

**EXPERIENCES OF ACCESSING MATERNAL HEALTH
CARE SERVICES IN A RURAL COMMUNITY OF
SOUTH AFRICA**

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DECLARATION

I, Lennox Tapera, hereby declare that the coursework master's degree mini-dissertation that I herewith submit for the master's degree qualification *Master of Development Studies* at the University of the Free State, is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.



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Date: 30 June 2020

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DEDICATION

I dedicate this scholarly work to my parents who ensured that I attain a good education through the various sacrifices they made.

I also dedicate it to my immediate family, my wife Patience, my son Matinatsa and my daughter Matida.

I urge you all to follow this path one day.

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To my wife, Patience, my soulmate, and tower of strength, who stood by me to see this development to its end. You endured the pain of sharing your husband with his studies. I am forever grateful.

ABSTRACT

Background

Access to maternal health care is a global concern, especially for developing countries. South Africa's health system faces numerous challenges and poor access to maternal health care services (MHS) is a major contributor to maternal deaths nationwide. Maternal health entails social and medical health care services rendered to both mother and child during pregnancy, at childbirth and after delivery. Few studies have been conducted on experiences of women in accessing maternal health care in rural areas. Therefore, this study aimed at exploring rural women's experiences in accessing MHS in Rethabiseng within the Tshwane Metropolitan Municipality. More specifically, the objectives of the study were to describe knowledge about maternal health care, to explore women's maternal health care needs, maternal health care seeking behaviour, the facilitators to accessing MHS, the barriers to accessing MHS and to suggest recommendations to improve access to maternal health services. The Social-Ecological Model guided the research, and women's experiences of accessing MHS were explored on each level from individual, interpersonal, community and organisational level.

Methods

The research used an exploratory study design. Focus group discussions were used to gather data from pregnant women in antenatal care (ANC) and mothers in postnatal care (PNC) over a period of three months. Additionally, semi-structured interviews were conducted with three key informants (primary health care nurses). The data were thematically analysed using both deductive and inductive data method strategies. The Social-Ecological Model was the main guiding conceptual framework.

Findings

Knowledge of and MHS needs: Pregnant women and mothers demonstrated knowledge of maternal health care during pregnancy, at birth and after delivery. Maternal health care needs were identified as: diagnosis of all pregnancy-related risks, HIV testing and counselling, Prevention of Mother-to-Child Transmission, assistance of a midwife at delivery and PNC.

Maternal health care seeking behaviour of women: The findings revealed that some women sought ANC services regularly and others fell short of the required eight visits. Few women registered for ANC in the first trimester (before 12 weeks), with more registering in the second trimester (12–28 weeks). Some women indicated that they preferred home deliveries, while others were forced into this option as ambulances took long to respond.

Facilitators to accessing maternal health care services

Individual level: Women demonstrated knowledge of the importance of MHS.

Interpersonal level: Partners, spouses, and close family encouraged women to seek ANC and PNC services and assisted them with chores during and after pregnancy.

Organisational level: Friendly and non-judgemental staff, provision of free services at health care facilities, the maternity case record which secured place of delivery, and effective services from community outreach-based.

Barriers to accessing health care services

Individual level: The nurses reported that a lack of knowledge and ignorance was a barrier to MHS for some women as many women only registered for ANC in the second and third trimester. No barriers were identified at **interpersonal level**.

Community level: Cultural and traditional beliefs were identified as hindering access to MHS. Many women delayed registering for ANC out of fear of losing the baby through miscarriage and witchcraft.

Organisational level: Geographic accessibility, poor infrastructure, inflexible opening hours, long waiting periods, shortage of human resources, staff attitudes, poor service delivery and lack of advanced equipment and resources emerged as barriers to MHS.

Recommendations

Individual level: Increasing maternal health awareness among women and education for nurses and re-introducing ANC exercise classes for pregnant women.

Interpersonal level: Increasing community maternal health care awareness.

Organisational level: Expanding infrastructure and operational hours; procuring and maintaining advanced equipment; improving service delivery; recruiting more nurses; improving response time of ambulances; and extending clinic hours to twenty-four hours per day.

Conclusion

The study explored the experiences of women in accessing MHS in the Rethabiseng rural community. While a number of positive factors were identified that facilitated access to MHS, there were many barriers to access as illustrated at the various levels of the Social Ecological Model. Key recommendations to improve access to MHS in rural areas included: extending the clinic's operating hours to a 24-hour service, procuring advanced equipment necessary to monitor pregnancies, repairing broken equipment, improving service delivery, and increasing the capacity of nurses in the maternal section.

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
CDC	Centers for Disease Control and Prevention
CMR	Child mortality rate
FGD	Focus group discussion
HIV	Human immunodeficiency virus
MDGs	Millennium Developmental Goals
MHS	Maternal health care services
MMR	Maternal mortality ratio
NMR	Neonatal mortality rate
PHC	Primary health care
PNC	Postnatal care
RSA	Republic of South Africa
SAHR	South African Health Review report
SBA	Skilled birth attendant
SDGs	Sustainable Development Goals
SSA	Sub-Saharan Africa
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

Chapter 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Increasing access to maternal health care is a worldwide concern and a vital developmental issue for any society, especially in low to middle-income countries (Ekpenyong, Bond & Matheson, 2019; Mashamba-Thompson, Sartorius & Drain, 2016). Maternal health entails social and medical health care services rendered to both mother and child during pregnancy, at childbirth and after delivery (Kolisa, 2016; Mashamba-Thompson et al., 2016). Some of the services include pre- and postnatal care (PNC), advice on diet, immunisations, care for babies with human immunodeficiency virus (HIV) positive mothers, surgical interventions, and general illness.

The time around birth and the first week after birth is the most critical period in the life of a mother and child. It is estimated that annually close to 300 000 maternal deaths occur worldwide (Khatri et al., 2017; Manu et al., 2018; Pasha et al., 2015). In addition, more than 2 500 000 stillbirths and over 2 500 000 neonatal deaths occur globally, with most of these happening during delivery and in the first year after delivery. The maternal mortality ratio (MMR) is higher in Global South (economically backward, poverty, conflict) countries when compared to Global North (economically developed, wealth, technological advancement) countries. In 2017, the statistics for MMR stood at 462 per 100 000 live births in Global South countries and 11 per 100 000 in Global North countries (World Health Organization [WHO], 2019). The huge difference in these statistics is an indicator of the differences in the services rendered in these different settings. Approximately 99% of the world's maternal deaths occur in developing countries because of poor access to MHS (Susuman, 2015; WHO 2019).

In sub-Saharan Africa (SSA), the MMR continues to be high despite efforts to reduce its occurrence (Amzat, 2015). In 2015, the MMR in the SSA stood at 546 per 100 000, compared to the universal statistics of 216 per 100 000 live births (Hodin et al., 2016). The SSA region had 66% of the global maternal mortality deaths (WHO, 2015) and they have remained high even in 2017 (WHO, 2019). The risk of women succumbing

to maternal death in the SSA region was estimated to be one in 160, compared to one in 3 700 in developed countries (Owili et al., 2016). While the MMR remains high, the available data suggests that for every woman who die of pregnancy-related causes, between 20 and 30 more women develop either a short- or long-term disability such as pelvic inflammatory disease and vesicovaginal fistula (Amzat, 2015; Owili et al., 2016). The region also has the highest death risk rate of children 92 out of 1 000 live births (Owili et al., 2016). This rate is estimated to be 15 times higher than that of developed countries (Beck, Munro-Kramer & Lori, 2018). In other words, children in SSA regions are 15 times more likely to die before they turn five years of age than those in developed countries. Manu et al. (2018) stated that about four million stillbirths and neonatal deaths occur yearly in low to middle-income settings, the SSA regions included.

In 2015, South Africa's MMR stood at 138 per 100 000 live births and the neonatal mortality rate at 40.5 per 1 000 live births (WHO, 2017). Many of these maternal deaths occurred because of impoverished people's failure to utilise health care facilities due to poor access (Mashamba-Thompson et al., 2016). Most South African women depend on free primary health care (PHC) facilities for MHS, yet the public sector is overburdened and under-resourced (Wabiri et al., 2016). In most rural areas, the population is poor and have less access to health care services, mostly because of the unequal distribution of resources between rural and urban areas (Peters et al., 2008). Hall et al. (2017) also added that most child deaths occur in South African rural communities. It is for these reasons that the research study sought to explore the experiences of accessing and providing MHS in a rural community of South Africa.

1.2 PROBLEM STATEMENT

South Africa has many PHC challenges, including poor health management, inequitable coverage and negative perceptions of services rendered at health care facilities (Tsawe & Susuman, 2014). In particular, poor access to MHS contributes to maternal deaths nationwide (Mashamba-Thompson et al., 2016). However, access to maternal health care is essential in preventing loss of lives during and immediately after pregnancy (WHO, 2019). Access to maternal services among pregnant women in South African rural populations has received limited attention (Wabiri, et al., 2013). Furthermore, there is a lack of qualitative research that document the experiences of

women accessing maternal health care (Chadwick, 2014). This has led to a recognition of the need for research to be done in rural communities in order to contribute to a deeper understanding of the accessibility of MHS. In view of this, the study sought to investigate the experiences of pregnant women in accessing MHS in Rethabiseng, a rural community in Gauteng, under the Tshwane Metropolitan Municipality, in order to give health users a voice to influence policy discussions and contribute to the scholarly body of knowledge in this field.

1.3 AIM AND OBJECTIVES

The aim of this study was to explore women's experiences of accessing and providing MHS in a rural community of South Africa.

More specifically, the objectives of the study were to:

- describe knowledge about maternal health care;
- identify women's maternal health care needs;
- explore maternal health care seeking behaviour;
- explore the facilitators to access maternal health care services;
- explore the barriers to access maternal health care services; and
- make recommendations to improve access to maternal health care services.

1.4 CONCEPTUAL FRAMEWORK

The study made use of the Social-Ecological Model as a conceptual framework to explore the barriers and facilitators to access to MHS among pregnant women and mothers. The framework has four levels – individual level, interpersonal (family) level, community and social level, and organisational and health system level– that are used to understand the interplays between individuals and the environment within a social system (Centers for Disease Control [CDC], 2014; Ekpenyong, et al., 2019; Sallis, Owen & Fisher, 2008; Shahabuddin et al., 2017).

1.5 OPERATIONAL DEFINITIONS

1.5.1 Access

Bearing in mind that there are many understandings of 'access' to health care services, access in this study was viewed as the timely use of MHS by women according to the need.

1.5.2 Maternal health care

Maternal health care is defined as services that are rendered to pregnant women during pregnancy, at birth and twelve months after delivery in order to ensure positive health outcomes for the mother and baby (Ekpenyong et al., 2019). The South African Department of Health (Guidelines for Maternity Care in SA, *A manual for clinics, community health centres and district hospitals*, 2016) listed these services as the following:

- Diagnosis of pregnancy.
- Prenatal supplementation.
- Basic antenatal care (ANC) services throughout pregnancy.
- Screening care for HIV and tuberculosis (TB) in pregnancy.
- Contraception and family planning.
- Assistance with registration of births and deaths.
- Support for PNC and breastfeeding.
- Information on nutrition and maintenance of a healthy diet during pregnancy.
- Delivery of uncomplicated and complicated pregnancies.
- Management of obstetric emergencies, for example, eclampsia, multiple pregnancies and prolapse.
- Surgical procedures, including caesarean sections.
- Clinical observation after birth.
- Postnatal care.
- Postnatal family planning advice and provision of contraceptives.

1.5.3 Rural health care

The definition for rural health care in this study refers to all the health care services that are rendered in places that are not within the urban areas, where the health workforce involves nurses and general practitioners, and areas where advanced

technologies for emergency operations, theatre rooms and specialist services are lacking (Versteeg, Du Toit & Couper, 2013).

1.5.4 Primary health care facility

A PHC facility is defined as clinics that clients use as their first point of contact when they have a health concern (WHO & United Nations Children's Fund [UNICEF], 2018). The contact should involve a health care provider who should provide access to high quality care to all patients in any health care setting. PHC facilities have the following mandate:

- To improve access to health care services.
- To improve the health of the population they serve.
- To improve the quality of health care services (WHO & UNICEF, 2018).

PHC facilities must have appropriate technologies in order to carry out their mandate.

1.5.5 Maternal death

Maternal deaths are deaths that women succumb to either while pregnant or within 42 days of a pregnancy termination regardless of the duration of the pregnancy (Mulaudzi et al., 2016; Pasha et al., 2015). The death is irrespective of the duration in the pregnancy as long as the death results from the pregnancy or its management.

1.6 STRUCTURE OF THE MINI-DISSERTATION

This mini-dissertation comprises five chapters. The first chapter gives the background to the study. It further outlines the problem statement, study aims, objectives, conceptual framework, and operational definitions. The second chapter reviews relevant literature on access to maternal health care globally, regionally, and nationally (South Africa). The third chapter outlines the study location, research methodology, instruments used for gathering data and data analysis. It also provides ethical considerations and limitations to the study. The fourth chapter is a presentation of the findings from data collected from focus group discussions and interviews held with the research participants. The fifth chapter discusses the results based on the analysis presented in Chapter 4. It concludes the main findings, looks at the implications of these findings and makes recommendations.

Chapter 2

LITERATURE REVIEW

2.1 INTRODUCTION

Maternal health care is a global developmental challenge requiring urgent attention for any society, particularly in developing nations (Mashamba-Thompson et al., 2016; WHO, 2019). Eight hundred and thirty women die daily while giving birth and of each woman that dies, 20 to 30 other women experience serious complications that lead to death (Lang-Baldé & Amerson, 2018). Furthermore, women in developing countries are 33 times more likely to die from a maternal-related cause than women in developed settings (WHO & UNICEF, 2018). Most of the deaths occur in rural areas of developing countries. In South Africa it is a challenge, especially in rural areas, since resource allocation is uneven (Peters et al., 2008; Tsawe & Susuman, 2014). For this reason, maternal users have limited access to health provisions and fail to access PHC services timeously.

The WHO (2016) affirmed that obstetric haemorrhage is the leading cause of maternal death worldwide. Other major causes of maternal deaths are infections that women experience during childbirth, high blood pressure during pregnancy (pre-eclampsia and eclampsia), abortion and complications from childbirth (WHO, 2019). In Africa, obstetric haemorrhage is the main reason for maternal deaths. In a study seeking to establish the causes of death in low and middle-income countries, the findings showed that 38.6% died from haemorrhage, 26.4% from pregnancy-related infection and 18.2% from eclampsia (Pasha et al., 2015). Available data obtained from a report on enquiries into maternal deaths in South Africa showed that haemorrhage increased maternal deaths among women who delivered through a caesarean section (Wabiri et al., 2016).

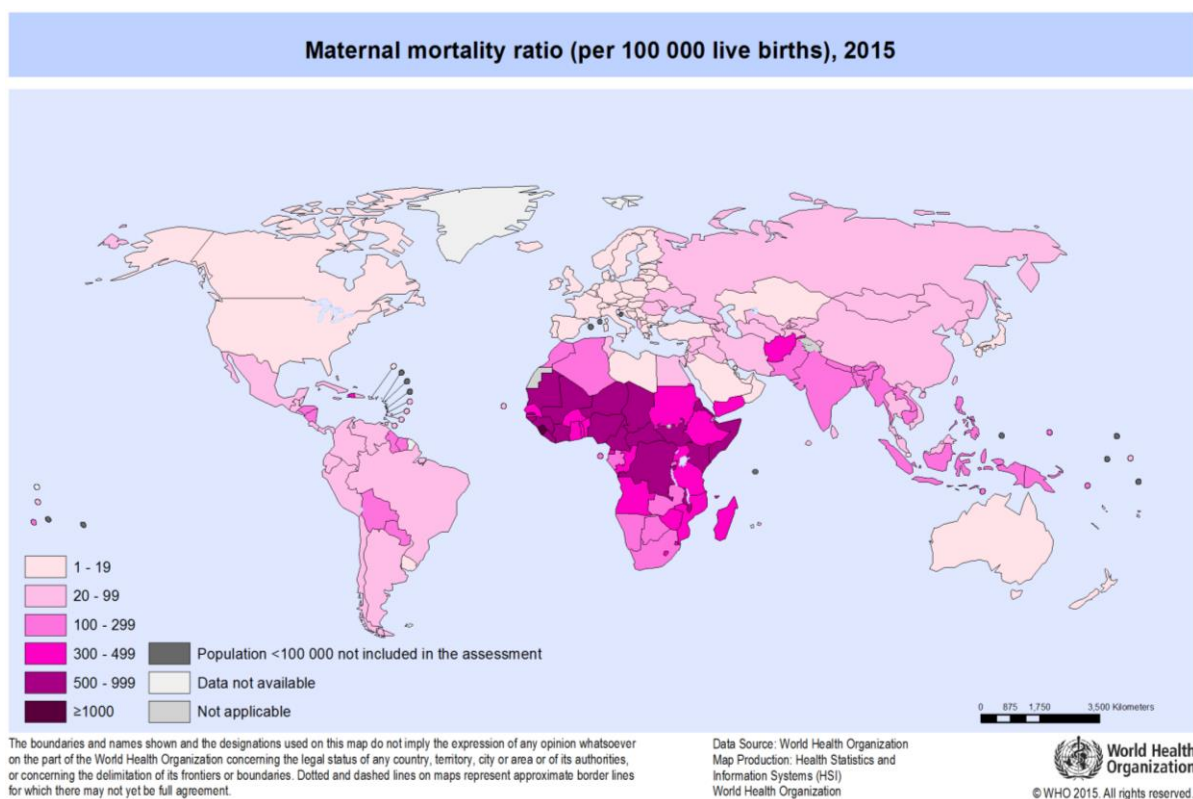
Maternal health entails social and medical health care services rendered to both mother and child during pregnancy, at childbirth and after delivery, and include ANC, safe delivery, PNC, emergency obstetric care, management of complications and family planning (Kolisa, 2016; Mashamba-Thompson et al., 2016; Nesane, Maputle & Shilubane, 2016). The aim of these services is to reduce maternal morbidity and

mortality. Maternal deaths are preventable if access to quality skilled care is provided to women during pregnancy, at childbirth and after delivery.

2.2 MATERNAL MORBIDITY AND MORTALITY

Morbidity is any departure from a state of physiological or psychological well-being (Gillam, Yates & Badrinath, 2012). In other words, it is a condition of being unwell or diseased. In maternal health circles, it refers to the illness or disability that result from pregnancy or childbirth. In most cases, these conditions do not result in death. However, they greatly affect the quality of life that an individual will lead (Gillam et al., 2012). Figure 2.1 depicts the maternal morbidity and mortality at a global scale as was the case in 2015.

Figure 2.1: Maternal morbidity and mortality at a global scale, 2015



Source: WHO (2015)

In Figure 2.1, countries were classified into six categories, namely countries with an MMR of less than 19, 20–99, 100–299, 300–499, 500–999, 1 000 and more and countries where data was non-existent. The figure vividly depicts that several countries in Africa had high maternal deaths as compared to other parts of the world. Africa had

several countries in the category of 300–499 and 500–999. In Africa, Libya was the only country with an MMR below 19 per 100 000 live births. Countries in the SSR, such as South Africa, Zimbabwe, and Namibia, had an MMR ranging between 100 and 299 per 100 000 live births, which is high. Countries such as the Democratic Republic of Congo, Niger, and Sudan had an MMR of between 500 and 999 per 100 000 live births. Continents such as Australia and North America had a small number of their population succumbing to maternal deaths. Australia's category of MMR was 19 and below, while North America has some countries with below 19, 20–99, and others with 100–299. Lower MMR were also reported for many European countries (WHO, 2015).

2.2.1 Global maternal mortality and morbidity

Increasing access to maternal health care is a worldwide concern and a vital developmental issue for any society, particularly in Global South countries (Mashamba-Thompson et al., 2016). This is because all women require easy access to quality maternal care while pregnant, during delivery and after childbirth. However, some are currently not accessing maternal care easily (WHO, 2019). Annual projections from 2015 to 2018 stated that close to 300 000 maternal deaths take place worldwide (Khatri et al., 2017; Manu et al., 2018; Pasha, et al., 2015). Khatri et al. (2017) stated that 95% of these deaths are in developing countries. In addition, more than 2 500 000 stillbirths and over 2 500 000 neonatal deaths occur globally, with most of these happening during delivery and in the first year after delivery. Approximately 99% of global maternal deaths were recorded in developing nations (Susuman, 2015; WHO, 2019).

The MMR is higher in Global South countries when compared to Global North countries. Research evidence presented MMR statistics for developing countries as 239 per 100 000 live births, and 12 per 100 000 in developed countries (WHO, 2019). In 2017 alone, the MMR in low and middle-income countries stood at 462 per 100 000 live births and 11 per 100 000 live births in developed countries (WHO, 2019). The differences between the foregoing ratios are high and point to the gaps in maternal service delivery provided in these diverse backdrops. Furthermore, the foregoing global statistics on MMR and neonatal deaths are a revelation that maternal health is still a

developmental global issue requiring immediate attention and interventions in both developed and developing countries.

Many parts of the world have a challenge of rural access to maternal health care. They are poverty-stricken, have poor infrastructure and a continuing decline in health care services. Papua New Guinea, a Global South country, is one such example of a large rural population and a high MMR. As of 2013, its rural population was 87% and the MMR was 733 per 100 000 live births (Vallely et al., 2013). South Sudan, another developing country, had an MMR of 1 150 per 100 000 live births in 2017 (WHO, 2019). The foregoing statistics are alarming and require a concerted effort to reduce the MMR to under 70 per 100 000 live births by 2030 as envisaged by the Sustainable Development Goals (SDGs).

2.2.2 Regional maternal mortality and morbidity in sub-Saharan Africa

The SSA region is the most affected global region when compared to other regions. The SSA had 66% of the global maternal mortality in 2015 (WHO, 2015). The MMR of the region stood at 546 per 100 000 live births in 2015, compared to the global average MMR at 216 per 100 000 live births (Hodin et al., 2016). The high rate of maternal deaths can be associated with the unavailability of skilled maternal health care in the SSA region (Ekpenyong et al., 2019). The chances of women succumbing to maternal deaths in the region was estimated to be one in 160, compared to one in 3 700 in First World Countries (Owili et al., 2016). Ekpenyong et al. (2019) stated that women in the SSA are 332 times more likely to die while giving birth, compared to those in Global North countries.

Furthermore, the available data revealed that for every woman who dies of a pregnancy-related cause, between 20 and 30 more women develop either a short or a long-term disability such as pelvic inflammatory disease and vesicovaginal fistula (Amzat, 2015; Owili et al., 2016). Ganle et al. (2015) stated that only 46% of children born in the SSA region are born in a health facility where a skilled birth attendant (SBA) assists them. Moreover, the SSA region had the highest death risk rate of children - 92 per 1 000 live births (Owili et al., 2016). This rate was estimated to be 15 times greater than that of Global North countries (Beck et al., 2018). Manu et al. (2018)

stated that about four million stillbirths take place yearly in Global South countries, SSA countries included.

The above discussion highlighted the maternal health challenge that the SSA region continues to struggle with. There is much that needs to be done through developmental interventions to increase access to maternal health in both urban and rural areas. Increasing access to quality maternal health care should decrease the high MMR, neonatal mortality rate (NMR) and child mortality rate (CMR).

2.2.3 Maternal mortality and morbidity in South Africa

South Africa has a high MMR. In 2017, the country's MMR stood at 135 per 100 000 live births (RSA Department of Health, 2018). The NMR was at 40.5 per 1 000 live births (WHO & The International Bank for Reconstruction and Development / The World Bank [hereafter WHO & World Bank], 2017). The majority of the maternal deaths that occur are as a result of the disadvantaged people's inability to utilise health care facilities due to inadequate access (Mashamba-Thompson et al., 2016; Mulaudzi et al., 2016; Owili et al., 2016). Women living in poverty have limited access to comprehensive health services. They cannot fully make use of facilities and available maternal intervention programmes (Mulaudzi et al., 2016). For example, the WHO recommends ANC during pregnancy to ensure the well-being of unborn children and their mothers. However, if ANC is delayed, the opportunity to detect complications during pregnancy is also delayed.

Considering that close to half of the South African populace reside in rural areas (Mburu & George, 2017), the expectation should be having an almost equal distribution of the health workforce between rural and urban areas. However, the distribution of the health workforce is imbalanced between urban and rural areas, yet health workers are a key element in providing access to basic health care in any health structure. Twelve percent of doctors and 19% nurses are serving rural facilities countrywide (Mburu & George, 2017). As of 2019, the number of nurses and doctors registered nationwide increased compared to that of 2016 (Gray & Vawda, 2019).

In 2016, there were 64 975 registered nurses compared to 68 776 in 2019. In 2016, there were 12 839 registered doctors compared to 14 439 in 2019 (Gray & Vawda, 2019). However, despite this increase, the unequal distribution of human resources

between urban and rural areas remains real. Murphy et al. (2014) stated that many African countries have a crisis in human resources for health workforce. The problem is worse in rural areas, resulting in failure by nations to either meet the set health targets or improve health outcomes in rural areas. With such challenges in the country of uneven skilled health workforce deployments, access to maternal service delivery remains a developmental challenge in South African rural communities.

According to Wabiri et al. (2016), many South African women residing in rural and urban establishments rely heavily on free public sector PHC facilities offered by the government for citizens to access MHS. However, the main challenge facing the public sector is being under-resourced and overburdened. Nearly 1 200 000 women in South African fall pregnant annually. Of these 1 200 000, the public sector handles 1 060 000, while the private sector handles 140 000 (Mvoko, 2018). The foregoing statistics provided by the former minister of health, Aaron Motsoaledi in an interview with Mvoko (2018), is a revelation of maternal challenges the government is currently facing in the public maternal health sector. These statistics illustrate the serious challenges the government is currently facing in making maternal health accessible to all, regardless of geographical location.

2.3 FAILURE TO MEET THE MILLENNIUM DEVELOPMENT GOALS AND THE SHIFT TO THE SUSTAINABLE DEVELOPMENT GOALS

The Millennium Developmental Goals (MDGs) contained eight global goals that were set by the United Nations (UN) member states in the year 2000 in order to address the pressing challenges among the poorest nations of the world (Brizuela & Tuncalp, 2017). MDG 4 and MDG 5 – to reduce child mortality and improving maternal health each by 75% – related specifically to health. Through the MDGs, notable progress in health was realised. Globally, MMR was reduced by 44% between the period 2000–2015 (Wilunda et al., 2016). Skilled staff assisted most mothers at birth during this period (Brizuela & Tuncalp, 2017; Hodin et al., 2016).

However, the progress made through the MDGs was far from what was envisaged. With a desired target of 75% reduction of MMR, South Asia, Eastern Asia, Latin America, and the Caribbean managed 64%, 65%, 40% and 36% by the end of 2015, respectively (Brizuela & Tuncalp, 2017). In Africa, the MMR decreased by 49% (UN,

2015). In 2013, South Africa had a high MMR of 230 per 100 000 live births, which was fourteen times greater than that of developed countries at 16 per 100 000 live births (Mulaudzi et al., 2016). In 2017, it was affirmed that South Africa was unsuccessful in its attempts to achieve the MDG target of decreasing MMR by 75% and affording maternal health beneficiaries universal access to reproductive health between the years 2000 and 2015 (Brizuela & Tuncalp, 2017).

Other than the reduction in the MMR ratio, significant progress was made in the reduction of CMR. The worldwide CMR declined by about 49% in the period 1990 to 2013 (Brizuela & Tuncalp, 2017). The African continent experienced a decrease in child deaths in different regions. North Africa, Southern Africa, West Africa, East Africa, and Central Africa managed a 59%, 60%, 50%, 60% and 50% decrease, respectively (You et al., 2016). Across the world, regions such as Asia and Latin America managed a 60% and 67% decrease. Although, such progress is commendable and a step in the right direction, inequities remain in maternal newborn and child health (Owili et al., 2016). Women from rural areas, poorer households and less educated backgrounds are bound to underutilise maternal care services, thereby perpetuating service delivery challenges in the post-MDGs (Owili et al., 2016). For instance, rich women are 2.7 times more likely to be assisted by an SBA at childbirth as compared to poor women in the SSA region (Singh, Story & Moran, 2016). South Africa is no exception.

Many countries did not meet the MDG 4 and 5 targets and it is highly probable that they will fail to meet SDG targets in 2030 (Vermund et al., 2016). The SDGs came into effect in 2015 and maternal health remained a key focus area. One target is to universally reduce MMR to 70 per 100 000 live births by 2030 (Fowkes et al., 2016; WHO, 2019). Essentially, on an annual basis, low and middle-income countries should aim to reduce their MMR by 7.5%. However, as of 2015, the SSA remained with the highest MMR indicating challenges that South Africa and other countries still face in attaining the 7.5% annual reduction rate (Hodin et al., 2016). This rate of reduction was being attained by only Rwanda, Cambodia, and Timor-Leste (Pasha et al., 2015).

2.4 MATERNAL HEALTH POLICY IN SOUTH AFRICA

The Department of Health (RSA, 2016) provides specific guidelines for the provision of maternal health care in South Africa. The guidelines entail the critical and minimum principles that need to be known by all professionals such as doctors and nurses in diagnosing and managing all common and serious pregnancy-related problems (RSA Department of Health, 2016). The aim of enforcing these guidelines should be to eradicate high mortality and morbidity rates in the country.

Some of the guidelines for maternal health stipulate that health professionals should render absolute services that show quality of care (RSA Department of Health, 2016). This implies that health professionals are expected to show genuine interest in clients who seek their services regardless of the environments they work in. The guidelines are envisaged to be used mostly in areas where specialist services are not usually available. The following is a summary of the guidelines for maternal health (Guidelines for Maternity Care in SA, *A manual for clinics, community health centres and district hospitals*, 2016):

- Maternal health care is offered free of charge at all government-owned clinics, hospitals, and health centres nationwide.
- The status of women in society should be uplifted through constant deliberate efforts in education, reproductive choices they make, employment and prevention of abuse.
- During pregnancy, health centres should ensure they have adequate skilled midwives and doctors rendering the required care to women in order to prevent maternal deaths. Furthermore, in order to prevent maternal deaths, all hospitals are envisaged to offer caesarean and blood transfusion services.
- Women are discouraged from delivering babies at home even under the care of an SBA.
- A 24-hour efficient referral system is vital if optimal care to all pregnant women is to be achieved. The referral system should have effective transport services that respond to emergency calls timeously. Moreover, a delivery kit and an experienced midwife or qualified paramedic must accompany the pregnant woman in the ambulance.

- Proper patient records should be developed and safely filed. This entails obstetric patient notes by doctors or nurses, referral letters, in-patient notes, and delivery notes.
- All pregnant women should attend antenatal care to ensure that all pregnancy-related complications may be identified and dealt with during the pregnancy. Every pregnant woman should have at least eight antenatal visits during pregnancy.
- All women should attend PNC after delivery. PNC ensures that mothers are assisted in the psychological and physical changes that occur in the first days after delivery. It is also aimed at detecting problems that may threaten the health of the mother and baby. In PNC, the mother and baby are expected to visit the clinic between three to six days after delivery.

2.5 ACCESS TO MATERNAL HEALTH CARE SERVICES

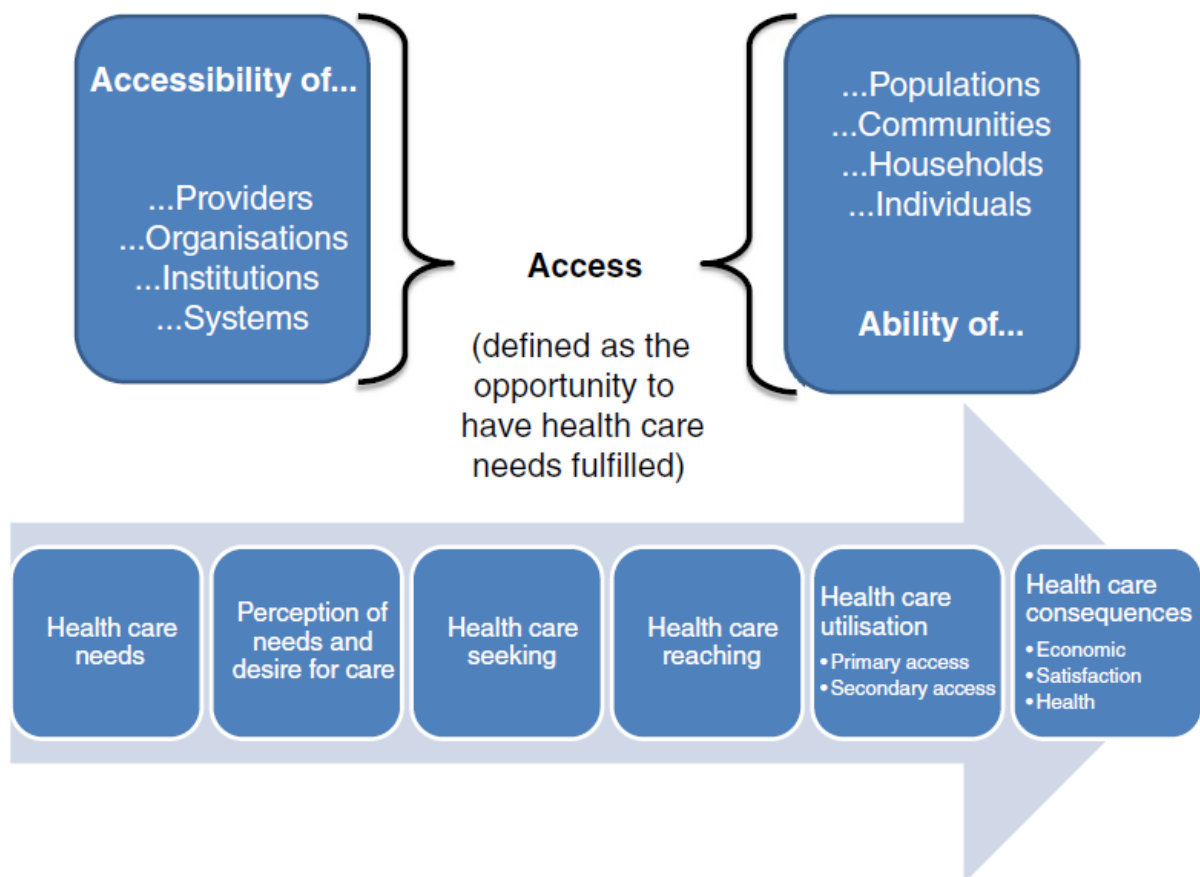
Access to maternal services remains a challenge in South Africa (Harris et al., 2014; Pieterse, 2016). Firstly, it is important to define what is meant by “access to maternal health care”. Scholars have postulated several meanings of the term ‘access’. It is therefore essential to briefly discuss some of these meanings and then bring forward the meaning of ‘access’ that this study will adopt.

Access is a multifaceted term that is understood in different ways by different scholars (Daniels, 1982). Access in health care is viewed as access to services, providers, or institutions. In other words, access is viewed as the likelihood or potential taken by users in using available health resources in relation to their needs. Frenk (1992) was of the view that access is a term that may be used to describe prompting factors or characteristics that enable users of services to seek these services. The list of these factors include distance, affordability, availability, and quality of care. However, Frenk did not state if emphasis lies more on describing the characteristics of providers or the actual process of health care.

Some scholars viewed access more as an element of health services. This notion emanated from the realisation that health services are only accessed by someone who requires health care (Salkever, 1976). Other scholars viewed access as all the influencing factors that prompt individuals to use health services (Donabedian, 1973).

When taking these different conceptualisations of access into account, one could conceptualise access as a health element that is influenced by varying characteristics of health providers and health services. Following this line of thought, Gulliford et al. (2002) defined access as a product of supply factors and demand factors. Supply factors are listed as availability, cost, location, and appropriateness of services, while demand factors are listed as knowledge, skills, attitudes, and self-care practices. This leads to a comprehensive definition of access by Levesque, Harris, and Russel (2013) who define access as the opportunity to have health care needs fulfilled. Figure 2.2 sums up this definition of access.

Figure 2.2: Definition of access to health care



Source: Levesque et al. (2013:4)

Having defined access in various ways, it is fundamental to note that access can be good or poor. Furthermore, health care systems achieve positive health outcomes when access to health care is good. When access is poor, health outcomes are also poor (Brizuela & Tuncalp, 2017). Therefore, this study views access as the possibility

by health users to identify, seek, reach, and use health care services that are appropriate to their individual needs

Access to MHS is fundamental because every pregnancy faces risks (Woldegiorgis et al., 2018). In the SSA region, access to MHS such as ANC and SBA is poor and the lowest in the world when compared to other regions (Woldegiorgis et al., 2018). Where access to maternal services is poor, there are poor health outcomes (high MMR and CMR) and prevalent health risks (Brizuela & Tuncalp, 2017).

2.5.1 Access to antenatal care, delivery, and postnatal care

In any pregnancy, ANC is a non-negotiable requirement. ANC is an intervention opportunity that is available for pregnant women during pregnancy (Ataguba, 2018; Ogunba & Abiodun, 2017; WHO & World Bank, 2017). It aims at foreseeing potential problems that may give rise to complications at birth and delivery in order to avert them and ensure well-being during and after pregnancy. In this regard, ANC creates an opportunity for pregnant women to have positive pregnancy experiences. ANC is important in monitoring pregnancy and reducing morbidity and mortality risks for the mother and the child during pregnancy (WHO & World Bank, 2017).

The WHO (2016) provided guidelines for the minimum number of ANC visits for pregnant women. There is a 'reduced visit' expectation of at least four ANC visits during pregnancy and the first visit should happen during the first 12 weeks of pregnancy (WHO, 2019). At each of these visits, the WHO further recommends that a skilled health care provider should attend to the pregnancy. This requirement of four ANC visits is usually met in Global North countries but not in Global South countries. As of 2017, 50% of pregnant women in developing countries were receiving the four recommended ANC visits before delivery (Brizuela & Tuncalp, 2017). Women who do not adhere to the recommended number of visits miss the chance of identifying potential problems as well as the opportunity to obtain suitable treatment. In Africa, the problem is prevalent.

The South African maternal health guidelines of the Department of Health (RSA, 2016) recommends a minimum of eight ANC visits during pregnancy. This increased number of visits is aimed at improving health outcomes and greater chances of receiving highly effective maternal health interventions as compared to the reduced four-visit model.

Receiving proper ANC and postnatal services as envisaged reduces MMR by 60% if women are empowered to make use of effective family planning methods. However, at national level, access to maternal health remains a problem just like in the rest of Africa. In a study conducted in the Eastern Cape by Tsawe and Susuman (2014), the findings revealed that only 35.2% of 267 women who participated in their study were accessing maternal services.

The 2019 South African Demographic and Health Survey (RSA, National Department of Health [NDoH], Statistics South Africa [Stats SA], South African Medical Research Council [SAMRC], and ICF, 2019) found that 94% of women who gave birth in the five years preceding the survey had only received ANC from a skilled provider once. Research conducted in rural and peri-urban communities of South Africa revealed that a large proportion of women only make their first ANC visit after 20 weeks in their pregnancy (Ebonwu, et al., 2018). Out of the 807 study participants, 585 women presented late for their first ANC visit. The implications of delaying ANC visits are the delayed opportunities to prevent adverse pregnancy outcomes for both mother and child.

Pregnant women are supposed to be assisted by an SBA during delivery (RSA Department of Health, 2016). Every effort must be made to ensure that a skilled professional assists a pregnant woman during labour and delivery. This should be the norm in towns, urban areas, rural areas, and remote districts. Delivery entails four stages of labour that a skilled professional should adhere to during this process (RSA Department of Health, 2016). The stages range from monitoring the woman's heart rate, temperature, blood pressure, full dilation (10 cm) up to the first hour after delivery where women are at risk of bleeding profusely.

PNC is another critical intervention that aims to reduce deaths of mothers and their newborns in the days and weeks after birth (Ruktanonchai et al., 2016). PNC is the care that is rendered to mothers and babies from the time of delivery until six weeks after childbirth (Mrisho et al., 2009). However, it does not end at six weeks after birth. It has a continued expanded immunisation programme that is observed for the first year of life of a child. In developing countries, it is worrying to note that women are not using these services as expected. Mrisho et al. (2009) stated that not much is known about the use of PNC, yet the period where most babies die is during labour and 24

hours after birth. Research done in Kenya revealed that PNC in all the facilities were low (Warren et al., 2015). This was an indicator that PNC continues to get limited attention from both women and the maternal providers.

2.6 CATEGORISATION OF CHALLENGES ASSOCIATED WITH MATERNAL HEALTH CARE: SOCIAL-ECOLOGICAL MODEL

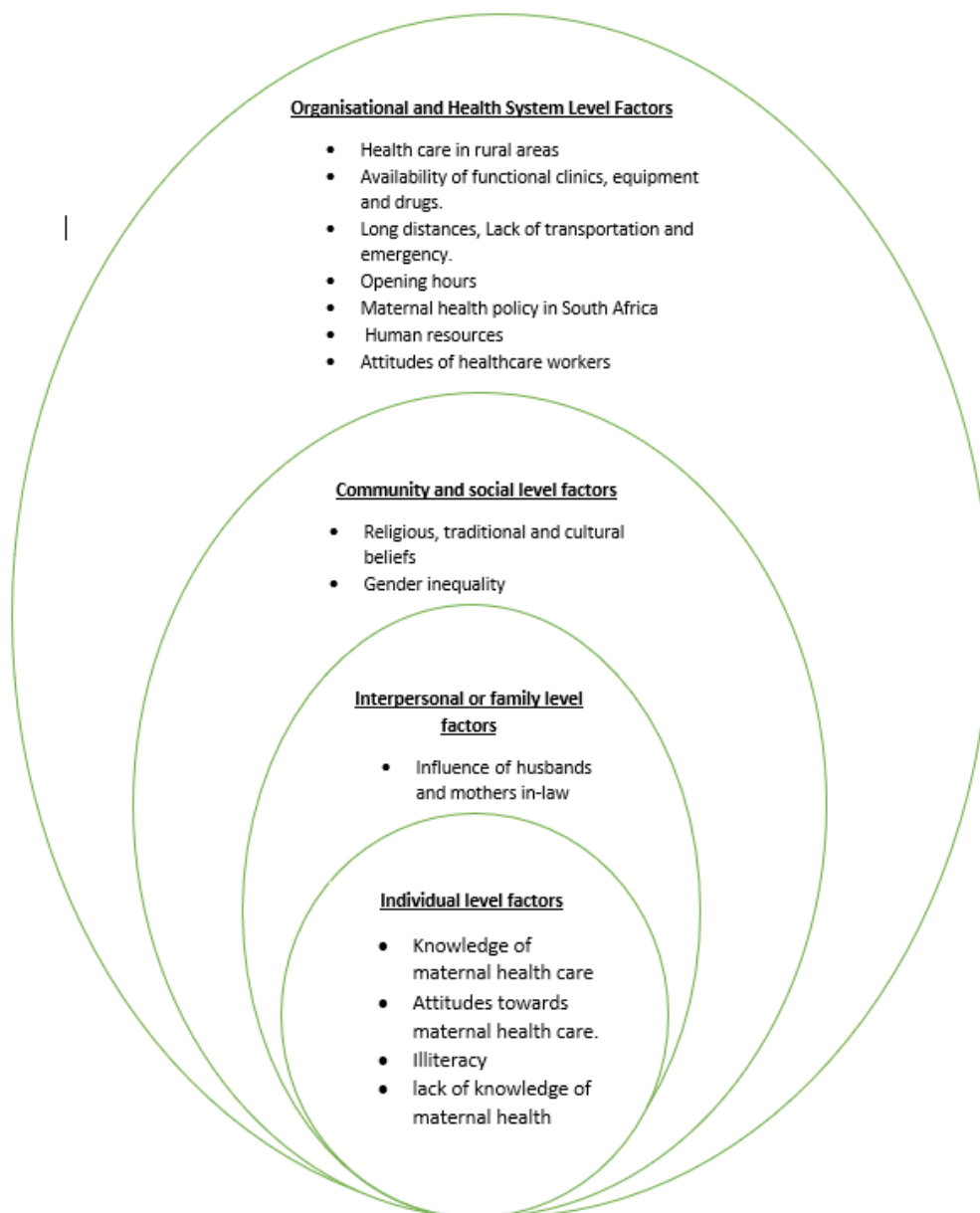
South Africa faces numerous challenges in its bid to render comprehensive MHS (Tsawe & Susuman, 2014), including the unequal allocation of resources between urban and rural areas, lack of functional clinics, lack of access, negative attitudes of health workers, shortages of advanced medical equipment and drugs, and unavailability of services. The Social-Ecological Model will be used to categorise and illustrate the various challenges associated with access to MHS.

In the Social-Ecological Model comprises of four interlinked levels: individual, social, community and societal (CDC, 2014; Ekpenyong et al., 2019; Shahabuddin et al., 2017). The Social-Ecological Model views individuals as rooted within larger social systems and describes the interactive characteristics of individuals and environments that underlie health outcomes. The Social-Ecological Model stipulates that people are influenced by factors of their immediate environments (Ekpenyong et al., 2019). An elaboration of the levels of this model is given below:

- The first level is the individual level. At this level, the focus is on characteristics of the individual such as knowledge and attitudes about maternal health care. In this study, the researcher sought to establish the knowledge and attitudes of women towards ANC, delivery, and PNC.
- The second level is the interpersonal or family level. It entails the attitudes of partners, family, or friends towards maternal health care. In this study, the researcher sought to establish whether husbands, family and community members have an influence on the respondents' maternal health care seeking behaviour.
- The third level is the community and social level. It entails religious, traditional, and cultural beliefs as well as issues related to gender inequality. In this study, the researcher was interested in the influence of culture and gender on access to MHS.

- The fourth level is the organisational and health systems level. It entails national policies on maternal and child health, as well as health systems factors influencing access to maternal health care. In this study, the researcher sought to establish whether the health system barriers (such as geographical accessibility) influence health-seeking behaviour of women in accessing MHS and what recommendations there are to improve access to MHS in rural communities.

Figure 2.3: Social-Ecological Model



Source: Adapted from Shahabuddin et al. (2017).

2.6.1 Organisational and health system factors

South Africa is confronted with several organisational and health system factors in its endeavour to afford its maternal users quality MHS. These factors include health care in rural areas, distance, lack of transportation and emergency services, infrastructure, availability of functional clinics, maternal policy in South Africa, human resources, attitudes of health care workers, and failure to meet MDGs. The upcoming subsection will highlight on these factors.

2.6.1.1 Health care in rural areas

Nearly 46% of the South African population reside in rural areas (Mburu & George, 2017). This is nearly half of the country's entire population. Unlike the urban population, a great percentage of the rural populace is underprivileged and entirely dependent on the free available health services (Sokhela et al., 2013; Versteeg et al., 2013). The resources between urban and rural areas in South Africa are unevenly distributed, with the rural areas being underprivileged (Mapukata, et al., 2017; Versteeg et al., 2013). The poorest 20% of South Africans utilise 4% of the goods and services, while the richest 20% consumes 61% (Chersich et al., 2016). This means that the poorest of the South African population has little access to MHS when compared to the rich, yet equal distribution would be ideal. A similar population percentage (20%) of either the poor or rich do not have equal access to services. This is entirely overwhelming especially for the rural communities. However, it is not the only challenge South Africa is encountering.

South African rural areas are part of the disadvantaged communities who struggle the most with access to quality health care (Peters et al., 2008). This is worsened by the huge disparities that exist between rural and urban life in South Africa. Peters et al. (2008) alluded to some of these disparities in their illustrations of the nature of the country's provinces. When looking at the total surface area of the country's provinces, some provinces are predominantly rural, while others are mainly urban. For example, the Eastern Cape and Northern Cape provinces are mainly rural, while the Western Cape province is mainly urban (Gray, Vawda & Jack, 2011). Similarly, the North West province is predominantly rural when compared to the Gauteng province that is predominantly urban. Under such circumstances, the expectation would be even distribution of resources across these areas. However, rural dwellers still have limited

options in quality maternal health care when compared to urban dwellers. The Western Cape and Gauteng provinces have more health care facilities and professionals than the Eastern Cape and North West (Versteeg et al., 2013). As a result of these imbalances, maternal health outcomes are better in urban areas than rural areas. Children born in the Eastern Cape and North West have higher chances of dying in the first year of life than those born in the Western Cape and Gauteng (Day, Gray & Ndlovu, 2018).

Ideally, global countries that have huge rural populations allocate their resources and time to formulating interventions for PHC, including maternal care (Versteeg et al., 2013). They initiate strategies and useful interferences that permit rural health beneficiaries to obtain satisfactory access to health care, thereby decreasing MMR through these initiatives. However, this has not been the tendency in South Africa and other Global South countries. As a result, this has not helped South Africa in terms of eradicating its rural maternal health challenges. Most rural health care facilities still do not meet the required expectations of ideal clinics and hospitals; thus, they disadvantage their communities (Tsawe & Susuman, 2014).

The South African rural setup is remote and less technologically advanced as compared to the urban setup. There are many referrals that health users are subjected to when seeking MHS, such as where patients are being referred to other health care facilities for services not offered at the current facilities. This presents a challenge to rural dwellers in easily accessing proper health care timeously. Harris et al. (2014) supported this view and validated that South Africa has been struggling to address inequalities between rural and urban areas since 1994.

The inequalities between rural and urban areas in South Africa can be reflected in the gaps and vast differences in health outcomes between these settings. The chances of children dying between the period of delivery and after delivery are high (Hall et al., 2017). As of 2015, South Africa's CMR stood at 40 per 1 000 live births and most deaths occurred in rural areas (Hall et al., 2017). This is high, considering that SDG 3 expects countries to reduce NMR to below 12 per 1 000 live births by 2030 (WHO, 2019). From the high CMR statistics in South Africa, it became evident that children delivered in rural areas are more vulnerable and have a higher probability to die during delivery, soon after delivery and in their infancy than children in urban areas.

Further available data showed that South Africa's CMR in rural settings double those in urban settings (Wabiri et al., 2013). This is an indication pointing to existing inequalities and pitiable services in maternal health care prevailing in South African rural settings as opposed to urban settings. Research evidence showed that as of 2015, South Africa had 138 maternal deaths per 100 000 live births (WHO, 2019). Most of the deaths occurred in rural areas (Hall et al., 2017; Mashamba-Thompson et al., 2016). This validates the problem of maternal health in South African rural communities and rural access to MHS.

2.6.1.2 Long distances, opening hours, lack of transportation and emergency services

Health care facilities should render quality health services that are conveniently accessible to users (Nyathi et al., 2017). The services are supposed to be within the user's geographic reach, physically accessible, affordable and be delivered in a manner that is acceptable to patients (Pieterse, 2016). However, this has been a challenge in most rural settings of developing countries. Studies in Nepal and India reported problems with birth and delivery due to distances to be travelled to health care facilities in rural areas (Gupta et al., 2018; Khatri et al., 2017). A study conducted in Nepal found that the nearest birthing centre for most rural women was far away and inaccessible for most women. They had to cross hills and pass streams along the way. In wet weather, it was difficult to access roads as there were no bridges over the streams. As a result, women preferred to deliver at home rather than risk being stranded along the way (Khatri et al., 2017).

Furthermore, rural areas have poor settings that are characterised by lack of transportation. There are no efficient emergency services such as ambulances readily available to transport maternal health users in times of need and in all emergencies. Research findings in Nepal revealed that in some instances, emergency services took long to respond and by the time they arrived at the point of call, the health workers were unavailable, absent, and disrespectful to women (Khatri et al., 2017).

In the SSA region, a research study conducted on establishing the extent to which distance to skilled care for childbirth affects utilisation, revealed that some women must walk up to 108 minutes to a health care facility. Furthermore, most maternal users lived 15 km away from the nearest clinic, yet 5 km is considered a reasonable

distance for pregnant women to walk. In some cases, the women did not have money to pay for transportation to the health care facility and resorted to home deliveries or traditional methods for health care (Wong, Benova & Campbell, 2017). In South Sudan, it was found that as a result of far distances to health care facilities, many rural women tend to deliver at home despite preferring to deliver at a proper health care facility (Mugo et al., 2018; Wilunda et al., 2016). Poor conditions of roads and floods during the rainy season make it difficult for ambulances to access patients in rural areas. Men are forced to carry their wives on their shoulders for far distances in order to get them to health care facilities when in labour. Women and their babies die because of bleeding after home deliveries (Wilunda et al., 2016). Similar problems with access to health care facilities in rural areas were reported in studies conducted in Zambia (Mutale et al., 2017) and Nigeria (Ekpenyong et al., 2019), and included far distances to health care facilities and poor conditions of roads. In Nigeria, it was also noted that a lack of fuel made it difficult to transport women by ambulance to health care facilities (Ekpenyong et al., 2019).

Far distances in rural areas to health facilities were also cited in South African studies as being problematic (Mji et al., 2017; Nyathi et al., 2017; Silal et al., 2012; Van der Hoeven, Kruger & Greeff, 2012; Versteeg et al., 2013). In some cases, this led to women giving birth at home, without an SBA, while they waited for ambulances to arrive (Silal et al., 2012). Lack of money for transportation (when available) to health care facilities was another barrier to access health care facilities (Van der Hoeven et al., 2012; Versteeg et al., 2013). In some cases, women indicated that due to far distances to health care facilities, they travelled while in early labour to reach the facility in time. This resulted in staff turning them away. The response time of ambulances was a further barrier to access health care timeously (Silal et al., 2012).

From the above discussion, the physical accessibility of health facilities in rural areas remains a global maternal health challenge in rural settings. However, opening hours for health care centres are another challenge maternal health care users face. PHC facilities ideally should be open for eight hours a day (Mji et al., 2017). Any emergencies that occur after these operating hours are ideally supposed to be handled at the nearest hospital. In many cases, the closest referral hospital is far, and patients are inconvenienced in terms of geographical accessibility. Although health care facilities are envisaged to be geographically accessible, this is not the real situation in

the Eastern Cape and Northern Cape rural communities. In Madwaleni, Eastern Cape, local clinics operate during the day only and the district hospital is located at a great distance. Similarly, in Fraserburg, Northern Cape, the closest referral hospital is far, and patients have no easy access to emergency services (Mji et al., 2017).

2.6.1.3 Availability of functional clinics, equipment, drugs, and infrastructure

Globally, having good infrastructure is key to positive health outcomes. According to the WHO (2017), improvements in existing rural facilities in developing countries must be done in order to improve care and reduce maternal deaths. In rural Nepal, research by Khatri et al. (2017) suggested that rural health care facilities are small and do not allow patients to have one-on-one sessions with health care providers in private. The birthing centre had only two rooms. One of them was used as a waiting room and the other for labour and giving birth. In the labour room, many women who are either in labour or giving birth wait in numbers and the room becomes congested. Space is limited. There is no privacy and women do not get the immediate attention they require while in labour. One woman indicated that while she was on the delivery bed, she witnessed another woman giving birth on the cold floor of the waiting room (Khatri et al., 2017).

In terms of proper maternal equipment and accessories in health care centres, clinics in rural Nepal have shortages. Findings from a research on the barriers to utilisation of childbirth services conducted in Rukum, Nepal (Khatri et al., 2017), and determinants of marginalisation in maternal health care in Vietnam (Binder-Finnema et al., 2015), revealed that there were numerous basic things lacking in clinics that compromised the quality of services offered. In Rukum, Nepal, clinic facilities lacked baby wrappers and changing clothes for mothers. They further did not have lighting, heating systems, regular water supply and placenta pits. The centre had only one broken delivery bed. In Vietnam, some clinics had limited equipment that were in a poor state. Most women were referred to other hospitals for assistance. The clinics could only handle normal births because of lack of equipment. One mother interviewed stated that it would be convenient to use the clinic near them if it had the required equipment.

Similar research findings on poor facilities and infrastructure in rural areas emerged in the SSA. Research conducted in Zambia exploring maternal health, depicted that poor

and small infrastructure of health facilities discouraged women from giving birth at health facilities (Mutale et al., 2017). There was lack of privacy since the delivery centres were so small. The research participants cited that this lack of privacy discouraged them from obtaining childbirth delivery services from the health care centres. People passing by the delivery room could hear screams or cries of women in labour. There were no toilets or showers and it was embarrassing as other patients could see you. In order to avoid this embarrassment, women preferred home deliveries where their comfort and privacy are guaranteed.

In South Africa, lack of proper infrastructure is also a common feature that characterises rural areas (Mburu & George, 2017; Pieterse, 2016), just like in Nepal (Khatri et al., 2017) and Vietnam (Binder-Finnema et al., 2015). Health care facilities in rural areas are underdeveloped compared to urban structures. There is lack of advanced modern technological equipment that leads to rural maternal users being referred to other health care facilities that has such equipment. The lack of these services limits accessibility, compromises on quality of service and results in health users having to pay private health care facilities to acquire these services timeously. For instance, in a study conducted by Haskins et al. (2016) in twelve clinics in rural districts in KwaZulu-Natal, it emerged that most health care facilities did not have comprehensive services for maternal users. The clinics had several challenges relating to the availability of advanced equipment, postpartum and hearing assessments of babies. This meant that children and mothers could not acquire the services they sought during pregnancy and after delivery. It further implies that the rural population remain at a disadvantage because they are not able to obtain the health care services befitting their various maternal needs.

The rural areas of South Africa do not have sufficient supplies and equipment to universally cater for the health needs of the respective communities (Versteeg et al., 2013). They lack proper facilities like hospitals that offer birth or delivery services, contemporary machinery, and equipment necessary in maternal service delivery. Proper facilities and advanced machinery are necessary and needed in the prevention of deaths during pregnancy and after birth delivery (Tsawe & Susuman, 2014). The Eastern Cape is the province with the worst maternal health outcomes (Mathole et al., 2018). It has the worst performing rural districts in maternal health. It is characterised by poor emergency transport, poor services in its health facilities, long queues and

waiting periods. This leads to poor maternal health outcomes considering that the lack of the above-mentioned factors hinders women from reaching maternal services.

Furthermore, unlike urban areas, some South African rural communities do not have pharmacies where residents can easily and readily purchase medication without a prescription (Van der Hoeven et al., 2012). In a study conducted on the differences in health care behaviour between rural and urban communities in four rural districts in the North West province in South Africa, Van der Hoeven et al. (2012) discovered that health users did not have facilities such as pharmacies. The lack of these facilities implies that the rural population have one choice of sitting in long queues at health care facilities and they have to travel long distances to reach MHS.

2.6.1.4 Human resources

An effective health system should have doctors and nurses that are efficient and responsive, and sufficient in numbers in order to obtain the best possible health outcomes (WHO, 2007, 2010). Developing countries have a lack of human resources for health (WHO, 2007), a problem that has prevailed for a long period. Since 2013, there were 17.4 million shortages of health care workers globally. This included nine million nurses and 2.6 million doctors (Mofolo, Heunis & Kigozi, 2019). An attempt to improve access to skilled attendance between the years 2000 and 2015 was unsuccessful. The shortage of skilled attendance in developing nations remained high. Since 2010, the ratio of nurses and midwives in Africa stood at 11 per 10 000 of the population, compared to 79 per 10 000 in Europe (Prata et al., 2010). The shortage of staff contributes to high maternal deaths (Bradley et al., 2015).

Research conducted by Gupta et al. (2018) in India and by Binder-Finnema et al. (2015) in Vietnam, revealed that there were shortages of doctors, nurses, and midwives to serve maternal users. These shortages lead to poor health outcomes. In particular, a programme official interviewed in a research study in India indicated that it was difficult to have doctors and nurses available 24 hours per day at health care facilities (Gupta et al., 2018). Worse still, it was hard to retain the services of doctors and nurses in rural areas because doctors did not wish to continue serving these areas for a long time. Instead, there was a need for more staffing to fill vacancies since there was a scarcity of doctors and skilled nurses in rural and remote settings.

The issue of staff shortages is also a problem in Southern Africa. In Zambia, some rural health facilities have only one nurse on duty, and she cannot assist all women in the queue (Mutale et al., 2017). Some women go back home without consulting a nurse. This discourages them from coming back again. In Ethiopia, nurses and doctors indicated that there was a lack of trained staff to handle obstetric emergencies (Austin et al., 2015). This increased the risk of maternal users succumbing to death during childbirth. All the above-mentioned illustrations of shortages of staff lead to nurses and doctors being overworked. This in turn results in mismanagement of health care users, burnout of the staff and work not being done properly. The consequences of this are that health care workers are unable to effectively manage patients as desired, leading to poor maternal health outcomes.

In South Africa, the shortage of human resources for health is more common in rural areas, leading to problems with the delivery of MHS and the occurrence of preventable deaths (Murphy et al., 2014). In South African rural areas, the density of doctors and nurses is 0.29 and 1.35, respectively, per every 1 000 people (Versteeg et al., 2013). This is far from the WHO recommendation of 2.28 per every 1 000 people (UN, 2015), revealing a serious lack of expertise and human resources for health in rural areas. Table 2.1 shows the distribution of nurses and doctors across provinces in South Africa.

Table 2.1: Distribution of nurses and doctors across provinces in South Africa

Province	Number of registered nurses	Number of registered doctors	Number of medical specialists
Eastern Cape	10 698	1 877	197
Free State	2 175	631	315
Gauteng	13 693	3 409	1 858
KwaZulu-Natal	16 719	3 460	843
Limpopo	9 188	1 231	72
Mpumalanga	5 389	868	74
Northern Cape	1 446	353	24
North West	4 361	761	124
Western Cape	5 107	1 849	1 318

Source: Adapted from the South African health review report (Gray & Vawda, 2019)

The figures in Table 2.1 show that human resources are not evenly distributed countrywide. The North West and Mpumalanga are the most rural provinces and do not have many medical specialists. Contrarily, Gauteng and Western Cape are the most urbanised provinces and they have the highest numbers of medical specialists. These huge variances reflect the uneven distribution of the health workforce in the country and the unwillingness of medical practitioners to practice in remote rural areas (Gupta et al., 2018). Since general practitioners and nurses see all patients in PHC facilities, the shortage of the health care workforce leads to poor maternal health outcomes (high MMR, NMR and CHR).

To illustrate further, the uneven distribution of the health care workforce depicted in Table 2.1 corroborates the findings of research done in South African provinces. In 2014, rural provinces such as the Eastern Cape, Northern Cape, Limpopo, and Mpumalanga had the lowest number of medical specialists per 100 000 people, with 2.8, 3.1, 1.8 and 2.0, respectively (Mburu & George, 2017). This meant that health outcomes were poor in areas where shortages of health workers were prevalent. The same can still be said in 2019 as represented in Table 2.1 above (Gray & Vawda, 2019). On the contrary, provinces such as Gauteng and Western Cape that have the country's major cities, had a higher percentage of medical specialists per 100 000 people with 20.5 and 31.3 per 100 000, respectively. Even in 2019, the picture was still the same as depicted in Table 2.1 above. In particular, the available research findings from a study conducted by Mathole et al. (2018) in the Eastern Cape, indicated that staff shortages and retention were huge problems in the rural districts of the province. At one clinic, there were only two professional nurses and a clinic manager who reported only once a month at the clinic because of another acting position she had at the district office. The clinic was supposed to have two medical officers but there were none. This has resulted in the two available nurses performing extra duties of long shifts to fill the gap of two medicals officers and the clinic manager (Mathole et al., 2018).

2.6.1.5 Attitudes of health care providers

Health care professionals are always required to exhibit professional conduct (Van der Hoeven et al., 2012). The requirement is from both patients and governing bodies. However, research showed that they also hinder access to MHS (Versteeg et al.,

2013). In a research study in rural Nepal, it emerged that nurses do not properly counsel and give enough attention to women in order for them to comprehend the use of medication they get during clinic visits (Khatri et al., 2017). One woman indicated that she had been given iron tablets and a deworming tablet during her pregnancy. However, because of the long queues at the clinic, the nurses were in a hurry to attend to everyone and did not give her enough time to explain why she needed to take the medication.

Research also found that doctors and nurses at some facilities did not provide adequate services. These experiences were reported in the northern central Vietnam where ill-treatment by health professionals during visits and discrimination in previous birth delivery kept pregnant women from seeking MHS (Binder-Finnema et al., 2015). As a result, women fail to acquire maternal services as expected, and pregnancy-related risks and complications are not detected and prevented. This results in the death of the mother or child during pregnancy, delivery or after delivery. Similarly, in West Africa, research findings in Nigeria indicated that doctors and nurses who are supposed to attend to patients timeously are not always on duty (Ekpenyong et al., 2019). They spend worktime sitting in their offices, chatting, or doing nothing while patients wait for as long as an hour for consultations.

These attitudes of health workers are prevalent in South Africa too. In a study conducted by Versteeg et al. (2013) in rural South Africa, one key informant (a doctor) stated that negative attitudes from health care workers prevented health care users from accessing services. Tsawe and Susuman (2014) stated that the doctors or nurses were not referring some women for ANC. This had a direct impact on the number of visits women had for MHS. As a result, where maternal users did not have an alternative health facility to visit, they did not access the desired number of ANC or PNC visits. Furthermore, the findings from a study conducted in eThekweni in KwaZulu-Natal on experiences of health care users revealed that some health care workers had negative attitudes towards women (Sokhela et al., 2013). One of the participants in the study stated that nurses' facial expressions showed that they either did not care about them or did not have time for them. The participant added that nurses need to learn proper public relations with people so that they can interact and play with babies when injecting them or weighing them.

2.6.2 Community and social level factors

Community and societal barriers to accessing maternal health care are discussed in this section and include cultural beliefs and gender inequality.

2.6.2.1 Cultural beliefs

Cultural beliefs are one of the factors preventing women from accessing health care services during pregnancy and childbearing (Amzat, 2015; Tsawe & Susuman, 2014). In rural Nepal, women are exposed to harmful cultural traditional practices that put them and their newborn babies at risk of dying during delivery (Khatri et al., 2017). Most women give birth at home with unskilled traditional birth attendants. These birth attendants are influential in their communities and encourage women to give birth at home. Such practices prevent women from seeking proper health care timeously.

Another cultural perception regards pregnancy as a natural process that does not need any extra attention (Khatri et al., 2017; Morgan et al., 2018; Wilunda et al., 2016). The implication is that pregnancy is culturally considered as a matter of fate and it therefore becomes unnecessary to seek ANC during pregnancy. Women further shy away from other men during pregnancy and delivery (Khatri et al., 2017). As a result of this, women prolong their decision-making in deciding whether they will seek ANC during pregnancy for fear of being assisted by male nurses and doctors. They then resort to home deliveries without a SBA and their risk of succumbing to maternal deaths increases if complications arise. On the other hand, men also refuse to touch women in labour and who have given birth, citing that God becomes angry if they touch them (Khatri et al., 2017). Such practices put women at risk of not getting any immediate assistance when they go into labour and there are only men around them.

Marriages are valued in many cultures such that falling pregnant outside wedlock is not tolerated by society. As a result, women in a US Marshallese community felt ashamed to seek ANC when they got pregnant out of wedlock (Ayers et al., 2018). Some of the women even felt ashamed if they got pregnant while they were still attending school. As a result, they became reluctant to seek ANC in the first trimester for fear of embarrassment, which makes them vulnerable to pregnancy-related complications and death.

Traditional and cultural norms have an effect on pregnancy and delivery outcomes. Research conducted in South Sudan revealed several findings. Mugo et al. (2018) found that women were discouraged from eating eggs and cheese products, as it was culturally perceived in their society that it induces swollen feet during pregnancy and delivery complications such as high blood pressure. However, eggs are a good source of protein that the baby needs for brain development. Not taking enough protein deprives wholesome growth of the foetus. It was further perceived that the baby would become big from eating eggs and dairy products. Furthermore, in one of the findings by Mugo et al. (2018), women believed that the placenta should be handled properly after giving birth as prescribed by their culture. It is supposed to be washed and covered in a tin. It is then buried, and this must be done by someone who is knowledgeable of cultural practices. As a result, women preferred home births because they had knowledgeable people to assist them with the process of handling the placenta. In doing so, the women put themselves at risk of complications and death at childbirth.

Wilunda et al. (2016) describe another cultural belief held by men. If a man suspected his wife of infidelity or that the unborn child was not his, it was believed the baby would not be born until the woman confessed who the real father was. This resulted in men instructing their wives to deliver at home so that they could be sure that they were the biological fathers. Men thought that midwives at the health facilities were would withhold this information from the husband and let women get away with infidelity. In light of this, men viewed home delivery as an opportunity to prove faithfulness or unfaithfulness of their wives.

In SSA, cultural practices and beliefs influence maternal health care seeking behaviour and place of birth in many communities. There are different perceptions about pregnant women, pregnancy care and birth. One of these perceptions focuses on the strength of womanhood, which equates to having birth free complications and a natural virginal birth. This becomes the ultimate symbol of womanhood. As a result, women who follow such cultural expectations and give birth without complications are viewed as real strong women. On the other hand, women who encounter complications during pregnancy or have a caesarean section are not valued and respected. They are viewed as inferior or having a weakness (Lang-Baldé & Amerson, 2018). Since women belong to a cultural system, they would want to adhere to these beliefs and refrain

from seeking maternal health care at clinics, thus increasing their chances of complications and maternal death.

Furthermore, it is postulated that women in low to middle-income countries fall pregnant more regularly than those in high-income countries. According to Taylor (2019), approximately 650 million were married before turning 18 years and 233 million of them married before 15 years. Women who tend to get married at a younger age marry due to cultural and religious reasons. This in turn leads to younger women (i.e. younger than 18 years of age) becoming pregnant, which makes them vulnerable to pregnancy-related complications while they are still teenagers (Amzat, 2015). In the Ghanaian culture, women are required to bear children in order to continue their lineage or that of the family they marry into (Ganle et al., 2015). A pregnant woman participating in a research study conducted in Ghana stated that every woman is expected to give birth. Failure fall pregnant and give birth means the collapse of their lineage. Furthermore, if a woman refuses to fall pregnant and give birth, her husband will divorce her. In order to avoid divorce, one woman cited that she gets pregnant for her marriage's sake (Ganle et al., 2015).

Countries have various cultural beliefs that discourage women from accessing maternal health care timeously (Lang-Baldé & Amerson, 2018). This is evident in most SSA countries, including South Africa. For instance, many women only prefer to talk openly about their pregnancy once the physical signs of the pregnancy begin to show. Before that, some women view it as forbidden to talk about the pregnancy as they fear they may lose the child by miscarriage, may deliver an abnormal baby, or may risk being bewitched (Ganle & Dery, 2015; Mulaudzi et al., 2016). All these beliefs increase the risks of morbidity and mortality as women fail to access ANC timeously. In Ghana, woman will not even tell their husband about the pregnancy in the first three months. In doing so, the woman believes she is protecting herself and the foetus from evil spirits, which are believed to cause a malformed infant or a miscarriage (Dako-Gyeke et al., 2015; Lori & Boyle, 2011). In South Africa, Wabiri et al. (2016) found evidence to substantiate this in their study where they discovered that only a few women in the Eastern Cape had accessed ANC services before 20 weeks of pregnancy due to this cultural belief.

2.6.2.2 Gender inequality

Most African cultures are patriarchal in nature. They are male dominated, and males possess a lot of power politically, socially, and morally over women (Kinanee & Ezekiel-Hart, 2009; Nesane et al., 2016; Shen & Williamson, 1999). Women do not have total control of their sexuality or the number of children they wish to have (Shen & Williamson, 1999). Many women have no control over their availability for sex, use of family planning methods and consensual marriage. Furthermore, in most patriarchal societies, there is a male child preference that puts unnecessary pressure on women to reproduce continually in search of male children without adequate spacing between births (Amzat, 2015). The implications are that the more women bear children (more fertility levels), the more vulnerable they become to pregnancy-related complications in these under-resourced rural settings where emergency services are not readily available. This then leads to high MMR and CMR.

Patriarchy makes women dependent on men for all household decisions such as the size of the family they want to have, when to get pregnant and whether they should seek ANC during pregnancy (Kinanee & Ezekiel-Hart, 2009; Nesane et al., 2016; Shen & Williamson, 1999). Women further depend on men to decide on the place of childbirth (Ganle et al., 2015; Wilunda et al., 2016). Studies conducted in SSA found that many men restricted their wives to home deliveries. The women cited that despite their awareness that hospitals were good and safe, they could not argue with their husbands because they have the final say. This leaves the women with low decision power and they are less likely to make use of skilled delivery at birth (Adjiwanou & LeGrand, 2014; Ganle et al., 2015).

Women are expected to remain at home and engage in cooking duties and rearing children (Wilunda et al., 2016). They cannot freely visit the clinic during pregnancy, as they would leave their children and homes unattended. Research findings in South Sudan (Wilunda et al., 2016) and Nigeria (Ekpenyong et al., 2019) illustrated this. In particular, a pregnant woman interviewed in Nigeria indicated that as a woman, she was expected to carry out all household chores without getting assistance from anyone. As a result, this became a hindrance to acquiring ANC services during pregnancy, as she could not even ask her husband or mother-in-law to assist with household chores when she plans to visit the clinic.

Women require support during pregnancy and after childbirth, and this is essential for the survival of the women (Amzat, 2015). The support should come in the form of assistance with household chores. However, this support is not always available, as men who are expected to assist do not do so because of masculinity and patriarchy (Ganle & Dery, 2015). Men are expected to provide as breadwinners for their households and all other responsibilities of house chores and child rearing are for women. This strains women as they are still expected to carry on doing household chores soon after childbirth. Therefore, the absence of men in giving a helping hand during pregnancy and after pregnancy negatively impacts on the well-being of the women. It strains women and increases the chances of maternal mortality.

The controlling behaviour and attitude of husbands and mothers-in-law towards maternal health care, influences the behaviour seeking trends of women. According to Ganle et al. (2015), husbands and mothers-in-law carry a lot of influence. They determine whether women will attend ANC, hospital birth delivery and PNC. One lactating mother reported that she wanted to attend ANC during her pregnancy, but her mother-in-law discouraged her, citing that she would be okay since she had no signs of being unwell (Ganle et al., 2015). She further wanted to give birth at a health care facility and her mother-in-law instructed her to have a home delivery just like her who had given birth to all her children at home without any problems. Similar findings emerged in Nigeria (Ekpenyong et al., 2019). A research participant cited that she was grounded at home because every time she went out, her mother-in-law accused her of visiting other men (lovers). To avoid these false allegations, she resorted to staying at home and was scared to ask her mother-in-law for permission to acquire ANC services.

2.6.3 Individual factors – knowledge and attitudes

Individual factors such as knowledge and attitudes of women influence their maternal health care seeking behaviour.

2.6.3.1 Lack of knowledge of maternal health

Maternal health education is a form of empowerment that all women require. This stems from the realisation that most maternal and child deaths are caused by illiteracy and lack of maternal health care knowledge (WHO, 2007). In a research study on

prenatal care in the United States (Ayers et al., 2018) and in Nepal (Khatri et al., 2017), the findings revealed that women delayed accessing ANC services. In a Marshallese community (Ayers et al., 2018), women delayed seeking ANC, citing a lack of knowledge. One of the participants cited that she did not know that she needed to see a doctor or visit a health care facility early on in pregnancy. The participant further mentioned that she was unaware of the importance of ANC since no information was given regarding the benefits of ANC. In Nepal, women revealed that instead of attending ANC at the clinic, they occupied themselves with their domestic roles of child rearing and household chores (Khatri et al., 2017). This implied that they had inadequate knowledge of the importance of ANC and on the risks that are associated with pregnancy.

In another research study to improve maternal and newborn health in Zambia, it emerged that a lack of knowledge resulted in low use of MHS (Mutale et al., 2017). Participants had little knowledge of family planning methods and home delivery. Some participants felt that family planning pills would result in infertility. Others did not like using condoms, citing that condoms promote promiscuity. All these misconceptions founded on illiteracy, lack of knowledge and ignorance hinder women from seeking MHS as expected during pregnancy, at delivery and after delivery.

Knowledge of maternal health is a facilitator to accessing maternal services, during and after pregnancy. Research undertaken by Regassa (2011) in Ethiopia and Ganle et al. (2015) in Ghana, found that knowledge of maternal education enables women to access the required services as anticipated. In Ethiopia, it was found that more ANC and PNC visits were undertaken by older women who were educated and had given birth before, compared to younger and less educated women. In Ghana, it emerged that educated women are decisive, attend ANC earlier and give birth with the assistance of a SBA. An experienced female health provider in Ghana cited that she observed that educated women do not rely on their husbands or mothers-in-law to make decisions for them. Educated women valued MHS and skilled assistance during birth.

A lack of education and knowledge hinders access to MHS in the country's rural communities. Some girls in SSA, including South Africa, drop out of school to engage in marriage at an early age, while others drop out of school when pregnant (Amzat,

2015). These girls often marry earlier and are usually not ready for pregnancy, which exposes them to greater risks of maternal morbidity and mortality (Khatri et al., 2017). As a result, they have no understanding of the importance of maternal health information and this account for low levels of literacy among women (Amzat, 2015). With low literacy levels, these women are highly unlikely to recognise danger signs and threats during pregnancy or childbirth. As a result, they will not take swift action when danger signs emanate, as they would regard them as normal conditions of pregnancy.

In South Africa, lack of knowledge is a barrier to women attending MHS during pregnancy. In a study by Myer and Harrison (2003) to determine the reasons why women seek ANC late, despite it being offered free in a rural district of Hlabisa in South Africa, the findings revealed that women had inadequate knowledge and understanding concerning health threats that could occur during pregnancy. Furthermore, they did not have adequate knowledge about the benefits of ANC, despite this information being made available through brochures, flyers, and the internet. As a result, they did not see the importance of ANC visits. They only valued the importance of giving birth in a proper health care facility where a skilled worker would attend to them.

Similar findings were reported by Tsawe and Susuman (2014) who found that women in the Eastern Cape also lacked knowledge about maternal health which contributed to them not utilising MHS. More specifically, they found that women were not aware that they should be going for ANC services during pregnancy and some did not even know what maternal care entailed. Another research study conducted by Susuman (2015) in the same province on the influence of maternal education in using maternal services, revealed a number of findings. First, it emerged that women were not acquiring PNC services. The percentage of women who did postnatal check-ups were reported to be below 50%. Seventy-one percent of the participants indicated that it was not important for them to attend postnatal services. Second, women with secondary or tertiary education made use of PNC more than those with lower levels of education. Third, women with several children used PNC more than women giving birth to their first child. From these findings, it become apparent that lack of knowledge keeps women away from the clinic during and after pregnancy.

2.7 CONCLUSION

This chapter synthesised previous literature regarding access and rendering of maternal services in resource-limited settings. The literature revealed that poor access and rendering of services affect the way users seek MHS and contributes to high MMR and CMR. Some researchers argued that South Africa's health challenges are immense while pointing out to its failure to meet the MDG targets set on improving PHC from 2000 to 2015. The literature further revealed that South Africa is most likely to also not meet its SDG targets and that there are various health system factors and social determinants that stand as barriers for health care users.

Chapter 3

RESEARCH METHODOLOGY

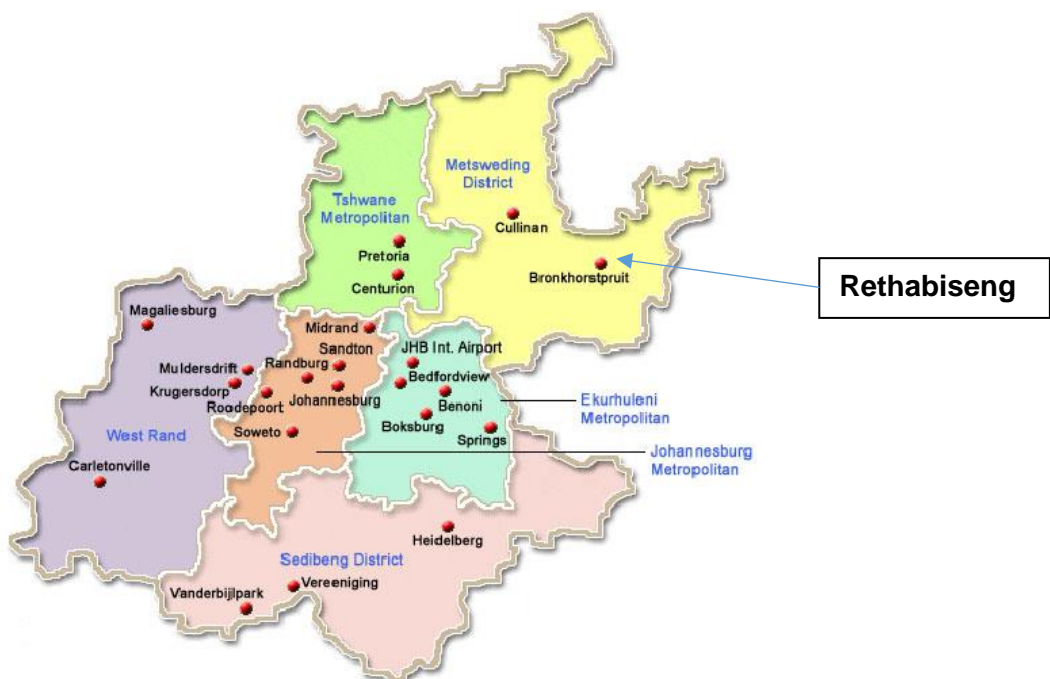
3.1 INTRODUCTION

This chapter provides a description of the research design and tools used in the study. Qualitative data was collected during key informant interviews to explore the challenges that maternal health care providers are confronted with when rendering services to maternal health care users. In addition, focus group discussions (FGDs) explored the experiences that women undergo when seeking MHS during and after pregnancy. Appropriate ethical guidelines were adhered to throughout the study.

3.2 SETTING

The study focused on a single community, Rethabiseng (Figure 3.1). Rethabiseng is a rural residential community that is in the City of Tshwane Metropolitan Municipality in Gauteng.

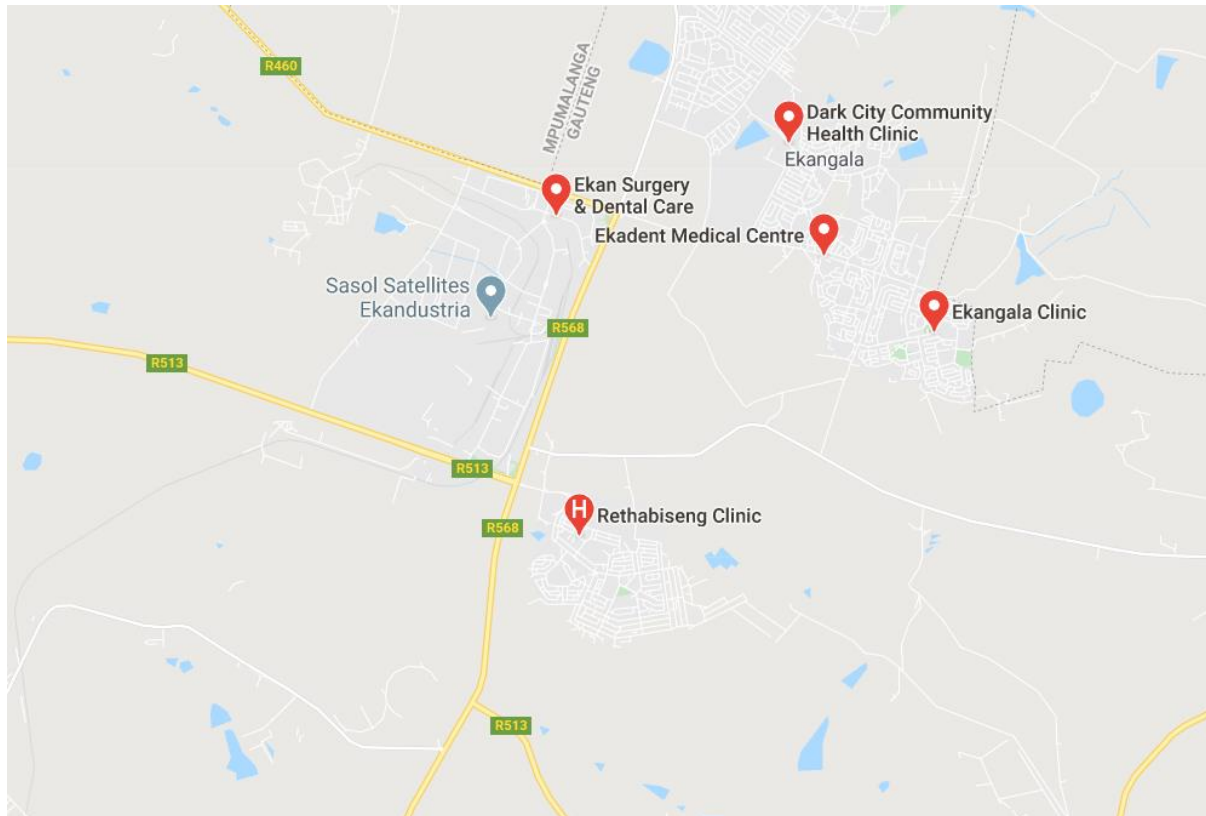
Figure 3.1: Map of Gauteng province



Source: Google Maps (2020)

Rethabiseng has one PHC clinic (henceforth referred to as Clinic A) that residents depend on. Most pregnant women registered for ANC at Clinic A are referred to Clinic B for birth delivery (Figure 3.2).

Figure 3.2: Location of Rethabiseng Clinic (Clinic A) and Dark City Community Health Clinic (Clinic B)



Source: Google Maps (2020)

Rethabiseng has a population of 15 258 people. Most of the population are African (99%), and of these, approximately half are women (51%). The remaining population are coloureds, Indians, and whites with a total of 82, 46 and 2, respectively (Statistics South Africa, 2011). Rethabiseng is a predominantly Zulu speaking rural community, although isiXhosa and seSotho are also spoken there. This setting was selected because it is a typical rural community. Logistically, it was also easily accessible to the researcher.

3.3 RESEARCH DESIGN

A research design is an intended plan put together to inform decisions that are either made or taken in collecting data and evaluating it (Bryman, 2016; Maree, 2016; Van Zyl, 2014). In other words, a research design entails all the procedures involved in planning and executing a research project from problem identification, reporting, and disseminating the findings (Punch, 2014). This study followed a descriptive and exploratory research design, employing qualitative methods to gather information from the mothers, pregnant women, and health care providers.

Descriptive and exploratory research is usually conducted when there is a need to investigate a phenomenon of interest where little is known (Polit & Beck, 2012). It sheds light on the phenomenon under exploration. This design was suitable because the researcher sought to describe the experiences of mothers, pregnant women, nurses, and clinic managers regarding MHS. They also shared the facilitators and barriers that encourage and discourage the use of MHS. This was in line with De Vos et al. (2011) who explained that qualitative research enables research participants to be heard as they share their stories.

Qualitative research also comes with criticism. Some scholars have criticised its subjective nature. Saunders, Lewis & Thornhill (2000) stated that qualitative research can be prejudiced by the researcher, resulting in bias. In addition, validating the information gathered poses as a challenge. The quality of the research relies on the abilities of the principal investigator in conducting research and is further prejudiced by the researcher's own preconceptions and way of thinking. Furthermore, the fact that the researcher is present during data collection can influence the participants' responses. Nevertheless, the qualitative methodology was preferred because of its capacity to collect information about human experiences. FGDs and semi-structured interviews were employed in data collection.

3.4 PARTICIPANT SELECTION

This section describes the sampling methods used to select mothers, pregnant women, nurses, and clinic managers as participants in this study.

3.4.1 Mothers

Purposive sampling was used to recruit mothers who had given birth in the past twelve months because they were key in relating their lived experiences on accessing ANC, delivery and PNC services. Purposive sampling is defined as the process taken by the researcher in selecting individuals because they can provide information that will answer the research questions (Creswell, 2013). The researcher asked a nurse who conducted maternal health care consultations (ANC and PNC) to assist with recruitment. The nurse informed potential participants about the study at the end of the consultations. The women who indicated that they were willing to participate in the study gave the recruiter permission to give the principal investigator their contact details so that he could call them to arrange a date for the FGDs.

The nurse recruited eight potential participants for the FGD for mothers and six availed themselves on the day of the discussions. The criteria for recruiting the mothers included:

- Must be 18 years and older as 18 is the legal age of consent in South Africa.
- Must have given birth within the last twelve months of the data collection date.
- Must have received ANC services at Clinic A.
- Must have been receiving PNC at Clinic A.

3.4.2 Pregnant mothers

Purposive sampling was used to recruit pregnant women into the study since they were central to answering the research questions on ANC. This method was valuable because it aimed at involving specific women that were pregnant and making use of Clinic A to access MHS. The researcher asked a nurse who rendered ANC services to assist with recruitment. The nurse informed potential participants about the study at the end of the women's ANC visits. The women who indicated that they were willing to participate in the study provided their names and phone numbers. They further gave the recruiter permission to give the principal investigator their contact details so that he could call them to set a date for the FGDs. The principal researcher contacted the potential participants and set an appointment date to conduct the FDGs.

The nurse recruited sixteen potential participants for the FGDs for mothers and fourteen showed up on the day of the discussions. The criteria for recruiting the pregnant women included:

- Must be 18 years and older as 18 is the legal age of consent in South Africa.
- Must be pregnant at the time of the data collection.
- Must be receiving ANC services at Clinic A.

3.4.3 Health care workers

A PHC nurse and two clinic managers were purposively selected to share their lived experiences of the facilitators and barriers to rendering MHS at Clinics A and B. The researcher contacted the managers and nurse, explained the purpose of the research and asked if they would be willing to participate in an interview.

The criteria for recruiting the nurse included:

- Must be 18 years and older as 18 is the legal age of consent in South Africa.
- Must be rendering MHS at the time of data collection.
- Must have at least five years' experience in MHS.
- Must be a midwife.

The criteria for recruiting the managers included:

- Must be 18 years and older as 18 is the legal age of consent in South Africa.
- Must have at least five years' maternal nursing experience.
- Must be managing PHC at the clinic.

3.5 DATA COLLECTION

Several methods can be utilised to gather primary data from participants. Kumar (2014) stated that the choice of research instruments used depends on the aim of the study, the resources available and the skills of the researcher.

To answer the aims and objectives of the research study, two main data collection methods were used: FGDs with mothers and pregnant women and semi-structured interviews with a nurse and clinic managers. In this section the data collection methods

are defined and the rationale for choosing these methods is discussed. The strength and weaknesses of the methods will be highlighted.

3.5.1 Focus group discussions

FGDs allow research participants to deliberate issues in a group setting (Maree, 2016). FGDs seek to learn the thoughts and perceptions of each participant concerning the topic at hand (Bryman, 2016; Van Zyl, 2014). The questions that are asked are open-ended and are meant for the whole group (Jackson, 2012). Participants may respond to questions in a manner they choose, thus creating a platform of sharing and comparing of experiences among participants (De Vos et al., 2011). Sherraden (2001) said that the social interaction within FGDs produces a wide range of meaningful views when participants are afforded an interactive and vibrant atmosphere within their group.

In this study, the researcher used a female facilitator (a senior social worker for the Bronkhorstspuit Municipality) to conduct the FGDs. This was done to ensure that the participants would feel free and relaxed to discuss maternal issues with a female facilitator. The Principal Investigator was not present during the FGDs. The language of facilitation was isiZulu, the dominant language of the community and a language the facilitator was affluent in. The FGDs were recorded with the permission of the participants. The researcher opted for FGDs because of their low cost and time saving nature. Since the participants were solicited from the local clinic, the FGD meetings took place at Clinic A on the days that some of the research participants had appointments with the professional nurses. That was convenient for the respondents and the researcher, as the respondents came to the clinic, a place of familiarity for all.

It was also advantageous to use FGDs in collecting data. Mothers and pregnant women were able to share their maternal experiences of accessing ANC, birth delivery and PNC services in the FGDs. They were further able to agree or disagree with one another, thereby providing an insight on their varying experiences with access to MHS. Participants spoke comfortably during the FGDs because they were a homogenous group facing similar challenges. Furthermore, the FGDs have high face validity and presented the facilitator with an opportunity to read participants expressions and body

language (Bryman, 2016). This assisted the facilitator in understanding the participants' responses better.

When it comes to policy formulation and research, FGDs are useful in contributing perceptions and opinions of the different parties incorporated in the specific process of policy development. In the study, one of the research study objectives was to identify strategies to improve maternal health outcomes in order to develop adequate maternal health outcomes for rural citizens of Rethabiseng. Therefore, bringing the maternal health users together in this case gave them a platform to recommend changes in service provision at health facilities.

On the other hand, there are limitations and disadvantages of FGDs that the researcher had to explore. The main disadvantage for FGDs lies in the difficulties which may arise with assembling people and finding convenient time slots for the discussions (Maree, 2016). This prolonged the process of data collection because participants were not conveniently available to all meet the researcher as per plan. In this investigation, the principal investigator postponed one FGD for pregnant women when some participants failed to show up as anticipated.

The FGDs were conducted at Clinic A. The principal researcher and facilitator introduced themselves before the start of the FGDs. The principal researcher welcomed everyone, reiterated on the purpose of the study, and handed over the remaining procedures to the facilitator. The facilitator handed out consent forms to get written informed consent from each participant before the discussion started (Appendix A & B). Participants received consent forms in the language of their preference (English, isiZulu and IsiXhosa). The facilitator sought permission from the participants to audio record the session. Participants were afforded an opportunity to set a few ground rules. The reason for the rules was to foster participation of all, instil order (discipline) and foster respect for each other's views. The questions and discussions were done in isiZulu, the dominant language of the community. However, participants were free to respond in any language of preference. Additionally, the facilitator took notes of observations made during the discussions and explained them later to the principal investigator. When the FGDs had ended, the facilitator provided them with some refreshments and thanked them for their participation.

3.5.2 Semi-structured interviews

Semi-structured interviews entail the use of prepared questions to solicit information from respondents, while simultaneously seeking clarification and probing further questions (Bryman 2016; Maree, 2016; Van Zyl, 2014). The study used semi-structured interviews with three key informants working at the health care facilities at Clinic A and Clinic B, respectively. The aim was to explore their experiences regarding the rendering of MHS at the clinic and the referral clinic, respectively.

The researcher contacted the participants, briefed them on the purpose of the study and sought for their willingness to participate. The researcher then set convenient interview dates for the informants. On the day of the interviews, the researcher introduced himself, explained the purpose of the research and obtained written consent from the participants (Appendix C). Before commencing with the research questions, the researcher conversed with the participants to build rapport in order to enable them to answer the questions comfortably. The interviews were carried out in English and were recorded with the consent of the participants. This enabled the researcher to devote undivided attention to listening to the respondents while taking down notes. A combination of open-ended and close-ended questions was utilised in gathering the data.

Semi-structured interviews have their strengths. They allow the interviewer and the interviewee an opportunity to seek clarification and engage each other further for more detail (De Vos et al., 2011; Silverman, 2000). The researcher was able to find out what the participants meant in their responses. The semi-structured interviews were flexible and enabled the interviewer to focus on specific issues that were meaningful to the participants. Furthermore, semi-structured interviews afford participants the opportunity to give valuable information based on their experiences (Bryman, 2016). The semi-structured interviews gave the study a rich qualitative analysis because it allowed the service providers an opportunity to share their first-hand experiences of maternal health service delivery at both clinics. In this regard, the researcher was able to explore their lived experiences by probing and following up on questions, thereby permitting relevant information to be gathered. Another strength of semi-structured interviews is uniformity in questions. Uniformity in questioning allows the same set of

questions to be posed to various informants, but still being able to compare and analyse similar findings (Maree, 2016).

There are some limitations or disadvantages of using semi-structured interviews as a data collecting technique. Semi-structured interviews may be biased at times. The respondents may give answers that they think the researcher wants to hear. This in turn compromises the credibility of the research data. The other disadvantage of the semi-structured interviewing technique is that analysing qualitative data requires one to transcribe the recorded data. This process is costly and time-consuming.

3.6 DATA GATHERING TOOLS

The data gathering tools (FGDs and semi-structured interviews) employed in the study are discussed in this section.

3.6.1 Focus group discussion schedules

The FGD data schedule was drawn from existing literature and guided by the Social-Ecological Model (see Chapter 2, section 2.6). The questions were developed and asked at the following levels (Appendix D and E):

- **Individual level:** The focus of questions was on measuring the knowledge, attitudes, and health-seeking behaviour of individuals regarding ANC, birth delivery and PNC services.
- **Interpersonal or family level:** The focus of questions was to establish whether husbands and family had an influence on the participants' ANC, birth delivery and PNC health-seeking behaviour.
- **Community level:** The focus of the questions was on exploring religious, traditional, and cultural influences on access to maternal health care.
- **Organisational and health systems level.** The focus of the questions was on exploring health systems factors which influence access to maternal health care, for example distance, infrastructure, long queues, working hours, human resources, staff attitudes, cultural beliefs and availability of maternal resources. In addition, recommendations were sought that were aimed at improving maternal health care access in rural communities.

3.6.2 Semi-structured schedules for primary health care nurses and clinic managers

The semi-structured data schedule was drawn from existing literature related to maternal health care in rural communities and guided by the Social-Ecological Model (see Chapter 2, section 2.6). The questions dealt with were of significance to the study. The questions were developed and asked at the following levels (Appendix F):

- **Individual level:** Professional knowledge of MHS, maternal health care needs of users and experience in rendering MHS. The focus of the questions was on measuring the knowledge of health care providers on maternal health care ANC, delivery, and PNC services. For instance, the study also had questions to measure the participants' understanding of the number of visits women attend for ANC and PNC and the routine checks they do on each visit.
- **Interpersonal level:** The focus of the questions was to explore the experiences of health care service providers regarding the maternal support systems that users have that facilitate or hinder access to maternal health care. Participants could share how maternal health users' relationships with partners and their immediate family facilitated or hampered access to MHS during and after pregnancy at their respective clinics.
- **Community level:** The focus of questions was on exploring the influence of religion, culture, and gender women's access to MHS.
- **Organisational and health systems level:** The focus was on noting health systems barriers and facilitators to accessing MHS as well as recommendations aimed at improving maternal health care access in rural communities.

3.7 RESEARCH QUALITY

The quality of the research was ensured using the trustworthiness framework that was coined by Lincoln and Guba in 1985 (Bryman, 2016). Trustworthiness is made up of four epistemological standards, namely credibility, transferability, confirmability, and dependability.

3.7.1 Credibility

According to Bryman (2016), credibility in research aims to establish the true value of research findings. It further seeks to determine whether the principal investigator had established confidence in the truth of the findings in such a way that they are believable. To demonstrate credibility, the researcher involved all aspects (recordings, notes, transcripts) to show links between the data and interpretations through a process of data triangulation. The researcher also engaged in regular discussions with the focus group facilitator and his supervisor for suggestions and recommendations to improve the data collection and analysis process.

3.7.2 Transferability

According to Bryman (2016), transferability is a standard of trustworthiness that demonstrates the transference of any study findings to separate different situations. However, transferability relies on a researcher's intention to transfer the findings to a separate context and the researcher has to provide a profuse explanation of the study that will enhance the transferability of the research outcomes (Polit & Beck, 2012). This study did not aim to generalise the research, but generated recommendations for maternal health care access in a rural community of South Africa.

3.7.3 Confirmability

Confirmability calls for the principal investigator to have integrity in the process of research. In other words, while it acknowledges that complete fairness is impossible in research, the principal investigator should not allow personal interests or theoretical preferences to influence the conduct of the study and its outcomes (Bryman, 2016). In this study, the principal investigator ensured that the study reflected the participants' experiences without any biases or personal motives. The process of transcribing and translating audio recordings was handled professionally to ensure objectivity. The researcher also kept notes of all decisions made during the research process.

3.7.4 Dependability

Dependability measures the uniformity and merit of the study (Bryman, 2016). In other words, dependability requires the findings of the inquiry to be consistent even if the

research study was to be done again with the same participants. In this research, the researcher determined dependability of the findings through a comprehensive description of the procedures used in collecting and analysing data. The researcher further addressed dependability in the study by following the same steps for all FDGs and interviews. Audio recordings were used, as they were a reliable method of data collection that allowed the researcher access to raw data in case any clarifications were required.

3.8 RESEARCH ETHICS

Research should be conducted in an ethically correct fashion (Maree, 2016; Van Zyl, 2014). The ethical issues are meant to protect both the researcher and the participants. The researcher sought permission to conduct the study from the Health Sciences Research Ethics Committee at the University of the Free State (UFS-HSD2019/1084/2611) (Appendix G) and the Gauteng Department of Health / Provincial Health Research Ethics Committee of Tshwane (GP_201908_044) (Appendix H). Approval was obtained from both committees and the researcher proceeded with data collection.

3.8.1 No harm

The study ensured that no harm would come to participants. The principle of no harm to participants is what Burns and Groove (2009) viewed as the principle of beneficence, that is, the respect for human dignity with emphasis on freedom from harm, exploitation, right to fair treatment, right to privacy and justice. In this regard, the research study focused on experiences of accessing and providing MHS and was not deemed likely to bring any harm to participants. However, if women had experienced any emotional distress during the discussion, the facilitator was prepared to refer them for counselling at Clinic A or Clinic B. No instances of emotional distress were experienced during the FDGs or interviews.

3.8.2 Informed consent / voluntary participation

The researcher obtained informed consent from all potential participants while stressing that participation was voluntary. Bryman (2016) advised that it is within the rights of research participants to decline to take part in the study and to withdraw from

participating whenever they see fit to do so during the study. In line with this, the researcher developed consent forms that were administered to all participants in FGDs and key informant interviews (Appendix A, B and C) in order to sensitise them about the study and to make them aware of their rights as participants. Each participant gave their consent in writing.

3.8.3 Confidentiality

Confidentiality was ensured by using pseudonyms during the data collections process (FGDs) and by setting rules that the participants had to adhere to at the start of each FGD. In this regard, FGD participants were asked not to repeat what was said during the discussions outside of the discussions. FGD participants were requested to respect one another's contributions and to keep confidential everything that was discussed. All data recordings and transcriptions were kept in password protected files. Only the researcher and his supervisor had access to these files.

3.9 BIAS

Bias is anything that can misrepresent the research data. The researcher's sample discrepancies, prejudice, inadequate study design and faulty methods can all lead to bias (LoBiondo-Wood & Haber, 2010). Bias can also be caused by intentional or unintentional acts in data collection or analysis (LoBiondo-Wood & Haber, 2010). Such actions may produce a misrepresentation or oversights in the study results, thereby affecting the quality of the qualitative study. All these factors were considered by the principal investigator in the planning of the study (Polit & Beck, 2012).

According to Bryman et al. (2011), it is difficult to totally avoid bias; however, it is essential for the researcher to put plans in place that are aimed at keeping bias to a minimum. Bias is also defined as a fundamental aspect of sampling that needs to be considered carefully. Personal judgements should not influence the sampling process because the samples will be biased in practice. To combat bias in this research study, the researcher described the necessary data collection and sampling procedures. In this regard, bias was minimised in the following manner:

- **Participant bias:** Research participants may provide false information during the data collection process. This may sometimes be a result of the participants

misunderstanding the questions posed. This was prevented by conducting a pre-discussion with participants to explain the procedures of the FGDs and interviews. In these pre-discussions, the participants were informed regarding the aims of the study and what was expected of them.

- **Interviewer bias:** During the interviews, the researcher's facial expressions, behaviour or language when asking questions may manipulate the data collection process. To eradicate bias, the interviewer made use of simple language and clear phrases when posing questions to respondents and provided accurate responses from the participants' experiences.
- **Language bias:** Language of conducting FGDs could have been a barrier to participants, thereby leading them to give false information when they misunderstood the questions. To eliminate language bias, the facilitator conducted the FGDs in the most spoken language of the area, isiZulu. She further allowed participants to respond in any of their preferred local languages.

3.10 DATA ANALYSIS

Data analysis is the process of breaking up the gathered information into manageable themes, patterns, trends, and relationships (Babbie & Mouton, 2001). It aims at providing meaning to data and information gathered through examining the link between concepts, possible patterns, and themes emerging from the research findings. Thematic analysis was used to analyse the data.

Thematic analysis can be done in two ways, that is, deductively or inductively. According to Bryman (2016) and Maree (2016), inductive analysis entails making use of collected data to determine the themes. Put differently, inductive thematic analysis is applied when existing theories are not used as a guide of deriving themes in a study. Deductive thematic analysis enables the use of existing theories and preconceived notions on a phenomenon to be used to look for certain themes a researcher expects to find reflected in a research study (Bryman, 2016; Maree, 2016). Both deductive and inductive data analysis approaches were used in the study. The reason being that the Social-Ecological Model was used to explore the experiences of pregnant women, mothers, and nurses in accessing and rendering services at health care facilities and themes were also derived from reading the transcriptions, respectively. In doing so,

the researcher managed to give a detailed data analysis. Furthermore, the researcher could answer the research questions since research schedules were constructed in a sensible and scientific way using the model and existing literature.

The raw data was managed at six different stages: familiarisation, coding, generating themes, reviewing themes, defining, and writing themes and writing up (Caulfield, 2019). The first stage entailed handling the raw data and getting familiar with it. The researcher listened to the audio recordings while he transcribed them. This was done to ensure that all the participants' responses were accurately captured. Second, the researcher read the transcripts and highlighted phrases and sentences while identifying codes to describe the content. Third, the researcher looked at the generated codes with the aim of identifying patterns in the codes. Microsoft Excel spreadsheets were used to capture the code numbers and quotes substantiating the codes. Themes were then generated.

The generated themes were grouped as per the Social-Ecological Model that guided this research. In some instances, several codes were combined to make one theme. In the fourth stage, the researcher ensured that all the generated themes were suitable and correct illustrations of the data. The researcher further ensured that all themes were available in the data and whether there was a need to split or combine some of them to be more useful and accurate. The fifth stage entailed defining the themes and naming them. The process of defining themes involved precisely wording the themes so that each worded theme would assist in comprehending the data. Moreover, naming themes involved giving a relevant name to each theme. Finally, the researcher began the write up of the data for the different themes.

3.11 CONCLUSION

This chapter detailed the research strategy and techniques used for conducting research on experiences of women in accessing MHS in Rethabiseng. The study utilised a qualitative methodology to describe and explore women's experiences of accessing MHS in Rethabiseng. Three FGDs were conducted with 20 participants. In addition, three semi-structured interviews were conducted with one nurse and two clinic managers. The interviewed nurse rendered maternal services at Clinic A. The chapter further explained the setting of the study, population, sampling strategies

taken, and the data collection tools employed. FGDs and semi-structured interviews were used to collect data. The ethical considerations taken for the study, as well as the measures taken to prevent bias, were outlined. These were principles of voluntary participation, informed consent, confidentiality, and no harm to participants. The modalities of managing the data were outlined. The study obtained ethical clearance from both the University of the Free State and the Gauteng Department of Health. The next chapter will discuss the research findings.

Chapter 4

RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, a detailed discussion of maternal health care experiences of pregnant women, mothers who have given birth in the past 12 months, nurses and clinic managers will be presented. The research findings are guided by the Social-Ecological Model and are presented in line with the aims and objectives of the research study. The aim of this study was to explore experiences of accessing and providing MHS in a rural community of South Africa, Rethabiseng. More specifically, the objectives of the study were to:

- describe knowledge about maternal health care;
- identify women's maternal health care needs;
- explore maternal health care seeking behaviour;
- explore the facilitators to access maternal health care services;
- explore the barriers to access maternal health care services; and
- make recommendations to improve access to maternal health care services.

The chapter ends with recommendations to improve access to and rendering of MHS that emerged from the research findings.

The following abbreviations are used when referring to the source transcripts:

Code	Real representation
FGD1	Focus Group Discussion 1 for mothers who gave birth in the last 12 months
FGD2	Focus Group Discussion 2 for pregnant women, Group 1
FGD3	Focus Group Discussion 3 for pregnant women, Group 2
KII1	Key Informant Interview 1
KII2	Key Informant Interview 2
KII3	Key Informant Interview 3
P1, P2, P3...	Participant 1, Participant 2, Participant 3, etc.

All quotations from participants are italicised and no real names of individuals or clinic facilities are used in the research findings.

4.2 BIOGRAPHIC CHARACTERISTICS AND BACKGROUND INFORMATION

This section describes the biographic characteristics of all the research participants.

4.2.1 Mothers

Six mothers participated in the FGD conducted in December 2019. The participants had all given birth during the 12 months preceding the FGD and were receiving PNC at the clinic. All participants were above 18 years of age and were of African descent. All the participants were South African citizens. The ages of the mothers ranged from 20 to 40 years.

4.2.2 Pregnant women

Fourteen pregnant women participated in two FGD groups in December 2019 and February 2020, respectively. The first FGD had six participants and the second had eight participants. The participants were all pregnant and above the age of 18 years. Their ages ranged from 20 to 40 years. All the women were South African citizens and of African descent.

4.2.3 Health care providers

Three professional nurses took part in this research. All participants were experienced midwives who had rendered maternal health care for a period ranging from nine years to twenty-four years. The health care services that they rendered included chronic care, maternal health care, HIV testing and counselling, and were engaged in the Expanded Programme of Immunisation and Mental Health Care. One of the nurses also provided birth delivery services.

4.3 SOURCES OF AND KNOWLEDGE ABOUT MATERNAL HEALTH CARE

This section describes the sources where pregnant women and mothers obtained information about maternal health care and included health care providers, internet, social media and instant messaging systems, and other parents. The section further

describes the maternal health care knowledge of pregnant women, mothers, and nurses.

4.3.1 Health care providers

Many of the participants pointed out that they acquired information about ANC, birth delivery and PNC from the clinic. Some of this information were related to the symptoms of labour. One participant noted:

I got information on the symptoms one might develop when you about to deliver from the clinic (P2, FGD1).

Another participant stated:

Yes, they give us tips like, if the water breaks, you must know that the baby is ready to be delivered or there is a problem. Therefore. You should call the ambulance or find your own transport to the hospital. When you also are having an unusual discharge like blood, you should call an ambulance too or use own transport to seek immediate care (P3, FGD2).

Participants also indicated that they knew what would happen after the delivery:

The clinic also informs you on how to take care of your child after birth. They inform you on how you should clean the umbilical cord wound. Also, you are informed after being discharged that you should visit the clinic after three days, so they check on you and the baby (P1, FGD1).

Another participant stated that the clinic had empowered her on how one can clean stitches after delivering with an operation, for example:

... how to clean your stitches if you were in operation, how to generally take care of your body during that period (P2, FGD1).

The participants attested to getting information they needed during pregnancy, at delivery and after delivery. In their explanations, the participants highlighted that the clinic provided them with information on what to eat during pregnancy, what medication to take when feeling weak or dizzy, the symptoms one may develop when in labour, dangers of bleeding during pregnancy, how to take care of a child after birth and when you should visit the clinic after birth. One participant explained:

We got information on the dangers of bleeding, dizziness, vomiting nonstop, information about the medication to take when weak and the importance of eating healthy food (P5, FGD2).

4.3.2 Internet and social media (Facebook)

The internet and social media were other sources of information on MHS. One of the participants said:

I usually get the information on the internet and I do research on social media like going on some Facebook pages for pregnant women to get information shared (P1, FGD3).

There were participants that highlighted that they acquired information through smart phone applications. One of them had this to say:

There are also apps that contain information on how to take good care of yourself during pregnancy and the baby (P2, FGD3).

A further source of information was a 'Mum and Baby' instant messaging system that gave maternal health information during clinic visits. The system simply required the participants to send a message from a cell phone device to a specific number. Inside the message, they wrote how far they were in their pregnancy and information was sent to them about what to do at that stage of pregnancy. A participant said:

There is this thing of Mum and Baby that the clinic advises women to make use of to get pregnancy tips. You insert a code on your phone stating how long you are in your pregnancy and then you get messages relevant to your stage in pregnancy each month (P3, FGD3).

4.3.3 Other parents

The women also indicated that they received information on maternal health care from other parents. These were identified as biological parents and mothers who had given birth in the past. A participant said:

I also receive information from the previous mothers and parents (P1, FGD3).

4.3.4 Knowledge about maternal health care

Pregnant women and mothers demonstrated their knowledge about maternal health care. Some women knew about ANC, childbirth, and PNC. The participants were knowledgeable that during pregnancy, there were certain foods that were encouraged or discouraged. One woman had knowledge that during pregnancy, women were discouraged from eating raw fish:

You are not supposed to eat raw fish during pregnancy; it is not good for the baby (P1, FDG1).

Another woman indicated that late registering for ANC was discouraged as it puts women at risk during their pregnancy:

One must go to the clinic as early as possible in order to find out how you and the baby are doing. They will then pick up complications and help you while it is still early and recommend hospital care (P3, FGD2).

This was affirmed by another participant:

When pregnant, you should be aware of certain danger signs and that I must be in a position to prevent them. Furthermore, if I experience some of the danger signs, I should call the ambulance without delay or use your own transport (P1, FGD2).

Another participant pointed out that early registration provides an opportunity to test for HIV and helps to prevent transmission of the virus to the child:

This helps the clinic to know your HIV status and take necessary measures to prevent the unborn child from getting infected. Furthermore, to further continue to take pills [Nevirapine] after delivery so that the child may not be affected especially when you are breast-feeding (P1, FGD1).

4.4 WOMEN'S MATERNAL HEALTH CARE NEEDS

During pregnancy, delivery, and post-delivery, women have specific maternal health care needs. They need to receive ANC from a professional nurse. This enables nurses to diagnose pregnancy-related risks earlier, do HIV testing and counselling, initiate Prevention of Mother-to-Child Transmission if needed, diagnose abnormalities in pregnancy, birth delivery and PNC. More specifically, two professional nurses indicated the following:

I am doing antenatal care, which is for pregnant patients on its own and we have a scan. We can do auto sum-scan for the patients, so to see how far is the pregnancy and we can also diagnose through that if there is any abnormalities and then refer to the respective areas (KII1).

Its HIV counselling and testing, Prevention of Mother-to-Child Transmission diseases. After they have delivered, they must come for postnatal visits and for immunisation (KII2).

4.4.1 Health-seeking behaviour

It emerged that many of the participants did not visit the clinic during their first trimester of pregnancy (first 12 weeks or three months). Of the few participants who had visited the clinic during the first trimester, the following reasons were provided:

I was 4 to 5 weeks. My energy levels were different, and I started to feel nauseas and vomited. I could not walk for long distances as I began to get tired easily (P1, FGD1).

I came to the clinic at two months. The nurse who attended to me asked me why I had come so early for ANC services (P2, FGD2).

I became suspicious after I missed my period. I went to the clinic and tested because I had missed my periods (P3, FGD2).

Most of the women visited the clinic after their first trimester, between four and six months. The reasons why women visited the clinic so late in their pregnancy included concerns in changing eating habits:

I was 4 months pregnant because I had started to have some cravings of nasty foods and I didn't like meat too (P1, FGD2).

I was 3 months pregnant because I had started not to eat some certain foods. I also wanted to test for HIV so that the child is protected as early as possible (P2, FGD2).

Some women presented late because they did not realise that they were pregnant:

I was 6 months pregnant and I did not know that I was pregnant. I was still going on my periods. When I eventually knew, I had bled for a whole month, I went to the clinic for assessment, and that is when I discovered I was pregnant (P3, FGD1).

Another woman preferred to only visit the clinic when necessary in order to avoid long waiting times:

I was 5 months pregnant. I came at 5 months because I was avoiding coming earlier on because it is boring to come and sit here the whole day (P4, FGD1).

The number of ANC visits that the women attended varied, with some women attending less than the required eight to ten times, while other women attended more visits. Reasons for attending less visits than required included late registration for ANC or that the number of visits was being restricted by the visiting dates provided by the clinic:

It was six times and I was visiting the clinic weekly (P1, FGD1).

I am 8 months pregnant and I have visited the clinic about 5 times. I follow the dates I am given (P2, FGD2).

I am 8 months pregnant and I have visited the clinic for about 5 times as per the dates given (P3, FGD2).

Women who exceeded the number of prescribed visits did so due to higher risks experienced during the pregnancy. This included late births (going over the nine months):

I visited the clinic many times until the day I was supposed to give birth on passed. They told me to wait for a week and they ended up transferring me to Mamelodi Hospital. I eventually gave birth at 10 months. So approximately numerous times, as I came every week until I gave birth (P1, FGD1).

It was approximately 15 times because I gave birth when I was 10 months (P3, FGD1).

Expecting twins was another reason for exceeding the number of prescribed visits:

Ten times. I visit the clinic twice a month since I am pregnant with twins. They consider me as a high-risk patient, hence two visits a month (P8, FGD3).

Concerning the place of birth that mothers preferred for delivering their babies, it emerged that some women chose for themselves and for some, the place was chosen for her. It was also circumstantial. However, for the women who made their own choices, the choices were influenced by the probable treatment they envisaged and closeness of the health facility to their homes, such as the following reasons:

I gave birth at Mamelodi because I knew that they would treat me without transferring me to another hospital even if I had any type of a complication (P1, FGD1).

I gave birth at Clinic B because it was near my home. My contractions were bad, I wanted a shorter distance (P2, FGD1).

I gave birth at Mamelodi because they had to perform a C-section (P3, FGD1).

One participant revealed that she was a high-risk patient and was told she would have to deliver at Mamelodi Hospital in Pretoria:

At Mamelodi Hospital because of my age, they booked me there (P5, FGD2).

Another participant cited that she preferred a home delivery rather than at a health facility:

I want to give birth at home because I find it simple to do so. I enjoy it that way (P3, FGD3).

4.5 FACTORS FACILITATING ACCESS TO MATERNAL HEALTH CARE SERVICES

The following sub-sections describe the aspects that made it easy for mothers and pregnant women to access maternal health care. These elements are explained according to three levels of the Social-Ecological Model: individual, interpersonal, and organisational (no facilitators were mentioned at the community level).

4.5.1 Individual level

4.5.1.1 Knowledge of maternal health care services

Many women had knowledge of the importance of MHS (see section 4.3.4). They made regular visits for ANC and honoured appointments as scheduled by the nursing staff. This ensured that continuous assessments of pregnancy were observed. The key informants affirmed this when they mentioned the following:

Yes, they do come. I must say my patients do come regularly when they are supposed to and they will be someone who will not come obviously; but most of our patients, they do attend on the day that we give the m and they come punctually to the visits (KII1).

4.5.2 Interpersonal level

The following sub-sections describe the influence and support rendered by partners and family members in encouraging maternal health users to access ANC, birth/delivery, and PNC services.

4.5.2.1 Support from partners

Many participants indicated that their partners/spouses were knowledgeable about maternal health care, including the need to attend ANC visits and visit the clinic if any health-related problems were experienced during pregnancy. As one participant said:

Yes. Whenever I am not well during pregnancy, they encourage me to visit the clinic and get immediate assistance without any delay (P2, FGD1).

In terms of physical support during pregnancy, the research findings revealed that most partners were supportive in several ways. Some assisted women with household chores:

Yes, he even helps me with house chores. He even asks what I would be craving for regularly. If I am not feeling well and cannot do chores, he encourages me to go and rest while he does the chores. So, I do have support from him (P2, FGD3).

Some rendered emotional and financial support:

Yes, he supports me financially and emotionally (P3, FGD3).

Others encouraged visits to the clinic and showed interest in acquiring feedback on ANC clinic consultations. Three participants mentioned the following:

Yes, he always reminds me to go for check-ups at the clinic. He even reminds me of the dates for check-up. He is very encouraging (P2, FGD3).

He does. My health is not 100% fine and he is supportive and want to know all that happens to me (P7, FGD3).

He is always away but he does encourage me to go to the clinic because there are some things I experience that we both do not understand and have to seek understanding from the clinic (P3, FGD3).

Some women indicated that even although they were not staying with their partners, they were financially supportive and took care of everything the pregnancy required:

I do not live with him because of his work. However, he sends me money in order for me to get all I need (P5, FGD2).

Other women revealed that their partners were working in other areas and were not staying with them. However, when they visited, they supported them physically:

I do not stay with him. He is working elsewhere. However, whenever he is around, he treats me well and massages my feet (P6, FGD2).

Men sometimes accompanied their partners for ANC visits:

He did the other time we went to the doctor. Sometimes, he does accompany me to the clinic and waits outside the clinic until I am done (P2, FGD2).

Another participant elaborated on her partner's concern for her well-being:

He is the one who encouraged me to visit the clinic and he came with me on my first visit and also on my second when I had an infection (P2, FGD1).

On the other hand, some women explained that there were times that their partners could not accompany them to ANC visits due to work constraints or because they did not live together:

I do not live with him. Therefore, he will not be available to do so (P5, FGD2).

The key informants confirmed that some men did accompany their partners for ANC visits:

I have found a few patients who are accompanied by their boyfriends or husbands, maybe they do encourage them at home (KI2).

If they are not on duty, they do accompany them; at times, fathers do bring the children without mothers (KI3).

The findings from the FGD with pregnant women revealed that some partners were not prescriptive about where the delivery or birth should take place as long as it was safe. On the other hand, some men seemed uninvolved in the decision where the delivery or birth should take place:

He has not said anything yet. Probably he does not mind where I deliver (P1, FGD2).

They do not care as long as you come home with a baby (P3, FGD3).

One pregnant women mentioned that her partner preferred a private health care facility as opposed to a government health care facility:

In my case, he prefers a private hospital but I do not want to because it is too expensive and we will struggle after the baby has come (P3, FGD3).

Mothers who had given birth in the past 12 months provided more information about their experiences with their partners during childbirth. Some mothers reported that their partners were present during childbirth:

He was there because he forced himself to be there. In that hospital, there are nurses who ill-treat patients. So, he wanted to make sure that I get treated well (P3, FGD1),

Others reported that their partners were not allowed in the labour rooms:

He was not there. Because in public hospitals they do not want him to be in the delivery room (P1, FGD1).

Some participants reported that their partners were very supportive after birth/delivery. The partners assisted them with chores, provided for the new-borns and encouraged them to visit the clinic for PNC. A participant elaborated:

Yes, he used to cook for me and buy all the necessities. Moreover, he still provides (P2, FGD1).

4.5.2.2 Support from family

Family support is vital during pregnancy. From the research findings, it emerged that some families (parents, mothers-in-law, sisters, and grandmothers) offered support to women during pregnancy: One such example of support was taking an interest in ANC visits:

My mother supports me well. Whenever I have an appointment to visit the clinic, she wakes me up to prepare going for the visit. When I come back, she is keen to know how the visit was like and if all is well in my pregnancy (P2, FGD2).

Furthermore, some family members provided support by also attending ANC visits:

My cousin sister supports me because I do not have parents. She accompanies me to the clinic (P4, FGD1).

Family members also took care of other children at home:

Yes, they would stay behind at home looking after my other child. Then in some cases, my mother used to come and queue for me early in the morning at the clinic when I had an appointment (P2, FGD1).

One participant also noted that family were very supportive: They would queue up for me and bring me lunch at the clinic if I am not back at home before 12 noon (P3, FGD1).

The participants also emphasised that their families were excited about having their first grandchildren:

I get support from both families because it would be their first grandchild (P2, FGD3).

When it came to deciding where to give birth, some participants cited that their families did not interfere with this decision. Their main concern was that they should give birth in a facility where they would be treated well as explained by one participant,

My mother wanted me to give birth at Mamelodi because that is where she gave birth to all her children. Therefore, she regards it as number one (P5, FGD1).

This sentiment was echoed by another participant who stated that

They prefer Clinic B because that is where my mother gave birth. However, my aunt gave birth at Mamelodi Hospital and she says I must go to Clinic B. She says I will not cope at Mamelodi because of the tenderly care I need (P2, FGD3).

There were also participants who indicated that they had not discussed the issue with their families. They only had that conversation with their partners:

We haven't spoken about it. She only related that I was a premature and she got good treatment at the Kalafoni Hospital where she delivered at (P6, FGD3).

We have never spoken about it with my family. I only spoke to it with my husband (P7, FGD3).

4.5.3 Organisational level

This section describes the factors that facilitates access to maternal health care at organisational level. These factors include geographical location, provision of maternal services, friendly staff, provision of medicine, provision of park homes for quicker service, desire for a ward book, access to other key services provided through referrals, community outreach team, maternal programmes and efficient transportation (ambulances).

4.5.3.1 Geographic accessibility and transportation

Most of the participants reported that Clinic A is centrally located in Rethabiseng. Many participants who resided in Rethabiseng walk to the clinic without any problems. This meant that they did not have to use money to board taxis. One of the key informants working at Clinic A indicated that the clinic was easily accessible for the Rethabiseng residents:

I think our clinic is accessible to them (KII3).

Similar findings emerged for Clinic B. The immediate community could access the clinic easily. The challenge was for the surrounding communities like Rethabiseng who referred their patients to Clinic B for birth delivery services. A key informant said:

I must say the distance I think that is one thing we go to the 4 km radius except for the people that are staying in Rethabiseng, that's a different story. But if you are staying round the corner, the facility is close by and you can walk (KII1).

Improved ambulance response times was another factor that helped women access MHS at Clinic B:

We used to wait for 4 hours for an ambulance from our facility to go to Mamelodi, I'm talking about 2011, now the waiting period is no longer 4 hours, it came to 10 minutes to half an hour because the ambulance facility is behind our clinic but I am not sure of the patients from outside, they are staying further and for them, they are waiting longer periods for ambulances (KII1).

4.5.3.2 Infrastructure and resources

The addition of park home structures at Clinic A increased the number of consultation rooms at the facility. Before park homes were donated as the clinic is small and maternal patients used to complain about sitting in one queue with other patients waiting for the few consultation rooms. A key informant cited:

They used to complain that the facility was too small and since were donated this park home, now there is a professional sister, a professional nurse, who works there all the time so that encourages them to come (KII2).

Another participant added that consultations rooms have increased from three and as a result, service quality has improved:

I think it is now better since we have this Park Home. Previously it was difficult because we had only three consultation rooms. One was being used by the doctor and was only accessible after 12 noon when the doctor has left. But since we have this Park Home, the services have actually improved (KII3).

This sentiment was echoed by one of the mothers accessing PNC services at the clinic

They have now changed their system. Mothers with babies go to the other side and this increases efficiency. They no longer queue in the same queue with outpatients and this is a bit quicker when compared to one long queue where everyone waits to use the same consultation room (P1, FGD1).

Medicine was reportedly always available at Clinic A as noted by a key informant,

What I have noticed is that we are always having medication in case of any medication stock out; we give an emergency order (KII3).

Another Key informant agreed,

The ARVs, the government is trying to keep continuous supply of the supplements (KII2).

4.5.3.3 Friendly and positive health care providers

The participants mentioned that one of the factors that encouraged them to visit the clinic was friendly and positive nurses. There are nurses who always carry a positive energy and conduct their consultations without being judgemental. One participant commented,

I am just grateful for two members of staff. Sister A and Sister B. They are the friendliest nurses around and the best service providers (P1, FGD1).

This sentiment was shared by another participant who stated,

Sometimes when you are supposed to visit the clinic, you are discouraged when you think of the service. However, when you think of the service rendered by Sister A and how she communicates and relates with patients, it encourages you to come (P3, FGD1).

Another participant explained,

There are some nurses that are friendly and patient who do their work expeditiously with patience and honesty. They give you good advice on to do certain things and even speak to you privately in the absence of your partner. They listen to your challenges and problems and they assist you (P3, FGD1).

One of the key informants cited that positive staff attitudes encourage women to attend ANC visits. She added that during their own staff meetings, they emphasised that staff should handle patients with great care:

When it comes to staff attitudes, the staff are always good because we emphasise on it during meetings ... Every time we have a meeting, we deal with staff attitudes. We also induct all newly appointed staff of the right attitude (KI13).

Pregnant women reported that a positive attitude and good service from midwives informed their choices on a place of birth delivery and encouraged them to access maternity services at health facilities. Participants shared the following:

I want to give birth at Clinic B because of the good service I received when I delivered my other child. Prior to that, I had given birth at Mamelodi Hospital and when I compare the two places, I was treated well at Clinic B (P1, FGD2)

Clinic B because I am satisfied with their service delivery. It is going to be the third time I deliver there (P2, FGD2).

4.5.3.4 Ward book

The key informant participants identified the clinic requirement for all pregnant women to have a ward book as a facilitator for maternal health care. Pregnant women who came to the clinic for late ANC registrations highlighted that they were only concerned about getting a ward book. According to one of the participants, a ward book is

... the booking booklet; so it is the maternity case record (KII1).

The ward book permits pregnant women to deliver at a health care facility that offers birth delivery services. Without the ward book, it would be difficult to be admitted for birth delivery. The key informant participants said:

They just come to get the card for them to go to the hospital ... they tell you that they just came for maternal care card in order to have a birth delivery place secured (KII2)

So those are the things that we do see and some of them just come to the clinic to get the ward book which is very bad because if they are HIV positive, there is a chance of the baby contracting it (KII1).

4.5.3.5 Community outreach

The clinic at Rethabiseng has community outreach teams – Ward-based Outreach Teams – that visit mothers and pregnant women who are registered for maternal services at the clinic. The Ward-based Outreach Teams also supply antiretroviral drugs:

We give them a one-month supply of medication and we have records that they are supposed to come back (KII2).

One of the mothers indicated that an outreach worker had visited her at her home:

... some educate you and help you. There is one that came to me doing her job as expected. She was sent from the clinic and she came as anticipated. She had indicated the date she would come, and she came when I least expected her to do so (P2, FGD1).

At Clinic B, Mentor Mothers are another outreach-based team that is sent to assist registered patients in the communities. The services offered by the Mentor Mothers were reported to be effective and encouraging for the maternal users' health-seeking behaviour at the clinic. A key informant explained:

Mentor mothers actually assist the pregnant women on how to breastfeed, they assist the women that have tested HIV positive, they have support groups and they have play corners for the children, those type of things, so they actually do help a lot with things that we do not get to (KII1).

She further added that all facilities should have Mentor Mothers since they fill in gaps that nurses cannot do:

We actually spoke about if each and every facility can have Mentor Mothers because the Mentor Mothers make a big difference. Since they have been with us, the HIV positive testing rate of babies have decreased and their impact on the community is very big and assisting us with health education (KII1).

4.6 FACTORS DISCOURAGING WOMEN FROM ACCESSING MATERNAL HEALTH CARE SERVICES

Several barriers emerged from the experiences that pregnant women and mothers encounter in their attempts to access maternal health care. These barriers will be discussed using the Social-Ecological Model as a guide.

4.6.1 Individual level

4.6.1.1 Lack of knowledge and poor attitudes

A lack of knowledge and poor attitudes towards maternal health care were identified as barriers to accessing MHS. A key informant noted that many women registered late for ANC and thought that this was because of insufficient knowledge, ignorance, poor attitudes, and indifference:

I think some are ignorant because it is posted everywhere the importance and we do have mothers that inform them, but they still ignore the fact. We still have late booking patients for ANC when they are about to deliver. Therefore, I think they are ignorant despite information being there. They do not listen (KII1).

The key informants added that most women do not register for ANC in the first trimester as expected. They registered after 20 weeks and it deprived the nurses the opportunity to pick up pregnancy-related risks at an earlier stage. It also made it difficult for nurses at that late stage to prevent the child from contracting HIV if the mother is positive. The key informants said:

We have some challenges. People here, I do not know, maybe its culture related are not starting ANC earlier. Most of them they are starting 20 weeks late whereas we want them to start earlier so as to examine and diagnose them so that if there is a problem, we treat them early (KII3).

It's a challenge especially if they come at 36 weeks with late bookings but we do give them the service but it's a challenge because there are lot of things that we are doing which they would miss during the ANC visits. The most important one is the HIV counselling. You find that the patient comes when it is time to deliver and you find that the baby is now exposed which and we could have protected the baby during ANC (KII2).

4.6.2 Community and social level factors

4.6.2.1 Cultural and traditional beliefs

Cultural and traditional beliefs have been impeding women from accessing MHS timeously. The key informants indicated that many women register late for ANC as they believe that if they register early, they may lose the baby through miscarriage. As a result, they hide their pregnancies and only register when the physical signs begin to show. One key informant explained:

In some cultures and religions, they believe that if they book early they will have some miscarriages but the problem is if they don't book as soon as they find out that they are pregnant, we have a problem then they don't get the vitamins that they are supposed to, then we end sitting with a problems like neurotubule defects. (KII1).

It was also indicated that women hide their pregnancy in the first trimester for fear of being bewitched:

According to the way I heard them they tell you according to their mother's and granny's experience, when you are pregnant, you are not supposed to be seen by other people until the pregnancy is visible. So, once they come to the clinic, everyone sees them, and they think that they might be bewitched and lose their babies (KII2).

Furthermore, several traditional practices were revealed that discourage women from accessing MHS:

They give them these mixtures to make them go into labour, it affects them very badly, and they put funny things on the baby's umbilical cord, so this does affect them. They are discouraged from drinking orange things because the baby will become orange. It is those basic beliefs. In addition, they eat soil and cannot stop eating it. They say it taste like chocolate (KII1).

Practices such as eating the soil during pregnancy are harmful to the foetus:

It can be harmful to the child and it can break down the baby's immune system and the mother may bleed to death when they continue eating the soil, or if they put charcoal or cow dung on the baby's umbilical cord, it may lead to death if the mother did not get a tetanus injection during her pregnancy. Especially if the patient is not from our area, it leads to serious problems (KII1).

Cultural beliefs and male dominance also hinder women from taking family planning measures. As a result, they get unplanned pregnancies. A key informant explained:

Because of their cultural beliefs, most do not use family planning. So that is also another problem we are sitting with which means most men do not condomise, especially the foreigners. Foreigners usually have a problem and have a dominancy over their wives. The wives do not have the right to say anything and if they use family planning, they use it without the man's knowledge (KII1).

4.6.3 Organisational factors

4.6.3.1 Geographic accessibility and inefficient transportation

Participants residing in Extension 5 in Rethabiseng reported that the clinic was located at a considerable distance from them. It also emerged from one of the key informants that people residing at surrounding farms are 20–30 km away from the clinic in Rethabiseng. These two groups found it difficult to frequently visit the clinic and public transport for them was also a problem. The participants said:

As for me, I struggle. I stay in Extension 5 and it is quite a distance. It is even worse when you are pregnant, I would walk to the clinic and feel exhausted before I get there. I would then seat down to rest before I resume the walk. At that time, I am already thinking that I will still have to wait for long when I get to the clinic again (P1, FGD1).

Some stay far from the clinic. It is about 20–30 km from here. There are farms around Rethabiseng, other go to Bronkhorstspuit and others come to Rethabiseng (KII2).

The research findings revealed that distance kept women from accessing ANC services. One of the key informants indicated that because of distance, most women tend to prioritise going to the clinic once to acquire a maternity case record (ward book) that would enable them to be accepted for delivery when in labour. The participant said:

The other challenge is for those women who stay far they don't come for antenatal care visits they just come to get the card for them to go to the hospital. Other ANC services they miss them. They tell you that they just came for maternal care card in order to have a birth delivery place secured (KI2).

An inefficient and ineffective transportation system was one of the challenges participants mentioned as hindrance to quality MHS. The response time of ambulances was poor in Rethabiseng. An ambulance took long to come when one called for it while in labour. One participant said:

The ambulance takes 5 to 6 hours to come and if you are in labour, you will deliver at home or on the way (P1, FGD2).

In some cases, it was reported that the ambulance would not show up at all:

I called the ambulance when I was in labour and the response I got was that they were washing and cleaning the ambulance. I was having contractions already and I had to look for transport to take me to a delivery facility (P3, FGD1).

Sometimes, you call an ambulance to take you to Clinic B and it does not come (P1, FGD3).

It was also reported that ambulances were not readily available to service their feeder areas. One would call for it and was told that it was in another area:

I once called an ambulance and I was told that it is at Clinic B or somewhere else, not in Rethabiseng. They then said they would call the one in Johannesburg and then Bronkhorstspruit to see if they can assist. The ambulance took more than 3 hours to eventually come to my home. By that time, I had already delivered and was discharged at Clinic B. The ambulance response time is just too long. (P2, FGD1).

Participants highlighted that the inefficient ambulance emergency system forced some women to have home deliveries. One participant indicated that she delivered at home after realising that she would not make it to the clinic timeously:

I gave birth at home because it was late for me to go to the clinic. I even called the ambulance and it did not show up on time despite it indicating that it was on its way. I then ended up delivering at home (P4, FGD1).

Other participants indicated that the ambulance staff were rough and unfriendly. They drove recklessly, not considering that they were carrying women in labour. One of the mothers mentioned:

The ambulance crew are carefree when they drive. They speed up and do not take caution when they approach humps. They just drive fast, you are in pain, and then the ambulance adds on to your pains too. In all this, you must persevere (P3, FGD1).

Another participant added that the ambulance staff do not take pleasure in transporting pregnant women. Instead, they prefer to use alternative transport when in labour:

They are not friendly. They do not like taking pregnant people. They always say you must have your own transport (P2, FGD1).

4.6.3.2 Poor infrastructure and inadequate resources

The participants reported that the infrastructure at the clinic was poor and that the clinic was too small to cater for the entire community that it served. Lack of space also impacted on privacy at the clinic. The participants complained that during consultation sessions, other nurses or staff would walk in when one is naked:

Sometimes when they are checking you, another sister just walks in while you are naked and starts chatting. There is no privacy at all, and it makes us feel uncomfortable (P1, FGD1).

Yes, there is no privacy (P2, FGD1).

Another participant raised concerns about the lack of toilet facilities:

There are only two toilets and one bed. The toilets are clean, but we feel they are not adequate for the people that are served here. They are just too few (P1, FGD1).

Participants were also concerned about the lack of equipment like a sonogram system to show if the foetus is in the right position in the womb. This made both access and rendering of MHS difficult. The health care workers are forced to use their hands on the pregnant women's stomach to establish the position of the child, which is unreliable. One participant noted:

It is difficult because there is no Sonar. Most of the services that are needed by pregnant women are not available (P1, FGD3).

The nursing staff affirmed that the unavailability of the sonar made rendering of services difficult at Clinic A. Nurses end up referring the pregnant women to other health facilities. A key informant said:

Sonar. That is the only equipment that we do not have, so if we query something, we have to refer them (KI2).

The key informant further added that she had requested for a budget for a sonar machine several times over the years. However, the authorities have not allocated any to the clinic. This makes it difficult to effectively render maternal services. The participant mentioned:

Yes, we do but they say we don't have the budget but maybe next year because I have been requesting for it for a very long time (KI2).

Pregnant women felt that if the clinic had a sonar,

... this would be advantageous and encourage us to attain maternal services here. It would stop the referrals of being asked to go to Mamelodi Hospital (P2, FGD1).

Furthermore, because of lack of adequate equipment, some pregnant women indicated that they went to private doctors and to Sunshine, a private clinic for maternal health care. The participants cited that Clinic A used old methods of checking for pregnancy, which were unreliable. To be certain of pregnancy, they would rather opt for private doctors and clinics:

At this clinic, we do not have a Sonar. They are still using the old method of checking the heartbeat of the child. Therefore, I preferred having a solid affirmation that I was pregnant before I came to the clinic so that I give them something concrete to work on. Sometimes, because of the old method they use, they tell you that you have twins yet you do not have them (P1, FGD1)

I visited the clinic twice and the results came out negative, then I went to a doctor who then told me that I was 5 months pregnant (P2, FGD3).

Concerns were also raised that where equipment was available, it often malfunctioned and needed to be replaced. Several women reported that the scale did not function properly, and it gave incorrect readings:

If they could change the scaling machine, that would be useful. It is not properly working. At one point, they said I weighed 157 kg. The next visit, it said 107kg. I then asked myself, how have I lost 50 kg in my pregnancy, yet I could see I was gaining in weight (P1, FGD1).

The glucose meter was also reported to be malfunctioning:

They tested me at 13:30 and did the tests several times. I do not know what was happening to their machine because the sugar tests gave high results of which I am not diabetic (P1, FGD3);

As was the Foetal Doppler,

They need to upgrade their machine for checking the baby's heartbeat because sometimes it sounds right and at times it does not. It even gives you a scare because sometimes I do not hear any sound and then at times I hear as if the sound of the heartbeat of the child is beating on me (P2, FGD3).

Lack of resources hindered access to MHS at Clinic A. The participants indicated that there were numerous times they failed to acquire the services they had envisaged to access. In some of the cases, they had to go back home unattended and in other cases they had to return to the clinic on another day in pursuit of the same service:

As for me, I have a problem with my sinuses. They always tell me that they do not have that medication and I must go and buy at the chemist (P3, FGD1).

The participants mentioned that both Clinic A and Clinic B occasionally ran out of medication for maternal health users and medical supplies for the maternity ward, respectively. According to the participants, it is not something that occurs regularly but when it happens, it a challenge that would make their work difficult to render quality health care. The participants mentioned the following:

Yes, we give them iron supplements and the challenge is that it's sometimes out of stock and those who are financially stable buy them from the pharmacy (KII2).

We do sometimes run out of stock but it doesn't always happen, but there was a time we didn't have gloves, there wasn't any certain syringes and these things happen unfortunately, not that we bargain for that, but they do happen (KII1).

Other than lack of resources, the key informants reported that Clinic A offered limited services. Birth delivery was one MHS that was not offered at Clinic A. All women who attended ANC visits at the clinic were referred to the following facilities: Clinic B, and the Bronkhorstspuit, Mamelodi or Steve Biko Hospitals. The participants said:

We don't deliver here. When they are in labour, we refer them to Clinic B, Bronkhorstspuit, or Mamelodi. If it is a high risk that is when we refer you to Mamelodi (KII2).

We give them maternal health education that they should call the ambulance if in labour and go straight to Clinic B or Mamelodi Hospital (KII3).

4.6.3.3 Shortages of human resources

Some key informant participants reported that the shortage of health care workers was another barrier to accessing services. As result, they struggled to service old and new

patients who visited the facility daily. New patients required more time since the initial registration of ANC requires a lot of background and history note taking. One key informant participant said:

We do not have enough hands on the floor to attend to all of them. Like I have said, we see between 300 to 400 patients monthly and the earlier they book, the better for us. But the problem is now to open those maternity case records for them. So, we do not have enough hands. So, if we see four new patients a day, it's a lot. Because it takes us an hour and a half to take one new patient to make sure we have all the history taking down and then we render quality health care (KII1).

Furthermore, the findings revealed that there were two nurses working with maternal care patients at Clinic B. The situation sometimes became dire when one of them was absent from work because the one nurse who was present could not manage the workload single-handedly:

If one of us is not here, no one can attend to the pregnant women because we are the ones that are specialised (KII1).

Some FGD participants felt that there was a shortage of nurses at Clinic A; hence, the long waiting periods. Others felt there was enough workforce, but it was poor service delivery and slowness that prevented them from accessing the services. Some participants were convinced problems arose when staff were absent from duty:

Yes. They are short staffed and that is why they are slow (P1, FGD2).

It was reported that some pregnant women who have been referred from Clinic A to Clinic B for birth delivery complained of staff shortages. One key informant indicated that women were not always happy to get a referral to Clinic B because of staff shortages. The women described their bad experiences where some of them got a further referral from Clinic B to Mamelodi Hospital and ended up delivering along the way. One key informant explained:

Most of them complain when referred to Clinic B; you find that there is not enough staff and they are further referred to Mamelodi because of shortage of staff and some of them even deliver in the ambulance on their way to Mamelodi (KII2).

4.6.3.4 Staff burnout and frustration

Staff burnout and frustration was identified as a consequence arising from the immense workload resulting from human resources shortages. This workload led to

staff frustration, burnout and sometimes sicknesses. One key informant mentioned that working under such circumstances led to sickness and frustration:

Not really, but you do get frustrated and you end up getting sick, but you try your best to not let it affect you (KI1).

4.6.3.5 Inflexible working hours

Participants mentioned that inflexible working hours at the clinic restricted maternal health care users and discouraged health-seeking behaviour. The operational hours did not allow an individual to access the clinic at any given time when the need arose. Some women worked during the day and preferred to visit the clinic after work. However, the current operational hours of 7:30 to 16:00 at the clinic did not permit this. The key informants elaborated:

Others [patients] ask when we are going to start working long hours because they work in far areas (KI3).

Others do mention that if they are working, their employers don't allow them to come to the clinic during the day because it's going to be a whole day thing. They end up going to the private clinics (KI2).

4.6.3.6 Poor service delivery

Some participants reported that poor service delivery made it difficult to access maternal health care. It was indicated that the clinic staff did not put the needs of patients first and were slow in providing services.

Sometimes you find that the nurses delay doing the BP [blood pressure] check-ups (making their own tea) and the doctor is already there waiting. When his time is over, he leaves without attending to patients since he would be needed elsewhere. If he is at the clinic for two hours, he sticks to that (P3, FGD3).

They also engaged in unnecessary meetings during office hours,

They hold meetings in the morning, and they are quite long. At least they should have the person dealing with pregnant women ready every time so that we do not wait for long and get hungry while waiting for service (P1, FGD3).

It also emerged that the clinic was once burnt down by the community because of poor service delivery:

Sometimes, we are happy to use the clinic in Bronkhorstspuit and Clinic B because of poor services here in Rethabiseng. They once burned down this clinic before (P5, FGD1).

Some participants were of the opinion that the Staff at Clinic A were not always truthful during service delivery and lied about the availability of medication at the facility. The following quotes illustrate this problem:

Yes, there was a time when my child was sick with sores in his mouth. I visited the clinic for proper medication, and they told me that they did not have it and said I should go and buy it. It is not like they would not be having the drugs and medication, but it is because they do not want to give out the medication. Even when you have a paining back and ask for Rub Rub, they will tell you that they do not have it, yet it would be there. I do not know why they do that (P2, FGD1).

If you bring a child with flu, they will tell you that there is no medication. They will then recommend a home remedy solution of honey and lemon (P3, FGD1).

The clinic must improve the medication variety and stock. There are some pregnant pills I used to get from my previous clinic, Pretoria West. When I came here, they have never given me those and they say they do not have them (P1, FGD3).

There are so many pills here, but they do not just give. There are some other brown pills that my friend got but I was not given. I only got two packets with white pills. We are supposed to get a similar service when pregnant, but they do not (P2, FGD3).

4.6.3.7 Long queues and waiting periods

Many pregnant women and mothers complained about the long queues and waiting periods at Clinic A. The participants reported getting up early in the morning so that they could arrive early at the clinic:

I can say it is difficult accessing services considering the waiting period you spend at this clinic. After all, we would have woken up early in the morning only to be kept waiting (P1, FGD2).

Despite this, they still had to wait in long queues as time was wasted by staff. The clinic was supposed to start rendering services at 07:30 but they only did so after 09:00. According to one participant:

When we arrive in the morning, they start with a devotion. They then ask for our appointment cards. They then give us numbers that are followed when services are being rendered. They ask for the baby cards and then give you numbers. After a very long period of probably two hours of waiting, that is when they start to give people

files. Then they start the BP [blood pressure] check-ups. When it is your first time, you become impatient but for those that are experienced, you just patiently wait. The service delivery of this clinic is very poor (P3, FGD1).

Furthermore, participants cited that time was wasted by health professionals who prioritise chatting to one another during working hours at the expense of queuing patients. As one participant indicated:

In my case, I have never come to the clinic and found them serving fast. I always wait long and get poor services (P3, FGD1).

Another problem was that patients were not attended to over the lunch hour:

I would love the nurses to do shifts during lunch because you seat and wait for them to return without anyone being served. I have visited the clinic three times to date and it is always the same trend (P1, FGD3).

In addition, women with babies were not prioritised at the clinic:

With me too, I have never been served within a short space of time. When one comes for postnatal check-up of 3 days with the baby, one is supposed to jump the queue. However, I was here in the morning with the expectation to jump the queue, but I left after 12 pm (P4, FGD1).

4.6.3.8 Attitudes of clinic staff

There were numerous complaints about staff attitudes at the clinic, which were confirmed to be a problem by a key informant:

There are some nurses that discourage them. Their attitude does discourage them especially when we are fighting with them but some of them we do fight with them and we explain to them that what they are doing is wrong and will end up harming the baby and it is our job to get you healthy. Some of them think we fight with them for booking late and they book even later. With their attitudes, they are scaring them off. They do not want to seat in the clinic the whole day, only to end up fighting with a nurse (KII1).

Some pregnant women noted that the staff were inattentive. They tended to waste time unnecessarily and easily digressed from attending to patients. They enjoyed chatting to one another instead of serving patients:

The staff is there but the way they work leaves a lot to be desired. The staff loves gossiping and spend most of their time on that (P2, FGD1).

Three examples of this behaviour are highlighted.

First:

During one of my visits, a nurse doing BP [blood pressure] check-ups was not entirely focusing on conducting the check-up on me and had to eventually repeat the process 7 times on me because of distractions. She would talk and chat or go somewhere for a while and then come back and restart the check-up. The BP machine presses hard on your hand to get a reading and it is painful. She has attitude too (P6, FGD3).

Second:

The sisters (nurses) are not the same. Some are good and professional, and others are not. One nurse once attended me, and she left me in the consulting room for a very long time. I had the impression that she had forgotten me. When she eventually came back, she then hurriedly injected my child at 6 weeks and my child swell from the injection. When I got home, my husband said I should not go to the clinic anymore after this ordeal (P4, FGD1).

Third:

On Friday I came to the clinic for a visit, they could not fully attend to me and I had to come back yesterday. I have pains on my abdomen, and I have previous history of a miscarriage. Had it not been for this, I would not have come here. I prefer going to Zithobeni Clinic because of the attitudes nurses give you here. I would never come here again. They have attitudes too much (P4, FGD3).

Participants also noted that nurses were insensitive, uncaring and impatient.

Quotes reflecting the insensitive attitudes of nurses included:

There is this one nurse who would ask you weird provoking question questions like, did you really wanted to have a child? Do you work? How old are you? Questions that make you feel belittled and interrogated (P3, FGD3).

I came on Friday to verify my pregnancy at an early stage since I had a miscarriage last year. They started to shout at me as they opened a file, asked me questions, and was supposed to do an HIV test. I was then told to come back on Monday. I do not even know why they could not complete my consultation because there were not many people that day (P1, FGD3).

There was a time when I came to the clinic asking them to attend to me earlier than my given date because there had been bereavement in the family and was supposed to be going to attend to it. They refused to understand and turned me back without any assistance citing that I must wait for my date (P2, FGD2).

Nurses' uncaring attitudes were explained in the following quotes:

There was one woman who came in labour with her parent. They gave her attitude citing that she comes here when in labour, yet we do not have delivery services. They do not want anyone who comes there even when in pain for delivery (P5, FGD3).

I am pregnant and was bleeding last week. I could not understand this situation I was in and I visited the clinic for assistance. When I got to the clinic, the bleeding had stopped. The nurses said that they could not help me as they cannot tell there was any bleeding (P4, FGD3).

When I came for a 6-weeks postnatal care with my child, I was asked to do a urine test. She asked me to hold the small glass, which is not the standard size. It was difficult to use it as you end up urinating on your hand. What made it more difficult was that I was breast-feeding my child at that moment. That is wrong considering that the proper glasses for urine tests are there. She is just lazy to take them out for use, as they will have to be washed afterwards (P8, FGD1).

I had a severe problem of a heartburn. I would vomit blood when I had it. That is how bad it was. They never helped me with anything. Instead, they said its normal and it happens with pregnancy (P4, FGD1).

Nurses were also impatient with pregnant clients:

I came to test for pregnancy for the first time. A nurse assisting me had attitude and was impatient. She took a urine test and as it was processing to give a result, she started to complain citing that it is taking too long. I then told her that it is her job to test and wait until it gives a result. She then carried on complaining that the queue is too long and there are many people still to be attended to. I told her that they should have started on time and she would not be complaining. The test eventually gave a result and if I had not insisted on waiting for the result, I am sure I was going to be turned away without the result (P7, FGD3).

Some participants complained that nurses did not respect them:

I always have a quarrel with one of the personnel. Her attitude and service are too bad. Her attitude upsets me. When you tell her that you do not want to do something, she does not respect that, and she would forcefully do it still. I remember telling her not to do a sugar test, she still went on to do it forcefully. I asked her why she was doing so without my consent and she said she has the consent as a nurse (P5, FGD1).

Concerns were also raised regarding unethical and unprofessional behaviour of clinic staff. A participant provided an example of such behaviour:

Service is not right. They do not do pre-counselling or inform minors on what they would do to them. My 12-year-old child came for an injection without any company.

She was tested for HIV by a nurse without the parents' consent. This did not go well with me because if she was positive, how was she going to tell her the outcome? How was she going to handle it? (P4, FGD1).

Numerous concerns were raised regarding judgemental attitudes of nurses:

Someone will judge you on the way you look. You do not even understand why they look you in that way, yet you know it is inappropriate (P3, FGD3).

Yes. They judge you here definitely when you are pregnant. They said provoking and infiltrating things to me. In my case, I am pregnant with twins. They make it seem like it is a problem to be carrying twins. They say your womb does not tire and why would someone say that. I could not hold my silence. I told the nurse that you have attitude towards people who come here for maternal services (P5, FGD3).

The participants reported that judgemental attitudes of the nurses made it difficult for them to relate their pregnancy ordeals:

In my case, I fail to eat properly, and I become so weak. When I am at the clinic, I find it difficult to relate this just to any nurse because they will judge you based on what you have related to them. One fails to open up so nurse can assist and even counsel for fear of being judged again the next time one comes for another visit (P6, FGD3).

Not only the attitudes of nurses, but also those of administration staff were found to be problematic:

The reception staff are discouraging in their conduct. They are not friendly and give attitudes (P1, FGD2),

They spoke rudely to me and it did not go well with me. I had gone to them waiting for them to give me a calendar date for 2020. As I waited, someone said that I was just standing there aimlessly yet there were so many people behind me. The tone was rude, and they had not brought it to my attention that they did not have a calendar for 2020 (P4, FGD2).

The people at the reception make me drag my feet if I have a clinic visit. They have attitudes. I just end up going for the visit for the sake of the unborn child. I do not permanently stay in Rethabiseng. I came to stay here so that I could be close to my family during my pregnancy and enable them to give me support since my husband is always at work. However, the reception staff gave me a hard time the first time I came to open a file. They cited that I should go back and open a file where I usually stay even after I had explained to them my situation. Despite having been the first one on the queue that day, waited and eventually opened the file when everyone who

had come for ANC had been served. From that day, I am always hesitant to visit the clinic when it is my appointment (P3, FGD2).

Negative attitudes of administrative staff discouraged some participants from visiting the clinics:

With me, I just force my coming for ANC for the sake of my unborn child (P4, FGD2).

The thought of just visiting the clinic is not ideal. Any clinic for that matter (P3, FGD3).

4.6.3.9 Suggestion box

The participants were asked if there was a suggestion box where they could leave complaints for clinic manager. They indicated that there was a box, but it was discouraging that the staff opened it and removed all bad reports and reviews. This left them helpless and powerless, as their voices could not be heard. This was expressed as follows:

There are suggestion boxes at the clinic. They open them and if there are bad reviews written there, they destroy it (P1, FGD1).

So, it end up not getting to the intended people because they remove them (P3, FGD1).

An example of a complaint that was ignored was noted by one of the mothers:

I have and always have been writing my frustrations. The issue of testing my 12-year-old child for HIV without my consent as a parent. However, I did not get any response and it has been a long time now (P4, FGD1).

4.6.3.10 Poor Wi-Fi coverage and limited landlines

Poor Wi-Fi coverage and limited operational landlines at Clinic B made it difficult for nurses to provided MHS. During consultations, nurses required access to landlines and Wi-Fi to make calls for bookings for referrals or to track laboratory results for maternal patients. There were times when the landlines were out of order in the consultation rooms. Nurses then had to look for an operational landline in other consultation rooms or offices. This wasted time and compromised the quality of health care. A key informant shared the following experience:

But the thing is we usually use our own phones to book for patients that are high risk patients. So, we do not ask from the department for the phones because sometimes there is no data. Even the patients' blood results, I do it with my own data, and the

lab track. The printing out obviously we are doing it here. We do have Tshwane Wi-Fi but from my office, I do not pick it up. So, I have to use my own data to do it. Sometimes the landlines are offline, and it takes us a long time to go from my office to come to this side to make a phone call. So, it's quicker on my phone for quality patient care (KII1).

4.6.3.11 Irregular attendance of postnatal care patients

Participants reported that some mothers took their children to their parents immediately after giving birth and returned to work without them. These mothers and children missed their PNC visits and check-ups as a result. It made it difficult for the nurses to determine whether the babies were receiving the required PNC services. Sometimes the clinic made follow-ups with no success because the addresses given by many patients were wrong. A key informant explained this:

When they leave the baby somewhere, you hear from the grandmother that she went to work or they couldn't come for 6 weeks. We try and contact them, but the problem is they give the wrong address. We try to follow up and the cell phone number is wrong or the address is incorrect; so, we cannot send people out to go and check. So those are the problems that we are facing (KII1).

4.6.3.12 Ineffective community outreach teams

While there are community outreach teams tasked with empowering women on maternal education, some participants complained that these teams were not performing their duties as envisaged. One participant said:

No. They do not visit us in our homes. They just indicate that they will do door to door visits and would come to visit you in your home (P1, FGD1).

It was felt that outreach teams only wanted personal information from participants in order for them to complete their paperwork and prove to their superiors that they have been working in communities:

Some just ask you your name as if they are going to come and educate you. When you tell them your name, they complete their forms and that will be the end of it (P2, FGD1).

Another participant agreed with this:

They just want us to complete their forms that they have done their job when they see us here at the clinic. They just promise to visit after you have filled their forms at the clinic, then they don't visit you (P5, FGD1).

4.7 RECOMMENDATIONS

The key informants, mothers and pregnant women made several recommendations to improve access to MHS. These recommendations will be presented using the framework from the Social-Ecological Model.

4.7.1 Individual level

The findings revealed that the clinic did not always provide pregnant women and mothers with all the required information about maternal health care. The FGD participants recommend that nurses be more resourceful and informative during consultations so that even first-time pregnant women get to understand the different stages of pregnancy. Below are the views of participants in this regard:

I am more of an internet person and I am resourceful in that way as I compare the information I get from my normal check-ups and the internet. The clinic provides limited information. There is a lot of information I did not get from the clinic but which I got from the internet. I would like that the nurses become more informative and educate us on other important issues (P1, FGD1).

As a first-time mother to be, there are several things you do not understand pertaining to the changes in your body. Like we are sitting now in this focus group, I wish the clinic could conduct similar discussions where an experienced informant comes to present about different stages in pregnancy so that we fully understand our bodies during pregnancy (P2, FGD3).

Key informants recommended that maternal users should understand that MHS is a service that is rendered for their benefit. MHS services are designed to protect them and their babies from all threatening risks during pregnancy, at delivery and after delivery. They should then register for ANC timeously and honour all their appointments. A key informant said:

They need to understand the importance of maternal health care because that's when we pick up problems like high blood and those sort of things so that we can monitor from the baseline up until the end, so we need to explain the importance of it and we also need to give health care education. (KII1).

4.7.2 Community level

The key informants mentioned the need to increase awareness in the community about maternal health care. They were of the view that continuous awareness raising in the community would improve women's understanding of maternal health as well as the services available. One key informant indicated:

On our side, I think if we can keep on educating them, for example, if there a community meeting, we can have a slot to educate them on the importance of starting ANC earlier and even in churches (KII3).

4.7.3 Organisational level

4.7.3.1 Better infrastructure

The participants pointed out that the clinic was small for the population it served. There was need for it to be extended as recommended by one of the participants:

They should extend the clinic because it is small (P1, FGD3).

Furthermore, the participants recommended the introduction of a mobile container that would deal with emergencies. This would keep consultations room open for ANC and PNC visits. The policy at the clinic was that mothers coming for three-day PNC should not wait in the queue but be served first. However, the policy was never upheld and worse still if emergencies occurred. To resolve this, a mother participant had this to say:

I would love them to introduce a mobile container for emergencies. When you bring a child for three days postnatal check-up, you will end up spending the whole day at the clinic if an emergency case arises (P1, FGD3).

Every patient is entitled to privacy and confidentiality. According to participants' responses during discussions, these were some of the areas that nurses were lacking. To bring change, the participants suggested that nurses should lock their doors during consultations to protect privacy and confidentiality. One mother participant expressed it in the following manner:

The clinic's staff should be able to give us privacy especially when they conduct tests that require us to undress, and they should lock the door so that no other personnel is able to gain entrance to the room during the session. As for the other staff members

at the clinic, they should not just enter consultation room when doors are closed. They should respect the privacy of patients (P1, FGD1).

This participant added that if doors are not locked, patients are always anxious and in fear that someone would walk in while they were naked. She said:

I was being checked for centimetres during my pregnancy. I was so scared and just hoping and praying that no one comes into the room during this time (P2, FGD1).

4.7.3.2 Increasing staff capacity at clinics

In order to curb the problem of staff shortages in the maternal section at Clinic B, the key informants recommended that the Department of Health authorities hire more midwives. The participants put the recommendation as follows:

The government should hire more midwives and doctors and people can benefit (KII2).

We just need just another professional nurse to work with us or midwife so that we can complete everything in full (KII1).

4.7.3.3 Extending operational hours to a 24-hour service

Extending the operational hours at Clinic A to a 24-hour service was another recommendation that came from the study. The participants complained that people were currently not getting immediate medical help whenever needed because of the 07:30 to 16:00 operational hours. One of the mothers said:

The clinic should accept and treat patients at any time of the day. If the service can be extended to 24 hours so that people can get medical help whenever needed. So, if the clinic could be open for 24 hours like Clinic B, they would not be such cases (P2, FGD1).

From another FGD, a pregnant woman said:

They should operate 24 hours a day. It would be the best (P1, FGD2).

4.7.3.4 Improving service delivery

Some mothers suggested that more staff should be allocated to work at the checkpoint station (i.e. the point where patients have their blood pressure after obtaining their clinic patient files). As one mother said:

I suggest they add one or two personnel to assist at the check-up point/station. It would be better (P4, FGD1).

Another recommendation was to decentralise the checkpoint so that the collection of files, checking of blood pressure, handing in of files and weighing do not happen at one point where there is limited space:

Space, space. Currently, everything is happening at the reception: checking of BP [blood pressure], checking of sugar, weighing, collecting files and handing files. They need to create space by putting another container where they will conduct certain assessments like checking your blood pressure and sugar; this will permit the patients to have privacy. It will create more working space too (P5, FGD1).

Another participant added that other clinics have better processes in place:

Like I have seen in other clinics, you go to a private room where these processes are conducted. They are not done in front of everyone and no one gets to hear what your results of the check-ups are (P6, FGD1).

A further suggestion to improve service delivery was the re-introduction of ANC classes:

They should bring back the programme where they exercise the pregnant mothers. Back then, it used to be there but now it is not (P4, FGD3).

The participants also recommended that staff members should prioritise the doctor's time by distributing maternal patients files earlier as well as conducting blood pressure check-ups early. A doctor visited the clinic daily from 08:00 to 12:00. Patients who do not get to see the doctor by 12:00, have to return the following day. One participant recommended:

They must properly plan and respect the doctor's time. They should not delay the doctor since he comes for a short time. Sometimes you find that the nurses delay doing the BP check-ups (while making their own tea) and the doctor is already there waiting. When his time is over, he leaves without attending to patients since he would be needed elsewhere. (P2, FGD3).

4.7.3.5 Addressing staff attitudes

In order to protect privacy, the participants recommended that nurses who were not from their own communities serve them. Such nurses would not know anything about

their personal lives. In that way, their maternal health issues would remain confidential and private. The participant expressed it as follows:

Another suggestion that may help is to hire nurses who are from different areas, who are not from the local community and do not know much about our personal lives. It is better to deal with someone whom you do not know at all than someone you know from the community (P3, FGD1).

The research participants also suggested that service efficiency could be improved at Clinic A if health care staff had a positive attitude towards maternal patients. For example:

The staff members should be able to work with patients in a proper manner at all times. They should be patient and stop being selfish. At the end of the day, they are here to serve the community and without us, they do not have their salaries (P2, FGD1).

The staff must stop chatting and catching up on weekend stories with each other during working hours (P5, FGD1).

I am one person interested in doing nursing. When they render poor services as personnel like they do, this discourages us who want to be nurses, as they seem not to love their jobs. (P1, FGD1).

4.7.3.6 Acquisition of essential equipment

Many participants recommended that the clinic should acquire a sonar machine. This would mean that pregnant women no longer had to visit other health care facilities for this service. The following quotes highlight this requirement:

They should buy a sonar so that we don't have to go to hospitals that are very far (P1, FGD1).

Yes, it will because we will no longer have to refer (KII2).

At this clinic, we do not have a sonar. They are still using the old method of checking the heartbeat of the child ... Sometimes, because of the old method they use, they tell you that you have twins, yet you do not have them (P1, FGD1).

Participants also advocated for an upgraded foetal heart monitoring device (Doppler ultrasound device):

They need to upgrade their machine for checking the baby's heartbeat because sometimes it sounds right and at times it does not. It even gives me a scare because

sometimes I do not hear any sound and then at times I hear as if the sound of the heartbeat of the child is beating on me (P2, FGD1).

There was also a recommendation that the clinic chairs needed to be replaced:

They should remove broken chairs and place them elsewhere so that the clinic becomes a safe environment (P2, FGD1).

4.7.3.7 Efficient transportation

Many of the participants recommended that ambulances should be manned by a skilled birth attendant or midwife:

It would be appreciated if the ambulance could have a nurse on board to deal with deliveries that happen before reaching the clinic or hospital (P3, FGD1).

There was also a recommendation that there should be transport for pregnant women who need to visit Clinic B:

We need assistance with transport services; like transport to go to Clinic B, we would really be grateful since some of us do not work and will not afford transport costs. For example, I do not work and there was a time I was going to Clinic B daily. In addition, the taxi fare is considerable. Besides, when you get there, you need money for food, as you will also sit in long queues. They would tell you that their transport does not put on board a pregnant woman (P5, FGD1).

4.7.3.8 Using proper medical resources

Mother participants were concerned about the small glass containers that they were given by some nurses for urine collection. They cited that proper wider glass containers were available at the clinic, but they were not handed to them. The ones they were given were small such that the urine sometimes overflowed onto their hands. They recommended:

The proper glasses are there for urination (P2, FDG1).

They should just allow us to urinate in the glasses (P3, FGD1).

...and she must stop loathing patients. Isn't it she took an oath to do the job with such responsibilities? (P4, FGD1).

4.7.3.9 Conducting multiple pregnancy tests using various methods

The research findings revealed that many women who first tested for pregnancy at the clinic tested negative, yet they were pregnant. Some women tested twice at the clinic in different months and at different stages of their pregnancy and still tested negative. Some went to private doctors and others bought home pregnancy tests and tested positive. This showed that the clinic's testing kits were unreliable. Participants recommended that they used various testing ways to ensure that pregnancy results would be accurate:

The other thing is that the clinic should also conduct multiple pregnancy tests to ensure that their results are accurate and not use solely one, but two at least. Last week I was not feeling well. I came here to access my family planning prevention method. They tested me for pregnancy and the result was negative. I went back home despite still not feeling well. I then bought my own pregnancy test and it confirmed I was pregnant. I then came back to the clinic and the test then was positive. Imagine if I had taken my family planning prevention method? This has happened to me before. I was once pregnant with twins. I became unwell and it was on a Sunday. I then went to Clinic B and they told me that I had an infection. They gave me pills to take and I came back home and stayed a while. During the week, my mother said that I was pregnant. I disputed and said I was not because I was on family planning prevention method and I had recently injected. My father took me to Sunshine Clinic, and they confirmed that I was pregnant. So, these are some of the things that the clinic personnel must be careful about. They put you on family planning, yet you are pregnant (P1, FGD3).

4.7.3.10 Improve hygiene

The clinic only had one water station with one cup. The participants complained about this unhygienic practice and recommended that:

They should also create more water stations and provide bottled water. That would be better (P3, FGD1).

4.8 CONCLUSION

This chapter presented the findings from the research in detail as per the objectives of the study and the conceptual framework, the Social-Ecological Model. The factors facilitating access to maternal health by participants included friendly staff, proximity, partner support, family support, provision of services, desire for a ward book,

community outreach-based programmes and efficient transportation. The barriers to access maternal health care included staff attitudes, long queues, long waiting periods, inefficient transport system, lack of equipment, cultural and traditional beliefs, ignorance to MHS, staff shortages, poor service delivery, lack of privacy, geographic accessibility, dysfunctional suggestion boxes, unfriendly and judgemental staff. Factors that made it difficult for nurses to render services at the clinic and included the attitudes of women towards MHS, late registration for ANC, staff shortages, lack of advanced equipment, poor Wi-Fi coverage and limited landlines, and irregular attendance of PNC visits.

A number of recommendations were made by the research participants on how to improve access to MHS. The primary recommendation was extending operating hours to a 24-hour service a day to allow users to be assisted at any time when the need arose. The maternal users also recommended the procurement of advanced equipment, improving staff attitudes, decentralising the checkpoint, and securing privacy for users at the clinic. Other recommendations included increasing staff at some points, improving service delivery, improving hygiene, efficient transportation, conducting various multiple pregnancy tests, and repairing broken equipment.

Chapter 5

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

As stated in the first chapter, the objectives of the study were to:

- describe knowledge about maternal health care;
- identify women's maternal health care needs;
- explore maternal health care seeking behaviour;
- explore the facilitators to access maternal health care services;
- explore the barriers to access maternal health care services; and
- make recommendations to improve access to maternal health care services.

Based on the objectives, the chapter comprises of the discussion and interpretation of the findings using the Social-Ecological Model and previous research findings. The chapter ends with recommendations to improve access and rendering of MHS that emerged from the research findings. The chapter further provides insight of the issues that need to be addressed and strengthened to improve access to maternal health care.

5.2 KNOWLEDGE OF MATERNAL HEALTH CARE NEEDS AND SERVICES

The main maternal health care needs were identified as ANC, a midwife for delivery and PNC. The women were knowledgeable about their pregnancy needs and understood that they should have all their pregnancy-related risks diagnosed, undergo HIV testing and counselling and initiate Prevention of Mother-to-Child Transmission, if required. The findings of the study are in line with that of Brizuela and Tuncalp (2017), whose study classified ANC, being attended by a midwife at birth, and PNC as maternal needs of women. More study findings by researchers such as Kolisa (2016), Mashamba-Thompson et al. (2016), Nesane et al. (2016) and Singh et al. (2016), revealed that maternal needs entail ANC, safe delivery, PNC, emergency obstetric care, management of complications and family planning. Knowledge of maternal health care needs and services are important as they facilitate access to maternal

services in pregnancy, at delivery and after delivery. This was confirmed by studies from Ethiopia (Regassa, 2011) and Ghana (Ganle et al., 2015) which found that knowledge of MHS enabled women to access MHS as required. In this study, most women had knowledge of MHS. They knew they could acquire maternal health information from clinics, the internet, and other parents.

5.2.1 Health-seeking behaviour

The research found that some pregnant women complied with the 2016 South African Maternal Health Guidelines which stated that women should visit PHC clinics at least eight times for ANC during pregnancy. In instances where women experienced complications, they were found to visit the clinic even more frequently than stated in the guidelines. Unfortunately, not all women attended the required eight ANC visits, which was also found to be the case in an Eastern Cape study (Tsawe & Susuman, 2014), where many women had not accessed MHS during pregnancy. Furthermore, some women did not register for ANC during the first trimester of pregnancy as required but left this to a later stage. Similar findings were reported from a study conducted in rural and peri-urban communities of South Africa, where many women only attended their first ANC visit after 20 weeks in their pregnancy (Ebonwu et al., 2018). The adverse consequences of delaying registering for ANC visits are the delayed opportunities to manage pregnancy-related risks for mother and child.

Some women preferred to deliver at home as it was more comfortable than at health facilities. This made them refrain from seeking childbirth delivery services from local health facilities. This is consistent with findings from a study in Zambia (Mutale et al., 2017) where it was reported that women preferred home deliveries at childbirth because they were more comfortable and gave them privacy when compared to health care facilities that were small, uncomfortable and had neither toilets nor showers for users. People passing by heard cries of women in labour. The current study also revealed that other women delivered at home because of the long response time that ambulances took when called by women in labour. Silal et al. (2012) reported similar findings that women gave birth at home while waiting for ambulances that had taken too long to respond.

The study revealed that most women made their own decisions on the place of childbirth without any influence from partners and or mothers-in-law. This finding is in line with the research the findings of a study done by Ganle et al. (2015) in Ghana where it emerged that educated women were decisive and did not rely on their husbands or mothers-in-law for decisions concerning maternal health care choice. These women valued attaining maternal health services and getting skilled assistance during birth.

5.3 FACILITATORS TO ACCESS

The following subsections describe aspects that made it easy for mothers and pregnant women to access maternal health care. These elements were explained according to the four levels of the Social-Ecological Model: individual, interpersonal, and organisational.

5.3.1 Individual level

Knowledge of MHS was an important facilitator for some women in accessing these services. For instance, some women knew they needed to attain ANC during pregnancy and others were knowledgeable about the importance of MHS. The women attended ANC visits as scheduled until they gave birth. Similar findings were reported in a study undertaken by Tsawe and Susuman (2014) in the Eastern Cape. Their study found that some women (though not many) had knowledge of maternal health care and accessed the recommended number of ANC visits during pregnancy.

5.3.2 Interpersonal level

Partner support made it easy for women to access MHS timeously. Some women received physical and emotional support from partners. Pregnant women were assisted with household chores, accompanied on clinic visits by their partners and given financial support during and after pregnancy. Similar partner support was reported by Ebonwu et al. (2017) in the rural and peri-urban communities of Tlokwe (North West) and Capricon (Limpopo) in South Africa, where some partners occasionally accompanied their spouses to the clinic for MHS.

5.3.3 Organisational level

Some respondents noted that there were health systems factors that made it easier for them to access MHS. These factors included geographical location, attitudes of some nurses, the use of the ward book, and community outreach. Firstly, with regard to the geographical location of the clinics, some participants reported that Clinic A and Clinic B were centrally located in their respective communities and they could easily walk to these clinics. This was also found in a study conducted in the Eastern Cape (Tsawe & Susuman 2014), where women who indicated that the hospital was within walking distance accessed MHS more often than those who stayed further away.

Secondly, some nurses were reported to be friendly to women and had positive attitudes. This was in direct contradiction to findings from Vietnam (Binder-Finnema et al., 2015), Nigeria (Ekpenyong et al., 2019) and South Africa (Versteeg et al., 2013) where health care workers were reported to be unfriendly and had negative attitudes. Thirdly, the use of a “ward book” also encouraged women to visit the clinic for MHS, mainly because the book was compulsory to produce at a birth delivery facility. This finding was unique to the current study.

Finally, community outreach teams were reported to facilitate access to MHS. Community outreach teams visited mothers and pregnant women who were registered at the clinic. These community outreach teams supplied them with medication, taught mothers about breast feeding and empowered them by providing maternal health education. Similar research findings were found by Khatri et al. (2017) in Nepal. Community outreach teams and volunteers in Nepal performed different activities in the communities such as counselling women, teaching women on maternal education and holding health campaign awareness programmes.

5.4 BARRIERS TO ACCESS

The study identified several factors that hindered women's access to MHS. These factors are discussed according to the different levels of the Social-Ecological Model, namely individual, interpersonal, and organisational.

5.4.1 Individual level

A lack of knowledge and poor attitude towards maternal health care was an important barrier to access MHS. Some examples of a lack of knowledge about maternal health care included not knowing that ANC was a requirement during pregnancy, late ANC registrations, poor knowledge on pregnancy-related risks and pregnancy-related threats during childbirth. This lack of knowledge kept women from accessing MHS. The study had similar findings to other studies undertaken in South Africa (Tsawe & Susuman, 2014), Africa at large (Amzat, 2015) and among a Marshallese community in the United States of America (Ayers et al., 2018). The research findings revealed that women were not knowledgeable that ANC is a requirement during pregnancy, the importance of ANC and the risks of not accessing ANC timeously.

5.4.2 Interpersonal level

Certain aspects of cultural and traditional beliefs made it difficult for women to access MHS timeously. For example, some women believed that discussing pregnancy in its early stages would lead to miscarriage and attract witchcraft. They preferred discussing their pregnancy when physical signs began to show, and this led them to register for ANC in the second trimester instead of the first. The same cultural beliefs were also reported by Lang-Balde and Amerson (2018), who stated that some women in sub-Saharan Africa avoided registering for ANC during the first semester for fear of losing their babies.

Some women opted to take traditional medicines during their pregnancy and labour. For example, some women reportedly ate soil and drank traditional juices to induce labour. They were discouraged from drinking yellow fruit juices during pregnancy as the baby would be born with an orange colour. After delivery, mothers smeared cow dung and charcoal on the umbilical cords instead of surgical spirits. Similar practices were reported in studies conducted by Mugo et al. (2018) in South Sudan and by Mburu and George (2017) in KwaZulu Natal in South Africa. In South Sudan, the findings revealed that women were discouraged from eating eggs and cheese products during pregnancy as it was a cultural belief that this would cause their feet to swell and result in delivery complications. The KwaZulu Natal study also revealed conflict between traditional and modern medicine. Women's beliefs were rooted in

their cultural, and prevented them from taking modern medicine, rather opting for traditional medicine.

5.4.3 Organisational level

5.4.3.1 Geographic accessibility

As in other research (Gupta et al., 2018; Khatri et al., 2017; Mugo et al., 2018; Wilunda et al., 2016; Wong et al., 2017), this study found that far distances to health care facilities hindered women's access to MHS. In particular, it was found that the lack of public transport made it difficult for women to walk far distances to clinics. This had a ripple effect that resulted in poor ANC attendance.

5.4.3.2 Poor infrastructure, inadequate resources, and equipment

The study identified poor infrastructure as a barrier to access MHS. Despite attempts to improve space at the PHC facility with the addition of a park home structure, the clinic was too small to accommodate the population of Rethabiseng. It was pointed out that there were too few consulting rooms and toilet facilities. This is not an uncommon problem and was also found in a study conducted in rural Nepal (Khatri et al., 2017), where the infrastructures of health facilities were indicated to be too small and congested.

Inadequate infrastructure at the PHC facility also meant a lack of privacy, with complaints of frequent walk-ins by other nurses or members of staff while pregnant women were in the consultation rooms. A Zambian study (Mutale et al., 2017) found that the delivery rooms were small and few. Every woman in labour was kept there and it embarrassed some women to have everyone looking at them. This lack of privacy discouraged pregnant women from accessing MHS at the clinic.

In addition to poor infrastructure, there was also a lack of necessary resources such as medication. Women were often told that the facility had run out of stock, and that they had to buy their medication from the pharmacy or use home remedies. Other studies also reported a lack or shortage of drugs and medicine stock-outs (Mathole et al. 2018; Van der Hoeven et al., 2012). More specifically, research in the North West province in South Africa revealed that rural communities lacked facilities like pharmacies. The lack of these facilities implied that the rural population relied heavily

on what they received from the clinic or they had to travel long distances to attain alternative medication from pharmacies (Van der Hoeven et al., 2012).

There was a lack of advanced equipment such as sonars, foetal Doppler's and ultrasound scans, which made it difficult to confirm pregnancy or view pictures of the developing foetus. Health workers were forced to manually use their hands (feeling the pregnant woman on the stomach) to determine the position of the child, which is an unreliable practice. The findings of the study are consistent with research done in twelve clinics in KwaZulu-Natal in South Africa, (Haskins et al., 2016), where it was found that the clinics did not have advanced equipment for postpartum (postnatal depression) and hearing assessments for babies. The implication was that mothers and babies could not get the services they needed during pregnancy.

A further concern was that where the necessary equipment was available, it sometimes malfunctioned and required replacement. For example, scales that gave incorrect readings and faulty foetal Doppler's. Similar findings were reported in a study conducted in Vietnam (Binder-Finnema et al., 2015) where some clinics had limited equipment that was in a poor state. Research findings by Mathole et al. (2018) in the Eastern Cape province in South Africa and that of Binder-Finnema et al. (2015) in Vietnam, were consistent with the findings of this study. Clinics lacked essential equipment such as ventilators, thermometers and blood pressure checking machines that were vital for early detection of pregnancy risks. Furthermore, the existing equipment in clinics malfunctioned and maintenance was a huge problem.

5.4.3.3 Shortages of human resources

A shortage of human resources for health was another barrier to women accessing maternal health services. This was not unique to this study, as many other researchers have reported the same barriers, for instance in India (Gupta et al., 2018), Vietnam (Binder-Finnema et al., 2015), Zambia (Mutale et al., 2017) and in the Eastern Cape province in South Africa (Mathole et al., 2018). The findings from these studies revealed that there were shortages of doctors, nurses, and midwives to serve maternal patients. The current study further found that only one doctor reported daily at the PHC clinic for only four hours. This finding showed the uneven distribution of human resources in rural areas and is in line with the findings by Versteeg et al. (2013) which revealed that the South African rural areas had a low density of doctors and nurses.

5.4.3.4 Inflexible opening hours

Inflexible opening hours was another barrier experienced by women in accessing MHS. The research findings revealed that women were not happy with the clinic's operational hours (07:30 to 16:00). They mentioned that the hours were restrictive in nature and did not allow services to be provided when the need arises since it was not a 24-hour clinic. Similar findings were revealed in a study conducted in the Northern and Eastern Cape provinces (Mji et al., 2017). Most clinics were open from 08:00 to 16:00. Any maternal health care emergency that occurred beyond 16:00 was supposed to be referred to the nearest hospital which was located a far distance away.

5.4.3.5 Poor service delivery

Poor service delivery discouraged women from accessing MHS, in particular the clinic staff were reported to be slow in rendering services such as issuing of files, not thoroughly consulting patients, and always engaging in office chats during working hours. It further emerged that the clinic was once burned down by the community because of poor service delivery. Similar research findings were reported in Nepal (Khatri et al., 2017) and Nigeria (Ekpenyong et al., 2019). In Nepal, the findings revealed that nurses were not properly counselling and giving adequate attention to patients during consultations. They were preoccupied with hurrying to attend to everyone in the queue. In Nigeria, the findings revealed that nurses were not rendering MHS efficiently as expected. Instead, they wasted time sitting and chatting in offices, while patients looked forward to receiving MHS.

5.4.3.6 Long queues and waiting periods

Long waiting periods also discouraged women from regularly accessing MHS. The study revealed that maternal users arrived at the clinic early in the morning, waited for a long time in the queues and left in the afternoon. Even women reporting for a three-day PNC visit were kept long; yet they were supposed to get preferential treatment of being served first. Similar findings were revealed in a study conducted in the Eastern Cape (Mathole et al., 2018). Their findings revealed that rural districts in the Eastern Cape were the worst in terms of service delivery performance. Clinics were characterised by long queues and waiting periods.

5.4.3.7 Staff attitudes and judgemental staff

The unfriendly and judgemental attitudes of nurses were a further deterrent to accessing MHS. Nurses were reportedly disrespectful and asked rude questions to women during clinic visits. Some nurses showed loathing attitudes towards maternal users when conducting urine tests. Similar findings on attitudes were found in studies conducted in Northern Central Vietnam (Binder-Finnema et al., 2015) and South Africa (Tsawe & Susuman, 2014; Mathole et al., 2018), where many women were discouraged from accessing MHS because of negative attitudes, ill-treatment, and discrimination at deliveries.

5.4.3.8 Inefficient transportation

The need for efficient transport systems was not unique in this study as similar research in South Africa (Silal et al., 2012; Mathole et al., 2018) reported severe challenges in accessing ambulance services. This study revealed that there were inefficient and ineffective transportation systems that hindered women from accessing MHS timeously. It was reported that ambulances responded late to emergency calls and in some cases, they did not come at all. This either resulted in women seeking alternative transportation or resorting to home deliveries.

5.4.3.9 Unavailability of maternity services

No delivery services were available at Clinic A. All women attending ANC services at the clinic were referred for deliveries to a nearby community health centre. High risk patients were referred to hospitals in surrounding towns. As with similar research (Mji et al., 2017), the findings revealed that several clinics in Madwaleni in the Eastern Cape, and Fraserburg in the Northern Cape only operated during the day and had no delivery services. Such clinics referred their maternal patients to their nearest district hospitals for delivery services.

5.4.3.10 Failure to acquire services at primary health care facilities when needed

Failure to access MHS when required was another barrier identified by the study. It was found that women were turned back on several occasions without being served. One pregnant woman who bled before arriving at the clinic was sent home upon arrival

without being assisted. The nurses cited that she should go to a hospital once the bleeding started again. Another pregnant woman had severe heartburn that made her vomit. The nurses told her it was normal in pregnancy and she was sent back home. This was not unique to the study, as many other researchers have reported the same barrier, such as in Vietnam (Binder-Finnema et al., 2015) and the Eastern Cape province in South Africa (Tsawe & Susuman, 2014). The findings from Vietnam showed that some clinics were not able to serve maternal patients with the equipment and resources at their disposal. Pregnant women had to be referred to other hospitals for assistance. In Mdantsane in the Eastern Cape province in South Africa, pregnant women who had HIV were chased away without being helped.

5.5 RECOMMENDATIONS

This section discusses the study recommendations on all the levels of the Social-Ecological Model. The recommendations are based on findings from the interviews and FGDs and augmented with the researcher's own thoughts as to how MHS in rural areas could be improved.

5.5.1 Individual level

5.5.1.1 Increase women's awareness of maternal health

It is recommended that nurses become more resourceful and informative for maternal patients during consultations. This should enable all women (first time in pregnancy included) to understand the different stages of pregnancy and the need for maternal health services. It is also recommended that nurses give ample time during consultations for women to ask any questions that they may have.

5.5.1.2 Re-introduce antenatal care exercise classes

ANC exercise classes should be re-introduced at Clinic A, as it provides an opportunity for women to gain information about MHS and prepare them for childbirth.

5.5.2 Interpersonal level

5.5.2.1 Increase community maternal health education awareness

Awareness of maternal health care should be raised in the community, for example at community meetings and church gatherings. This is in line with recommendations made by Susuman (2015) and Khatri (2017), which indicated that women should be given information about maternal health care in their communities.

5.5.3 Organisational level

5.5.3.1 Better infrastructure

The infrastructure at Clinic A should be revisited and plans made for more consulting rooms, HIV testing and counselling rooms and toilet facilities. The recommendation is similar to that of Wilunda et al. (2016) who also encouraged for the expansion of infrastructure to enable health facilities to have more consultation rooms and maternity rooms.

5.5.3.2 Increase staff capacity at clinics

More midwives are required to adequately provide MHS. This should also eradicate work overload, staff burnout and staff frustrations.

5.5.3.3 Extend operational hours to a 24-hour service

Clinic A should be upgraded to a 24-hour facility.

5.5.3.4 Improve service delivery

The study recommends several measures aimed at improving service delivery at Clinic A. Firstly, the decentralisation of the checkpoint station so that the collection of files, vital observations, handing in of files and weighing does not happen at one point where there is limited space. Secondly, an additional staff member should be assigned to work at the checkpoint station so that the queue can move faster. Thirdly, a separate area/room is needed for the pretesting processes that happen before consultations. Fourthly, mothers reporting for the three-day PNC visit should be prioritised. Fifthly, there is a need for a dedicated room to deal with emergencies. Finally, patients needing to see the doctor should be prioritised.

5.5.3.5 Improve staff attitudes

Attention needs to be given to the attitudes of staff. This may entail motivational talks for staff and refresher training.

5.5.3.6 Procurement and maintenance of equipment

Clinic A should look at the feasibility of acquiring a sonar and foetal Doppler. In addition, medical supplies such as urine collection bottles and accurate pregnancy tests should be procured. All broken equipment and resources (e.g. chairs and scales) should be repaired or replaced. The water station at Clinic A should be improved and more cups made available for drinking water.

5.5.3.7 Efficient transportation

It is also recommended that ambulances transporting women in labour have a skilled birth attendant or midwife present. The study further recommends that the clinic assists women with transportation for all scheduled referrals.

5.5.3.8 Secure privacy and confidentiality

Doors should be locked during consultations to safeguard privacy. Locking doors should put women at ease whenever they undress or do tests that require privacy. Furthermore, the study recommends that nurses and staff members respect patients' consultation time and avoid barging into consultation rooms as this put patients at unease. A similar recommendation was given by Haskins et al. (2016) who also encouraged the practice of privacy during clinic visits.

5.6 VALUE OF THE RESEARCH

The study added to the body of knowledge on experiences of rural women in accessing MHS. Not much research has been previously conducted on qualitatively exploring the experiences of women in accessing MHS in South Africa. The recommendations from this study will be helpful for the provincial Department of Health to address some of the difficulties that women experience in accessing MHS.

5.7 STUDY LIMITATIONS

One of the limitations of this study could be the bias associated with social desirability. More specifically, some participants might have given the researcher answers that they thought he would like to hear. This was addressed by continuously emphasising and assuring participants that any information they provided would be kept confidential (i.e. no name would be associated with an particular response).

In any qualitative research, time and resources are a huge factor. FGDs and semi-structured interviews required time for both the participants and the researcher. The researcher had to conduct the study not as a full-time student but one in full-time employment. As a result, competing demands interfered with data analysis and dissertation write-up (Tuckett, 2004). The study explored the experiences of women from one clinic and to generalise the findings to the whole country is not possible as different experiences may be obtained from other clinics. The study sourced only mothers who were receiving services from Rethabiseng Clinic. Sourcing mothers from other places such as traditional leaders and healers could have brought different insights to the research. The study also utilised qualitative methods to explore the experiences of women in accessing MHS and, as such, the purposively selected participants do not represent the entire population of pregnant women and mothers in Rethabiseng.

5.8 CONCLUSION

Pregnant women, mothers and nurses shared their experiences regarding access and rendering of MHS. Through their lived experiences, the facilitators, and barriers to MHS were explored. While the study revealed some positive factors facilitating access to MHS, for example knowledge about maternal health care and partner support, they were largely overpowered by the vast array of barriers hindering access, such as geographic accessibility, poor infrastructure, inflexible opening hours, long waiting periods, shortage of human resources, staff attitudes, poor service delivery, lack of advanced equipment and resources. The study made several recommendations aimed at finding ways to overcome the barriers to access to MHS. The predominant ones were expanding infrastructure, expanding operational hours, procuring, and maintaining advanced equipment. Other operational recommendations that were

made included improving service delivery, recruiting more nurses, improving ambulances response time, and extending clinic hours to twenty-four hours.

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Appendix A

INFORMED CONSENT: MOTHERS



RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM

DATE

November 2019 – February 2020

TITLE OF THE RESEARCH PROJECT

Experiences of accessing maternal health care services in a rural community of South Africa.

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER(S):

Lennox Tapera 2016355832 +27 81 086 2871

FACULTY AND DEPARTMENT:

Economic and Management Sciences

Centre for Development Support

STUDYLEADER(S) NAME AND CONTACT NUMBER:

Dr. M. Engelbrecht

051 – 4012181 / 051 4013256

WHAT IS THE AIM / PURPOSE OF THE STUDY?

The aim of this study is to explore experiences of accessing and providing maternal health care services in PHC facilities in Rethabiseng.

WHO IS DOING THE RESEARCH?

My name is Lennox Tapera from the University of the Free State. I am a final year student doing a Masters in Development Studies in the Faculty of Economic and Management Sciences.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher. The approval numbers are: **UFS-HSD2019/1084/2611** and **GP_201908_044**.

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You have been purposively selected to participate in this research study as you are currently a mother (who has given birth in the past year) who is accessing maternal health services at Rethabiseng Clinic. I would like to ask you about the factors that make it easy or difficult for you to access these services. In addition, I would also like to hear your suggestions for improving women's uptake of maternal health care services in a rural community.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

You will be asked to participate in a group discussion, along with other mothers (women who gave birth in the past year) accessing maternal health care services at Rethabiseng Clinic. The group discussion will take approximately one hour and will be held at a date and time that is convenient for all the women who will be participating. This group discussion will include six to eight women and one female facilitator.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Participation in the research study is voluntary. You are free to withdraw from the study at any given time. You are also free to decline to answer any questions that you are not comfortable answering, without giving any reason to the researcher. If you decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Please note that there is no benefit or incentive being given for participating in the group discussion. The findings will however be shared with the Tshwane District Office in the hope that they may be used to improve uptake of maternal health care services in rural communities.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

If you experience any psychological distress during your participation in the study, please feel free to contact the counselling team Rethabiseng Clinic, where counselling services are offered free of charge. The Clinic is located at 310 Matukane Street, Extension 1, Rethabiseng and can be reached telephonically at the following numbers 013 932 7804.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

All information that you share with me will be kept confidential. Confidentiality will be maintained by using pseudonyms during the group discussions and by setting ground rules at

the start of each discussion. Specifically, all participants will be asked not to repeat what was said during the discussions outside of the discussions. Participants will be requested to respect one another's contributions, privacy and to keep confidential everything that will be discussed.

Please keep in mind that it is sometimes impossible to make an absolute guarantee of confidentiality/anonymity especially on focus groups. While every effort will be made by the researcher to ensure that you will not be connected to the information that you share during the focus group, I cannot guarantee that other participants in the focus group will treat information confidentially. I will, however, encourage all participants to do so.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Data collected during the study will be kept electronically for a period of five years in a password-protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will not be any payment to be made to participants. Participants will not incur any cost too to be part of the study. I will cover transport costs incurred to attend group discussions and provide refreshments.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

Should you want to be informed of the final research findings, you can contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. Alternatively, you may contact Dr van Rooyen, the Program Director for Development Studies at: 051 401 3812 or griesd@ufs.ac.za.

Should you have any concerns about the way in which the research has been conducted, you may contact:

Dr Engelbrecht: 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za (Supervisor)

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

SIGNED CONSENT OF PARTICIPANTS (FOCUS GROUPS FOR MOTHERS)

I _____ (participant's name) have been informed about the study entitled "Experiences of accessing maternal health care services in a rural community of South Africa" being conducted by Lennox Tapera. I consent to take part in this research study and have been told about the nature, procedure and anticipated inconvenience of participation. I understand the purpose and the procedures of the study of participating in focus groups. I have been given an opportunity to ask questions about the study and I was answered to my satisfaction. I am prepared to participate in the study.

I declare that my participation in this study is voluntary and that I may withdraw anytime without affecting any of the benefits that I am usually entitled to. I have been informed about the availability of counselling services that will be provided in case any trauma occurs as a result of study related procedures.

If I have further questions or concerns /queries related to the study, I understand that I may contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. If I have questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

Dr Deidre van Rooyen (Program Director for Development Studies): 051 401 3812 or griesd@ufs.ac.za.

Dr Michelle Engelbrecht (Supervisor): 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

I am aware that the findings of this study will be anonymously processed into a mini-dissertation / journal publications and / or conference proceedings.

I have received a signed copy of the informed consent agreement.

I agree to the audio recording of the group discussion.

Full Name of Participant _____

Signature of respondent:

Date:

Full name of Field Worker _____

Signature of Fieldworker:

Date:

Appendix B

INFORMED CONSENT: PREGNANT WOMEN



RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM

DATE

November 2019 – February 2020

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PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER(S):

Lennox Tapera

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FACULTY AND DEPARTMENT:

Economic and Management Sciences

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This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher. The approval numbers are: **UFS-HSD2019/1084/2611** and **GP_201908_044**.

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You have been purposively selected to participate in this research study as you are currently pregnant and accessing maternal health services at Rethabiseng Clinic. I would like to ask you about the factors that make it easy or difficult for you to access these services. In addition, I would also like to hear your suggestions for improving women's uptake of maternal health care services in a rural community.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

You will be asked to participate in a group discussion, along with other pregnant women attending maternal health care services at Rethabiseng Clinic. The group discussion will take approximately one hour and will be held at a date and time that is convenient for all the women who will be participating. This group discussion will include six to eight pregnant women and one female facilitator.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Participation in the research study is voluntary. You are free to withdraw from the study at any given time. You are also free to decline to answer any questions that you are not comfortable answering, without giving any reason to the researcher. If you decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Please note that there is no benefit or incentive being given for participating in the group discussion. The findings will however be shared with the Tshwane District Office in the hope that they may be used to improve uptake of maternal health care services in rural communities.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

If you experience any psychological distress during your participation in the study, please feel free to contact the counselling team Rethabiseng Clinic, where counselling services are offered free of charge. The Clinic is located at 310 Matukane Street, Extension 1, Rethabiseng and can be reached telephonically at the following numbers 013 932 7804.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

All information that you share with me will be kept confidential. Confidentiality will be maintained by using pseudonyms during the group discussions and by setting ground rules at the start of each discussion. Specifically, all participants will be asked not to repeat what was said during the discussions outside of the discussions. Participants will be requested to respect one another's contributions, privacy and to keep confidential everything that will be discussed.

Please keep in mind that it is sometimes impossible to make an absolute guarantee of confidentiality/anonymity especially on focus groups. While every effort will be made by the researcher to ensure that you will not be connected to the information that you share during the focus group, I cannot guarantee that other participants in the focus group will treat information confidentially. I will, however, encourage all participants to do so.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Data collected during the study will be kept electronically for a period of five years in a password-protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will not be any payment to be made to participants. Participants will not incur any cost too to be part of the study. I will cover transport costs incurred to attend group discussions and provide refreshments.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

Should you want to be informed of the final research findings, you can contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. Alternatively, you may contact Dr van Rooyen, the Program Director for Development Studies at: 051 401 3812 or griesd@ufs.ac.za.

Should you have any concerns about the way in which the research has been conducted, you may contact:

Dr Engelbrecht: 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za (Supervisor)

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

SIGNED CONSENT OF PARTICIPANTS (FOCUS GROUPS FOR PREGNANT WOMEN)

I _____ (participant's name) have been informed about the study entitled "Experiences of accessing maternal health care services in a rural community of South Africa" being conducted by Lennox Tapera. I consent to take part in this research study and have been told about the nature, procedure and anticipated inconvenience of participation. I understand the purpose and the procedures of the study of participating in focus groups. I have been given an opportunity to ask questions about the study and I was answered to my satisfaction. I am prepared to participate in the study.

I declare that my participation in this study is voluntary and that I may withdraw anytime without affecting any of the benefits that I am usually entitled to. I have been informed about the availability of counselling services that will be provided in case any trauma occurs as a result of study related procedures.

If I have further questions or concerns /queries related to the study, I understand that I may contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. If I have questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

Dr Deidre van Rooyen (Program Director for Development Studies): 051 401 3812 or griesd@ufs.ac.za.

Dr Michelle Engelbrecht (Supervisor): 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

I am aware that the findings of this study will be anonymously processed into a mini-dissertation / journal publications and / or conference proceedings.

I have received a signed copy of the informed consent agreement.

I agree to the audio recording of the group discussion.

Full Name of Participant _____

Signature of respondent:

Date:

Full name of Field Worker _____

Signature of Fieldworker:

Date:

Appendix C

INFORMED CONSENT: INTERVIEWS



RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM

DATE

November 2019 – February 2020

TITLE OF THE RESEARCH PROJECT

Experiences of accessing maternal health care services in a rural community of South Africa.

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER(S):

Lennox Tapera

2016355832

+27 81 086 2871

FACULTY AND DEPARTMENT:

Economic and Management Sciences

Centre for Development Support

STUDYLEADER(S) NAME AND CONTACT NUMBER:

Dr. M. Engelbrecht

051 – 4012181 / 051 4013256

WHAT IS THE AIM / PURPOSE OF THE STUDY?

The aim of this study is to explore experiences of accessing and providing maternal health care services in PHC facilities in Rethabiseng.

WHO IS DOING THE RESEARCH?

My name is Lennox Tapera from the University of the Free State. I am a final-year student doing a Master's in Development Studies in the Faculty of Economic and Management Sciences.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher. The approval numbers are: **UFS-HSD2019/1084/2611** and **GP_201908_044**.

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You have been purposively selected to participate in this research study as you are currently working as a health professional while rendering maternal health services at Rethabiseng Clinic / Dark City Clinic. I would like to ask you about the factors that make it easy or difficult for women to access maternal services. In addition, I would also like to hear your recommendations for improving women's uptake of maternal health care services in a rural community.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

You will be asked to participate in a semi-structured interview, since you render maternal services at Rethabiseng Clinic / Dark City Clinic. The interview will take approximately one hour and will be held at a date and time that is convenient for you.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Participation in the research study is voluntary. You are free to withdraw from the study at any given time. You are also free to decline to answer any questions that you are not comfortable answering, without giving any reason to the researcher. If you decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Please note that there is no benefit or incentive being given for participating in the semi-structured interview. The findings will however be shared with the Tshwane District Office in the hope that they may be used to improve uptake of maternal health care services in rural communities.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

If you experience any psychological distress during your participation in the study, please feel free to contact the counselling team at Rethabiseng Clinic, where counselling services are offered free of charge. The Clinic is located at 310 Matukane Street, Extension 1, Rethabiseng and can be reached telephonically at the following numbers 013 932 7804.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

I will do my best to ensure that all information you provide me with is kept confidential. I will not link any information with your name.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Data collected during the study will be kept electronically for a period of five years in a password-protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will not be any payment to be made to participants. Participants will not incur any cost too to be part of the study.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

Should you want to be informed of the final research findings, you can contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. Alternatively, you may contact Dr van Rooyen, the Program Director for Development Studies at: 051 401 3812 or griesd@ufs.ac.za.

Should you have any concerns about the way in which the research has been conducted, you may contact:

Dr Engelbrecht: 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za (Supervisor)

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

SIGNED CONSENT OF PARTICIPANTS (KEY INFORMANT INTERVIEWS)

I _____ (participant's name) have been informed about the study entitled "Experiences of accessing maternal health care services in a rural community of South Africa" being conducted by Lennox Tapera. I consent to take part in this research study and have been told about the nature, procedure and anticipated inconvenience of participation. I understand the purpose and the procedures of the study of participating in interviews. I have been given an opportunity to ask questions about the study and I was answered to my satisfaction. I am prepared to participate in the study.

I declare that my participation in this study is voluntary and that I may withdraw anytime without affecting any of the benefits that I am usually entitled to. I have been informed about the availability of counselling services that will be provided in case any trauma occurs as a result of study related procedures.

If I have further questions or concerns /queries related to the study, I understand that I may contact the researcher at 081 086 2871 or lennoxtapera@yahoo.co.uk. If I have questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researcher then I may contact:

Dr Deidre van Rooyen (Program Director for Development Studies): 051 401 3812 or griesd@ufs.ac.za.

Dr Michelle Engelbrecht (Supervisor): 051 401 2181 / 051 4013256 or engelmc@ufs.ac.za

Dr SM Le Grange (Chairperson), Health Sciences Research Ethics Committee, Faculty of the Health Sciences, University of the Free State, 051 4017794/5, ethicsfhs@ufs.ac.za.

I am aware that the findings of this study will be anonymously processed into a mini-dissertation / journal publications and / or conference proceedings.

I have received a signed copy of the informed consent agreement.

I agree to the audio recording of the semi-structured interview.

Full Name of Participant _____

Signature of respondent:

Date:

Full name of Researcher _____

Signature of Researcher:

Date:

Appendix D

FOCUS GROUP DISCUSSIONS: MOTHERS



FOCUS GROUP QUESTION GUIDES

Women who have recently given birth (mothers)

Individual level:

1. Health information
 - Where do you usually receive information about: antenatal care, deliveries and post-natal care?
 - What information have you been given about: antenatal care, deliveries and post-natal care?
 - What additional information would you like to receive about antenatal care, deliveries and post-natal care?
2. Health seeking behaviour
 - Which health care provider did you visit first when you suspected that you were pregnant? Why?
 - How many months were you pregnant when you first accessed maternal health services at this facility? Why?
 - How many antenatal care visits did you have? Explain.
 - Where did you give birth? Explain.

Interpersonal level

1. Is your husband/partner aware of your maternal health care needs?
2. Did your husband/partner encourage you to go for antenatal care visits at the clinic? Explain
3. Did your husband/partner attend antenatal care visits at the clinic with you? Explain.
4. Was your husband/partner present when you gave birth? Explain
5. Who decided where you would give birth? Explain
6. What support does your husband/partner provide for you now that you have recently given birth?
7. Does your husband/partner encourage you to go for postnatal visits at the clinic? Explain
8. Does your husband/partner attend postnatal care visits at the clinic with you? Explain.
9. Did your immediate family (e.g. mother, mother-in-law) support you during your pregnancy? Explain.
10. Did your immediate family (e.g. mother, mother-in-law) encourage you to go for antenatal care visits at the clinic? Explain.

11. Where did your immediate family (e.g. mother, mother-in law) want you to give birth? Explain.
12. Does your immediate family (e.g. mother, mother-in-law) support you now that you have given birth? Explain.
13. Does your immediate family (e.g. mother, mother-in-law) encourage you to attend postnatal care visits at the clinic? Explain.

Community and organisational levels

1. How easy/difficult is it to access maternal health care services at this clinic?
 - geographic accessibility
 - opening hours
 - health care provider availability
 - availability of resources
 - health care worker attitudes
2. Has there ever been a time that you needed to access maternal health services at this clinic, but you were not able to? Explain.
3. What role does the community outreach team play in providing you maternal health care services?
4. Is there anything at the clinic that prevents you from accessing maternal health care services?
5. Is there anything at the clinic that encourages you to access maternal health care services?
6. Are there any cultural beliefs in your community that encourage you to seek maternal health care services at the clinic?
7. Are there any cultural beliefs in your community that discourage you from seeking maternal health care services at the clinic?

Conclusion

1. Are there any other factors that you have not yet mentioned, that make it difficult for you to access maternal health care at the clinic? Explain.
2. Are there any other factors that you have not yet mentioned, that make it easy for you to access maternal health care at the clinic? Explain.
3. What do you recommend could be done to improve uptake of maternal health care services in your community?
4. Is there anything else that you would like to add?

Appendix E

FOCUS GROUP DISCUSSIONS: PREGNANT WOMEN



FOCUS GROUP QUESTION GUIDES

Pregnant women

Individual level:

1. Health information
 - Where do you usually receive information about: antenatal care, deliveries and post-natal care?
 - What information have you been given about: antenatal care, deliveries and post-natal care?
 - What additional information would you like to receive about antenatal care, deliveries and post-natal care?
2. Health seeking behaviour
 - Which health care provider did you visit first when you suspected that you were pregnant? Why?
 - How many months were you pregnant when you first accessed maternal health services at this facility? Why?
 - How many antenatal care visits have you had? Explain.
 - Where are you considering giving birth? Explain.

Interpersonal level

1. Is your husband/partner aware of your maternal health care needs?
2. What support does your husband/partner provide for you now that you are pregnant?
3. Does your husband/partner encourage you to go for antenatal care visits at the clinic? Explain
4. Does your husband/partner attend antenatal care visits at the clinic with you? Explain.
5. Where would your husband/partner like you to give birth?
6. Does your immediate family (e.g. mother, mother-in-law) support you during your pregnancy? Explain.
7. Does your immediate family (e.g. mother, mother-in-law) encourage you to go for antenatal care visits at the clinic? Explain.
8. Where would your immediate family (e.g. mother, mother-in law) like you to give birth?

Community and organisational levels

1. How easy/difficult is it to access maternal health care/antenatal services at this clinic?
 - geographic accessibility
 - opening hours
 - health care provider availability
 - availability of resources
 - health care worker attitudes
2. Has there ever been a time that you needed to access maternal health services at this clinic, but you were not able to? Explain.
3. What role does the community outreach team play in providing you maternal health care services?
4. Is there anything at the clinic that prevents you from accessing
5. Is there anything at the clinic that encourages you to access maternal health care/antenatal care services?
6. Are there any cultural beliefs in your community that encourage you to seek maternal health care services at the clinic?
7. Are there any cultural beliefs in your community that discourage you from seeking maternal health care services at the clinic?

Conclusion

1. Are there any other factors that you have not yet mentioned, that make it difficult for you to access maternal health/antenatal health care at the clinic? Explain.
2. Are there any other factors that you have not yet mentioned, that make it easy for you to access maternal health/antenatal health care at the clinic? Explain.
3. What do you recommend could be done in order to improve uptake of maternal health care services in your community?
4. Is there anything else that you would like to add?

Appendix F

INTERVIEW SCHEDULE: KEY INFORMANT INTERVIEWS



SEMI-STRUCTURED INTERVIEW GUIDE

Health care provided interview schedule

1. How long have you worked as a nurse?
2. Do you only provide maternal health care services at this facility?
3. For how long have you been providing maternal health care services at this clinic/hospital facility?
4. What maternal health care services are provided at this facility?
5. What makes it difficult for you to provide maternal health care service at this facility:
6. How many antenatal care visits should a pregnant woman attend?
7. Is antenatal care provided on a daily basis at this clinic? Explain.
8. In general, do women attend antenatal care visits at this facility? Explain
9. How many postnatal care visits should a pregnant woman attend?
10. Is postnatal care provided on a daily basis at this facility? Explain
11. In general, do women attend postnatal care visits at this facility? Explain.
12. What difficulties do pregnant women experience in accessing delivery services?
13. What encourages women to attend maternal health care services at this facility?
 - Geographic accessibility
 - Open hours
 - Availability of human resources
 - Availability of material resources
 - Health care worker attitudes
 - Support from husband/partner
 - Support from immediate family
 - Awareness about maternal health care
 - Traditional/cultural beliefs

14. What discourages women from attending maternal health care services at this facility?

- Geographic accessibility
- Open hours
- Availability of human resources
- Availability of material resources
- Health care worker attitudes
- Support from husband/partner
- Support from immediate family
- Awareness about maternal health care
- Traditional/cultural beliefs

15. What would you recommend to improve women's use of maternal health care services in your facility?

16. Is there anything else that you would like to add?

Appendix G

HEALTH SCIENCES RESEARCH ETHICS CLEARANCE



Health Sciences Research Ethics Committee

12-Nov-2019

Dear Mr Lennox Tapera

Ethics Clearance: **Experiences of accessing maternal health care services in a rural community of South Africa.**

Principal Investigator: **Mr Lennox Tapera**

Department: **Centre for Development Support Department (Bloemfontein Campus)**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2019/1084/2611**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee

Office of the Dean: Health Sciences

T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za

IRB 0006240; REC 230408-011; IORG0005187; FWA00012784

Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G-40) | Bloemfontein 9300 | South Africa

www.ufs.ac.za



Appendix H

TSHWANE RESEARCH COMMITTEE CLEARANCE CERTIFICATE



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 17/12/2019
PROJECT NUMBER: 63/2019
NHRD REFERENCE NUMBER: GP_201908_044

TOPIC: Experiences of accessing maternal health care services in a rural
community of South Africa.

Name of the Researcher: Lennox Tapera
Name of the Supervisor: Dr Michelle Engelbrecht
Facilities: Dark City CHC
Rethabiseng Clinic
Name of the Department: University of the Free State

**NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE
RESEARCH DONE AND**

**NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS
REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES
AS APPROVED BY THE COMMITTEE.**

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Mpho Moshime-Shabangu
Acting Chairperson: Tshwane Research Committee

Date: 17/12/2019

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2019.12.18



DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Lennox Tapera** to do his or her research on
**“Experiences of accessing maternal health care services in a rural community of
South Africa.”** in

**Dark City CHC
Rethabiseng Clinic**

I know that the final approval will be from the Tshwane Regional Research Ethics
Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

*The researcher to have an entry meeting with potential facilities before starting
with the data collection.*



MR M MAKHUDU
PRIMARY HEALTH CARE: TSHWANE
Date: 11/12/2019

Appendix I

CODING BOOKS

CODING BOOK 1: FGDs MOTHERS

FGD With Mothers Theme Coding

Coding		
Deductive	Code	Example
FGDs		
Individual Level		
Understanding Knowledge of MHS		
Pregnancy related information from clinics	1	The clinic also informs you on how to take care of your child after birth
Pregnancy related information from internet	2	That is the kind of information I found on the internet
Dos and Don'ts in pregnancy	3	You are not supposed to eat raw fish during pregnancy
Information on how to take care of the baby after birth	4	They inform you on how you should clean the umbilical cord wound
Information on the importance of ANC and PNC	5	This helps the clinic to know your HIV status and take necessary measures to prevent the unborn child from getting infected
Clinic Provides limited Information as compared to the internet	6	The clinic provides limited information
		There is a lot of information I did not get from the clinic but which I got from the internet
Information about friendly nurses	7	There are some nurses that are friendly and patient who do their work expeditiously with patience and honest
Information on where pregnancy was confirmed	8	I skipped periods for a month then I came here for a check-up
		I found out that I was pregnant when I went to Sunshine to do a sonar. (FGD 1) Page 2
Information on reasons for seeking pregnancy affirmation at other clinics	9	At this clinic, we do not have Sonar.
		They are still using the old method of checking the heartbeat of the child

Information on first ANC visit and reason for coming at that stage	10	I was 5 months pregnant because I was avoiding coming earlier since the waiting period is just too long easily.
		I was 2 months pregnant because I felt that I was not ok body wise and I decided to come to the clinic
Information on number of ANC visits before giving birth	11	Between 10 to 15 times
		It was approximately 15 times because I gave birth when I was 10 months
Information on when ANC visits start to be weekly before birth	12	When you are 8 months pregnant
Information on place of birth and why	13	I gave birth at Mamelodi because of C-section
		Clinic because its close
Interpersonal Level		
Partner Knowledge of ANC	14	Yes. Whenever I am not unwell during pregnancy, they encourage me to visit the Clinic
Partner Support in ANC	15	Yes, because I wanted him to be well informed as it was his first baby
		He accompanies me to the clinic if he is not working that day
Partner support at Delivery	17	He was not there. Because in public hospitals they do not want him to be in the delivery room
		He was there because I gave birth at home. He then took me to Clinic B
Partner support after birth	18	Yes, he used to cook for me and buy all the necessities.
		Moreover, he still provides
Information on who decided on the place of birth	19	It was the clinic because I had to give birth by C-section
		I decided to choose the clinic
Information on whether partner encourages PNC visits at the clinic	20	Yes, he still encourages me
Family support in ANC	21	Yes, they were very supportive. She would come and queue up for me in the morning
		Bring me lunch at the clinic if I am not back at home before 12 noon
Family support at birth	22	They wanted me to give birth at Clinic because it was close by
		My mother wanted me to give birth at Clinic B
Organisational Level		
Barriers at Rethabiseng	23	Her attitude upsets me
		She as attitudes and ill-treats patients

		There is no privacy
		I stay in extension 5 and its quite a distance
		Some of their equipment malfunctions
		There are only two small toilets and 1 bed
		Because of poor services here at Rethabiseng
Facilitators at Rethabiseng	24	They have now changed their system
		Mothers with babies go to the other side and the queue is fast
		Sister A and Sister B are the friendliest nurses
		Its close for us. We walk to the clinic
Information on failure to access maternal health services when needed	25	I visited the clinic for proper medication, and they told me that they didn't have it
		They always tell me that they do not have that
		They never helped me with anything.
Dysfunctional suggestion box	26	if there are bad reviews written there, they destroy it
		They burn them
Incompetence of Community Outreach Teams	27	They do not come to us in our homes
		Some do not even greet you
		They just want us to complete their forms that they have done their job when they see us here
Information on sanitation and hygiene at the clinic	28	Yes, water is offered, but their cups are dirty
Inductive		
Recommendations to improve efficiency	29	They should also create more water stations
		Staff should be patient with patients
		They should lock doors during consultations
		We must urinate in wider proper glasses
		Hire nurses from different communities
		Remove broken chairs from the public space
		Buy a sonar so we do not for to Mamelodi
		I suggest two people do the BP check-ups
		The staff must stop chatting and catching up on weekend stories
		Have a midwife in the ambulance
		If the service can be extended to 24 hours

CODING BOOK 2: FGDs PREGNANT WOMEN

Coding		
Deductive	Code	Example
FGDs		
Individual Level		
Pregnancy related information from clinics	1	We get it from the clinic
Pregnancy related information from internet	2	I usually get the information on the internet
		I do research social media like going on some Facebook pages for pregnant women
Information on what to do and what not to do in pregnancy	3	Things you need to avoid doing when pregnant which may cause miscarriages.
Pregnancy information from parents and previous mothers	4	I also receive information from the previous mothers and parents
Clinic programmes from others sources that you wish the clinic to embrace	5	I wish the clinic could conduct similar discussions where an experienced informant comes to present
		What causes someone to carry on periods while they are pregnant
Information on healthcare provider visited upon suspecting pregnancy and the reasons	6	I came to the clinic because I was not sure if was pregnant or not
		I went to a doctor who then told me that I was 5 months pregnant
Information on poor testing / singular testing methods at the clinic	7	I came to test twice, and it said negative.
Information on first ANC visit and reason for coming at that stage	8	I was only 4 weeks pregnant. I was constipated and was very sensitive to certain scents.
		I was 3 months pregnant. I had begun to feel different
		17 weeks. I was gaining in weight and then I decided to do a pregnancy test.
Number of ANC visits and months in pregnancy	9	Four times
		10 times. I visit the clinic twice a month since I am pregnant with twins.
Information on place of birth choice and why	10	Clinic because it is easy and close by its close by.
		Steve Biko Hospital. At Clinic B, they ill-treat pregnant women.

Information on concerns of dangers of home delivery	11	It is risky because you may get infections.
Interpersonal Level		
Partner knowledge of ANC	12	Yes, he even helps me with house chores.
		He even asks what I would be craving for regularly.
		Yes, he supports me financially and emotionally. He also focusses too on my health
Partner support during ANC	13	Yes, he always reminds to go for check-ups at the clinic
		He even reminds me of the dates for check-up
		He is very encouraging. He is very happy of the pregnancy
Partner support at delivery	14	They do not care if you come home with a baby.
		They just follow what you as a woman opt for
Family support during ANC	15	I am getting support from my family
		My family is more involved than his family because they live far.
Family support at delivery	16	Most women in my family have had children before. Based on their experiences, they discourage me from giving birth at Clinic B.
		My mother prefers Bronkhorstspuit Hospital because she has experience on how they treat patients
Organisation level		
Barriers to access	17	It is difficult because there is no Sonar.
		Someone will judge you on the way you look.
		One fails to open up so nurse can assist and even counsel for fear of being judged
		I prefer going to Zithobeni Clinic because of the attitudes nurses give you here.
		I would prefer that they operate for 24 hours like Clinic B
		The clinic is too small
		Sometimes. You call an ambulance to take you to Clinic Band it does not come. FGD 3 Page 8
		They should extend the clinic because it is small. FGD 3 Page 9
Facilitators to access	18	It is not far for us. Proximity

		The staff are adequate
Information on failure to access maternal health services when needed	19	I do not even know why they could not complete my consultation
		The nurses said that they could not help me as they cannot tell there was bleeding.
Role of Community Outreach Teams in MHC	20	No, they only go around testing people for HIV and AIDS and TB
Inductive		
Recommendation to improve access	21	At least they should have the person dealing with pregnant women ready every time so that we do not wait for long
		They must properly plan and respect the doctor's time
		I would like them to expand the services and equipment they currently have
		The clinic must conduct multiple tests
		The nurses must be more resourceful

CODING BOOK 3

SEMI STRUCTURED INTERVIEWS WITH KEY INFORMANTS: THEME CODING

Coding		
Deductive	Code	Example
FGDs		
Individual Level		
Information on working experience	1	Fifteen years.
		24 years
		9 years
Areas of expertise in rendering MHS	2	Maternity care
		Antenatal care
		HIV and TB testing and counselling
		Chronic diseases and mental health
Information on whether the facility provides maternal health care services	3	We do
		We refer to Clinic B
		We refer to Mamelodi, Steve Biko, Bronkhorstspuit Hospital
Information on whether MHC is provided daily	4	Monday to Friday
	5	

Information on how busy the maternity ward is		We see between 300 and 400 patients a month for pregnancy.
Information on feeder areas / surrounding communities that use of the facility	6	Rethabiseng
		Surrounding farms
Information on the period the informant has rendered services at the facilities	7	8 years
		3 years
		9 years
Information relating to the maternal health services rendered at the facilities	8	antenatal care
		We can do auto sum-scan for the patients,
		We can do auto sum-scan for the patients,
		Post-natal care and immunisation
Information on referral for high risk patients and low risks patients	9	To Mamelodi
		Steve Biko Hospital
		Bronkhorstspuit
Information on number of ANC visits pregnant women must attend.	10	It is 14, 20, 26, 30, 34, 36, 38 (counting), I think it is at 14 weeks, 20 weeks, 26 weeks, 30 weeks, 34, 36, 38, 40.
		They will come when they are 20, 26, 30, 34, 38 and 40
		Eight times. At first, it is earlier than 20 weeks, she return at 12, 20, and 26,30,34,38.
		I think its 8 visits
Information on ANC registrations (first trimester)	11	No they do not.
		Some of them come at 36 weeks and they are about to deliver.
		Around 30 weeks and some around 34 weeks,
Information on the maternity ward book	12	It is the booking booklet so it is the maternity case record.
		They tell you that they just came for maternal care card in order to have a birth delivery place secured.
Information on services rendered during the recommended 8 ANC visits.	13	We see how far if the pregnancy is growing
		We check the baby's heart rate we ask the mother if she has any problems at that stage.
		Family planning

		Maternal education
Information on whether registered women attend ANC as scheduled	14	Yes, they do
		I must say my patients do come regularly when they are supposed to
Information on whether PNC is offered at the facility.	15	They deliver then they come after 3 days for check-up and then obviously at 6 weeks.
		Yes, it given.
		They come between 3 -6 days.
Information on services rendered during the recommended PNC visits.	16	To see if they are coping with the baby
		To see psychologically how they are doing
		Particularly how they are doing and if there are any complications.
Information on whether the mothers attend PNC visits	17	They come at 3 days most of the women,
Information on what the clinic does to assist mothers whose children are staying with guardians	18	So, we try and contact them, but the problem is they give the wrong address
		or we try to follow up because the cell phone number is wrong, or the address is incorrect
Interpersonal Level		
Partner support during ANC	19	No is very rare to find a patient coming with their partner to the clinic.
Family support during ANC	20	Most of them are assisted by their mothers
		Mental patients
		We ask mothers to come with Teenagers
Information on importance of maternal health information during pregnancy	21	I think some are ignorant because it is posted everywhere the importance
		We still have late booking patients for ANC when they are about to deliver.
Information on whether the turn away patients because they cannot see them that day.	22	No, we try and see them all at the same time
Information on family planning services	23	Yes, we give family planning advice,

rendered to the women at the facility.		
		We give them during pregnancy
Information on what makes it difficult for women to use family planning methods.	24	Because of their cultural beliefs
		Most men do not condomize, especially the foreigners
		Foreigners usually have a problem and have a dominance over their wives.
		if they use family planning, they use it without the man's knowledge. KII 1 Page 12.
Community level		
Information on whether culture / tradition encourages / discourages them to access maternal health services.	25	It affects them badly especially for breastfeeding they end up misfeeding the baby.
		They eat soil and cannot stop eating it. They say its taste like chocolate.
		They give them these mixtures to make them go into labour,
		They are discouraged from drinking orange things because the baby will become orange.
		They put funny things on the baby's umbilical cord so this does affect them.
Information on mentor mothers	26	Mentor mothers actually assist the pregnant women on how to breast feed,
		they assist the women that have tested HIV positive
Information of the roles, responsibilities, and impact of mentor mothers in MHC	27	Since they have been with us the HIV positive testing rate babies have decreased
Information on whether they have skilled / experienced midwives in their communities to assist with home deliveries	28	No, I doubt it. KII 1 Page 8
Information on the detrimental effects of these cultural beliefs and practices	29	It can be harmful to the child and it can break down the baby's immune system
		and the mother may bleed to death when they continue eating the soil,
		If they put charcoal or cow dung on the baby's umbilical cord, it may lead to death if the mother did not get tetanus injection during her pregnancy.
Organisational level		
Facilitators to access	30	We have a sonar

		Mentor mothers assist us
		24-hour clinic
		The location of the clinic. They walk.
		They tell you they want the ward book.
		Park homes.
		Maternity ward
Factors making it difficult to provide services	31	I do it with my own data, and the lab track.
		We do have Tshwane Wi-Fi but from my office I do not pick it up.
	32	We do sometimes we run out of stock but it doesn't always happen
		but there was a time we didn't have gloves
	33	The long queues are one of the biggest things
		Some wait from 10am until 4pm.
		They come at 30 weeks, some at 34
		We need a sonar
		When one of us is not there
Inductive		
Recommendation on rendering	34	If they use family planning properly
		We need extra hands
		We no longer have to refer
		Keep on educating them
		Government must hire midwives and doctors
		We need to explain the importance of it