule  
38 Surprise Ridge Road  
Hillcrest  
3610

Dear Ms Khambule

**Experiences of pregnant women from a rural community regarding antenatal care services in eThekweni district, Kwa-Zulu-Natal**

I am pleased to inform you that Provisional Approval has been granted to your proposal REC 133/15 subject to:

- Piloting of the data collection tool and
- Obtaining and submitting the necessary gatekeeper permission/s to the IREC.

Full approval is subject to meeting the above conditions.

The Proposal has been allocated the following Ethical Clearance number **IREC 136/15**. Please use this number in all communication with this office.

Approval has been granted for a period of two years, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

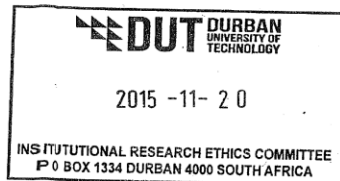
Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

**Please note that you may continue with validity testing and piloting of the data collection tool. Research on the proposed project may not proceed until IREC reviews and approves the final document. If there are no changes to the data collection tool, kindly notify the IREC in writing.**

Yours Sincerely



Professor J K Adam  
Chairperson: IREC





## Appendix 1b: University acknowledgement of the pilot study



**Institutional Research Ethics Committee**  
Faculty of Health Sciences  
Room MS 49, Mansfield School Site  
Gate 8, Ritson Campus  
Durban University of Technology  
P O Box 1334, Durban, South Africa, 4001  
Tel: 031 373 2900  
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Email: lavishad@dut.ac.za  
[http://www.dut.ac.za/research/institutional\\_research\\_ethics](http://www.dut.ac.za/research/institutional_research_ethics)  
[www.dut.ac.za](http://www.dut.ac.za)

13 January 2016

IREC Reference Number: **REC 133/15**

Ms N Z B Khambule  
38 Surprise Ridge Road  
Hillcrest  
3610

Dear Ms Khambule

**Experiences of pregnant women from a rural community regarding antenatal care services in eThekweni district, Kwa-Zulu-Natal**

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

Please note that **FULL APPROVAL** is granted to your research proposal. You may proceed with data collection.

Yours Sincerely  
  
Professor J K Adam  
Chairperson: IREC



2016 -01- 13

INSITUTIONAL RESEARCH ETHICS COMMITTEE  
P O BOX 1334 DURBAN 4000 SOUTH AFRICA

## Appendix 2a: Letter to eThekweni Municipality

38 Surprise Ridge Road  
Hillcrest  
3610  
20 November 2015

The Head of Health Unit  
eThekweni Municipality  
9 Archie Gumede Road  
Durban  
4000

Dear Sir/ Madam

### **REQUEST FOR A PERMISSION TO CONDUCT A STUDY IN KWAMKHIZWANA AND UMQEKU HEALTH POSTS.**

I hereby request a permission to conduct a research study in your institution. I am currently registered at the Durban University of Technology in faculty of Health Sciences Nursing Department. The research project is for my studies towards Masters of Technology Degree. The title of the study: **Experiences of pregnant women from a rural community regarding antenatal care services in eThekweni district, KwaZulu-Natal.**

The primary goal of the study is to explore the experiences of pregnant women from a rural community in KwaZulu-Natal, regarding antenatal services. The study will be conducted in the above mentioned health posts clinics that are providing antenatal care services. The allocated timeframe will be 2 years. Copies of the summary of the proposal, interview guide and DUT ethics clearance are enclosed for your perusal.

The research will require that semi structured interviews be conducted with the pregnant women who permanently live at KwaMkhizwana area. The researcher will ensure that service delivery is not interrupted during data collection process and the research findings will be shared with eThekweni Municipality at the end of the study.

Your support and permission in this regard will be highly appreciated. Please do not hesitate to contact Ms TSP Ngxongo, my supervisor if you have questions. Her telephone number is 031- 373 2748. Her email address is thembelihlen@dut.ac.za.

Yours sincerely



Mrs. Z. Khambule  
Masters Student

## Appendix 2b: Approval letter from eThekwini Municipality



Dear NZB Khambule

10 December 2015


**Subject:** Approval of a research proposal.

The research proposal titled: **Experience of pregnant women from a rural community regarding antenatal care services in eThekwini district, kwaZulu Natal** was reviewed by the eThekwini Municipal Health Department research Committee. The study is hereby **approved to be conducted at Umqeku and Mkhizwane clinics.**

**The following conditions need to be noted:**

- Submission of the indemnity form obtainable from the EThekwini Municipality Health Unit before commencement of the study.
- Prior arrangements to be made with the facility and an assurance that all services will not be disrupted.
- No staff member should be used for collecting data for the researchers.
- Progress reports to be provided and the final report of the study to the eThekwini Municipality Health Unit or emailed to: **ntombifuthi.mangeni@durban.gov.za** and Cc: **grace.mufamadi@durban.gov.za**
- Obtain permission from the eThekwini municipality health department for press releases and release of results to communities/stakeholders.
- The department has to receive recognition for the assistance given.
- Any amended to the study to be communicated with the eThekwini Municipality Health Unit and the relevant amendment form obtainable from the unit to be submitted.
- Withdrawal of permission to conduct research will be left to the discretion of the eThekwini Municipality Health Unit.

Yours faithfully

  
Deputy Head of Health

Signature: \_\_\_\_\_

Date: 11.12.2015

## Appendix 2c: Indemnity letter

No. M.1/1/2

Director : Health  
Box 2443  
DURBAN  
4000

Researcher- Name: NEWINE L. BARBARA KHAMBANE  
Institution- Name: DURBAN UNIVERSITY OF TECHNOLOGY  
Institution- Address: GATE NO 8 MANDELA SCHOOL SITE  
ROOM MS 49, RITSON CAMPUS  
(FACULTY OF HEALTH SCIENCES)  
Research Subject: EXPERIENCES OF PREGNANT  
WOMEN FROM A RURAL COMMUNITY  
REGARDING ANTE-NATAL CARE SERVICES  
IN ETHEKWINI DISTRICT, KWAZULU-NATAL

Dear Sir/Madam

### RESEARCH SITE : ETHEKWINI MUNICIPALITY HEALTH DEPARTMENT

I, the undersigned, hereby wish to apply for permission to attend the eThekweni Health Department to undertake research on Council property.


I understand that any permission granted to me will be subject to:

- (a) there being no additional cost to the Council; and
- (b) the exigencies of the eThekweni Health Department, and provided that no interference with its programme will ensue.


In consideration of the facilities given and to be given to me by the eThekweni City Council, as aforesaid, I hereby indemnify the said Council and its officers and hold it and them harmless against and hereby waive, renounce and abandon any claim for damages or compensation arising from injury or loss which I may sustain whilst on Council property or transport or on the way to or from any Council property or place of research or which I may sustain in any way whatsoever whilst conducting research.

I further indemnify the eThekweni Council and its officers against any claim whatsoever which may in any way result from the facilities afforded to me and be brought against the said Council or its officers.

Date: 11.12.2015

  
Researcher's Signature

Witness: 

  
Researcher's Name (in capital letters)

Permanent Address:

Period

From: DECEMBER 2015 to MARCH 2016

## Appendix 2d: Acknowledgement of research conditions



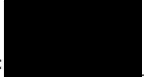
Health Unit

### ACKNOWLEDGEMENT OF RESEARCH CONDITIONS:

I NEWSIWE ZANDILE BARBARA KHAMBULWE undertake to comply to

EThekweni Municipality Health Unit's conditions for the study, as stipulated in the permission letter.

### Name and signature of principal investigator:

Name: NEWSIWE Z. KHAMBULWE Signature:  Date: 11-12-2015

### Name and signature of other researchers:

|             |                  |             |
|-------------|------------------|-------------|
| Name: _____ | Signature: _____ | Date: _____ |
| Name: _____ | Signature: _____ | Date: _____ |
| Name: _____ | Signature: _____ | Date: _____ |
| Name: _____ | Signature: _____ | Date: _____ |



### Appendix 3a: Letter of Information



#### LETTER OF INFORMATION FOR THE PARTICIPANT

Thank you for agreeing to participate in this study.

Title of the Research Study: **Experiences of pregnant women from a rural community regarding antenatal care services in eThekweni district, KwaZulu-Natal.**

**Principal Investigator:** Ms NZB Khambule (B Cur)

**Supervisor:** Ms. TSP Ngxongo (M Tech: Nursing)

**Co- supervisor:** Prof. MN Sibiya (D Tech: Nursing)

**Brief Introduction and Purpose of the Study:** I will be conducting a study about antenatal care services in KwaMkhizwana. The aim of this study is to look at experiences of the pregnant women regarding antenatal care services in KwaMkhizwana area. I will be focusing at how pregnant women living in KwaMkhizwana rural area access and utilize such services.

**Outline of the Procedures:** I will ask you few questions written in isiZulu, on your experiences regarding antenatal care services. Interviews will last for 30 to 45 minutes. The interviews will be scheduled for the day, time and place that best suits you. Responses will be recorded on an audiotape and field notes will also be taken. Participation in the study is completely voluntary. Names of participants will remain confidential to the researcher.

**Risks or Discomforts to the Participant:** None

**Benefits:** The results of the study will assist to making recommendations for ANC service improvement in KwaMkhizwana area.

**Reason/s why the Participant May Be Withdrawn from the Study:** You are free to withdraw from the study at any time and there is no penalty that will be imposed on you.

**Remuneration:** There is no remuneration for participating in the study.

**Costs of the Study:** You will not bear any costs by participating in this study.

**Confidentiality:** All the information gathered during the study will be kept in private. Your name will not be written on data collection sheets and the information that you give will be used for this study only.

**Research-related Injury:** There are no anticipated research-related injuries.

**Persons to Contact in the Event of Any Problems or Queries:** Please contact the researcher, Ms. NZB Khambule (031-765 7436), my supervisor, Dr TSP Ngxongo (Tel no 031-373 2609), my co-supervisor, Prof MN Sibiya (Tel no 031-373 2606), or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031-373 2382 or [dvctip@dut.ac.za](mailto:dvctip@dut.ac.za).

## Appendix 3b: Incwadi yokwaziswa ngocwaningo



### INCWADI YOKWAZISWA NGOCWANINGO LOMAMA ABAKHULELWE

#### Wamukelekile kulolucwaningo

**Isihloko socwaningo:** Zibonakala zinjani izinhlelo zokunakekela izimpilo zomama abakhulelwe endaweni yasemakhaya KwaMkhizwana esifundazweni saKwaZulu-Natal.

**Umcwaningi omkhulu:** Nkk NZB Khambule (B. Cur)

**Umeluleki Omkhulu:** Dokotela TSP Ngxongo (M Tech: Nursing)

**Izekela likameluleki omkhulu:** Solwazi MN Sibiya (D Tech: Nursing)

**Isingeniso esifishane kanye nenjongo yalolucwaningo:** Inhlalo yalolucwaningo ukuphenya omama abakhulelwe ngezinsizo zokunakekelwa kwenu endaweni ya KwaMkhizwana. Lolucwaningo luyogxila kakhulu ekutheni zizebenza kanjani okanye ziyatholaka yini zona lezizinsizo kulendawo.

**Izinhlelo zizohamba kanje:** Uzobuzwa imibuzo emibalwa ngesiZulu maqondana nezinsizo zokunakekelwa komama abakhulelwe endaweni yaKwa- Mkhizwana. Izingxoxo ziyohlelwa ngokosuku, isikhathi nendawo eyothandwa uwe. Izimpendulo ziyoshicilelwa ephepheni ziphinde futhi zigqoshwe. Konke lokhu kuyothatha imizuzu engamashumi amahlanu noma amashumi amane nanhlanu emizuzu, egunjini elizeceleni. Ukuhlanganyela kulolucwaningo akuphoqe muntu. Wonke amagama ayogodlwa umcwaningi.



**Ubungozi nokuhlukumezeka kwabangenele ucwaningo:** Abukho.

**Inzuzo ngongele uncwaningo:** Ayikho.

**Inkokhelo:** Ayikho.

**Ukuhoxa kongenele ucwaningo:** Uvumelekile ukuhoxa esivumelwaneni socwaningo ngokuthanda kwakho. Awuyikuhlukunyezwa ngalokho.

**Abantu ongaxhumana nabo uma unemibuzo noma izinkinga ngocwaningo:** Umncwaningi Nkk NZB Khambule (031 765 7436), umeluleki, Dokotela TSP Ngxongo (Tel no 031-373 2609), noma Solwazi MN Sibiya (Tel no 031-373 2606), okanye abaqondisi kwezomkhakha wocwaningo 031 373 2900. Abezikhazazo, DVC: TIP, Prof F. Otieno on 031 373 2382 or [dvctip@dut.ac.za](mailto:dvctip@dut.ac.za).

## Appendix 4a: Consent form



### Statement of Agreement to Participate in the Research Study:

- I .....I.D number.....hereby confirm that I have been informed by the researcher, Zandile Khambule, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 133/15.
- 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.
- 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.

---

Full Name of Participant

---

Date

---

Time

---

Signature/Right Thumbprint

I, \_\_\_\_\_ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

\_\_\_\_\_  
**Full Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Full Name of Witness (If applicable)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Full Name of Legal Guardian (If applicable) Date**

\_\_\_\_\_  
**Signature**

## Appendix 4b: Imvume



### IMVUME

#### Isitatimente sesivumelwano sokuhlanganyela ocwaningweni

- Mina..... (Igama longenele ucwaningo), izinombolo zomazisi..... Ngiyavuma ukuthi ngichazeliwe Umncwaningi Nkk Zandile Khambule, ngohlobo locwaningo, ukuziphatha, nangenzuzo yocwaningo kanye nangobungozi balo. Research Ethics Clearance Number: 133/15.
- Ngiphinde ngathola ukufunda ngaqondisiza ngokusembhalweni ongenhla (incwadi yokwaziswa ngocwaningo), maqondana nocwaningo.
- Ngazisiwe ukuthi imininingwano yobulili, iminyaka, usuku lokuzalwa, amagama, nokugula kwami akuyukuvezwa uma sekuphuma imiphumela yocwaningo.
- Ngiyazi ngivumelekile ukuhoxhiza esivumelwaneni engizenzile ngokuthanda kwami futhi angiyikuhlukunyezwa ngalokho.
- Nginikiwe ithuba elanele lokubuza futhi ngachazeleka ngokwanele, ngakho ke ngiyavuma futhi ngizimizele ukuhlanganyela kulolucwaningo.

Amagama aphelele..... Usuku.....  
Sayina.....

Mina ..... izinombolo zomazisi.....  
ngiyavuma ukuthi ngimazisile umhlanganyeli ngocwaningo.

Amagama  
aphelele.....Usuku.....Sayina.....

Amagama ..... aphelele  
(ufakazi).....Usuku.....Sayina.....

## Appendix 5a: Interview guide (English)

|                     |                      |                 |                      |
|---------------------|----------------------|-----------------|----------------------|
| Participant Number: | <input type="text"/> | PHC facility:   | <input type="text"/> |
| Age:                | <input type="text"/> | Marital Status: | <input type="text"/> |
| Gravidity:          | <input type="text"/> | Parity:         | <input type="text"/> |
| Level of education: | <input type="text"/> |                 |                      |

Date of interview: -----

Grand Tour Question:

Please share your experiences regarding ANC services in your area.

### Probing Questions

Probing will be done depending on the responses by each participant. Most of the probing questions will be open ended to allow the participants to share more information regarding their experiences. Closed ended questions will be included as required. Some of the probing questions will include the following:

Please share the experiences that you had before attending ANC regarding ANC attendance.

What was your experience when you attended for the first time?

What were your experiences with sub-sequent visits?

What were your actions regarding the untoward experiences regarding ANC?

What are your perceptions regarding ANC services in KwaMkhizwana?

## Appendix 5b: Uhla lwemibuzo

Inombolo yomhlanganyeli:

Umtholampilo:

Iminyaka:

Isimo somshado:

Ukukhulelwa:

Abantwana:

Izinga lemfundo:

Usuku lokuxoxizana: \_\_\_\_\_

---

### Umbuzo omkhulu:

Ngicela ungixoxele ngaloko owahlangabezana nakho maqondana nezinsizo zokunakekelwa kwabakhulelwe endaweni yakini.

### Imibuzo yokuqhwanda izimpendulo:

Imibuzo yokuqhwanda iyobuzwa ngokuhlukana kwezimpendulo. Iningi lemibuzo yokuqhwanda iyoba imibuzo evulelekile, ukwenzela ukuthi abangenelele bakwazi ukunikeza imininingwane engaphezulu ngaloko abahlangabezana nako. Imibuzo evulelekile iyobuzwa uma kunesidingo. Eminye imibuzo yokuqhwanda kuyoba ngelandelayo;

- Ngicela ungixoxele ngolwazi owabe unalo maqondana nokuhamba umtholampilo ngaphambi kokuqala ukuhamba umtholampilo wabakhulelwe

Ngabe kuyini owahlangabezana nakho ngenkathi uya okokuqala emtholampilo?

Ngabe kuyini owahlangabezana nakho ngenkathi usuphinda?

Yisiphi isinqumo owasithatha ngaloko okungalungile owahlangabezana nakho maqondana nokunakekelwa kwabakhulelwe?

Luthini uvo lwakho maqondana nezinsiza zokunakekelwa kwabakhulelwe Kwa-Mkhizwana?

## Appendix 6a: Example of an interview transcript

### Demographic Information

| Study Site | Participant No. | Age | Para | Grav | Level of ed | Date       |
|------------|-----------------|-----|------|------|-------------|------------|
| A          | A1              | 37  | 2    | 1    | 2           | 17/02/2016 |

| Recorded information  | Themes  |
|---|---|
| <p><b>Grand Tour Question: Please share your experiences regarding ANC services in your area?</b></p> <p>The majority of pregnant women are using uUMsunduzi clinic because <b>they don't want people to know that they are pregnant</b>. Some pregnant women <b>delay to start ANC deliberately because they perceived that they are vulnerable</b> (especially during first trimester), to spiritual attacks associated with witchcraft that can lead to destruction of pregnancy. This is due to <b>jealousy in the society</b>. Hence early disclosure can expose us to spiritual attacks (playing with the signed consent form).</p> <p>Another reason for them to go to uMsunduzi clinic is that this <b>clinic opens once a week</b>, and we cannot wait for them if one is really sick, because sometimes they <b>don't open at all</b>, like in December last year (please don't tell them that). Sometimes the nurses will tell you to go to uMsunduzi cilinic and start ANC clinic there, and then for subsequent visit come to this clinic. They will tell you that <b>they don't do first ANC visits</b>. I was also going to attend ANC at uMsunduzi clinic (smiling), because I've never seen any pregnant women in this</p> | <p>Access and availability</p> <p>Established practices</p> <p>Socio-cultural taboos and beliefs</p> <p>Access and availability</p> <p>Management and administration</p> <p>Access and availability</p> |



|   |   |
|---|---|
| <p>clinic. I came here just because I was not feeling well and they did a pregnancy test and found that I am pregnant (avoiding eye contact), and I had to start ANC clinic.</p> <p><b>Probing questions</b></p> <p><b>Please share the experiences that you had before attending ANC regarding ANC attendance?</b></p> <p>I've never seen any pregnant women attending ANC clinic in this clinic. The majority of pregnant women in this area go to uMsunduzi clinic. I was told that in this clinic pregnant women sit in one queue with all the patient and this exposes you to the society and then they will start gossiping about you.</p> <p>Most women start ANC <b>Clinic at 5- 6 or more months of gestation because they are protecting their unborn babies from bad spirits.</b></p> <p><b>What were your experiences when you attended for the first time?</b></p> <p>The first time I attended clinic I was not feeling well and the nurses advised me to do a pregnancy test which came as positive. Then the nurses advised to start the clinic, but booked me for another day. They said they did not have the Maternity card and there was no medication.</p> <p><b>What was your experience in the sub-sequent visit?</b></p> <p>On the second visit they gave me the Maternity card and the medication they said they will bring for me.</p> <p><b>What were your actions regarding the untoward experiences regarding ANC?</b></p> <p>Nothing because they said they will bring everything next week, which they did.</p> <p><b>What are your perceptions regarding ANC services</b></p> | <p>Access and availability/<br/>Management and administration</p> <p>Established practices</p> <p>Management and administration</p> |
|---|---|

|  |               |
|--|---------------|
| <p><b>in KwaMkhizwana</b></p> <p>ANC services are a big challenge in this area, because we have to rely on uMsunduzi clinic which is far from here. When we go to uMsunduzi clinic, the nurses there always ask us if we don't have a clinic around KwaMkhizwana and why are we not using it for ANC. Sometimes when we go to uMsunduzi clinic the nurses there send us back to our clinics, because we don't belong to them, and also because we do have our clinic here.</p> <p>There is no hospital for deliveries we go to R.K. Khan or St. Mary's hospitals because uMsunduzi clinic also does not conduct deliveries. We have got a challenge with transport to take you to hospital when you are in labour, and others end up delivering babies at home or be assisted by Traditional birth attendance.</p> | <p>Access</p> |
|--|---------------|

## **Appendix 6b: Isibonakaliso semibuzo nezimpendulo**

### **IKLINIKI A1**

**Umhlanganyeli: A1 Iminyaka: 37 Ukukhulelwa: Okwesibili Ingane:1**

**Izinga lemfundo: Ibanga lesibili Isimo Somshado: Akashadile**

**Usuku lokuxoxizana: 17/02/2016**

**Umbuzo Omkhulu: Ngicela ungixoxele ngalokho owalhangabezana nakho maqondana nezinsizo zokunakekelwa kwabakhulelwe endaweni yakini**

Omama abakhulelwe basizakala eMsundudi kliniki ngenxa yokuthi abafisi ukuthi umphakathi wazi noma ubabone ukuthi bakhulelwe (Ikakhulu ngezinyanga ezintathu zokuqala). Abanye baze baphuze nokuyiqala ekliniki yabakhulelwe ngoba benokuthi bangase bazithole sebe khunkulwa ngemeqo okungadala ukuthi kuphume nesisu ngenxa nje yomona (idlala ngephepha).

Ukusheshe uqale ikliniki kusho ukuziveza emphakathini kungakafaneli.

Okunye okwenza sihambe e uMsunduzi ukuthi lekliniki ivula kanye ngesonto okunye ibuye ingavuli nhlobo, ngengo Desemba wonyaka odlulile, ngalokho ke ngeke uhlale ulinde into ongayazi uma ugula ngempela.

Ngesinye isikhathi utshelwa yibo abahlengikazi ukuthi uma uzoqala ikliniki yabakhulelwe hamba uye e uMsunduzi, bese ubuya uzoqhubeka lapha, ngoba bona ababoni abaqalayo.

Nami nje bengizoya... (emamatheka) koqala eUMsunduzi ngoba la angikaze ngibone muntu okhulelwe eza kulomtholampilo. Bengize la ngoba ngigula base bengihlolela umchamo base bethola ukuthi ngikhulelwe, base bethi kuzofanele ngiqale ikliniki.

### **Imibuzo yokuqhwanda izimpendulo**

**Ngicela ungixoxele ngolwazi owabe unalo maqhondana nokuhamba umtholampilo ngaphambi kokuqala ukuhamba umtholampilo wabakhulelwe**

Angizange ngibone muntu okhulelwe ehamba ikliniki kulomtholampilo. Abaning bahamba eUMsunduzi kliniki. Abangitshela bathi uma ukhulelwe la uhlala kulayini owodwa nabagulayo, lokho kwenza ukuthi ubonwe umphakathi bese uqala ukhuluma ngasese ngawe.

Omama abaningi kulendawo ikliniki bayiqala izinyanga zinhlanu noma ziyisithupha ukuze bavikele abantwana abangakazalwa kwimimoya.

**Ngabe yini owahlangabezana nayo ngenkathi uya okokuqala emtholampilo?**

Ngosuku lokuqala ngeza emtholampilo ngoba ngigula ngase ngitshelwa ukuthi ngikhulelwe kodwa ngoba abakhadi okuxhukuza ayengekho neminye imithi kwabe sekuthiwa angibuye ngelinye ilanga ngizoqala ikliniki.

Ngabe kuyini owahlangabezana nakho usuphinda?

Ngenzelwa ikhadi elisha nganikwa namaphilisi engangawatholanga.

**Yisiphi isinqumo owasithatha ngalokho okungalungile owahlangabezana nakho maqondana nokunakekelwa kwabakhulelwe.**

Asikho ngoba ngesikhathi ababethe bazongiphathela ngaso amaphilisi nekhadi bakwenza lokho.

**Luthini uvo lwakho maqondana nezinsiza zokunakekelwa kwabakhulelwe endaweni yaKwaMkhizwana.**

Izinsiza zomama abakhulelwe kulendawo yakithi zona ziyinkinga ngoba sithembele kuUMsunduzi lo okude nawo. Uma siya e uMsunduzi abahlengikazi bakhona basibuza ukuthi asinayo yini ikliniki ngakithi Kwa Mkhizwana pho yini singayi kuyo, ngesinye isikhathi basixoshe bathi asiphindele emakliniki ethu.

Okunye asikho isibhedlela esibelethizayo ngaphandle kwe R.K. Khan ne St. Mary's hospital ngoba uMsunduzi nowo awubelethisi. Nezinto zokukuphuthumiza iesibhedlela uma ususikwa ziyinkinga ingakho abantu baze babelethiswe emakhaya.

## Appendix 7: Certificate from the professional editor

### **DR RICHARD STEELE**

BA, HDE, MTech(Hom)

**HOMEOPATH and EDUCATOR**

Registration No. A07309 HM

Practice No. 0807524

**Freelance academic editor**

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Fax 031-201-4989

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Email: rsteele@telkomsa.net

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### **EDITING CERTIFICATE**

**Re: Nelisiwe Zandile Barbara Khambule (DUT)**

**Master's dissertation: EXPERIENCES OF PREGNANT WOMEN FROM A RURAL  
COMMUNITY REGARDING ANTENATAL CARE SERVICES IN ETHEKWINI  
DISTRICT, KWAZULU-NATAL**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy I supervised numerous Master's degree dissertations.

Dr Richard Steele

08 May 2016

*electronic*