Are We There Yet: **Investigating the perceived causes of maternal mortalities in KwaNyuswa, Ezinqoleni Municipality.**

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Declaration

I, Mbali S Vilakazi, declare that the work presented in this dissertation is my own, and that any work done by other persons has been duly acknowledged.

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Mbali S Vilakazi   Date

Abstract

Are We There Yet: Investigating the perceived causes of maternal mortalities in KwaNyuswa, Ezinqoleni Municipality.

Studies conducted within Southern African countries link causes to the absence of the provision of maternal healthcare through accessible healthcare structures. Other factors which perpetuate mortalities are infections deriving from HIV/AIDS, particularly in South Africa and more specifically, within the province of KwaZulu-Natal. Maternal mortalities are, by definition, the death of pregnant women at childbirth or during pregnancy due to various complications. With an annual record showing almost half a million pregnant women dying from causes, some known and others not, it is imperative to conduct this study, which is aimed at investigating causes of maternal mortality from perspectives of communication and culture, particularly within the rural community of KwaNyuswa.

In conclusion, pertinent findings gathered through this study reveal that maternal health knowledge is lacking amongst pregnant women and women prior to falling pregnant. This included knowledge on prenatal and antenatal care. Additionally, the fear of HIV-testing acts as a barrier for mothers who seek maternal healthcare. The pregnant women fear testing positive, which then affects their agency meaning programmes such as the prevention from mother to child transfer (PMTCT), which are fully operational in KwaNyuswa. Additionally, traditional birth attendants (TBA) do not exist in this rural community; therefore they cannot be listed as contributing to maternal mortalities in this community.

This study indicates that community caregivers act as a source of information and accountability for pregnant women, as they ensure attendance at necessary antenatal care appointments. This investigation revealed more than one child mortality case in the area and that a lack of transportation to healthcare facilities contributes to maternal mortalities. Lastly, inadequate service further disempowers pregnant women's ability to secure maternal healthcare services. It is recommended that community perceptions around the PMTCT programme and the causes of child mortalities be considered for further investigation. Further, suggestions include a quantitative study which should be conducted in the KwaNyuswa rural area to determine the maternal mortality rate (MMR).

Key words: Maternal mortality, perceptions, maternal healthcare, traditional birth attendants, culture-centered approach, communication for participatory development (CFPD), healthcare facilities.

List of Acronyms and Abbreviations

BEOC   - Basic Essential Obstetric Care

CCA   - Culture-Centered Approach

CEOC   - Comprehensive Essential Obstetric Care

CFPD   - Communication for Participatory Development Theory

CSIR   - Council for Scientific and Industrial Research

HIV/AIDS   - Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome

KZN   - KwaZulu-Natal

MDG   - Millennium Development Goal

MEC   - Member of Executive Council

MMR   - Maternal Mortality Rate

NVP   - Nevirapine

PMTCT   - Prevention of Mother to Child Transmission

SANDH   - South African National Department of Health

TBA   - Traditional birth attendant

UKZN   - University of KwaZulu-Natal

UNICEF   - United Nations International Children's Emergency Fund

WHO   - World Health Organization

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Chapter 1

Introduction

More than half a million women, globally, die each year during childbirth, and it is necessary to investigate the causes which lead to these deaths in our societies (Rowen et al., 2011:229). In 2002, the United Nations set the Millennium Development Goals (MDGs) to address existing socio-political and socio-economic inequalities in the aim of eradicating maternal and child mortality, "extreme poverty and hunger; combating HIV/AIDS, malaria and other diseases, ensure environmental sustainability, promote gender equality and empower women and achieve universal primary education" (UNICEF, 2003:7). Of these goals, maternal health is the fifth and it is targeted at the global reduction of the maternal mortality ratio by 75%, of the current overall rate (Fillipi, 2006:1). Recent statistics show that South Africa's target for MMR was 38 deaths per 100 000 live births in 2015, from a baseline of 150 deaths per 100 000 live births in 1990 (StatsSA, 2015).

Problem statement

This study seeks to investigate the perceived causes of maternal mortalities in the KwaNuyswa rural community; to understand the role played by traditional birth attendants (TBA) in combating maternal mortalities by communicating maternal health knowledge; and the role of communication in alleviating maternal mortalities in KwaNyuswa.

In addition, the study will look at the existing level of knowledge of maternal healthcare amongst women in the community. Understanding the experiences and knowledge of women will establish the basis of the perceptions under investigation. The MGD target of 38 deaths per 100 000 live births by 2015 has not been reached. While some progress has been made since the MDGs were adopted in 2000, hundreds of women die everyday during pregnancy or during child birth related complications (UNAIDS MGDs Report, 2015). As such there is continuing global commitment to reduce maternal mortalities and improving maternal health remains part of the development agenda post 2015. However, it is concerning that only a few countries know the maternal cause of deaths. There have been numerous local quantitative and qualitative studies conducted to identify the causes of maternal mortalities. One study has focused on the community of Manxili (Selepe & Thomas, 2000) in the province of KwaZulu-Natal (KZN). The Ezinqoleni Municipality has identified maternal mortality as a local health concern but has not identified causes (Ezinqoleni Municipality Integrated Development Plan, 2015).

This study is a qualitative research investigation. The investigation took a culture-centered approach (CCA), which allowed the researcher to engage with community members to record, analyse and identify the causal knowledge of mortalities. The decision to avoid engagement with the municipality is based on the communication for participatory development model which captures that community members better understand and can communicate their social issues. This, therefore, defines the problem in the most culturally relevant way.

Millennium Development Goals in the South African context

This study focuses on the fifth goal of the MDGs – within the context of South Africa and the province of KZN – which is to improve maternal health globally. One of the leading strategies set to effectively achieve this goal was to ensure the presence of a professional healthcare worker at childbirth (WHO, 2015). One of the leading strategies set to effectively achieving fifth goal was to ensure the presence of a professional healthcare worker at the moment of childbirth. Access to reproductive health services was also an integral part of achieving the success of this goal (WHO, 2015). However, since 2010 the number of maternal mortalities occurring in KwaZulu-Natal health care facilities has decreased from 209 deaths per 100 000 live birth to 160 deaths per 100 000 live births (McGee et al., 2016). Access to reproductive health services was also identified as an integral part of successfully attaining this goal, however, there are several barriers to ensuring these strategies are fully effective.

> It is furthermore worthy to note that South Africa has recorded progress in the expansion of its healthcare infrastructure and improved access to healthcare services for all South Africans. We are mindful that many challenges still abound with respect to matters of healthcare and mortality, but we have made significant progress with the reduction of child mortality and the improvement of maternal health (MGD Country Report, 2015).

The provision of maternal healthcare is essential for the reduction of pregnancy and childbirth complications as these are some of the key factors leading to of death amongst women globally (Walraven & Weeks, 1999). In some African countries, the perceived causes of maternal deaths included lack of access to maternal healthcare services due to distance, costs, lack of knowledge, inadequately skilled healthcare workers and a lack of facilities (Thomas et al., 2007). Ezinqoleni Municipality, within which KwaNyuswa falls, uses those standards and access to health facilities provided for by the Council for Scientific Industrial Research (CSIR) (Ezinqoleni Municipality Integrated Development Plan, 2015:90). Inaccessibility has been identified by the CSIR and there is consequently a policy-driven mandate to address this health concern. However, this mandate does not deal with the currently unknown causes of maternal mortality in KwaNyuswa, of which the researcher aimed to identify through this

study.

Maternal mortality in KwaZulu-Natal

In KZN, the maternal mortality ratio in 2002 was 150 per 100 000 (Rotchford & Rotchford, 2002). This ratio is now 140 per 100 000 deaths (StatsSA, 2015).The issue of access to maternal healthcare is an identified obstacle to securing primary healthcare services in rural South Africa (Myer & Harrison, 2003). Although there are initiatives such as mobile clinics, these often operate on a limited basis (Rotchford & Rotchford, 2002). Secondly, "in rural areas, there is inadequate understanding of health threats during pregnancy and the potential role of antenatal care in addressing these threats" (Myer & Harrison 2003:268). This represents a fundamental barrier to accessing maternal care services because pregnant women require adequate knowledge in order for them to seek healthcare for themselves and their unborn child. However, since 2010 the number of maternal mortalities occurring in KwaZulu-Natal health care facilities has decreased from 209 deaths per 100 000 live birth to 160 deaths per 100 000 live births (McGee et al., 2016).

Maternal health facilities

The state of the overall health system in post-apartheid South Africa was largely dependent on the installation of a new constitution, which ensures equal health rights for all despite location. Furthermore, the establishment of well-equipped health facilities in areas which were formerly marginalised by apartheid laws became a government mandate (Tlebere et al., 2007). To date, government policy ensures that each South African citizen is lawfully entitled to accessible and free healthcare (Tlebere et al., 2007).

Figure 1.2 Apartheid did not permit equal provision for different races in the healthcare sector. (Source: History.com, 2010).

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Marginalisation

Marginalisation is defined as lack of access to the healthcare system whereby an individual or group are unable to secure health resources (Dutta, 2008). Segregation laws intended to ensure that there was little or no interaction between racial groups in various settings. This meant that those within majority rule were afforded adequate provision of healthcare, whereas the rest, were marginalized with regards to basic services.

During apartheid, segregation meant the different provision of services in accordance with the diverse racial groups. In a study conducted by Charles Ngwenya (2000:28), the author reveals that during the apartheid regime "healthcare was highly politicized as it was used to shape up and reinforce white dominion". Therefore, racial fragmentation contributed to the disparities in the South African health system. At the same time, health became a global concern as different nations were undergoing political, social and economic changes (Kautzkyi & Tollmani, 2008).

Post-apartheid, community dwellers residing in rural areas throughout South Africa continue to experience difficulty securing affordable, good quality and comprehensive healthcare (Gaede & Versteeg, 2013). There are noticeable levels of deprivation in rural areas, which is influenced by the travelling distances to access facilities. Regarding maternal healthcare knowledge, additional access barriers are linked to economics, which involve the costs of travelling to healthcare facilities (Rotchford & Rotchford, 2002). In South Africa, the accessibility of health facilities is protected by the constitution which includes the freedom and opportunity to acquire services (Chopra et.al, 2009). Several rural areas in KZN, however, lack both in terms of the number of facilities and people's ability to access those facilities.

Arguably, "marginalisation in the context of healthcare is indicative of the lack of access to basic healthcare resources such as basic medical supplies, preventative resources and hospital staff" (Dutta, 2008:150). Although marginalisation is indicated as a lack of basic healthcare resources, preventative resources and services are also considered as primary healthcare. Marginalised communities have very little access to culturally appropriate healthcare information and the basic understanding of health meanings (Denboba et al.,

2013). To account for cultural beliefs and preferences within communities, the South African constitution holds a Traditional Health Practitioners Act 22 of 2007, which governs traditional birth attendants' (TBA) practices by ensuring safety, efficacy and quality are fundamental considerations during their attendance to pregnant women (Peltzer & Henda, 2006).

The South African government supposedly ensures that each South African citizen is lawfully entitled to accessible and free health care (Tlebere et al., 2007). In South Africa, the accessibility of health facilities is protected by the constitution which includes the freedom and opportunity to acquire services (Chopra et.al, 2009). Residents of rural communities throughout South Africa experience difficulty securing affordable, good quality and comprehensive health care (Versteeg et al., 2013). As a result, National Health Insurance was developed to provide more access to high quality health services to citizens (Mayose et al., 2014). Further, what governs and insures the steady progress towards equal access to healthcare are policies under Section 27 of the South African Constitution states that human beings have the right to access to health care services. This is further ensured by the National Health Act which is a "culmination of key health system policies promoting the access of healthcare services to everyone" (Gaede & Versteeg, 2011: 100).

Traditional birth attendants

In South Africa, a TBA is defined as "a person who engages in traditional health practice and is registered under the Traditional Health Practitioners Act" (Peltzer & Henda, 2006). Additionally, a TBA is most commonly "a middle-aged or elderly woman with no formal training who acquired her skills through experience and attends to women during pregnancy, labour and the postnatal period in various ways" (Peltzer & Henda, 2009:140). TBAs also assist the new mother by offering her advice on childcare. According to the World Health Organisation (WHO), TBAs can assist in improving maternal health and the health of newborns at a community level (Selepe & Thomas, 2000). Although this may be an initiative with mixed results, it is essential for women to receive care from a trained health worker to avoid complications (Tlebere et al., 2007). For example, the problem of HIV/AIDS in South Africa means that TBAs are positioned to protect mothers, newborns and themselves from exposure to blood and body fluids (Peltzer & Henda, 2006).

Over the years, the role of midwives during pregnancy and the child delivery process were necessary, particularly in settings where women did not have the opportunity of visiting a clinic or hospital for maternal healthcare services (Peltzer & Henda, 2006). In 2014, births which occurred in health care facilities increased to 85,6% from 79,5% in 2010 (Peltzer and

Henda, 2006). In South Africa 40 – 60% of home births in rural areas have been recorded. Further, 44,1% of these births occurred with the assistance of a traditional birth attendant (Peltzer et al., 2006). TBAs have played their role in many home-births in African communities by applying their own customs and beliefs when caring for women during pregnancy and childbirth. The reliability and safety of TBA practices, however, have been questioned by health scholars and professional health workers as their traditional methods as midwives do not always correlate with methods applied in formal healthcare settings (Tlebere et al., 2007).

The role of TBAs in maternal healthcare has become controversial as some in the formal healthcare fraternity have accused their practices of increasing the maternal mortality rate (MMR). On the other hand, however, some health scholars believe that the attendants could be a solution to eradicating maternal mortality, granted TBAs incorporate methods and practices offered through professional training (Walraven & Weeks, 1999). Many women in rural communities subscribe to the services of TBAs (Bhengu & Mchunu, 2004), and so it is the intent of this study to investigate whether or not TBAs provide services within the rural community of KwaNyuswa and establish if the women sampled for this study secure any maternal care service from attendants in their community.

Within this fragmented health system, health professionals and TBAs play an important role in addressing diseases such as HIV/AIDS, tuberculosis (TB) and cancer (Udjo & Pillay, 2013). As with any other country, these diseases impact the steady socio-economic growth and socio-political development in South Africa (Zupan, 2007). Maternal mortality remains high in South Africa. This, coupled with the fact that South Africa battles against the highest HIV-infection rate in the world, means the country has the highest MMR in Sub-Saharan Africa (Thomas et al., 2007). Further, the MMR reflects that South African women living in urban and rural regions are accounted for (Zupan, 2007). However, a recent analysis of studies conducted within KZN reveals modest representations of MMR for women residing in rural areas (Myer & Harrison, 2003). The question which this study seeks to address is that of community perceptions of the causes of maternal deaths and part of the discussion that is offered in particular chapters in this study will also take into consideration the above tabulated factors.

Study rationale

The entire process of eradicating maternal mortalities in the KwaNyuswa rural

community means that the causes need to be established first to be addressed accordingly. Only 51% of countries globally have some data on maternal mortalities (UNAIDS, 2015). Therefore, the purpose of this study was to investigate the perceived causes of maternal mortalities from the community dwellers through the selected research methodology. The aim of this introduction is to convey the motivations behind investigating the perceived causes of maternal mortality in the context of KwaNyuswa rural area in the Ezinqoleni Municipality.

Study background

The Ezinqoleni Municipality has four clinics and no hospital serving the population threshold. These are namely, Ezingolweni Clinic, Mthimude Clinic, Thembalesizwe Clinic, and Thonjeni Clinic. Ideally, clinics should be within a walking distance of 1 to 2.5 km and a maximum walking distance of 5km (Ezinqoleni Municipality Integrated Development Plan, 2015:30). However, "the municipality does not conform to this CSIR standard, as facilities are fairly evenly spread along main access routes and concentrated within dense core area, with a limited access to service in some of the outlying areas in the south" (Ezinqoleni Municipality Integrated Development Plan, 2015:90). Distance and limited access to maternal healthcare facilities were previously identified as one of the causes of maternal deaths but there is no compact study which accounts for these two factors as contributors to mortality rates in the Ezinqoleni Municipality communities such as KwaNyuswa. Therefore, the limited access to maternal healthcare facilities is a possible cause of maternal mortality in this rural area. The WHO estimates that 60% of births in the developing world occur outside of a health facility with 47% women assisted only by TBAs and family members, or are without any assistance (Walraven & Weeks, 1999:527). In Sub-Saharan Africa, the excess burden of poor health has not been thoroughly documented, particularly in relation to maternal mortality. Poorly functioning health systems in Sub-Saharan Arica have been identified as a fundamental reason to poor health (Thomas et al., 2007). Among all the African countries, South Africa has had maternal and prenatal mortality rates

which are higher than expected considering the countries efforts to promote free maternal health through policy changes (Hoque et al., 2008:66b). The MMR for South Africa is estimated to be approximately 175 to 200 per 100 000 live births. Some of these rates are linked to the increase of HIV which accounts for nearly 38% of the deaths (Tlebere et al., 2007:342).

Thus, the South African National Department of Health (SANDH) has identified the reduction of maternal mortality as a health problem which requires immediate address (Zupan, 2007). In addition, the accessibility of maternal healthcare services is a major issue influencing women as travelling and money is required to secure these services (Tlebere et al., 2007:343). Healthcare facilities provide access to people seeking to secure services, particularly in areas which are affected by maternal healthcare (Dutta, 2008). These are considered socio-economic constraints to securing maternal healthcare such as basic essential obstetric care (BEOC) and comprehensive essential obstetric care (CEOC) (Tlebere et al., 2007). However, even with these noticeable statistics, South Africa women still have difficulties reaching primary healthcare facilities which offer maternal health services (Tlebere et al., 2007:344).

The post-2015 Development Agenda prioritises maternal health, thereby placing even more emphasis on the urgent requirement for reliable MMR statistics in the future as the last rates were gathered in 2014[3]. As a point of discussion, the South African post-2015 health goal includes approximately five targets with two of these focusing on girls and women in the country. Other targets include reducing the MMR and increasing access to sexual and reproductive health services and rights.[4]

Approach to study

The research has been conducted using a qualitative approach, enabling the researcher to investigate, analyse and draw conclusions from a social phenomenon, based on human experience and knowledge. This approach becomes a process of constructing meaning from human experience, characterised by a precise sampling of the study group, a refined process of developing research questions, and data analysis which allows the researcher to structure the data in an easily accessible manner. As with most social phenomena, there are a set of theories which are applied in a qualitative research approach which enables the researcher to construct meanings towards identifying key conclusions for the research inquiry (Levison & Kuper, 2008:689).

Human interaction is a factor in qualitative studies, requiring consideration and a plan of action when dealing with the sample group and any other participants in the study. Ethical considerations, such as confidentiality and anonymity, are important for the outcome and quality of the research conducted.

Culture-Centered Approach

The culture-centered approach (CCA) is applied throughout this study. The culture-centered approach was selected as a theory to include in the study as its locale is of a cultural background. Culture plays a huge role in the decision-making processes of communities, sometimes at an individual level and other times at a community level. Culture is overtly discussed in this chapter. Culture includes all the experiences of the community over a period of time and forms a pattern of beliefs which people then act upon such as health seeking behaviors during pregnancy.

The approach has three components which are essential to understanding social phenomenon, namely agency, structure and culture. These theoretical points will be discussed in more detail in Chapter 3, which outlines the theoretical framework of the study.

Within the context of maternal healthcare, 'cultural sensitivity' refers to the consideration of women's beliefs and traditional methods of child birth (Dutta, 2008:253). Mohan Dutta (2008) highlights the need for a sensitive approach to communities in marginalised areas as they may still have a predisposition to their culture.

Firstly, culture places the active participants at the fore of the construction of experiences and meanings, customs and beliefs which are then shared in the community (Dutta, 2008:55). Secondly, the cultural component of the theory will be applied to establish whether maternal health communication lacks cultural sensitivity (Dutta, 2008:55). For instance, TBAs are considered to practice customs which are harmful to the mother and child during the delivery process, such as performing resuscitation by blowing cigarette smoke on a baby's nose (Selepe & Thomas, 2000). For this reason, the cultural component of the approach is necessary for the process of understanding the beliefs, knowledge and the perceived causes of maternal mortalities in the KwaNyuswa community.

Structures play a role in how we understand what surrounds us as human beings, the meaning we derive thereafter is based on our prior knowledge or cultural beliefs and norms. Our palate for the new environment is based on our prior experience (Basu & Dutta, 2009). Structures in a community such as KwaNyuswa refer to systems such as the municipality, the shops, the schools, farms, dirt roads and clinics. In addition, structures also refer to the facilities and infrastructure which enable community members' access to healthcare. Mohan

Dutta (2008: 62) associates healthcare access to the access of services and resources; the absence of these facilities constrains members trying to engage with primary healthcare structures. Therefore, considering the structures in the KwaNyuswa community is pivotal in the investigation towards understanding the perceived causes of maternal mortality.

Lastly, agency is a practical component in the approach as it considers the human interaction with structures; how and what meaning they derive is filtered by their culture (Basu & Dutta, 2009). Agency is co-dependent on structures in the sense that the active participation of community members requires the presence of structures. In the absence of structures, community members do not have a platform for enacting their human agency. For this reason, the relationship between agency and structure is important for the engagement of the community with structures (Basu & Dutta, 2009). In other words, the relationship between agency and structure is important for the cultural component which determines how community members engage with their surroundings daily and it also influences the meaning they derive. In this study, this approach can be understood through the factors that influence the agency (or lack thereof) of women in KwaNyuswa in their attempts to secure maternal health services. The CCA is applied in this study as it provides the researcher with a culturally sensitive approach when engaging in dialogue with the sample group in the community.

Within the context of maternal health care, "culture sensitivity" refers to the consideration of the women's beliefs and traditional methods of child birth (Dutta, 2008: 253). Mohan Dutta (2008) highlights the need for a sensitive approach to communities in marginalised areas as they may still have a predisposition to their culture. The culture-centred approach has three components which are namely; structure, agency and culture. Moreover, these components are necessary for the investigation of perceptions amongst community members in the KwaNyuswa rural area. Culture is therefore perceived to be an important component of a community's existence and its inclusion often assists in the formulation of strategies to improve or completely eradicate health issues at community level. To account for the cultural beliefs, the South African constitution holds a Traditional Health Practitioners Act 22 of 2007 which governs traditional birth attendants practices by ensuring safety, efficacy and quality are fundamental considerations, during their attendance to pregnant women (Peltzer and Henda, 2006).

Communication for Participatory Development

Communication for Participatory Development (CFPD) is a theory which captures the essence of communication as a two-way process towards achieving progress especially in an environment where dialogue is acknowledged and accepted (Melkote & Steeves, 2001). This theory was applied to this study to analyse the communication processes between healthcare providers and the community members in KwaNyuswa.The communication for participatory development (CFPD) approach, encourages participation in creating knowledge and meanings. This approach allows communities to believe in their capacities to challenge and transform structures to enable their participation in developments pertaining to their local issues. Active participation in developmental initiatives engage the community in determining their challenges and address these challenges through using the power of participation to make beneficial decisions. The CFPD approach was applied to this study to understand and analyse participation practices in the KwaNyuswa which are aimed at addressing issues pertaining to the maternal mortalities in the community.

Study location: Ezinqoleni Municipality

The location of the study is the KwaNyuswa rural area which is located in the lower South Coast region in KZN. According to the Ezinqoleni Integrated Development Plan (2015:5), the municipality holds a population threshold of 52 540. This population group is dominated by 98.6% black isiZulu-speaking South Africans, of 46% (24101) are male and 54% (28439) are female. The majority of this population consists of people between the ages of 15 to 34 years. "Ezinqoleni Local Municipality is one of six local municipalities under Ugu District Municipality in the province of KwaZulu-Natal. It is located in the south-western boundary of the district and has a total of six (6) wards with a total combined extent of 649 square kilometres, making it the second smallest municipality in the district" (Ezinqoleni Municipality Integrated Development Plan 2014:30). In terms of goal five of the MDGs, the municipality relies on the Department of Health for interventions to address issues pertaining to maternal mortality amongst communities such as KwaNyuswa.

This location was selected for several reasons, including that the community is in KZN, a province with the highest MMR in the country. Secondly, according to the municipality's recent reports, the MMR is currently unknown in this community. Thirdly, the causes pertaining to the MMR in the community are unknown. Fourthly, the municipality relies on the provincial Department of Health for intervention in dealing with maternal mortalities,

which could be enrolled once the causes of the mortalities in the area are identified. Lastly, the proximity of the location to the researcher's home town influenced the selection of the KwaNyuswa rural community.

Figure 1.3 Map of the inner Southern region of KwaZulu-Natal, where the Ezinqolweni Municipality is located. (Source: Ezinqoleni Municipality, 2014).

Structure of dissertation

The first chapter of this dissertation provides a roadmap of the study. The second chapter consists of critically discussed literature. The literature discussion focusses on the topics such the fifth MDG, maternal health, maternal mortalities, TBA, prevention of mother to child transmission (PMTCT) and culture in health.

Chapter 3 is the theoretical framework in which the researcher offers an in-depth discussion of the CCA and the CFPD; both are analysed and discussed to support the data analysis chapter of the study. Chapter 4 is the methodology chapter in which the researcher describes the nature of this study in terms of it being qualitative and the relating methodologies are discussed. These include the research design, namely the data collection methods, sampling participants data analysis tools, and validity reliability and rigour. In addition, the selection of the study participants is discussed in this chapter. For example, thematic analysis was selected as a tool for organizing and analysing the data collected.

Chapter 5 consists of the research findings and analysis from the investigation. Lastly, Chapter 6 offers a conclusion to the study. Whilst maternal mortality research conducted through studies such as this are on-going, the next chapter critically engages the reader with the background information of maternal health and mortality gathered from previous studies.

Chapter 2 Literature Review

As part of a greater plan to eradicate poverty and many health issues globally, in1995, the World Health Organisation (WHO) adopted Goal five of the Millennium Development Goals (MDG's) which was aimed at reducing the maternal mortality rate by 75% in developing countries (Hogan et al., 2010). This chapter reviewed a broad scope of literature pertaining to the issue of maternal mortalities. The chapter contains statistics of recent mortalities globally and locally, detailing the maternal mortality ratio in the province of KwaZulu-Natal. The chapter discusses topics namely, the Millennium Development Goals, the recognition of the need for maternal health care, maternal healthcare, maternal mortality, factors contributing to maternal mortality in South Africa, antenatal care in KwaZulu-Natal, knowledge of maternal mortality amongst pregnant women and traditional birth attendants.

"Every minute a woman dies during labor or delivery" (Nour, 2008:78).

The term maternal mortality was described by the United Nations International Children's Fund (UNICEF) as the "unnecessary death of mothers," and maternal mortalities were also identified as a global health issue over two decades ago (Wilkinson, 1997:161). In other words, global organisations understand there to be interventions which could be implemented to ensure the eradication of maternal mortalities. As part of a greater plan to eradicate poverty and many health issues globally, in 1995, the WHO adopted Goal Five of the Millennium Development Goals (MDG) which was aimed at reducing the maternal mortality rate (MMR) by 75% in developing countries (Hogan et al., 2010). This chapter reviewed a broad scope of literature pertaining to the issue of maternal mortalities. The chapter contains statistics of recent mortalities globally and locally, detailing the maternal mortality ratio in the province of KwaZulu-Natal. The chapter discusses topics namely, the Millennium Development Goals, the recognition of the need for maternal health care, maternal healthcare, maternal mortality, factors contributing to maternal mortality in South Africa, antenatal care in KwaZulu-Natal, knowledge of maternal mortality amongst pregnant women and traditional birth attendants.

Millennium Development Goal Five – Improving Maternal Mortalities

In the early 2000s, communities from all over the globe committed to the eradication of extreme poverty and they also made a commitment to improving the status of health and wealth within extremely poor communities. These economic, health and social issues were a response targeted at barriers to achieving success in global development (McArthur, 2014:5). The commitment to the MGDs united these communities to set and achieve quantifiable targets over a 15-year period, from 2000 to 2015. The achievement of these goals required

the involvement of wealthy countries in the process of eradicating poverty and improving the state of health in many underdeveloped nations. Improvements in global reproductive health would be achieved through the attainment of the target set under the goal, that being the reduction of three-quarters of maternal mortalities worldwide (McArthur, 2014:10). The entire process of eradicating maternal mortalities means that causes need to be established to be addressed accordingly, but without research, there are no findings upon which interventions can be based.

The MGD target of 38 deaths per 100 000 live births by 2015 has not been reached. While some progress has been made since the MDGs were adopted in 2000, hundreds of women die everyday during pregnancy or during child birth related complications (UNAIDS MGDs Report, 2015). One of the leading strategies set to achieve the fifth MDG was to ensure the presence of a professional healthcare worker at childbirth. Access to reproductive health services was also identified as an integral part of achieving the success of this goal, however, there are numerous barriers to ensuring these strategies are fully effective. The following sections will explore these barriers as well as some of the effects of not having the above-mentioned strategies in place in communities within the sub-Saharan region of Africa (Gerein et al., 2006) and in the South African context (Tlebere et al., 2007). This chapter will also place greater focus on KwaNyuswa in KwaZulu Natal (KZN).

Further, the literature discussion focuses on topics such as maternal health, maternal mortality, traditional birth attendants (TBA), antenatal care and prevention of mother to child transfer (PMTCT) programmes. The chapter also discusses the factors which have been identified as causes for the state of the health system in South Africa, and those factors which contribute to the current maternal mortality rate (MMR). The purpose of this chapter is to critically discuss and analyse the findings from previous studies to identify gaps in the knowledge collated on maternal mortalities. Secondly, this body of literature helped the researcher understand the existing causes of maternal mortalities to add to the current body of knowledge through the researcher's findings in Chapter 5 of this study.

Progress Chart - MMR
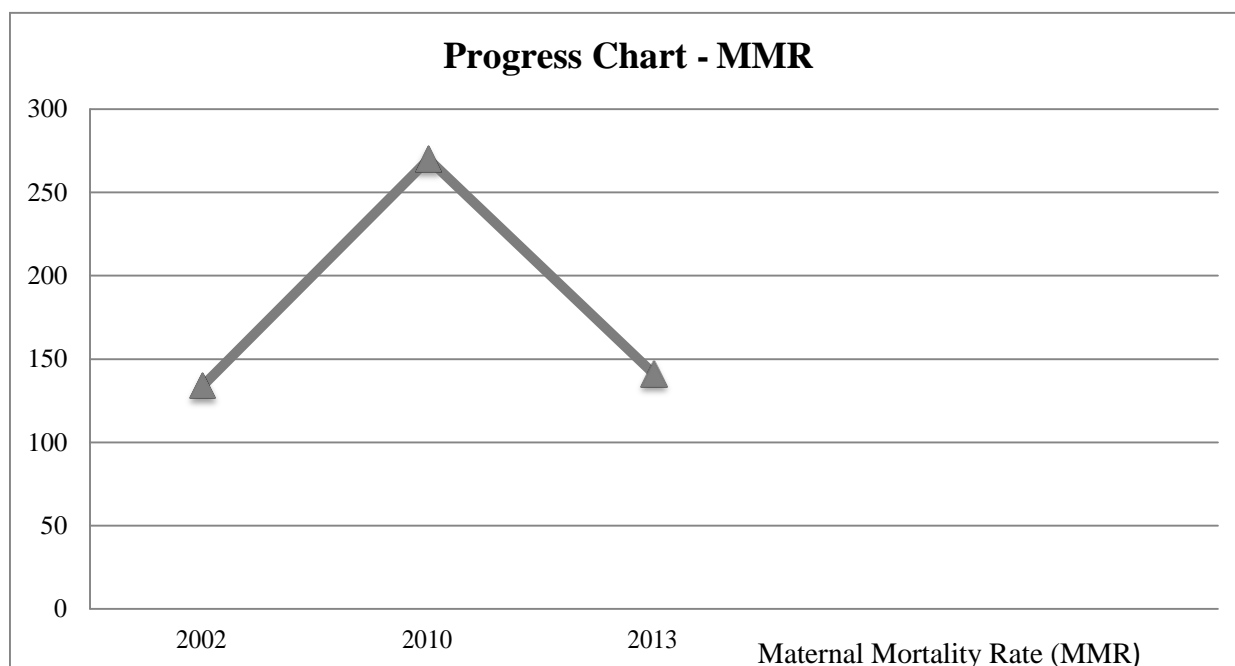
Maternal Mortality Rate (MMR)

Figure 2.2 A graph reflecting progress towards the fifth MDG's in South Africa. (Source: Millennium Development Goals: Country Report 2015 / Statistics South Africa, 2015).

The above graph reflects the progress made towards decreasing the MMR by 75% from 2002 to 2013; it is clear the targets were not met. As mentioned previously, South Africa has a history of high expenditure when it comes to implementing healthcare facilities for women to access free maternal health services (Rotchford & Rotchford, 2002). Recent statistics show that South Africa's target for MMR was 38 deaths per 100 000 live births in 2015, from a baseline of 150 deaths per 100 000 live births in 1990 (StatsSA, 2015). However, the statistics reflect slow progress and it is important to understand why this is so. The absence of efficient delivery of strategies was identified as one of the causes for slow implementation (Lalthapersad-Pillay, 2015). In addition, a lack of accurate and consistent reporting on MMR is problematic in trying to strategise and implement health facilities in any initiative the government rolls out.

Recognition of the need for maternal healthcare

In Sub-Saharan Africa, the excess burden of poor health is thoroughly documented, particularly within the context of maternal mortality. The poorly functioning health systems in Sub-Saharan African countries have been identified as a fundamental reason for poor health (Thomas et al., 2007). In comparison to other African countries, South Africa has had maternal and prenatal mortality rates which are higher than expected considering the

country's efforts to promote free maternal health through policy (Thomas et al., 2007). The MMR for South Africa is estimated to be 141 deaths to 200 per 100,000 live births (StatsSA, 2015). Some of these rates are linked to the increase of HIV/AIDS which accounts for nearly 38% of the deaths (Tlebere et al., 2007: 342). As a result, the reduction of maternal mortality has been identified by the South African National Department of Health (SANDH) as an issue which requires immediate addressing (Zupan, 2007). In 2010 it was estimated that 3000 South African women died during child birth but the latest estimates show that maternal mortality has halved (StatsSA, 2015). In addition, the accessibility of health services is a major issue affecting women who seek maternal care, as the distance, time and money needed for travel impedes their ability to access these services (Tlebere et al., 2007).

In KZN, the MMR is 30 deaths150 per 100 000 live births (SAPA, 2014). The problem amongst rural populations in South Africa is an inadequate understanding of health threats during pregnancy and the potential role of antenatal care in addressing them (Myer & Harrison, 2003:270). This lack of knowledge presents a fundamental barrier to improving antenatal services and can be linked in part to healthcare providers. Residents of rural communities throughout South Africa experience difficulty securing affordable, good quality and comprehensive healthcare (Gaede & Versteeg, 2013).

What is maternal healthcare?

With hundreds of thousands of women dying globally during pregnancy and at childbirth, maternal health was prioritised to alleviate these deaths and increase healthy reproductivity amongst women in developing countries. Maternal healthcare refers to the wellbeing of a woman during pregnancy and the puerperium period, which is the period after birth when the placenta is removed from the womb (Moran & Moodley, 2012). The care received by the mother during the puerperium period is an essential component for preventing infections (Moran & Moodley, 2012). The World Health Organisation (WHO) defines maternal health as the health of women during pregnancy, childbirth and the post-birth period (UNICEF, 2014).. "Maternal healthcare during the pregnancy is offered through antenatal care programmes which were originally designed in Europe in the first decades of the 20th century" (Mathole et al., 2003:123).

Originally, the antenatal care programme was intended for women in socially difficult living conditions and the programme was thus implemented with the structured mandate of improving maternal and perinatal outcomes for the least privileged pregnant women (Moran & Moodley, 2012). Statistics reflect that in most parts of the world, however, the least

privileged groups of mothers are usually not the beneficiaries of antenatal care (Hogan et al., 2010; (Simkhada et al., 2007).

Even with this criticism at play, the provision of antenatal care is regarded as a cornerstone of maternal healthcare and is expected to have considerable impact on achieving the MDGs. Antenatal care has been praised for leading to early detection of high-risk pregnancies (Hoque, 2011: 1). The provision of antenatal care in South Africa is offered through midwives within the structure of public health facilities. Part of the antenatal process includes the communication of a booking for an antenatal check-up, where the full medical histories of the patients are taken and a pregnancy examination is conducted (Hoque et al., 2008).

What is maternal mortality?

Maternal mortality is described as the death of a woman while pregnant or during childbirth. The deaths of 530 000 women annually result from pregnancy-related illnesses and complications (Hoque, 2011:1). As mentioned, in the introductory chapter, UNICEF describes maternal mortality as the unnecessary death of mothers (Wilkinson, 1997:161). "Maternal mortality is the health indicator that shows the greatest differential between developing and industrialised countries" (Carroli et al., 2001). This suggests that the more industrialised the country, the more efficient healthcare services are present for women. This may not be necessarily true as the next section of this chapter will discuss the challenges pertaining to maternal healthcare in South Africa. Only 51% of countries globally have some data on maternal mortalities (UNAIDS, 2015). Identified as a global health issue in the year 1995 by the WHO, maternal mortality currently remains a global issue (Hogan et al., 2010).The maternal mortality ratio (MMR) for South Africa is estimated to be approximately 141 deaths per 100,000 live births (StatsSA, 2015). In 2010 it was estimated that 3000 South African women died during child birth but the latest estimates show that maternal mortality has halved (StatsSA, 2015). This indicates that the South African government failed to meet its maternal mortality reduction goals

Factors contributing to maternal mortality in South Africa

Top Three Causes of Maternal Mortality in South Africa

- 33,7% - Non-pregnancy related infections (caused by AIDS)
- 18, 1% - Hypertension complications of pregnancy 18, 1%
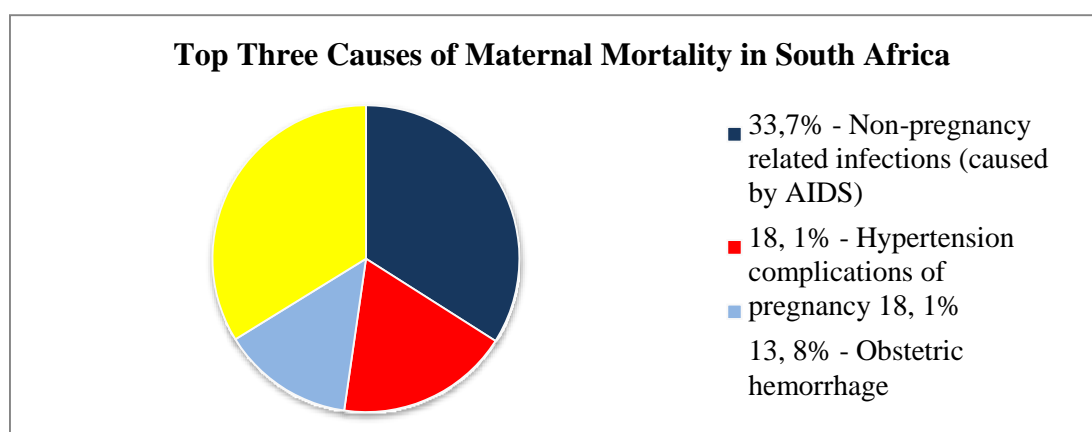- 13, 8% - Obstetric hemorrhage

Figure 2.1 showing the top three causes of maternal mortality in South Africa. (Extrapolated from: Tlebere et al., 2007: 342).

The factors impacting on the usage of maternal health services can be grouped into various categories as seen in Figure 2.1; namely, "administrative factors, medical personnel factors and patient-related factors" (Tlebere et al. 2007: 342; Lalthapersad-Pillay, 2015).

Administrative factors

South Africa's colonial and apartheid history had negative influences on the delivery of public healthcare facilities and services particularly to rural dwellers (Kautzky & Tollman, 2008). According to Amnesty International, rural dwellers in South Africa make-up 43,6% of the entire population (Lalthapersad-Pillay, 2015). This history has also impacted on the dispersion of health professionals, as 12% of doctors and 19% of nurses in the country serve the entire rural population. In addition, accessibility is also a major issue in areas where clinics or hospitals are located far from the community (Lalthapersad-Pillay, 2015). In 2014, births which occurred in health care facilities increased to 85,6% from 79,5% in 2010 (StatsSA, 2015). In South Africa 40 − 60% of home births in rural areas have been recorded. Further, 44,1% of these births occurred with the assistance of a traditional birth attendant (StatsSA, 2015). In other instances, there is a lack of transportation, in the form of ambulances, to and from the hospital. This unavailability of healthcare facilities may negatively affect woman's entire pregnancy (Lalthapersad-Pillay, 2015).

South Africa spends millions of Rands annually on improving its healthcare system but even with these improvements the MMR is excessive (Rotchford & Rotchford, 2002). This, despite the country's policies which ensure free access to reproductive health services. Additionally, maternal mortalities in South Africa occur even amongst women

who receive some healthcare though antenatal care and delivery at a health facility, a trend which may indicate that pregnant women are inconsistent with their clinic visits. There are multiple shortcomings which were identified in the public sector by Lalthapersad-Pillay (2015), particularly regarding the facilities which deliver services in rural areas such "as lack [of] sufficient medical supplies, insufficient supply of information about contraception and substandard fertility management services" (Lalthapersad-Pillay, 2015:6476).

Medical personnel factors

About 63% of pregnant women in Sub-Saharan Africa have a minimum of one antenatal care checkup and 42% pregnant women have a professional midwife at their delivery (Bulterys et al., 2002:222). Often, quality maternal care is unavailable and as an alternative mothers utilise the services of traditional midwives and TBAs who are often easier to access as they reside within the community (Bultery et al., 2002). In a study undertaken in 2003, "delayed agency in seeking antenatal care services was found among individuals belonging to African cultural groups characterised by ethnic beliefs, traditional families and groups in who shared similar skepticism about western medicine" (Shamaki & Buang, 2014:2). Barriers created by communication problems, where the community member is unable to communicate in the language of the healthcare provider, affect the confidence and trust of community members in the medical care offered. This, in turn., decreases the likelihood of a medical follow-up (Shamaki & Buang, 2014:3)
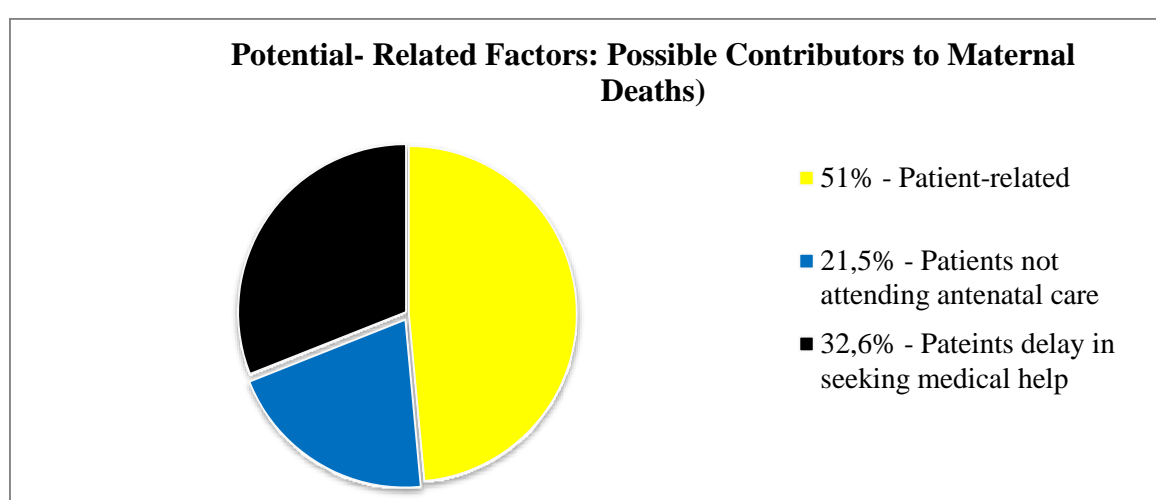

Figure 2.3 Showing patient-related factors: possible contributors to maternal deaths. (Extrapolated from: Tlebere et al., 2007: 342).

Patient-related factors

The knowledge patients display towards antenatal care is important as this can influence health seeking behaviors in pregnant women (Maputle et al., 2013). Adequate health knowledge enables pregnant women to seek and secure appropriate antenatal healthcare services in line with their rights and needs (Maputle et al., 2013). Where a lack of maternal healthcare knowledge is concerned, the lack of antenatal care attendance is inevitable and may continue to exist as a common patient-related avoidable problem. Unfortunately, often women who do not attend maternal care services are said to be limited by financial and social factors, women not realising they are pregnant, and difficulty in obtaining time off from work (Malacrida, 1999:506). A study by Silal et al., (2012) showed that in south Africa 92% of women had at least two antenatal visits. Further, in 2003 skilled attendant at delivery for urban women was 94 % compared to 85% for rural. Poor and black women in rural areas were less likely to have a skilled attendant at delivery than wealthier or white counterparts. Some of the inequalities in access to and use of maternal health care services between urban and rural communities listed aspects such as affordability of transport. Many women in rural areas had to travel long distances and pay high amounts of money to access health facilities as compared to women in urban areas who had less travel time before reaching a clinic or a hospital. In addition, the cost of purchasing supplies required for delivery and costs incurred on the date of delivery were barriers for women in rural settings (Silal et al., 2012). Therefore, it can be argued that even an immediate surplus of money – considered to be an economic barrier to maternal healthcare - may not necessarily equate to an increase in the usage of maternal healthcare services (Tlebere et al., 2007).

Antenatal care in KwaZulu-Natal

In the province of KwaZulu-Natal, the maternal mortality ratio is 30 deaths per 100 000 live births (SAPA, 2014). Further, in the year 2010, the province was estimated to have a population of approximately 10.6 million people. This large population needs to be considered in relation to the MMR as there could be more female mortalities in KZN than in other provinces with smaller populations. According to a Department of Health report (2010:14), approximately "22% of 15 to 24-year-old women attending state antenatal clinics in the province were HIV positive, which… leads to direct and indirect infections harmful to both mother and child". To date, in KZN, HIV/AIDS is a health obstacle which the South African government battles annually to overcome (Kautzkyi & Tollmani, 2008). HIV affects the health of both woman and unborn child as seen below in Figure 2.4 (Hoque et al., 2008).
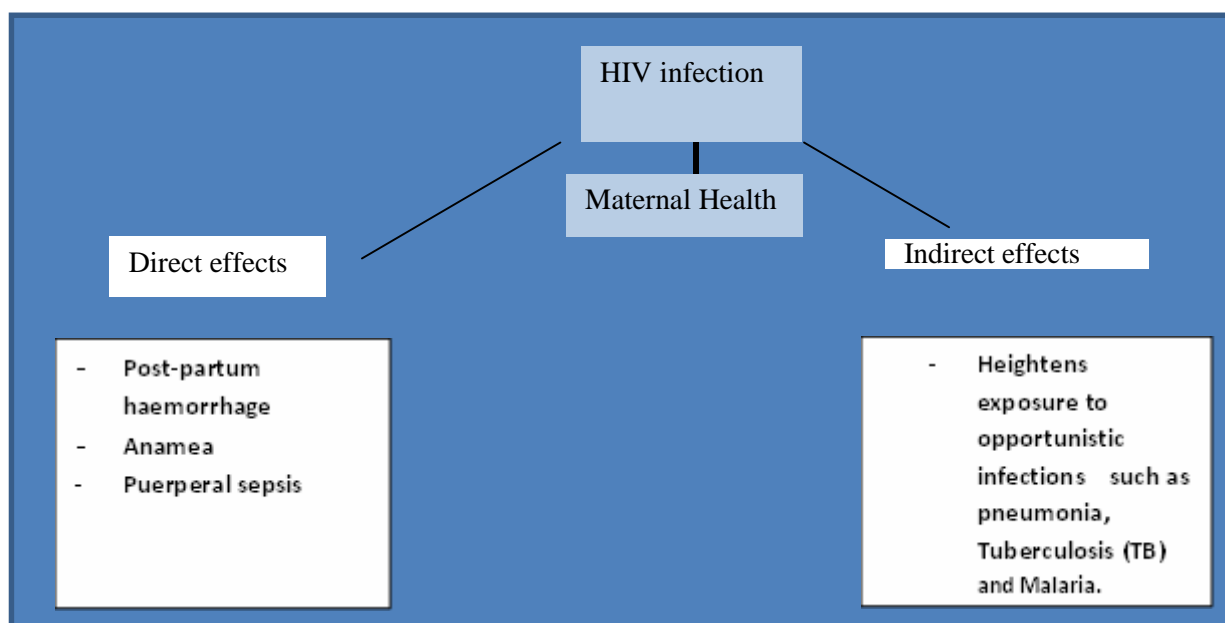
Figure 2.4 showing the direct and indirect effects of HIV on maternal health.
(Source: Lalthapersad-Pillay, 2015).

The above figure shows the direct and indirect effects of HIV on maternal health. Direct effects are namely, post-partum haemorrhage, anemea and puerperal sepsis. For example, postpartum haemorrhage (PPH) is described as the loss of blood after a delivery. The blood loss can be between 500ml and 1500ml. PPH is a leading cause of maternal mortality amongst women globally (Edhi et al., 2013). In addition, some of the indirect causes include opportunistic infections which occur during the pregnancy such as tuberculoisis, pneumionia and malaria (Latherpersad-Pillay, 2015). In a recent Amnesty International report[5], early attendance at antenatal clinics is considered a necessity for HIV positive pregnant women (Kautzkyi & Tollmani, 2008). This report identifies three barriers contributing to women and girls delayed agency in seeking antenatal care. These barriers are, "a lack of privacy, patient confidentiality and informed consent at health facilities, especially around the implementation of HIV testing during antenatal care[6]". This implies that there are women and girls who are too afraid to attend antenatal care because they will test positive for HIV and that test privacy will not be kept. Lastly, HIV is a barrier because women must get tested before they are put into antenatal care (Lalthapersad-Pillay, 2015).

To conclude the first section of this literature chapter, the above discussion has identified that while there are multiple barriers to securing antenatal care from clinics and hospitals in South Africa, HIV is one of the major barriers impeding attempts at reducing the MMR. As mentioned previously, the major cause of deaths amongst pregnant women are non-pregnancy HIV-related infections. Pregnant women die from HIV–related infections-

when they do not want to be tested and subsequently, forfeit antenatal care (Tlebere et al., 2007). To ensure the effectiveness of antenatal care, a pregnant woman must be tested for HIV to ensure her safety and that of her unborn child (Bolton et al., 2004). Areas with a high HIV-infection rate result in a higher rate of deaths in pregnant women, such as in the case of KZN. The next section of this chapter discusses the role which the PMTCT programmes, introduced by national government, play in maternal healthcare and in reducing the MMR (Bolton et al., 2004).

Knowledge of maternal mortality amongst pregnant women

Health knowledge is one of the key factors enabling pregnant women to seek appropriate antenatal healthcare services. The standard of knowledge of maternal mortalities amongst pregnant women, access seems to be health care facilities remains a major problem in communities (StatsSA, 2015). Lack of attendance of antenatal services continues amongst maternal care seeking mothers because of access barriers. It is therefore imperative that the value of health care is communicated and it is also important to ensure that access to healthcare facilities is made possible to women and girls (Maputle et al., 2013). Antenatal care is the healthcare that a woman receives from the time she discovers she is pregnant (Hoque et al., 2008), and for women to understand the benefit of this service, they need to possess accurate maternal health. This ensures that the pregnant woman attends antenatal care early, which consequently increases the chance of a safe pregnancy (Maputle et al., 2013).

Antenatal care services focus on identifying small and major risk factors, diagnosing pregnancy complications earlier on in the pregnancy, offering appropriate management of these complications once identified, and providing mothers with maternal healthcare education (Maputle et al., 2013). The initial visit to the antenatal clinic should ideally occur as soon as the woman comes to the realisation of her pregnancy (Ntombela et al., 2005). The standard of knowledge of maternal mortalities amongst pregnant women, access seems to be health care facilities remains a major problem in communities (StatsSA, 2015). Lack of attendance at antenatal services continues amongst maternal care seeking pregnant women and a factor contributing to this is a lack of pregnancy knowledge. It is, therefore, imperative that the value of healthcare is communicated to women and girls to encourage them to attend antenatal classes early in pregnancy (Maputle et al., 2013).

This highlights the importance of pregnant women possessing appropriate knowledge and

perceptions as this will regulate the frequency of the attendance at antenatal care programmes by pregnant women (Gross et al., 2012). Additionally, the Department of Health (2007) maintains that good antenatal care will be evidenced in decreased MMR, and will be followed by improvements in the health status of women (Maputle et al., 2013).

Prevention of mother to child transfer

Statistically, of the 36.7 million people living with HIV globally, 77% are recorded to be pregnant women (United Nations Programme on HIV/AIDS, 2015). Each year, more than two million pregnant women globally are recorded to be HIV positive. These statistics are not accurate, as the South African health system is said to contain discrepancies in the reporting and recording of maternal mortalities based on the different areas under investigation (Lalthapersad-Pillay, 2015). Previously discussed is the agency a pregnant woman enacts by being tested for HIV to ensure appropriate care is provided to her and her baby when attending the PMTCT programme at a clinic (Bolton et al., 2004). Unless pregnant women use agency, the woman and child are both at risk of HIV-related infections as displayed in Figure 2.4. Secondly, this poses a barrier to interventions geared towards reducing MMRs.

In South Africa, a national confidentiality enquiry into maternal deaths instituted in 1998 identified AIDS as the second most common cause of maternal deaths in 1998, accounting for 13% of all maternal deaths. There were 1560 recorded maternal deaths in the year 2011 and 1426 in 2012. A third of these deaths was linked to HIV (Amnesty International, 2014:16).

A major portion of the MMR in KZN can be attributed to HIV-related infections; the early detection of HIV in pregnant women could decrease the number of mortalities (Doherty et al., 2010). However, a barrier to early-testing is the fear of stigmatisation. Ultimately, this makes it difficult to enroll women who require the PMTCT programme services (McIntrye, 2013).

The PMTCT was first initiated in South Africa in 2001 and the actual programme was implemented in 2002 (Bolton et al., 2004). One of the reasons for implementation of the PMTCT programme was to enable pregnant women to access the nevirapine drug (NVP), which prevents the transfer of HIV from mother to child. Part of the process which leads to pregnant women being enrolled within the PMTCT programme is that they are required to test regularly for HIV from the time they discover that they are pregnant until birth (Doherty, 2010). Usually, the PMTCT programme is offered within the context of a primary healthcare facility where antenatal care is provided to pregnant women. Bolton (et al., 2004: 299)

describes PMTCT as a programme which offers "voluntary counselling and testing, administration of NVP to mother and baby, and the provision of free milk formula for the first six (6) months of life."

This cascade of interventions requires a pregnant woman to be consistent in her attendance during the programme. However, this is often a difficult exercise for many pregnant women who lack the economic means to travel to health facilities in which antenatal care is offered (Bolton et al., 2004). According to Janet Turan and Laura Nyblade (2013), a successful cascade of the PMTCT programme involves women attending antenatal care services and testing for HIV. Further, the programme involves the HIV positive pregnant woman using antiretroviral medication and the implementation and execution of safe childbirth practices. After the childbirth, mothers are provided with appropriate methods of feeding their infants and other services are offered to both mother and child during the postnatal phase. As uncomplicated as the PMTCT programme may seem, pregnant women in South Africa maintain their reasons for not enrolling themselves as a result of social factors, such as the stigma that accompanies HIV-infected individuals (Turan & Nyblade, 2013).

There is evidence to suggest that the absence of appropriate maternal dietary needs may exacerbate the symptoms of HIV during the pregnancy. PMTCT is beneficial not only for the prevention of HIV transfer from mother to child but may be helpful in the early detection of HIV amongst pregnant women (McIntrye, 2013). It crucial for a mother to be in good health during her pregnancy to ensure the safe delivery of the child; death of the mother often equates to the death of the unborn child, especially if a mother's death occurs during pregnancy. James McIntyre (2013) states that the problem with HIV-infection and AIDs-related deaths is the major contribution these diseases have made to the increase of maternal mortality in areas with very little resources. Further, McIntrye (2013) asserts that the availability of antiretroviral treatment in identified under-resourced settings will assist the attempts made to reverse the toll of HIV-related maternal deaths. This may help minimise HIV-related infections, which are a major problem when dealing with the issue of maternal mortality (McIntrye, 2013).

More diseases which contribute to the mortalities

Tuberculosis (TB), malaria and the condition of anaemia are HIV-related infections which lead to life-threatening complications amongst pregnant women. These are all identified as "opportunistic diseases" which frequently affect pregnancy (McIntrye, 2013:132). "Other pulmonary diseases have been described more rarely in pregnancy and these include bacterial

infections, fungal infections, viral infections and opportunistic neoplasm" (McIntrye, 2013:131).

Notably, the impact of TB in HIV-infected pregnant women is far greater than malaria and anaemia (McIntryre, 2013). In fact, KZN has the highest TB infection rate (Department of Health, 2013). TB and HIV have a "synergetic effect on each other", meaning that together these diseases will pose an even greater negative impact on pregnant women (McIntryre, 2013:132). While this requires further investigation, to keep this literature discussion relevant to the main research questions, the next part of this section will discuss the role of the traditional midwife or TBA in both perpetuating maternal mortality and performing life-saving practices.

Traditional birth attendant's cultural practices

One could easily assert that the involvement of traditional midwives is pivotal in combating maternal mortality in resource-poor settings, but much criticism of these 'cultural doctors' reinforces the importance of discussing their role in their community (Byrne & Morgan, 2011). A TBA is defined as someone who engages in cultural practices when offering health assistance (Kamal, 1998:44). In South Africa, a TBA is characterised as a "middle-aged or elderly woman with no formal training who acquired her skills through personal experience" and plays the role of a midwife to women during pregnancy, at childbirth and during the post-birth period in (Peltzer & Henda, 2006:140).

As part of the cultural practices and initiatives taken, TBAs engage in a communication process with ancestors to warranty the safety of the mother and child (Selepe & Thomas, 2011). It is claimed they discern good and evil spirits, which may try to harm the mother and/or baby, which may also offer the mother a sense of security (Leferber & Voorhoever, 1997: 1175). In other instances, during delivery, mothers are given medicines made with unprocessed herbs and are instructed to give birth in an upright position – they are encouraged to sit, squat or kneel (Selepe & Thomas, 2000). During labour, the herbs are used to rub the mother's abdomen and her vomit induced using a spatula (Leferber & Voorhoever, 1997). The care offered by TBAs extends to care for the umbilical cord, the placenta and the child (Leferber & Voorhoever, 1997). The newborn is cleansed, covered with cloth and remains indoors with the mother for a week; this is done to protect the child from bad spirits (Leferber & Voorhoever, 1997).

These practices all appear to be guided and ritualistic in the sense that they have been performed over an extended period of time which has, perhaps, allowed the TBAs to improve

the quality of their offering so as to ensure that no mortalities occur when pregnant women are in their care. Therefore, one cannot state that the above practices necessarily cause maternal mortalities.

The role and function of a traditional birth attendant

The role of TBAs in offering care for pregnant women and assisting with the delivery process is acknowledged. However, TBAs generally do not receive the training required to manage pregnancy complications (Peltzer & Henda, 2006) and are often criticised for their unhygienic practices and perceived unsafe cultural methods when offering care to pregnant women (Peltzer & Henda, 2006). In previous years, the employment of TBAs and village midwives in assisting with interventions aimed at reducing maternal mortality and improving pregnancy outcomes have had mixed outcomes (Byrne & Morgan, 2011). With an HIV/AIDS epidemic in South Africa, it is necessary for attendants to protect the mother, child and themselves from exposure to blood and body fluids during deliveries. Knowing and understanding the issues surrounding HIV/AIDS infection control can help birth attendants to protect themselves and others (Bhengu & Mchunu, 2004). TBAs are generally believed to have inadequate knowledge of HIV and unsatisfactory hygienic practices (Peltzer & Henda, 2006:142).

The function of the TBA is made relevant and is mostly appreciated by women in rural settings who seek pregnancy advice and assistance during delivery but are not located near to primary healthcare facilities (Bulterys et al., 2002). In rural areas, TBAs are the alternative to securing maternal healthcare services from professional healthcare personnel. In the case of women located in rural communities, sometimes the decision to not seek maternal care from healthcare facilities result from a lack trust in the health professionals, their techniques and their capabilities (Selepe & Thomas, 2000). Consequently, homebirths are still desirable amongst many women (Walvern & Weeks, 1999).

The option versus the preference of using traditional birth attendants

In 1999, the WHO estimated that 60% of births in the developing world occur outside of a health facility, with 47% of pregnant women receiving assistance from only TBAs or their family members (Walvern & Weeks, 1999). Many of these homebirths occur in the absence of skilled midwives (Bhengu & Mchunu 2004:42). Nevertheless, recent studies indicate that TBAs are still preferred amongst some in rural communities (Hossain, et al., 2016; Sialubanje et al., 2015; Titaley et al., 2010). Between 60% and 80% of the South African population sought health advice from traditional healers, in 1999, and it is asserted that

pregnant women may fall under these percentages (Prestorius, 1999:250).

Who becomes a traditional birth attendant?

These statistics provide a contextual relevance for the TBA in their communities, including the area under study in this dissertation. The rural TBA is often an elderly relative or a neighbour who assists during childbirth (Kalmal, 1998). However, the TBA must have a relationship with the mother in labour prior to the childbirth because midwifery in rural communities is considered a favour and sometimes an act of goodness not a responsibility (Bhengu & Mchunu, 2004). Midwives in general, can be requested by a pregnant mother and expect payment for their assistance. However, this differs slightly in rural areas, in that TBAs are paid money or they are provided with a token of appreciation (Kamal, 1998).

The existence of traditional birth attendants

It is apparent that TBAs exist and operate in rural areas, as many women based in remote locations are still reliant on TBA's antenatal assistance, which includes information on nutritional diets, sex during pregnancy and traditional medicine taken during pregnancy. Asghar (2001:1) argues that 99% of all maternal mortalities occur as a result of pregnant women being located in resource-poor local settings and within countries that generally have limited economic resources. Therefore, one could argue that TBAs are not only consulted as a matter of necessity owing to the inaccessibility of Western healthcare services but also as a matter of preference (Asghar, 2001).

Advantages and disadvantages of using a traditional birth attendant

There are some identified advantages of TBAs, such as the close personal relationship they have with the client. This is usually due to their ability to speak the local language, and share cultural experiences and health beliefs with women (Byrne & Morgan, 2011). Further, the long acquaintanceship between the TBA and the community, understanding of the context, emotional support, and belief in their kinship, trust and assurance of privacy are other advantages (Bhengu & Mchunu, 2004). A number of flaws in the practices highlight the disadvantages of the TBAs, including poor hygienic practices and infection control; for example, lack of hand washing, unsafe cutting of the umbilical cord threatening the safety of the baby, and interference with the labour process (Selepe & Thomas, 2000).

Training traditional birth attendants

TBA training programmes are conducted to reduce maternal mortality and improve the status of reproductive health amongst women. This is achieved through enhancing the links

between the modern health system and traditional healthcare practices used by a community. Further, this goal is also achieved through the incremental attendance of traditional midwives at childbirths. Lastly, the improvement of the skills and overall practices of TBAs is an important aim of these training programmes (Bulterys et al., 2002).

The health system involves community health workers such as traditional birth attendants (TBAs) to try and address the issue of shortages of skilled health workers particularly in rural areas where the need for reproductive and child health care services is dire. In South Africa, TBAs who have received additional training have played a role in delivering counselling, treatment and health for diseases such as HIV, tuberculosis and malaria (Sarmento, 2014). Programmes such as Safe Motherhood Programme offer training to TBAs as an intervention to reduce mortalities amongst women. This programme also aims to upskill TBAs to improve reproductive health in women. Effective programs offer some form of follow-up training in which trained professionals can reevaluate and sustain practices in TBA care. Interventions have been proven to increase the quality of care offered by TBAs (Smith, 2016). Ultimately, trained TBAs are able to assist with these interventions but it has been argued that without back-up services they may not be in a position to be fully effective. Therefore, while these training programmes are beneficial to TBAs and help reduce mortalities in communities, accessible health services are still required for their practices to be fully effective (Sarmento, 2014).

In order to train a TBA to improve the quality of their services, they would also require training in safety practices. TBAs ideally would be trained on the importance of early recognition of obstetric complications, how to conduct obstetric emergency care, the skills to prevent unsafe traditional practices, and how to refer a patient to a clinic or hospitals (Asghar, 2001). TBAs' unsafe and unhygienic practices put them at risk of exposure to blood in their occupation, putting them in the vulnerable position of contracting HIV. Programmes such as PMTCT are not enforced culturally, and without these programmes, the TBA could transmit HIV from mother to child during pregnancy by offering inaccurate advice and practice during labour. However, TBAs can also play a major role in the prevention of HIV transmission from mother to child if they receive proper training on the PMTCT programme and can refer women to medical personnel in a health facility to receive accurate treatment when necessary (Peltzer & Henda, 2006).

There are anticipated challenges which may come with healthcare facilities training TBAs, such as providing payments, accommodation and stipends for postings in rural areas, work opportunities for their spouses, and educational facilities for their children (Walvern & Weeks, 1999). The WHO suggests training TBAs to work in their own villages.

Retention of birth attendants is high because they share cultural and health beliefs with the women and have strong ties with the community. TBAs already offer preventative health services to pregnant women and their newborns in rural settings. In some settings, it may be possible to train TBAs to provide confidential HIV counselling and testing, perhaps using rapid tests or whole blood testing. This could assist with the eradication of mortalities as the TBAs could refer HIV positive pregnant women to a health facility to receive accurate treatment through programmes such as the PMTCT.

Traditional birth attendants in combating HIV-related deaths

There is a need for more HIV prevention interventions which involve TBAs. These interventions would be based on a horizontal axis, allowing TBAs to offer home-based care in remote areas where access to health facilities is problematic. Generalisable models applicable to other poor settings could be developed from demonstration projects that involve TBAs as part of an innovative and successful model of rural healthcare delivery that emphasises prevention of perinatal transmission of HIV (Bultery et al., 2002). Presently, TBAa offer most help amongst pregnant women in many resource-poor countries and communities; it is pertinent to ask whether the abandonment of TBAs would be wise (Sibley & Sibe, 2006); Ana, 2002).

Culture and healthcare

Communities in which traditional practices and beliefs have existed for a very long time are generally harder to penetrate in terms of bringing new knowledge which may be beneficial to their community (Shah, 2011). Furthermore, communities where tradition is still a very important component, exercise and practice from a monopoly of cultural beliefs (Shah, 2011). Externally, culture is often seen as a barrier which must be uprooted in order to achieve social development. However, as discussed in the previous section, culture forms a huge part of the TBA practice.

Culture includes perceptions, interactions, relationships, customs, beliefs, practices and values into a pattern that is seen through human behaviour (Obermeyer, 1993; Denboba et al., 2013). In KZN, 70% of the population is isiZulu-speaking, therefore one can only

presume that most people in various communities in the province communicate in the language. Culture influences how health, illness and disability are perceived; attitudes towards healthcare providers and facilities; how health information is communicated; help-seeking behaviours; the preference for traditional versus non-traditional approaches to healthcare; and perceptions regarding the role of the family in healthcare. Culture and ethnicity create a unique pattern of beliefs and perceptions as to what it means to be in good or ill health, as perceptions are formulated from experiences (Denboba et al., 2013). In turn, this unique pattern of beliefs influences how symptoms of illness are interpreted. This has a direct effect on the agency enacted towards healthcare (Anderson et al., 2003).

Cultural competence refers to both the individual and programme's ability to understand and respect the beliefs, attitudes and behaviours of a specific community they are offering their services in (Denboba et al., 2013). In other words, cultural competence is the ability to recognise and consider the beliefs, attitudes and behaviours when offering healthcare in the context of maternal health. In doing so, the programme can incorporate these values at the levels of policy, administration and practice. It takes us from a level beyond acknowledging cultural sensitivity to a level where this sensitivity is integrated into the planning, implementation and evaluation of service systems and encompasses cultural diversity. There is a combination of issues, including the impact of poverty which influences health-seeking 32ehavior and the utilization of services. Culture, ethnicity and race are also major factors in the provision of healthcare services and the extent to which they are clinically competent (Denboba et al., 2013).

Thus, the importance of cultural sensitivity is felt greatly in the provision of services to members of cultural groups (Chin, 2000). Ideally, a culturally competent healthcare system acknowledges and incorporates at all levels the importance of culture by taking into consideration the beliefs, behaviours and attitudes pertaining to the culture when addressing health issues (Denboba et al., 2013). Appropriate and effective communication requires the willingness to listen to and learn from members of diverse cultures, and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of an individual's cultural health beliefs and practices (Chin, 2000).

"Culture places traditional birth attendants at the fore of the construction of experiences and meanings, customs and beliefs which are then shared in the community" (Dutta, 2008: 55). This occurs almost instantaneously as TBAs acknowledge cultural practices, which then places them in a position to be more sensitive to their culture (Chin, 2000). The impact of the birth attendants is recognised in their ability to influence community members through their

help and advice. This is considered to be just as important as having the technical skills required in maternal healthcare (Anderson et al., 2003). This influence is a supposed entry-point for strategies set to improve maternal health in resource-poor settings and in turn, combat MMRs.

There is a need for the provision of maternal health knowledge and care which appeals to communities that are served by TBAs. In KZN, approximately 70% of the population is isiZulu-speaking (Rudwick, 2008). Factors such as language play an important role in healthcare and an inability to communicate with a healthcare provider in a language they understand creates a barrier to securing accurate healthcare services, undermines trust in the quality of medical care received and decreases the likelihood of appropriate follow-up (Denboba et al. 2013). Furthermore, lack of a common language between patient and provider can result in errors concerning diagnosis, leading to inappropriate service (Obermeyer, 1993). According to Mohan Dutta (2008), taking a culturally sensitive approach is more beneficial for combatting health issues especially in communities where culture is respected and adhered to.

TBA training in South Africa

The health system involves community health workers such as traditional birth attendants (TBAs) to try and address the issue of shortages of skilled health workers particularly in rural areas where the need for reproductive and child health care services is dire. In South Africa, TBAs who have received additional training have played a role in delivering counselling, treatment and health for diseases such as HIV, tuberculosis and malaria (Sarmento, 2014). Programmes such as Safe Motherhood Programme offer training to TBAs as an intervention to reduce mortalities amongst women. This programme also aims to upskill TBAs to improve reproductive health in women. Effective programs offer some form of follow-up training in which trained professionals can reevaluate and sustain practices in TBA care.

Such interventions have been proven to increase the quality of care offered by TBAs (Smith, 2016). Ultimately, trained TBAs should be in a position to assist with these interventions but it has been argued that without back-up services they may not be in a position to be fully effective. Therefore, while these training programmes are beneficial to TBAs and help reduce mortalities in communities, accessible health services are still required for their practices to be fully effective (Sarmento, 2014).

Ugu District Maternal Mortality Rate Profile

The MMR in the KwaZulu-Natal province has decreased from 2013 and currently reflects that there are 125 deaths per 100 000 births in the entire province. The maternal mortality in facilities located within the UGU District are recorded as 112 deaths per 100 000 live births. The KwaNyuswa community is located in the upper region of this district. The community has four clinics and no hospital serving the population threshold. These are namely, Ezingolweni Clinic, Mthimude Clinic, Thembalesizwe Clinic, and Thonjeni Clinic. At present, there is no profile detailing the MMR in these facilities which presents a statistical gap in the existing data.

Case study: Manxili, KwaZulu-Natal

The following case study illustrates the competency of TBAs during the baby delivering process. In addition, it displays an occasion in which their safety practices worked to ensure the safe delivery of the baby and the usefulness of the protection measures taken for them. Manxili is a rural area in the province of KZN, South Africa and is serviced by one hospital, Charles Johnson Memorial Hospital. As a result, most babies are delivered at home through the assistance of a TBA. In this community, traditional Zulu cultural beliefs and practices intended to protect a woman and child during childbirth include the delivery of the child in a safe place, usually the house of a relatively old member of the family where the child supposedly cannot suffer spiritual attacks (Selepe & Thomas, 2000).

A study conducted by Hilda Selepe and Debera Thomas (2000) on the TBAs in Manxili revealed that prior to labour, all TBAs in the study offered dietary advice to the pregnant women in their care. Further, all the TBAs in this area monitored physiological changes in the women and used these changes to diagnose pregnancy. For example, the TBAs noted skin changes on the breasts and abdomen and the pause of menstrual periods as an indicator of pregnancy. "When the pregnant woman is illiterate, the number of successive new moons from the time of her missed period is used as a way to determine the stage of the pregnancy because the period between new moons roughly equals a month" (Selepe & Thomas, 2000:98).

This case study confirms the existence of TBAs in KZN, as well as their operations within communities such as Manxili. TBAs are an alternative for many women in this community, despite the criticism of their unsafe practices. They seemingly fill a health service gap in the community not only through their midwifery service but also through the dietary knowledge

they share with the women in their care. Further, this case study does not identify the TBAs' practices as a cause of maternal mortalities but rather as an aid in the reduction of mortalities.

Whilst the presence and operation of TBAs is a reality for the Manxili community, the researcher in the current study endeavoured to establish whether TBAs exist in the location of the KwaNyuswa community. The researcher sought to establish whether TBAs are the alternative for many women who are challenged by inadequate health facilities. The Manxili community is similar to that of the KwaNyuswa community as they are both serviced by one hospital, however, the alternative for women in the KwaNyuswa community, if any, has not been identified. Therefore, the absence of an alternative method of securing maternal healthcare could be a leading cause of mortalities in the KwaNyuswa community.

Conclusion

Usually, maternal mortalities are the result of a knowledge gap pertaining to maternal healthcare, lack of facilities, transport problems with accessing the facilities and illness such as HIV/AIDS, TB, anaemia and malaria. This is particularly the case in the sub-Saharan region in Africa. In South Africa, a major challenge to the attempts made to reduce MMR is the high HIV/AIDS infection rate. KZN has the highest infection rate nationally as well as the highest rate of deaths amongst pregnant women and unborn children. While scholars cannot account for all the contributing factors, HIV-infection is listed as one of the leading causes of maternal mortality in the province. The lack of early attendance of antenatal care, during which mothers are tested for HIV, is considered a barrier to PMTCT of the virus. In addition, early attendance of antenatal care is a preventative method for HIV-related infections and often one of the main barriers is inadequate health facilities. Although criticized for unsafe practices, TBAs offer maternal healthcare according to their cultural understandings and beliefs. They have been commended for their intimate involvement as a midwives in the communities where there are communication barriers between professional personnel and pregnant women. TBAs are positioned as an alternative for women who cannot reach and secure the services of a health facility, which occurs mostly in rural areas.

However, their lack of formal training disables them from offering and enrolling pregnant women in programmes such as the PMTCT. They are not equipped with the tools to deal with issues such as HIV-infections, which also puts them at risk of contracting the virus. On the other hand, mothers cannot enroll in programmes such as the PMTCT if they are neither aware of this resource nor fully understand what the programme is intended to help with.

Other barriers which challenge intervention to decrease MMRS are mothers who are afraid of testing positive for HIV and who fear to test because of a lack of privacy in healthcare facilities. The effectiveness of a programme such as the PMTCT is dependent on the willingness of mothers to test for HIV. Without a willingness to test, there is a proven chance of HIV being transferred to an unborn child and the pregnant woman dying from HIV-related infections. This signifies one of the gaps in the process of a pregnant mother attending a clinic to secure antenatal care. KZN has a high mortality rate and a high HIV-infection rate; there is a direct correlation between these two social and health phenomena. On the other hand, a lack of culturally relevant knowledge pertaining to maternal healthcare could be a contributing factor to the mortalities. In addition, as an alternative to health facilities, the untrained TBAs could be used as a tool to distribute this knowledge but they would lack the tools to offer the maternity services and their own beliefs would be challenged.

In conclusion, the achievement of the fifth MDG, which is to improve maternal health, is subject to the investigation of the leading causes of maternal mortalities in order for various local government departments to develop strategies to combat them in KZN. However, the mortality causes discussed in this chapter do not account for maternal mortalities in the KwaNyuswa rural area the qualitative research methods applied towards this investigation are discussed in Chapter 4.

The following will explore two theories, namely, the CCA and the CFPD. The application of these theories will help the reader to understand the impact of on-the-ground communication, which occurs on a horizontal axis and offers stakeholder involvement for sustainable development respectively.

Chapter 3
Theoretical Framework

The culture-centered approach (CCA) and the communication for participatory development theory (CFPD) were selected for discussion and application in this study. Further, these were discussed with regard to the investigation of the perceived causes of maternal mortality in the KwaNyuswa rural area.

The CCA was selected as a theory to include in the study as its locale is of a cultural background. Culture plays a huge role in the decision-making processes of communities, sometimes at an individual level and other times at a community level. Culture is overtly discussed in this chapter. Culture includes all the experiences of the community over a period of time and forms a pattern of beliefs which people then act upon. Therefore, if there has been a certain pattern of behaviour that is occurring in the community, it is most likely that the beliefs are normalized and accepted, and eventually passed on from one generation to the next (Dutta, 2007).

To remind the reader about the context of study location, the KwaNyuswa rural community is located in the province of KwaZulu-Natal (KZN). A map is provided in Chapter 1. KZN holds a population threshold of 52 540 individuals of which 98, 6% are classified Black, isiZulu speaking South Africans (Ezinqoleni Municipality, 2014). This community is seemingly underprovided in terms of healthcare facilities, which could be leading to the maternal mortalities. Amongst the difficulties, accessing health facilities and a lack of knowledge pertaining to maternal healthcare may be other leading causes. The CCA articulates that people act on the condition that there are structures available to process and provide for their specific needs (Dutta, 2007). This concept of agency will be discussed in detail further in this chapter, along with two other components of the culture-centered approach, namely structure and culture (Airhihenbuwa & Webster, 2004).

The CFPD is included in the theoretical framework of this study for its component on dialogue, which is complimentary to the CCA as both advocate for communication through participation and dialogue for the development of communities (Inayatullah, 1976). Furthermore, the CFPD accounts for the communication of maternal healthcare knowledge amongst rural dwellers (Keerthirathne et al., 2009: 4). Following the discussion of these two theories, the next section of this chapter will contextualise the theories by discussing them within the research questions and literature study based on previous findings associated with maternal mortalities.

Culture-Centered Approach

There are numerous authors associated with the CCA, some of which include, Mohan J Dutta (2007, 2008, 2014), Zhuo Ban (2012), Ambar Basu (2007), Iccha Basnyat (2008), Collins Airhihenbuwa (1995, 2004), Graham Bodie (2008), Teresa L Thompson (2011), Jon Nussabaum (2011), Christina Jones (2013), Pal Mahuya (2010) and Rubin Jamil (2012). On a historical timeline, the CCA is placed in the post-colonial period, during which the study of subalterns took rise (Beverly 1999, 2004). In this period, post-colonial theories based on the history of the control of knowledge production pointed distributed to colonies at the margins through the creation, communication and management of knowledge (Spivak, 1988). Subaltern studies were concerned with the erasure of indigenous communities on the margins by developed colonizers (Dutta & Pal, 2010:364). These studies exposed the erasure of communities on the margins, leading to global outcry and advocacy through scholarship for their inclusion of development plans in Africa and different regions across the globe.

In the CCA, listening is closely connected with social change (Desmarais, 2007 cited in Dutta, 2011:3). 'Listening', in this sense, implies that marginalised people are provided with opportunities to contribute to changes which impact on their current way of life or local cultures; it encourages participation at grassroots level. As stated by Dutta (2014), listening encourages change: "One of the key elements of the culture-centered approach is in depicting the value-based nature of knowledge production, documenting the broader cultural logics that are reified through the production and circulation of knowledge" (Dutta, 2014:69).

Culture as a component of the approach places the active participants at the fore of the construction of experiences and meanings, customs and beliefs which are then shared in the community (Dutta, 2008:55). Under the banner of the CCA, members of communities participate actively in interpreting and interacting with social structures (Dutta, Ban & Pal, 2012:4). For this reason, the cultural component of the approach is necessary for the process of understanding the perceptions of maternal mortality amongst women in the KwaNyuswa rural area.

The CCA offers a framework for communication which facilitates understanding and recognition of the people side-lined by previous colonial eras. This inclusion is achieved through the consideration of the cultural background of the communities in the margins (Chai, 2007). As opposed to acknowledging that communities in the margins had their own respective ways of life, centered on their cultural beliefs, these margins or underdeveloped

communities were served with Western knowledge filtered through communication processes which excluded communication theories (Servaes, 2008).

Diffusing cultural beliefs

In the early 1970s, the theorist Everett Rogers alluded to the diffusions of innovations theory, a set of ideological concepts and a model which offered a solution to a set of social developmental problems. Rogers (1976) suggested diffusions of information, technology, and knowledge from Westernized societies could be passed to underdeveloped or so called "traditionalist" societies as a strategy to develop these societies. Rogers (1976) called for the rejection of traditional customs, beliefs and ways of thinking amongst these communities as it delayed the progress of development and innovation. This development strategy included a top-down communication model whereby the innovated societies communicated their ideas to the underdeveloped communities with the hope that the underdeveloped would recognise their 'delay' and gravitate towards Western ideologies.

The researcher identifies at least the problems with the diffusions theory were at least threefold. Firstly, it rejected the community's traditions, culture and ancient beliefs of the community in which the development was taking place; secondly, it involved passive ways of communicating; and thirdly, it encouraged innovation in societies that did not have the technological know-how which is not sustainable development.

Paulo Freire (2000) heavily criticised this theory for its passivity, as he claimed that participation from these traditionalist communities and states was essential for sustainable development. The inclusion of the communities in development and decision-making processes, and implementation strategies, created a sense of ownership. Further, the participation of the traditional community calls for a horizontal development process whereby the dialogue between developers and traditionalists is held at a community level (Gumucio-Dargon, 2009). It requires developers to consider the lack of resources and political power of the traditionalists (Gumucio- Dagron, 2009). This highlights the importance of the involvement of community members in developments; it is a common error of communication and development agents to bypass grassroot cultures and omitting culture may delay development. "Communities use communication tools to strengthen their cultural identity, to share their knowledge or to make their voices heard" (Gumucio-Dagron, 2009). Later, Rogers (2006:117) conceded to the role of participation in development, referring to it as a process that is required for social change in a society.

Hence the CCA, which is culture-centric, advocates for communicationists and development agents to place the community culture at the center of their strategies, which contradicts and opposes the diffusions theory. Alfonso Gumucio- Dagron (2009) argues for a culture-centric approach by criticising the motives of institutions which embrace top-down communication approaches as he claims these were mainly for knowledge retention not engagement. The knowledge remains in their power and are not held accountable by those communities they intend to develop, as these communities do not have the knowledge to oppose certain approaches. Therefore, communities are expected to submit to the leadership of these institutions and trust the decisions which are made on their behalf. This trust is hard to gain in instances in which the community places its trust in traditional leaders. These leaders also take decisions on behalf of the community, however, have earned trust but because of practice of a common culture (Bulterys et al., 2002).

Linking this back to the discussion on the main purpose of the study which is to understand the perceived causes of maternal mortalities in KwaNyuswa, to understand the role played by traditional birth attendants (TBA) in combating maternal mortalities by communicating maternal health knowledge, and the role of communication in alleviating maternal mortalities in this rural community. TBAs center all their practices around culture and traditional ways of life, which would potentially make them more appealing to cultural communities (Selepe & Thomas, 2011). The following section discusses this in the context of the CCA.

Culture-centered approach

It is important to understand that participatory forms of communication have existed for long periods in communities around the world, including in marginalised places which have been classified as passive to innovations (Rogers, 1970). However, this view does not take into consideration the reasoning for this so called 'passivity.' The CCA, consistent of three components, will which be discussed in the following sections.

Structure

To begin with, structures refer to the organised communicative resources and material that allow or disallow accessibility to rituals processes and roles that make-up participation (Dutta, 2011:65). They also refer to systems, institutes and organisations in societies which direct the outflow of information and knowledge. Structures also serve the purpose of being a site where individuals and communities interpret meanings and share experiences (Dutta, 2014). In addition, structures shape the information and resources which communities receive (Dutta &

Basu, 2007). However, within the context of this undertaking, structures may also refer to physical places where women can solicit knowledge on maternal healthcare services or actual knowledge about maternal health (Dutta, 2009).

Further, structures determine the organisation of communities, functions of communities and human interaction within communities; structure provides the setting for the enactment of agency. They define the limits of human action, at the same time creating the scenario for the enactment of human agency (Kautzky & Tollman, 2008). Within the context of the CCA, greater emphasis is placed on understanding structures in healthcare settings which either enable or disable the community to seek health services.

Communicatively, structures constrain human action by setting up communicative barriers. The marginalised state of having minimal access to healthcare is communicatively enacted and reinforced through the healthcare system. In other instances, those communities in the margins are constructed as passive recipients of interventions directed at them due to structures which create conditions of stigmatisation (Dutta & Pal, 2010).

Lastly, structures play a pivotal role in the activity and participation of community members as a means to access and secure health services. Interestingly, structures may also constrain the activity and participation of community members (Basu & Dutta, 2009).

In addition to defining the possibilities in the context of health, it is through the enactment of agency in relationship with structure that individual communities and societies come to experience maternal health (Maputle et al., 2013). The CCA aims to achieve social development initiatives which are meaningful to community members by emphasisng the importance of community participation in identifying healthcare problems from the outset. This approach prioritises the development of programmes within structures to develop initiatives that are consistent with the cultural framework of the community (Airhihenbuwa, 1995). Of course, this completely goes against theories which support the notion of top-down development and challenges structures that withhold knowledge production processes from communities as these approaches are perceived as oppressive of the community's belief system and way of life.

Structural preferences

As discussed in the previous chapter, an inadequate understanding of health threats during pregnancy and the potential role of antenatal care in addressing these threats is a significant challenge in rural South Africa (Myer & Harrison, 2003). This lack of knowledge presents a

fundamental barrier to improving antenatal services and can be linked in part to healthcare providers. Residents of rural communities throughout South Africa experience difficulty securing affordable, good quality and comprehensive healthcare (Gaede & Versteeg, 2013). There are noticeable levels of deprivation in rural areas as this is influenced by the travelling distances to access facilities. Additional access barriers are linked to economics, which involves the costs of travelling to the facilities (Rotchford and Rotchford, 2002). In this case, the structures and systems within these structures are not enabling the communities to secure health facilities.

Therefore, TBAs are used by mothers in rural settings who seek pregnancy advice and assistance during delivery but do not have close access to health facilities (Bulterys et al., 2002). In rural areas, TBAs are the alternative to securing maternal healthcare services from professional healthcare personnel.

Between 60% and 80% of South African pregnant women who do have access to formal Western healthcare, including antenatal clinics, visit traditional healers before attending Western or formal healthcare services; pregnant women who seek this alternative may form part of this percentage (Prestorius, 1999:250). "The women also trust the knowledge of traditional birth attendants, generally preferring their care and expertise to the harsh treatment that they receive from midwives in hospitals and clinics who look down on their indigenous beliefs and practices" (Mulaudzi, 2010: 30). Asghar (2001:1) has pointed out that 99% of maternal mortalities occur in developing countries which have scarce resources and crippled economies. Therefore, one could argue that TBAs are consulted as a matter of preference and not to necessarily owing to the inaccessibility of healthcare structures (Asghar, 2001). Additionally, James McIntyre (2013) states that the additional concern with HIV-infection and AIDS-related deaths is the major contribution these diseases have made to the increase of maternal mortality in areas with few resources.

In as much as structures are said to be the enablers or disablers to pregnant women who seek adequate maternal healthcare, cultural beliefs influence the decision-making process to secure healthcare, which the next point will discuss further.

Cultural preferences

It is interesting to note that a reason women located in rural communities may occasionally decide to not seek maternal care from healthcare facilities is because of a lack trust in the health professionals, their techniques and their capabilities (Gebreyesus et al., 2014:3). As a result, homebirths remain a strong preference, and often the only option, for many women in

the developing world (Butlerys et al., 2002:223). It is apparent that pregnant women in rural communities worldwide still rely on TBAs who continue their practice within communities even when formal health services are available (Mchunu, 2004: 42).

Culture

Culture is defined as a pattern of meanings that are continually shifted by people's interactions with structures. Culture is localised in the contexts within which meanings are created, experienced, and negotiated. Further, culture provides a framework for meanings and shifts through the everyday participation of individuals and communities in their interpretation of experiences (Dutta, 2009). The values, beliefs, norms, rituals and codes form part of a community's cultural constituents. Culture can be understood as a process which is in a continuous state of production and reconfiguration through communication. This continuous process of change leads to the formation of complex social, economic and political structures. These structures are characterised by the cultural system's values that influences perception and communication, attitudes, behaviours and practices within the society (Airhihenbuwa 1995 as cited in Ford & Yep 2003:248).

Culture is often seen as a barrier which must be uprooted in order to achieve social development. However, as discussed in the previous section, culture forms a huge part of the TBA practice. It is suggested that communities in which traditional practices and beliefs have existed for very long time are supposedly harder to engage in terms of bringing knowledge intended to benefit them (Rogers, 1976). Furthermore, these communities where tradition is still a very important component exercise and practice from a monopoly of cultural beliefs (Shah, 2011).

Culture can be constructed as the living framework of individuals and of their collectives; "a learning experience, a process of evolving, knowledge – within which every individual and social group operate" (Ford & Yep 2003:248). Participants within cultural communities actively engage in dialogue, to identify the issues that are critical to the community. The dialogues uproot critical challenges being faced by the community.

As alluded to previously, culture influences how health, illness and disability are perceived; attitudes toward healthcare providers; facilities and how health information is communicated; help-seeking behaviours; preferences for traditional versus non-traditional approaches to healthcare; and perceptions regarding the role of the family in healthcare. Culture and ethnicity create a unique pattern of beliefs and perceptions as to what it means to be of good or ill health as perceptions are formulated from experiences which shape understanding of what being

healthy is (Denboba et al., 2013). In turn, this pattern of beliefs influences how symptoms are recognised, to what they are attributed, and how they are interpreted, and it affects how and when health services are sought. Cultural differences in the recognition and interpretation of symptoms and in the use of health services are the subject of rich literature (Anderson et al., 2003).

Thus, the importance of cultural sensitivity is felt greatly in the provision of services to members of cultural groups (Chin, 2000). Ideally, a culturally competent healthcare system acknowledges and incorporates at all levels the importance of culture by taking into consideration the beliefs, behaviours and attitudes pertaining to the culture in which health issues are addressed (Denboba et al., 2013). Appropriate and effective communication requires the willingness to listen to and learn from members of diverse cultures. It further requires the provision of services and information in the context of cultural health beliefs and practices and in appropriate languages, literacy levels and comprehension (Chin, 2000).

Cultural beliefs are formulated over a period of time, literature has revealed vast knowledge about the traditional beliefs of maternal healthcare and maternal mortality. Often, maternal healthcare procedures include the protection of the mother and child from evil spirits other negative elements of the outside environment where could affect the pregnancy, therefore potentially leading to the death of the woman and baby (Leferbe r & Voorhoever, 1997).

Agency

Lastly, agency is a practical component in the approach as it considers the action taken by community members in the process of accessing primary healthcare (Basu & Dutta, 2009). Agency is co-dependent on structures in the sense that, the active participation of community members requires the presence of structures. Supposedly, in the absence of structures community members do not have a platform for enacting their social agency. For this reason, the relationship between agency and structures is important for the engagement of the community with structures (Basu & Dutta, 2009). In other words, the relationship between agency and structure is important for the cultural component which determines how community members engage with their surroundings daily (Huesca, 2008).

Agency is the capacity of members of the community to express to actively participate in the process of creating meaning, which draws from the interactions members have with structures. These meanings sustain the structures but also set the context for the interaction. In this context, agency is understood in its relation to structures of organising and is expressed through culture. Agency is limited by structures, however agency also provides a framework

for community members to transform structures through challenging them (Gumucio-Dagron, 2009).

Communication is located at the intersection of culture, structure and agency. These three concepts are constantly in relationship with each other. Further, it is agency that is required to work in relationship with structures to generate meanings from marginalised communities (Dutta, 2009). In this study, agency was important to consider as it provides a framework for understanding the meanings that influence the agency or lack thereof of women in KwaNyuswa in their attempts to secure maternal health services. Additionally, the CCA was applied in this study as it provides the researcher with a culturally sensitive approach when engaging in dialogue with the women in the rural area.

Agency amongst pregnant women

As previously discussed, the agency a pregnant mother enacts by being tested for HIV to ensure appropriate care is provided to her and her baby when attending the prevention from mother to child transfer (PMTCT) programme at a clinic (Bolton et al., 2004). Unless pregnant women show agency, the mother and child are both at risk of being affected by HIV-related infections, as displayed in Figure 2.4.

Health knowledge is one of the key factors enabling pregnant women to seek appropriate antenatal healthcare services. It is critical for women to possess accurate health information on the importance of antenatal care services to ensure early attendance and a safe pregnancy (Maputle et al., 2013). Therefore, when a woman is pregnant, knowledge and attitudes on early booking, nutrition during pregnancy, follow-up, screening test and preparation for delivery are all essential. Lack of attendance at antenatal services continues amongst maternal care seeking mothers and one of the factors contributing to this is a lack of pregnancy knowledge.

It is, therefore, imperative that the value of healthcare is communicated to women and girls to in order to encourage them to attend antenatal classes early in pregnancy (Maputle et al., 2013). As discussed earlier, knowledge alone is insufficient, rather what is required is that women are convinced of the efficacy of a clinical intervention, and that this is preferable to no intervention. Adequate antenatal attendance is mainly the responsibility of the pregnant woman; women need to be motivated and committed to accept the care provided to them. Although their assistance in alleviating maternal mortalities has been heavily debated, research has shown that TBAs could play a critical role in ensuring the safe delivery of babies, operating as a referral point for pregnancy complications and offering advice on

various maternal healthcare topics (Falle, et al., 2009).

Voice and dialogue

As mentioned previously, the CCA is committed to the voice of the subaltern people (Beverly, 1999). The CCA seeks to include the voice of the local communities into the ways in which issues of health are understood, interpreted and communicated. Further, the emphasis of the CCA is on creating a communicative space for dialogue between the subaltern participants and participants of the dominant discourse. It is important to note that this emphasis is not on representing the subaltern position or perspective, but is built upon dialogical engagement with subaltern communities (Servaes, 2008). The CCA focuses on gaining a sense of understanding of subaltern perspectives based on these dialogues with the community. It is through this engagement that the culture-centered perspectives bring about an understanding of how health meanings are constructed in communities.

The communicative space fostered in the CCA is also a reflexive space for the researcher, who can locate their cultural values in the dialogue. By locating themselves within the dialogical space, the researcher demonstrates a commitment to the co-construction of meanings rather than taking the position of an external, 'objective' observer (Huesca, 2008).

Context and space

Context, in relation to the CCA, is understood as the surroundings in which cultural participants make choices. The structures and processes at the macro–level are played out through micro-level contexts within which health meanings are continuously created and recreated (Servaes, 2008). These contexts are part of the day-to-day life experiences of community members and are characteristics of the local community within which the participants live (Dutta, 2008). Localised contexts surround health meanings, health values, health beliefs and health practices, and exist in a continuous flux with the members of the cultures within which they live. They simultaneously offer opportunities for enacting cultural change through the practices adopted by individuals in response to them. Contexts are intertwined with the structures within which communities are embedded, providing a local interference through which structure constrains the life experiences of the community member. The local contexts include language issues, cultural practices, religious practices and minimal access to healthcare (Dutta-Bergmann, 2005).

Members of rural communities are often marginalised by geographic location (Dagron, 2009). The geographic location of the participants in distant villages, which are not connected by tarred roads, is central to the experience of lack of access to healthcare resources. The spatial location at the margins is typically accompanied by marginalised practices such as attempts to reform, to control and to transform. However, this may not always be the case; sometimes in a health system, there are administrative problems which institutions have not addressed and which lead to marginalised communities remaining in their disposition (Lalthapersad-Pillay, 2015).

Values

The CCA suggests that values are central to the ways in which people conceptualise the problems they consider to be important and the corresponding solutions they develop to these problems (Dutta-Bergmann 2004, 2005). The extent to which something becomes a problem depends on the lens through which the problem is perceived. Cultural values are not only intertwined with the way health problems are defined but also with the types of solutions proposed (Dutta, 2007).

Communication for Participatory Development

The communication for participatory development (CFPD) approach, encourages participation in creating knowledge and meanings. This approach allows communities to believe in their capacities to challenge and transform structures to enable their participation in developments pertaining to their local issues. Active participation in developmental initiatives engage the community in determining their challenges and address these challenges through using the power of participation to make beneficial decisions. The CFPD approach was applied to this study to understand and analyse participation practices in the KwaNyuswa which are aimed at addressing issues pertaining to the maternal mortalities in the community.

In the context of modernisation, communities situated in the periphery of developing countries delay their own development by totally rejecting the adoption of new knowledge with alternative ideas and ways of life offered through economic, socially and politically development (Melkote & Steeves, 2001:34). This development is offered to communities because of cultural ways of living deeply embedded in their culture which is claimed to hinder local and international development (Melkote & Steeves, 2001:248). Furthermore, these communities are classified as traditionalist societies because of the monopoly of cultural beliefs (Shah, 2011). Culture is viewed as a burden which must be uprooted to

achieve development in the previously mentioned spheres.

Firstly, the communication of healthcare messages has a profound impact on the agency enacted by community members who seek to understand the information they receive about healthcare services. Secondly, healthcare information impacts on the extent of action taken by the community members in seeking healthcare. Therefore, appropriate health information is also pivotal for its facilitation and dispensation of information into communities that are affected by health issues such as maternal mortalities (Obermeyer, 1993). The information either contains context relevant and/or context irrelevant health knowledge which diverse communities are unable to understand. According to Dutta (2007: 306), top-down approaches which use a one-way flow of communication from internal and external institutions to communities located in the periphery is problematic as health communication may dispense information that has no relevance to marginalised communities.

In addition, health communication through the top-down approach excludes the voices of the people within marginalised communities (Dagron, 2009). This occurs when the community members' participation and involvement in contributing to knowledge to information is not existent. The exclusion of these voices and the lack of feedback channels from these communities that carry critical cultural knowledge is often a developmental error towards addressing healthcare issues in a specific marginalised area (Airhihenbuwa et al., 2014). Communicating health message then constructs this process as a political power struggle between institutions and local communities (Lupton, 1994 cited in Dutta-Bergman, 2008: 105). As the paradigm shifts occurred in social development from a top-down approach to embracing strategies which encouraged dialogue, health communication scholars also challenged the top-down approach (Marshall & McKeon, 1996 cited in Dutta-Bergman, 2005:104). This was done through the reconfiguration of health communication to adhere to and serve marginalised communities (Marshall & McKeon, 1996 cited in Dutta-Bergman, 2005:104).

Participation in development

Development is defined as the change of patterns in societies which allow human values awareness and contributes to a society's deciding power over its own surroundings and the nature of its political prospect (Inayatullah, 2006:117). As mentioned earlier, this definition of development, includes participation as a process that is required for social change in a society (Rogers, 2006:117). A lack of scholarly definitions has produced a compact literature study of development. However, what can be comprehended from the above are some of the

underlying principles of development; change, advancement and participation (Inayatullah, 1976). Development involves agents of change that require a society to adopt their idealistic model of development; this is potentially a strategy to develop traditionalist societies into a modernized state of being. This development perspective is criticized for its materialistic approach concerning economic growth and the widening of the gap between societies that have structured knowledge systems, technological expertise and development models and those who do not.

Defining participation

Participation requires people to listen to what others say, respect other participants and possess mutual understanding and trust. In practice, however, the implementation of the concept represents a significant challenge (Msibi & Penzhorn, 2010:3). One of the main challenges is in distributing power through structures to the people. In the practice of participatory approach, it is aimed to share power equally, to minimize the chance of power serving certain groups within the community. In many cultures, the application of the requirement for all community members to participate runs counter to traditions of the communities that recognise the superiority of the opinion of certain groups of people (Bessette, 2006:115). Therefore, a participatory communication approach requires development communicators and agents with skills that enable them to transfer information, thoughts, attitudes and feelings in a manner that is understandable to others involved in the communication process (Msibi & Penzhorn, 2010:2).

Participation implies a higher level of public involvement in communication systems. It includes the involvement of the public in the production process, and in the management and planning of communication systems (Servaes & Malikhao, 2007:96). Participation may be no more than representation and consultation of the public in decision-making. Participation involves the most equitable sharing of both political and economic power, which often decreases the advantage of certain groups. Structural change involves the redistribution of power (Servaes & Malikhao, 2007:97). Participatory development communication is a planned activity, based on participatory processes which facilitate a dialogue among different stakeholders (Servaes, 2008). This kind of communication means moving from a focus of informing and persuading people to change their behaviour or attitudes, to a focus on facilitating exchanges between different stakeholders to address a common problem.

Alma Ata and the Principle of Participation

The Alma Ata Declaration of 1978 is a set of policies which were established to promote and protect the health rights afforded to people globally, such as the right to Primary Healthcare. The declaration also functions as a framework which governs the participation of people at an individual or collective capacity in the planning and implementation of their healthcare (Alma Ata, 1978). As such, this forms an integral part of most countries' health systems and the overall social and economic development of the community to ensure the provision of preventative, rehabilitative and promotive services. The participation of people is allowed by 'voice' which is defined as the right to participate in decision-making in social, economic, cultural, and political life – and as a crucial human and citizenship right (Keerthirathne et al., 2009:4). Further, voice can be used to promote communication and participation as a right. Within a context of maternal mortality, voice relates to the right to communicate and participate in the processes and decision-making that affects one's life and the life of one's child (Keerthirathne et al., 2009:4).

Arguably, a health communication effort can be successful if the community can participate. The community may or may not relate to health communication for an issue within their context (Merzel & D'Afflitti, 2003:558). The communication model applied in the participation process facilitates the occurrence of dialogue and meaning construction. Participants are encouraged to share ideas and reach a common understanding of the many explored concepts. Communication which involves all participants is evidenced by understanding and empowerment (Dandala, 1996 cited in Durden &Nduhura, 2011:92).

Participatory communication

Participatory communication is seen by some as being a potential source of social transformation (Nair &White, 1994a; Riaño, 1994). Participatory communication reveals how power functions to subordinate certain groups of people (Servaes, 2008). A community's involvement is of great significance in the discussions and implementation of mechanisms which help to address health issues, such as maternal mortality, within their context. It is crucial too for a more sustainable development strategy (Servaes, 1999:13; 225). The key to participatory communication is the need for development agents and the participants involved in the process to work jointly by engaging in dialogue throughout the decision-making process. Further, the two-way communication in dialogue means people are able to participate throughout most, if not all, stages of a development process (Bessette, 2006:8; 226). Communication which takes place between development agents and the community thrives when participants focus on the skill to listen well. The failure of participants to voice their views does not occur because people do not have an opinion, but rather occurs because nobody exercises an ability to listen to them. Participation requires listening as it builds trust between development agents and communities (Servaes & Malikhao, 2007:91).

Principles of participation: Power, control and liberation

According to Robert White (1994:23), "the idea of generative power and control is consistent with and appropriate to the concept of participation". In other words, within a participatory framework, one can expect to identify those with the power over the development process and who also control the extent to which community members can participate in decision-making processes (Msibi & Penzhorn, 2010:2). This affords the community members an opportunity to exercise their agency (Ayee, 1993:167). Discernment is valuable to vulnerable communities who experience this emancipation for the first time. Participation develops the confidence in members to make beneficial decisions for the community at large (White, 1994:25).

Participation in the South African context

South Africa's development is affected by the apartheid era, which pursued an authoritarian government. The approach deployed by the apartheid government resulted in the majority of black South Africans being deprived of the rights to participate in decision-making processes (Tadesse et al., 2006:20). During the apartheid era, black people within their restricted communities were denoted as passive recipients of many developmental initiatives and were afforded no say in these initiatives. With the ushering in of a democratic South Africa in 1994 and a new government was brought into power, reconfigurations in the former approach to development were required. This new approach advocated for more participation from communities in the margins and encouraged the empowerment of communities through their active participation in developmental processes (Everett & Gwagwa, 2005: 4). This complete policy driven transition engages communities even in rural areas by encouraging them to partake in dialogues for their development.

Conclusion

The CCA consists of three major components namely, structure, agency and culture, which together provide a framework for understanding the decision-making processes made by community members. The approach also provides lenses through which certain cultural behavior traits are understood; the meanings through which the groups interact and interpret their surroundings determine their actions and choices concerning development initiatives. However, as denoted by the CFPD, when there is an absence of participation in creating knowledge and meanings, dialogue needs to be encouraged. Communities are required to believe in their capacity to challenge and transform structures to enable their participation and voices to be heard. Active participation in developmental initiatives would engage the community in determining and addressing their challenges through using the power of participation to make beneficial decisions. Furthermore, this builds trust between the structures and marginalized community as their capabilities are projected. For participation to take place, dialogue through communication is required. This also decentralises the power from a monopoly construct to a democratic process of power-sharing amongst the people.

In South Africa, the decentralisation of power is evidenced by the new democracy in which active participation is required to make changes and develop interventions and

programmes aimed at addressing identified challenges. The KwaNyuswa community members have governing structures, such as the local municipality, which could enable or disable community members from actively participating in their own development. Hindrances such as structures can be challenged and transformed by the community members to allow them to be active and enact agency in line with their rights and needs for positive outcomes. The next chapter will discuss the methodological procedure through which this study's findings were gathered, including the framework that provided a guided process for the researcher to follow.

Chapter 4

Methodology

The purpose of this chapter is to describe and discuss the social science processes applied to this study for the purpose of obtaining data, analysing data and producing findings for the research question (Kothari, 2004: 2). Further, this chapter is a description of the research processes undertaken by the researcher towards investigating the perceived causes of maternal mortalities in the KwaNyuswa community. The methodological process includes a research design as well as a toolkit which was configured and used to collect the data required to answer the research question. The methods include the research background, the study approach, sampling method for participant recruitment, thematic analysis, ethical considerations, study reliability, and validity and study limitations.
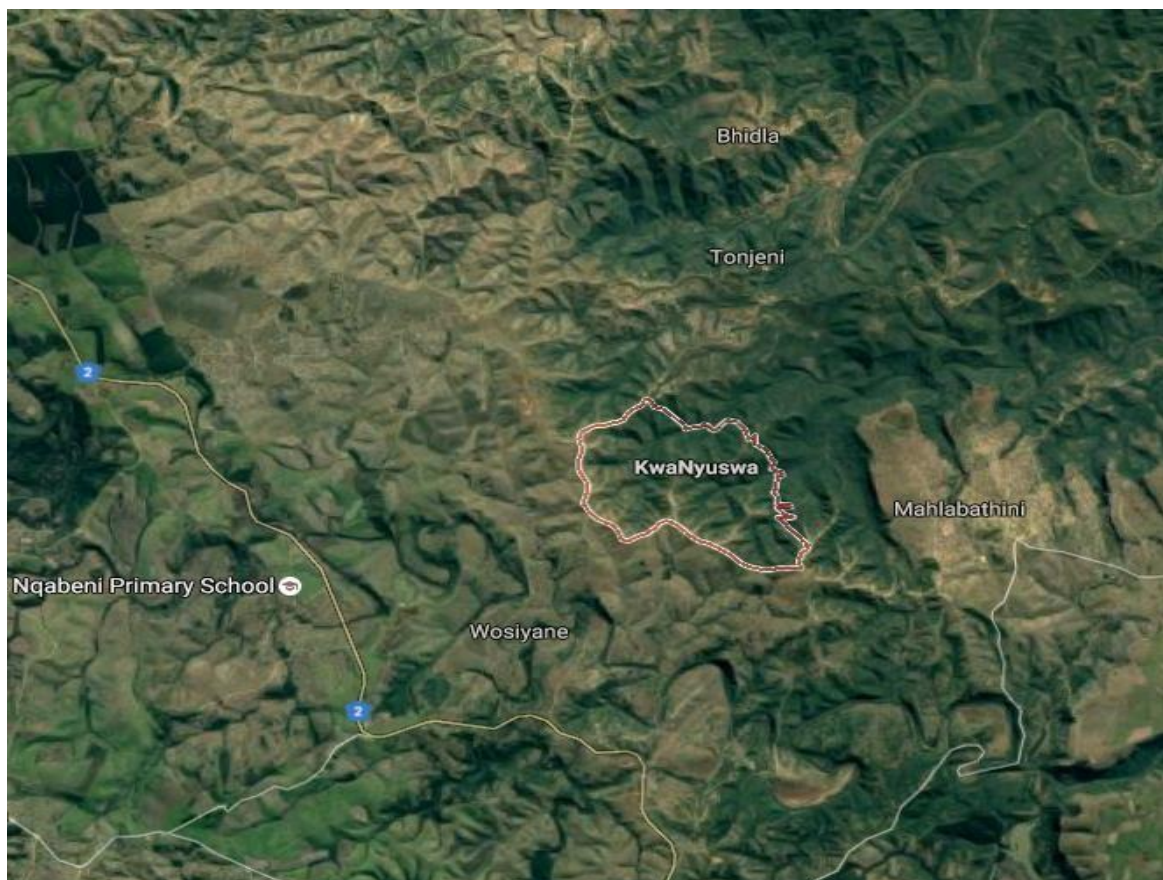
Study location

Figure 2.5 Map of study area KwaNyuswa. (Source: Google Maps, 2016).

The location of the study was the KwaNyuswa rural community, located in the lower South Coast region in KwaZulu-Natal (KZN) (Ezinqoleni Municipality, 2014). The rural community is situated within the Ezinqoleni Municipality which is one of six other local municipalities which fall under the Ugu District Municipality in KZN. It is located in the South-Western boundary of the district and has a total of six wards, making it the second smallest municipality in the district (Ezinqoleni Municipality, 2014).

This location was selected because of the proximity of the community to the researcher's home town. Secondly, the it is situated within KZN, the province in South Africa which has the highest maternal mortality rate (MMR) (Myer &Harrison, 2003).

The Ezinqoleni Municipality has four clinics and no hospital serving the population threshold. These are Ezingolweni Clinic, Mthimude Clinic, Thembalesizwe Clinic, and Thonjeni Clinic. Ideally, clinics would be within a walking distance of 1 to 2.5 km and a maximum walking distance of 5km (Ezinqoleni Municipality, 2014). However, the municipality does not conform to this standard, as facilities are fairly evenly spread along main access routes and concentrated within a dense core area, with a limited access to service in some of the outlying areas in the south (Ezinqoleni Municipality Integrated Development Plan, 2014:84). Distance and limited access to the maternal healthcare facilities were previously identified as one of the causes of maternal deaths; however, there is no previous compact study which concretes these two factors as contributors to mortality rates in the Ezinqoleni Municipality. Therefore, the researcher seeks to investigate the knowledge perceptions of the local community members by ascertaining their understanding of what the causes of mortalities are in the KwaNyuswa rural community.

Location population

According to the census conducted by Statistics South Africa in 2011, the Ezinqoleni Municipality holds a population threshold of 52 540. The majority of this population includes people between the ages of 15 to 34 years of age. The participants selected for this study form part of this population. A challenge that presented itself was that of the fluency of IsiZulu spoken by the researcher. However, this challenged was solved by getting a research assistant from the local community.

Study overview

The study's focus was to investigate a selected number of KwaNyuswa community members in terms of their perceived causes of the maternal mortalities within the KwaNyuswa rural area. The research hypothesis guiding the project was that MMRs are a direct result of a lack

of maternal healthcare knowledge in KwaNyuswa. Others causes of maternal mortality are possibly a subsequent result of lack of access to maternal healthcare services. As has already been identified in Chapter 2, traditional birth attendants (TBA) are believed to be in a potential position to help reduce the MMRs as they are in close proximity to pregnant women, particularly in rural areas (Bulterys et al., 2002). However, their existence in the KwaNyuswa community is unknown.

The main questions addressed in the current study include the following:

   1.) What are the perceived factors that contribute to maternal mortality in the
        KwaNyuswa rural area?
In addition, the following sub-questions will also be addressed by the findings presented in this chapter:

   1.2.   How do expectant mothers compensate for the apparent lack of healthcare
           facilities in the KwaNyuswa area?
   1.3.   To what extent does inaccessibility of healthcare facilities contribute to
           maternal mortality in KwaNyuswa rural area?
   1.4.   How can maternal mortality be reduced?

Question one, which is the main research question, sought to understand the perceived causes of maternal mortality in the KwaNyuswa community from the participating community members. Question two was interested in the compensatory agency exerted by pregnant women towards securing maternal healthcare services and knowledge (Bulterys et al., 2002). Question three sought to investigate the impact lack of access to healthcare facilities has on the MMR. Question four was asked directly to the study participants to obtain recommendations which are included in the findings chapter of this study.

Research design

The qualitative research design chosen for this study has been included in Chapter 3 including a summary on p. The qualitative research design used in this study includes a purposeful sampling which involved the selection of participants on the basis of a pre-set criterion , focus group which were conducted in a semi-structed format, thematic anaylsis which involved following the six steps discussed later in this Chapter.

A qualitative research design was selected for this study because qualitative research is broad and comprises of a range of methods and approaches to collecting and analysing social data (Ritchie et al., 2013: 217). Studies associated with understanding society usually apply a qualitative research design as a qualitative research design enables the researcher to collect

data through methods such as focus groups and interviews (Ritchie et al., 2013: 170). Qualitative research extrapolates data through asking questions that seek to know why and how a particular social phenomenon is occurring. Further, this enabled the researcher to investigate the perceived causes of maternal mortalities in the KwaNyuswa community through the application of a qualitative research design discussed I this chapter (Ritchie et al., 2013:5). Quantitative research usually includes a hypothesis which is proven through research (Silverman, 2010), which this study does not intend do; rather it is guided by the set of assumptions laid out above.

Advantages and disadvantages of a qualitative inquiry

Qualitative studies place focus on socially constructed reality. Researchers critically study social phenomena whilst seeking the most accurate answer for why a certain phenomenon has occurred or is occurring (Denzin & Lincoln, 2011: 8). Further, qualitative researchers focus their research on exploring, examining, and describing people and their environments (Orb et al., 2001: 93), which becomes an opportunity for the researcher to locate themselves in the participants' world of the location in which the study is being conducted.

Additionally, qualitative research enables researchers to engage in analytical processes and practices which involve collecting data, applying methods such as interviews, focused group discussions and questionnaires (Kothari, 2004: 2). In turn, the researcher proceeds to interpret the data producing critically analysed findings to complete the study. This attempts to present a logical argument which takes into consideration all qualitative study processes (Denzin & Lincoln, 2005: 3).

Mostly, researchers who take on qualitative research begin with an assumption, or an understanding of a worldview which they wish to research further. "Researchers also select the most appropriate and reliable theoretical lens in an attempt to try and understand their worldview by critically analysing the problem" (Creswell, 2007:37). For example, this study began with an assumption that maternal deaths in the KwaNyuswa rural community are linked mainly to issues of inadequate knowledge, and as an additional cause, to the lack of access to maternal healthcare services. In other words, qualitative researchers use the collection of data in settings sensitive to the study participants and data analysis is conducted to establish patterns or themes. "The final written study includes data collected from participants in the form of their verbatim or transcription, this, however, is based on the selected method of analysis and the process in which data is interpreted"(Creswell, 2007: 37).

Approach to study: Culture-Centered Approach

The culture-centered approach (CCA) is applied in this study as it provided the researcher with a culturally sensitive approach when engaging in dialogue with the women in the rural area. A CCA offers a framework for communication which facilitates understanding and recognition of the people side-lined by previous colonial eras. This inclusion is achieved through the consideration of the cultural background of the communities in the margins (Chai, 2007). A CCA was applied to this study as it accounts for dialogue with members of a cultural group in the community. This approach seeks to introduce the voice of the local communities into the ways in which issues of health are understood, interpreted and communicated. It is through dialogue that the culture-centered perspectives are applied to establish an understanding of how health meanings are constructed in communities.

As discussed in the previous chapter, the CCA has three lenses – culture, structure and agency – through which variables such as lack of access, compensation for this lack and the identification of factors contributing to maternal mortality shall be considered. . Firstly, culture as a component of the approach places the active participants at the fore of the construction of experiences and meanings, customs and beliefs which are then shared in the community (Dutta, 2008: 55). This component of the theory will be applied to establish whether or not maternal healthcare knowledge lacks cultural sensitivity (Dutta, 2008: 55). As already mentioned, culture is defined as a dynamic and constitutive framework of meanings that is continually shifting in its relationship to structures of organising. This component is localised in the contexts within which meanings are located, experienced and negotiated. Further, culture provides the framework for meanings; culture is shifted through the everyday participation of individuals and communities in meaning-making (Dutta, 2009).

Structures play a pivotal role in the activity and participation of community members as a means through which they can access and secure health services. Interestingly, structures also constrain the activity and participation of community members (Basu & Dutta, 2009). Further, structures determine how a society is organised, how it functions, and how individual members within it behave towards each other and to social organisation. Structure provides the setting for the enactment of agency, defining the limits of human action, whilst simultaneously creating the scenario for the enactment of human agency (Kautzky & Tollman, 2008). In the realm of the CCA, the emphasis is on understanding those structural processes in healthcare settings which limit the possibilities of health for community

participants.

Lastly, agency is a practical component in the approach as it considers the action taken by community members, in this instance pregnant women, in the process of accessing primary healthcare (Basu & Dutta, 2009). Agency is co-dependent on structures in the sense that, the active participation of community members requires the presence of structures. In the absence of structures, community members do not have a platform for enacting their human agency, and therefore, the relationship between agency and structure is important for the cultural component which determines how community members engage with their surroundings daily (Huesca, 2008). Therefore, the CCA is culture-centric and it advocates for community culture to be acknowledged and included at the center of their strategies. Agency is understood here both in terms of everyday forms of meaning-making that negotiate the structures and configure creative strategies of addressing the structural barriers that are experienced by individuals, their families and communities. In this study, it was important to understand the factors that influence the agency (or lack thereof) of women in KwaNyuswa in their attempts to secure maternal health services.

Researcher subjectivity

Researcher subjectivity refers to the extent that the researcher's own feelings, biases and interpretations influence the research methods (Roberts-Holmes, 2014:15). Subjectivity guides everything from the choice of topic that one studies, to formulating hypotheses, to selecting methodologies, and interpreting data (Morgan, 2003:49). In qualitative methodology, the researcher is encouraged to reflect on the values and objectives being brought to the research and how these affect the research project (Ratner, 2002:1). The researcher avoided subjectivity by soliciting different views from the reviewed literature in the second chapter of this study. Further, the researcher noted the biases prior in order to assess the impact of any bias in this study.

Ethical considerations

All researchers are responsible for ensuring that participants are well-informed about the purpose of the research they are being asked to participate in so that they are given a chance to understand the risks and the benefits that might accrue as a result (Orb et al., 2001:95). Ethical clearance was granted to the researcher to commence this study by the Ethics Committee of the University of KwaZulu-Natal (UKZN) (see Appendix G). The participants were given an opportunity to make an independent decision about their participation in the

study without fear of any negative consequence. This particular ethic was ensured by supplying the participants with detailed consent forms with information about the researcher, the institution through which the research is being conducted and a clear description of the study. The informed consent forms were offered in both English and isiZulu, the local language spoken in KwaNyuswa (Ezinqoleni Municipality, 2014).

Ethics pertains to avoiding harm to participants which can be prevented or reduced through the application of appropriate ethical principles (Orb et al., 2001:93). An interview is usually equated with confidentiality, informed consent and privacy (Orb et al., 2001:94). For this research study, interviews were held in two private locations within the community, namely the KwaNyuswa War Room situated at the KwaNyuswa Sports Centre and the Sihlosokuhle Development Centre. The research protocols clearly detailed the manner in which the study was to be conducted. This was aligned with the injunction provided for by Kaiser (2009:12). The protocols regarding focus groups and individual interviews, the access to participants, informed consent and storage of data were followed by the researcher and explained to the participants.

Informed consent

Respecting people in the context of research involves a process of recognising their rights as participants, which includes the right to be completely knowledgeable about the study to ensure informed decisions about participation were made freely (Orb et al., 2001:94). As briefly mentioned above, the researcher ensured that participants were fully aware of their rights to withdraw from participating in at any point. The researcher was aware of the possible language barriers and translated the informed consent form into isiZulu (see Appendix D).

Utilising 'best practice', prior to engagement, all the participants should have been well informed of the study. This, however, was not always possible due to the challenge of distance between the researcher and the participants. When the researcher experienced distance constraints, notes were referred to for the process taken to ensure that participants are still well informed. It is suggested that the purpose of the study be disclosed to the participants at the initial meeting and an opportunity created for questions to be directed at the researcher (Richard & Schwartz, 2002:137). In a qualitative research study, this principle is honoured by informed consent, which means making a reasonable balance between over-informing and under-informing (Kvale, 1996). In this instance, the researcher was mindful to not overwhelm the participants with too much information prior to the focus group discussion

(Kvale, 1996) as this may have influenced the responses provided by the participants.

Beneficence

The use of pseudonyms is recommended and participants should be told how results will be published as quotations or other data from the participants, even though anonymous, could reveal their identity (Orb et al., 2001:95). The structure of the consent form (see Appendix C) enabled the participant to indicate whether they required a pseudonym. The researcher provided publishing details to the participants and requested permission to use the verbatim from the discussion, in doing so ascertaining whether extracts from all participants could be featured. Some of the participants involved in this study requested to remain anonymous in fear of being wrongly implicated. Although the researcher tried to explain that this was highly unlikely, some insisted on a pseudonym. This was a challenge for the researcher because of the impact this may have on the validity of the study.

Data collection methods

"Conducting research in another setting may mean that researchers have to spend more time and effort establishing rapport and learning the new setting. The researcher's perceptions of field situations are determined by this interaction" (Orb et al., 2001:94). There are various tools through which one is able to collect data such as conducting interviews or focus groups (Ritchie et al., 2013). Through the application of various data collection tools, social scientists have been able to address pivotal issues, by asking the right questions through the right methodology (Silverman, 2010). Thus, a research design is pivotal to ascertaining the most reliable data from a group of participants through interviews or group discussions (Ritchie et al., 2013). This study has used focus groups for the data collection process.

Qualitative interviews provide the researcher with an opportunity to focus specifically on investigating individual responses to questions. In addition, these one-on-one interactions provide a platform to ask further questions as a way of gaining a deeper understanding of an individual's thought patterns (Ritchie et al., 2013). Moreover, it is anticipated that the participant's perspectives are given more attention and investigated thoroughly when responses have been gathered from individuals as opposed to gathering responses from a group discussion (Ritchie et al., 2013).

Although individual interviews provide a thorough method for in-depth interviewing, the reliability of the responses can be questioned. This is because some individuals may become uncomfortable during the interview leading them to render responses which differ from their initial thought (Barriball & White, 1994). The data collected for this study was stored in

verbatim format on the Quick Voice application and was backed up using Voice Memos on the researcher's cellphone device. The recordings were transferred onto an electronic disc to be stored at UKZN, Howard College Campus over the next five years.

Focus groups

Focus group discussion was applied as a data collection tool in this study. Group discussions comprise of a small sample of people selected based on a research inquiry (Silverman, 2010). Facilitating group discussions offers minimum opportunity for an in-depth investigation of individual perspectives and responses (Ritchie et al., 2013). However, there are many benefits of facilitating group discussions, for example, individuals can think creatively and refine their response in a group setting. Furthermore, group discussions reflect the influence of context on individual perception, which is beneficial for studies that investigate the various attitudes within a broader social context (Ritchie et al., 2013). Although personal interviews reduce opportunities for poor responses, a focus group enabled the researcher to identify the shared meanings and/or experiences of maternal healthcare constructed by community members in KwaNyuswa. The focus group schedule is attached as Appendix A. This schedule was also made available to the focus group participants in IsiZulu (see Appendix B).

Sampling method

Purposeful sampling involves the careful selection of information-rich cases which will provide insightful answers to the study research question (Emmel, 2013:33). Information - rich cases are selected for soliciting great amounts of data for the research question (Emmel, 2013: 34). These the sort of cases a researcher can gather in-depth understanding about the main question. There are different strategies one can apply in the process of purposeful sampling, such as extreme or variant case sampling, intensity sampling, maximum variation sampling, homogenous sampling, typical case sampling, stratified purposive sampling, critical care sampling, and/or snowball or chain sampling (Patton, 1990: 171 - 181). For this study, the critical case sampling and intensity sampling were used, as both provided the researcher with information-rich cases through the selection of cases which dealt directly with the research problem.

However, in total there are sixteen methods of purposeful sampling. A researcher would require an informant in the community to assist with identifying information-rich cases (Suri, 2011:66). For this study, an informant, Ms. Nokubonga Gumede assisted with identifying participants for this study according to a criteria selection list which the researcher   provided

her with prior to the data collection period. This selection criterion is discussed below in the sampling participants section of this chapter.

Advantages and disadvantages of the purposive sampling method

According to Martin Marhsall (1996), purposive sampling is advantageous to researchers seeking to study a broad range of subjects or participants thereof. For example, subjects or participants who hold experiences which are particularly useful to the study. Further, the application of a purposive sampling method can be used to increase the credibility of the study results (Duan et al., 2015). The range of variations in a sample from which purposive samples is to be taken is often not known at the outset of a study. In addition, purposive sampling is not as representative of the population as a probability random sample.

Sampling participants

In a study conducted by Pulani Tlebere (et al., 2007:343), participants were selected through the assistance of community healthcare workers who were asked to identify all women in their communities who had delivered a baby in the last nine to 12 months. This included women who had homebirths or did not attend an antenatal clinic. The researcher adapted a similar criterion for the participant selection process in this study. The project manager of the Sihlosokuhle Development Centre, Ms. Nokubonga Gumede, assisted by gathering participants who had given birth in the last nine to 24 months. The community was asked to gather women between the ages of 18 and 34 years.

Twenty-four black South African mothers between the ages of 18 and 34 years residing in the KwaNyuswa rural area were purposely selected as the participants for the study. The specificity in selecting 24 female participants was to elicit rich data. Female participants were selected for this study because females are the most affected by issues pertaining to maternal health in rural communities. Research shows that,

> In South Africa, more than half of the population is classified as poor, with women and children, and the rural population disproportionately affected. Rural women and children are affected (Ngwena, 2000).

This sample included relatively young and middle-aged black mothers with whom the researcher engaged in dialogue to gather information relating to their experiences of maternal healthcare services and their childbirth experiences.

Sample size

Twenty-four female participants were selected to participate in the focus group which was conducted for this study. The researcher conducted two focus groups comprising of eight female participants. Each focus group ran for one and a half hours. The focus groups were conducted at the Sihlosokuhle Development Centre in KwaNyuswa located in the rural area. The Sihlosokuhle Development Centre provides a feeding scheme to poverty-stricken women with children in the KwaNyuswa Rural Area (Shusha, 2013).

The young women spoke in their personal capacities, and they were not representatives of the Centre. The researcher did not require gatekeeper permission as the Centre is a convenient community structure in the area where the young women interact. The researcher secured the study participants through the assistance of the Centre co-director, Mrs. Margaret Shusha, who is familiar with residents of the KwaNyuswa rural area. The director assisted with securing twenty-four female participants and the venue. According to Sonia Thompson (1996), payments are rarely considered when designing qualitative research. Despite this, the researcher gave each participant a tin of Dove antiperspirant deodorant which was sponsored for this study by Unilever. The researcher requested sponsorship prior to the commencement of the data collection process (see Appendix F).

Figure 2.6. Focus group participants holding the donated Dove antiperspirant deodorant. (Source: Mkhwanazi, 2015).

Limitations

A limitation of this study is that it does not represent the entire municipality. However, the study is still valid as it can present findings which hold valuable insights into maternal mortality in rural areas. In addition, the sample size was limited to accommodate the time period in which this study could be completed.

Data analysis tools: Thematic analysis

Thematic Step	*Description*
Step 1: Familiarisation with the data	Researcher immerses themselves in the data collected whilst noting any initial observations.
Step 2: Coding	Code data by generating labels for important features in the data. This is also considered a way of reducing data to the most relevant information. The coding will be conducted using analytic insights and observations.
Step 3: Searching for themes	Researcher searches for themes through identifying coherent and meaningful patterns in the data which are relevant to the main research questions.
Step 4: Reviewing themes	Requires a review of themes, which entails checking that the themes work in alignment with the codes.
Step 5: Defining and naming themes	The researcher should clearly define and name the organizing themes.
Step 6: Writing up	A write up has to be done in order to tell the reader of the findings. In addition, the write up should correlate to the existing literature.

Table 2. Six phases of thematic analysis. (Source: Bruan & Clarke, 2013).

Analysing data for this study required a technique that complemented the qualitative research design. For this reason, a thematic analysis was applied as an analytical tool for this study (Attride-Stirling, 2001: 387-388). It is also a method of identifying and analysing patterns in qualitative data. A thematic analysis is suitable for diverse research interest, such as this study and it can be used to analyse focus group transcripts (Bruan & Clark

2006:57) and it provides tools for organising data (Attride-Stirling, 2001:389). These organising tools are referred to as thematic networks, under which textual data is grouped according to different themes derived from the data collected.

A thematic analysis is a tool to use in a qualitative research design for various reasons. Thematic networks provide a simple way of organising themes. Secondly, when applied thematic networks uncover relevant themes in the data. Thirdly, the thematic networks facilitate the structuring of themes collected from the text. Lastly, thematic networks are a technique for identifying significant implications from the data (Attride-Stirling, 2001:389).

There are three organising themes in a thematic network, namely a basic theme, an organising theme and a global theme (Attride-Stirling, 2001:388). A basic theme is the simplest to form as it is gathered from the data, and groups data of significant meaning from the analysis. An organising theme joins together similar basic themes into clusters; it is a group of basic themes (Bruan & Clarke, 2013:64). However, the role of an organising theme is to extract significant meaning from the clusters to form a broader theme. In a thematic network, a broader theme is referred to as a global theme, which comprisesgroups of organising themes. Together these themes form an assertion or hypothesis about an issue given through the study being conducted (Attride-Stirling, 2001:389). Furthermore, the global themes summarise the previously mentioned themes by providing an interpretation of the textual data. The significance of the global themes is that it is only at this point of a thematic network that an interpretation of the data is provided.

In applying a thematic analysis, a researcher must carefully comply with the following six steps in order to gather the most accurate details (Bruan & Clarke, 2013:60–69). These steps are namely; familiarization with the data, coding searching for themes, reviewing the themes, defining themes, naming the themes and compiling a write-up on the findings or results. Firstly, the researcher was required to immerse themselves in the data collected whilst noting any initial observations. This required listening to the verbatim, transcribing it to text and listening to it once again when it was completely transcribed to take notes. The researcher listened to the audio once before beginning the transctiption process, during the transcription process and after the transcription process was completed to check for any outstanding audio and to identify and mistakes in the transcription. The second step required the researcher to code the data by generating initial labels for important features in the data. This is also

considered a way of reducing data to the most relevant information (Bruan & Clarke, 2013:61). Once the researcher went through the audio transcription to check for any outstanding text and to check for mistakes, the researcher read through the transcription and grouped similar sets of data under themes. This third step involved searching for themes through identifying coherent and meaningful patterns in the data which are relevant to the main research questions.

The fourth step involved a review of themes, which entails checking that the themes align with the codes. The themes were clearly labelled with excerpts of data to support the selection and organisation of the themes. The researcher placed the themes in a table format which can be viewed in the fifth chapter. These themes were also discussed in Chapter 5. Fifthly, the researcher clearly defined and named the organising themes whilst discussing each of them and the meaning they carried in relation to the study. Lastly, the write up or analysis which was conducted to formulate the findings is included in Chapter 5 and Chapter 6. The data was analyzed using the theoretical framework chosen for this study. Further, the discussion is linked the existing literature in Chapter 2 (Bruan & Clarke, 2006:69).

Actions taken:

Qualitative research extrapolates data through asking questions that seek to know why and how a particular social phenomenon is occurring. Further, this enabled the researcher to investigate the perceived causes of maternal mortalities in the KwaNyuswa community through the application of a qualitative research design discussed I this chapter (Ritchie et al., 2013:5). Quantitative research usually includes a hypothesis which is proven through research (Silverman, 2010), which this study does not intend do; rather it is guided by the set of assumptions laid out above.

Firstly, the researcher was required to immerse themselves in the data collected whilst noting any initial observations. This required listening to the verbatim, transcribing it to text and listening to it once again when it was completely transcribed to take notes. The researcher listened to the audio once before beginning the transcription process, during the transcription process and after the transcription process was completed to check for any outstanding audio and to identify and mistakes in the transcription. The second step required the researcher was to code the data by generating initial labels for important features in the data. This is also considered a way of reducing data to the most relevant information (Bruan & Clarke, 2013:61). Once the researcher went through the audio transcription to check for any outstanding text and to check for mistakes, the researcher read through the transcription and grouped similar sets of data under themes. This third step involved searching for themes through identifying coherent and meaningful patterns in the data which are relevant to the main research questions.

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Reliability and validity of the research

The reliability of a study is the extent to which the result of an inquiry can be repeatedly found over a period of time, and it considers whether the population under study is accurately represented (Golafshani, 2003:598). Validity refers both to the extent to which the study is truthful and answers the research question set out by the researcher (Golafshani, 2003:599).

To ensure the reliability of this study, the municipal reports used in the literature review and further chapters were the most recent. This ensures that information was still relevant to the study period and should the study be repeated using the reports the same results would be produced. Secondly, a qualitative research design enables the researcher to collect accurate information. By describing the methodological procedures in this study, the reader should be able to identify whether all the steps and processes were applied to extract the data which reviewed in Chapter 5 of this study. In addition to this, the phases of the thematic analysis were followed in the analysis chapter and the reader will be able to check whether all the steps were adhered to.

Conclusion

This chapter contains several methods and processes strategically selected to answer the main research question of this study. Every section of this chapter is fundamental for attaining accurate results which are produced in the data analysis chapter. As discussed, a methodology is especially important in social sciences qualitative research as it is a roadmap for the reader to understand how certain results will be achieved. In addition, aspects of a methodology are important for ensuring the validity and reliability of a study.

The location of this study consists of women who were previously affected by maternal mortalities, as evidenced in the findings of the next chapter. These information-rich cases were necessary for the development of the research results and the purpose of answering the research questions in this paper. Ethics were considered before and during the data collection process. Participants were provided with adequate information pertaining to their rights as participants of this study. Further, participants were also given time to ask questions for clarity about their involvement in the study. As mentioned a thematic analysis was applied to analyse the data, and each step was applied in the process of achieving the analysis in the next chapter.

Chapter 5

Findings and Analysis

The process of conducting qualitative research involves writing and analysis (Bruan & Clark, 2013). This is mainly a result of the great amount of data which is collected in the form of notes taken during interviews and focus group discussion, which are then transcribed verbatim (Mays et al., 2000). Further, qualitative data analysis involves separating collected data into categories which the researcher interprets, describes, explains and produces a report that aims to answer a research question (Dey, 2003). According to Ian Dey (2003), the initial step taken in qualitative data analysis is the development of a description of the social phenomenon selected for the study. This analysis relates the findings back to the research question of the study in the form a report. The presentation of findings for this study are presented according to the steps of a thematic analysis, in which the researcher has the flexibility of applying compressed descriptions to sets of data (Bondas et al., 2013).

This chapter aims to present the reader with findings from the investigation conducted in the KwaNyuswa community in the Ezinqoleni Municipality. The investigation involved soliciting the perceived causes of maternal mortalities from the selected community participants. Chapter 4 details the process of data collection which was conducted using focus groups in the study locations (see figure 2.5). This data was then stored in verbatim and transcribed into text format using the thematic analysis method. All data was analysed thematically and the findings are categorised by descriptive themes throughout this chapter.

The following main research question will be addressed by the findings in this chapter:

1.) What are the perceived factors that contribute to maternal mortality in the KwaNyuswa rural area?

In addition, the following sub-questions will also be addressed by the findings presented in this chapter:

1.2. How do expectant mothers compensate for the for the apparent lack of healthcare facilities in the KwaNyuswa Area?
1.3. To what extent does inaccessibility contribute to maternal mortality in KwaNyuswa rural area?
1.4. How can maternal mortality be reduced?

The next section of this chapter discusses the findings collected from the data and categorised by descriptive themes.

Study Findings

List of Findings	Sub-findings
Theme One: A lack of maternal healthcare/ prenatal care knowledge amongst mothers	- Knowledge sits with the community caregivers - Awareness of the importance of check ups - Maternal knowledge through community caregivers
Theme Two: No evidence of family planning (Or prior pregnancy knowledge)	- Late discovery of pregnancy
Theme Three: Fear of testing for HIV and stigmatisation	- Awareness about the prevention form mother to child transfer programme (PMTCT) - Awareness of disease transfer from mother to child
Theme Four: Non-existent Traditional birth attendants (TBA)	- No community reliance on for maternal healthcare - Lack of trust of TBAs' ability to support mother & child (lack of them toward their help)
Theme Five: Community Caregivers enact agency	- Agency and responsibility amongst the community caregivers
Theme Six: Caring for mother than baby	- Frequent child mortalities
Theme Seven: Challenging transport system	- Unreliable transport system - Unaffordable alternative transport options (affecting agency)
Theme Eight: Challenges healthcare facilities and medical personnel	- Under-equipped mobile clinic system - Hospitals not responding to pregnant women's agency - Hospital personnel negligence and bad service – causes of child mortalities - Causes of poor maternal healthcare attendance (bad hospital service/personnel) - A lack of privacy in mobile clinic affecting maternal healthcare attendance - Confusion about sync between clinic & mobile clinic.
Theme Nine: Bad service and attitudes	- Mobile Clinic nurse's attitudes – barriers to securing maternal healthcare (No understanding of mobile clinic system; bad personnel attitudes - Bad treatment discourages pregnancy women's agency - Delayed agency of Hospital midwives

Table 3. Lists all the findings and sub-findings from the study. (Source: KwaNyuswa and Sihlosokuhle focus groups, 2015).

Theme One: A lack of maternal healthcare/of prenatal care knowledge amongst mothers

A finding which emerges from the data is that some of the women from the KwaNyuswa rural community do not possess any maternal healthcare knowledge. They source information from the community caregivers who advise the mothers of the importance of regular check-ups during the pregnancy. The caregivers visit the homes of the pregnant women which mean the agency is initiated by the caregiver and not the mothers. Maputle et al., (2013) mentions that a lack of maternal health knowledge may impact the mother's agency; the lack of knowledge acts as a barrier to enacting agency for mothers as theorised in the culture-centered approach (CCA) (Dutta, 2008). However, the communication for participatory development theory (CFPD) calls for this horizontal communication approach (Dargon, 2009). Although many of the caregivers are community members who work with the local governing authorities, the engagement between the community members is important for ease of relation. One cannot simply be critical of the women's lack of proactive behavior, ; it is important to question when and how the information reaches the mothers.

> *I am not sure if I have the adequate knowledge about maternal healthcare, but the knowledge I have, I got from neighbours, family and people who I know have had children before me* (Participant, from KwaNyuswa War Room, 15 September 2015)..

> *If a woman is pregnant, there is a number that was given from the Office of the Premier. It is used to encourage pregnant women to visit the clinic and even when the mother has given birth the clinic links that mother with a community* (Participant, from KwaNyuswa War Room, 15 September 2015).

This respondent's comment reflects an expectation that pregnant women will respond to the information they receive from the government office. This can be viewed as a top-down approach of communication whereby culture is neither central nor acknowledged. Research substantiates the concept of family support and encouragement as a stimulus for mothers to engage in activities that will lead not only to theirs but their baby's health too. Research findings show that women need to be motivated and committed to accept the care provided to them; good antenatal care greatly improves a woman's health status as the reproductive years, between 15 to 49 years of age, cover almost half of their lifetime (Maputle et al., 2013).

Theme Two: No evidence of family planning or prior pregnancy knowledge

An additional finding which has emerged from the data is that some of the first-time mothers that participated in the focus groups had a late discovery of their pregnancy. They only found out they were pregnant due to bodily sicknesses such as influenza, body pains and a change in vaginal discharge. The late discovery of pregnancy is an issue which has been identified in previous studies as it impacts on the effectiveness of prenatal care, particularly in the instance where the woman may be HIV positive. The delay impacts the effectiveness of the PMTCT programme leading to deaths of both the mother and/or child at childbirth (Maputle et al., 2013). Research shows women are in a better position to seek appropriate healthcare service if their pregnancy knowledge is adequate, as this would help the mother avoid any pregnancy complications (Maputle et al., 2013).

The apparent absence of planned pregnancy would require clinics and hospitals with maternity facilities to be in reach to the pregnant women. In the area under study, this is not the case with most of the healthcare facilities being further than the prescribed distance. In analysing these findings, it can be argued that in this context community caregivers are the conduit for maternal health knowledge to women. Currently, however, the caregivers can provide information only once a pregnancy is discovered. Therefore, this does deal with the issue of making prior pregnancy knowledge available, to ensure women are securing services from the time of discovering their pregnancy. This puts into question the effectiveness of the agency exerted by the caregivers.

> *I was two months pregnant when discovered my pregnancy.*
> (Participant from Sihlosokuhle Development Centre, 15 September 2016).
>
> *Even when the mother has given birth the clinic links that mother with a community care giver (CCG) so that the CCG is able to visit the mother and conduct regular checkups on the mother and the baby, the CCG also has the responsibility to educate the mother to identify and illnesses in the baby so that the mother can take the baby to the clinic.*
> (Participant from KwaNyuswa, War Room, 15 September 2016).

The above excerpts reflect a major responsibility on the community caregivers to ensure the health of the mother and baby. Post-natal maternal health education is also recognised as an important feature of providing care.

Theme Three: Fear of testing for HIV and stigmatisation

What the researcher gathered from the responses of the participants is that awareness and knowledge of the importance of HIV testing early into the pregnancy is present in the KwaNyuswa community. However, mothers show hesitance towards this because they fear testing positive, which puts both the woman and child at risk of HIV/AIDS-related infections. Statistically, 33.7% of maternal mortalities in South Africa are caused by AIDS (Tlebere et al., 2007), and the province of KwaZulu-Natal (KZN) was once recorded as having the highest maternal mortality rates (MMR) (Hoque et al., 2008).

Due to the severity of the HIV/AIDS epidemic, there is also a lot of stigmatisation in the KwaNuyswa community. According to the participants, women fear testing as they fear sharing their results with family members. Some women choose to not enact agency to obtain maternal care services because of the influence their families have on their lives. In addition, the structures in the area do not accommodate this already existing fear of stigmatisation as the testing process is not conducted privately.

> *We often find that the people who do not want to go to the clinics are people who do not want to know their status.*
> (Participant from the KwaNyuswa War Room, 15 September 2015*).*

The above excerpt confirms research on stigamatisation of HIV-infected mothers, which means it is also an issue which affects the women in the KwaNyuswa rural area. This is a key finding as previous research indicates a fear of testing and stigmatisation as one of the causes of maternal mortalities. Evidentially, this is one of the barriers to early intervention for pregnant women in this area. This data shows that the mothers who do test cannot be treated with nevirapine (NVP), the drug that prevents mother to child transfer of HIV (PMTCT) during pregnancy (Bolton et al., 2004). One of the reasons the PMTCT programme was implemented was to enable pregnant women to access NVP. A major portion of the MMR in KZN are caused by HIV-related infections; the early detection of HIV in pregnant women could decrease the number of mortalities (Doherty et al., 2010). However, greater agency is required from pregnant women.

> *Others already know they status but they don't want their families to find out their status. Because of this, the baby is affected and sometimes dies during delivery because when she is giving birth her immune system becomes weaker and weaker.*
> (Participant from the War Room, 15 September 2015).

> *Since there is no private room, so everybody sees that they have the disease.*
> (Participant from Sihlosokuhle Development Centre, 15 September 2015).

This respondent's comment confirms the stigmatisation in the area which is preventing mothers from securing appropriate healthcare from the available clinics. The biggest threat to 'the system' of caregivers and maternal healthcare education in this area is this fear of testing.

> *Sometimes it happens that the transmission from mother to child of the disease occurs because of a lack of knowledge.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

This respondent's comment contradicts the previous data which reflected that community caregivers provide pregnant women with all the necessary information, and thus provides evidence of the inefficacy of the caregivers and their knowledge.

Theme Four: Non-existent traditional birth attendants

According to the participants of this study, the TBAs in the KwaNyuswa community no longer exist, and there is no longer any reliance on their services or practices. It has been noted that a lack of trust in their safety practices prevails as many pregnant women fear contracting diseases or infections if the labour process is not held in a health facility. Pregnant women in this area prefer to use clinics rather than a TBA, even though the attendance of mothers in rural settings at clinics such as this community is recorded to be relatively low. In the literature discussed, TBAs are also known to exacerbate the mortalities. However, with their non-existence in this community, one cannot account for the mortalities by claiming that TBA's unsafe practices are the main cause.

One would expect that in a rural community, TBAs would still exist particularly because of their engagement with cultural practices such as communication with ancestors and discernment of evil spirits which may harm babies (Selepe & Thomas, 2000). Further, all their rituals are performed in the homestead of the pregnant woman. Other functions usually performed by TBAs, such as providing dietary advice and assistance during pregnancy, are functions now performed by caregivers in the

KwaNyuswa community. It has been asserted that women who do seek maternal healthcare from medical personnel do so because of a lack of trust in the medical professionals and their techniques (Selepe & Thomas, 2000). However, the same mistrust is shown for TBAs in this community.

This also suggests that the argument presented in the CFPD model is invalid; which suggests that a traditional community will be slow in adapting to beneficial if community members are not engaged with on issues which affect them, such as securing appropriate healthcare services for pregnant women. This model of communication in the KwaNyuswa community involves caregivers who are community members bringing maternal healthcare knowledge to some mothers who are seemingly responding by attending antenatal care in clinics nearby as per their referral. The knowledge presented by the caregivers is leading women to available healthcare facilities.

> *There are no more traditional birth attendants in this area.*
> (Participant from Sihlosokuhle Development Centre, 15 September 2015).

Contrary to the research conducted on TBAs, there is no knowledge of their existence in this area. Therefore, their practices cannot be identified as part of the causes of maternal mortalities as research shows that although there is a strong preference towards TBAs in the rural areas, their practices are always safe for the pregnant women.

> *If I treated badly at the hospital, I change hospitals because it's not safe to give birth at home. There's no way of checking the midwives and if my baby has a problem the traditional birth attendants may not be able to assist me. So, it's better to change hospitals than not go at all.*
> (Participant from Sihlosokuhle Development Centre, 15 September 2015).

This data confirms quality maternal care is often unavailable and the mothers choose to alternate between hospitals as opposed to utilising the services of TBAs who are often easier to access as they reside within the community (Bultery et al., 2002). Critically, the respondent's comment reflects a lack of trust in the ability of the TBAs.

> *Traditional birth attendants do not exist in this area anymore because people were introduced to the clinic and were told that they should visit the clinic.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

The challenge presented by having facilities far from the community is, even though the community caregivers provide referrals and advise pregnant women, it does not guarantee that they will attend.

Theme Five: Community caregivers enact agency

The services provided by caregivers to the community include home visits to see both mother and baby; to conduct regular checkups; to provide maternal healthcare education; to make clinic referrals; and inform the mother about an information system which supports new mothers.. It is the responsibility of the mothers to visit the clinics once they are referred for checkups.

Culture as a component of the approach places the active participants at the fore of the construction of experiences and meanings, customs and beliefs which are then shared in the community (Dutta, 2008: 55). In this experience, the caregivers possess the knowledge required to extract meanings, customs and beliefs which create a co-dependency between them and the pregnant women. Community caregivers provide a sense of responsibility for pregnant women, however, ideally, it should be the mothers who enact most of the agency shown by the caregivers as pregnant women (Maputle et al., 2013).

> *Community caregivers know that there is "Mama Connect" and they have the responsibility to inform the public about it.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

The above comment suggests interconnectedness between the women in the community and the local government system. However, there is still responsibility placed on the community caregivers to ensure that the pregnant women in the community are connected to the system in order that they may receive adequate maternity information. According to the data, the responsibility to inform mothers in the KwaNyuswa community sits mainly with the caregivers, which confirms a process of top-down communication (Rogers, 1976). This is with exception to pregnant women whose mothers have passed on knowledge about pregnancy onto them. As opposed to the community participating, in creating the knowledge base from which information is transmitted to pregnant women, the Mama Connect system forms part of a system which governs the community. Mama Connect is a government initiative run from the local municipal offices in a district, This initiative is use to provide antenatal and post-natal information to pregnant women. Information includes important

activities which pregnant women should engage in such as regular checkups during pregnancy. Each community caregiver has the responsibility to visit the home of the pregnant woman and register them onto the system. This sometimes leads to misinterpretation of information and/or does not lead pregnant women to seek maternal healthcare services.

> *Community caregiver is able to visit the mother and conduct regular checkups on the mother and the baby, the caregiver also has the responsibility to educate the mother to identify and illnesses in the baby so that the mother can take the baby to the clinic.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

Home visitations are services offered by midwives, and in rural areas, a TBA. To the knowledge of the focus group participants, the community caregivers provide this service by means of regular check-ups on both the mother and the baby. In addition, the caregivers provide home-based education for the mothers so they are well-equipped to act to secure the appropriate services; maternal health knowledge is crucial for any agency to be enacted. As discussed in previous chapters, a lack of knowledge is not dissimilar to a structural barrier, preventing the pregnant women from possibly securing the help they need from the clinics and hospitals situated in the local municipality. Structures shape the material resources that communities have access to, and are simultaneously shaped by the participation of communities (Dutta & Basu, 2007). They define the limits of human action, at the same time creating the scenario for the enactment of human agency (Kautzky & Tollman, 2008). Structures play a pivotal role in the activity and participation of community members as a means through which they can access and secure health services. Structures can also constrain the activity and participation of community members (Basu & Dutta, 2009).

> *The mother has the responsibility to look for the community caregiver that has been assigned to her. The caregiver then has the responsibility to go and check on the mother and child. The caregiver then signs the form to confirm that they have checked on the baby's performance and the mother's wellbeing. If there is a problem that the caregiver identifies they writes a referral form for the mother to take to the clinic.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

Regarding the above comment, there is a reasonable amount of responsibility placed on the pregnant woman to locate their caregiver. There is data to suggest that some of the women do not locate their caregivers, which in the case of the below respondent comment resulted in the death of a baby. The data also indicates there is a middle-ground on which both the agency of the pregnant woman and the caregiver meet if both enact agency. Nevertheless,

the caregiver still functions as an intermediary between the pregnant mother and the maternal healthcare service providers. This data does not totally reflect a commitment from the mothers to seek those services. Further, the apparent system of accountability functions to ensure the mothers secures maternal healthcare services. This works juxtaposed to clinic referrals and checks up. This function of a caregiver as an intermediary makes sense in the context considering the distance pregnant women must travel to secure maternal healthcare services. This is an important finding as previous research conducted suggests the causes of maternal mortalities, to be distance and a lack of agency from pregnant women (cross-reference). While it is easy to label these as patient-related factors, an investigation into the factors which lead to the women not enacting agency should also be understood.

> *As her caregiver I didn't know that she was pregnant because she stayed in Durban. Her due date came but there was no transport, she walked and crossed UMzimkhulu River in her attempts to access transport or a bus. She was already in labour along the way so she gave birth and the child died. When I did a follow up with her family, they said her blood pressure was very high.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

This horizontal interaction amongst community members does not always guarantee safe pregnancy, especially when it is the woman's responsibility to show agency and seek their assigned caregiver for advice and guidance.

> *Pregnant women in this area do get access to maternal healthcare services because community caregivers visit their homes and gave them advice to visit a clinic even though the clinics are far and it isn't easy for them. They listen to us and they also do what we tell them to do. We plead with those who don't really want to. We often make examples of other woman who have visited clinics and the benefits they received by attending a clinic.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

Contrary to the above comment, a common theme that is apparent in the data is that of women having access to maternal healthcare information but not the actual services which are ideally secured from a clinic and hospital. The hindrance seems to be in actualising the information the pregnant women receive to enact agency which will then lead to them experiencing the maternal healthcare services available to them, although distance is a factor. Cultural factors do play a role in the interpretation of the information provided to the mothers by the caregivers. Depending on whether culture was centralised, the information is not put into action because of a lack of cultural inclusion or local beliefs of the women in the rural community.

Theme Six: Caring for mother more than the baby

This finding is pertinent as it reflects frequent child mortalities in the rural area. Although this study is investigating the perceived causes of maternal mortalities, the data reflects greater mortalities amongst children than with mothers. Research shows that child mortalities are largely caused by HIV-infections, errors during the childbirth process and a lack of antenatal attendance on the woman's part. The following respondent's comment reflects knowledge of child mortalities and the perceived causes.

> *There is a mother I know who has lost her child. She was pregnant with twins, one twin survived, the other twin died.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

The below participant's response reaffirms the knowledge of child mortalities but also the inefficiency of the woman in securing services to ensure the child is taken care of during the pregnancy. Due to the lack of agency on the woman's part and the process of securing antenatal services, the child's life was lost. Further, the system of accountability between the caregivers and the mothers is questionable as the participant's response reflects unawareness of the woman's whereabouts during her pregnancy which makes caregiver check-ups impossible.

> *There is woman I know who lost her child. She's from this area too but she lived in Durban and she came back closer to the time of her due date.*
>
> (Participant from KwaNyuswa War Room, 15 September 2015).
>
> *There is a lot of teenage pregnancy and these girls rely on their grandmother financially. The grandmother gives money to the young girl to go to hospital for check-ups till they give birth. Young school girls,15 years of age.*
>
> (Participant from KwaNyuswa War Room, 15 September 2015).

Theme Seven: Challenging transport system

The reports included in the study reflect challenges for community dwellers who are required to commute from the rural area to the nearest clinic or hospital. Many respondents indicated that they often struggle to reach healthcare facilities due to this problem. In other studies, a similar issue was identified as a factor leading to the death of mothers. However, in this context, the data reveals a death of child whilst women are in labour. Therefore, the

data reflects that unreliable transport is a challenge for women who are in labour and about to give birth. The caregiver cannot guarantee that the mother will have transport as they are often walking from house to house to conduct their regular checkups. This is not to say that maternal deaths in this are caused by unreliable transport or distances to healthcare facilities, but it is rather to analyse the implications of these shortages on the deaths.

> *Sometimes, women give birth on the road because if there aren't any ambulances available and people don't have money to hire a car.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

Another pertinent finding is that of unaffordable alternative transport options, which arose in the discussion about hospital and clinic ambulances. The respondents indicate that ambulances sometimes do not reach their homes because of the distance or poor quality of the roads leading to the women's homes. These circumstances force women to use their money to hire private vehicles to transport them to hospitals to give birth; this has an impact on the baby and woman. As seen in the responses below, some women gave birth to their babies on the side of a road, which is hazardous for both woman and baby. It affects the agency which women can exert as transport becomes a barrier to securing maternal healthcare services.

> *There is a shortage of ambulances already.*
>
> (Participant from Sihlosokuhle Development Centre, 15 September 2015).

> *There is a problem with regard to transport because even when you call an ambulance in the morning it will take a very long time to arrive, sometimes even arriving at three in the afternoon.*
> (Participant from KwaNyuswa War Room, 15 September 2015).

Further, dysfunctionality exists in the communication between community members and facilities which deploy ambulances to fetch women in labour. Reflected in the women's responses, is that the difficulties found in this community have an impact on the lives of both women, mothers and their babies. Other responses from the participants reflect unavailability of transport, which acts as a complete impediment to securing health services. The extent to which the impact of not having transport has on the prenatal period, in which a woman is expected to secure local services, could not be gathered within the limits of this study.

I walked. I never took a taxi. There was no transport going there.

(Participant from KwaNyuswa War Room, 15 September 2015).

There is transport to Thonjeni Clinic but it only goes there three times a week. If you missed it, it's difficult to get to the clinic by your own.
(Participant from KwaNyuswa War Room, 15 September 2015).

Theme Eight: Challenging healthcare facilities and medical personnel

Common challenges between medical personnel and pregnant women are that quality maternal care is often unavailable or there exists an inability to communicate in the language of the healthcare provider . The latter challenge creates a barrier to healthcare accessibility, undermines trust in the quality of medical care received and decreases the likelihood of appropriate measures are taken to ensure the health of the woman and baby (Anderson et al., 2003). As discussed in the theory chapter of this study, communication is vital to avoiding inaccurate services from medical personnel to the pregnant woman. Aside from the caregiver, pregnant women in this community come into contact with medical personnel when visiting healthcare facilities. According to the participant responses, this not always a positive interaction and the pregnant woman may not want to further secure services for her pregnancy from health facilities.

They visit a clinic that is closest to them and they receive bad service and then they decide to change clinics.
(Participant from KwaNyuswa War Room, 15 September 2016).

This participant's response indicates that bad service is a cause of inconsistency in clinic visitations, which means that there is the risk of inaccurate record keeping. Further, the experiences of these pregnant women have shaped their perceptions of clinic medical personnel to the point where they find it easier to access maternal healthcare from different clinics in different locations despite the challenges in transport.

Sometimes who come across women who have experienced bad service and they decide to change clinics even if they don't have the money they will borrow so that they are able to visit a new clinic.

(Participant from KwaNyuswa War Room, 15 September 2016).

I went to Meadowsweet. I was scolded at the clinic for attending sooner because if there were any diseases in my body it wasn't easy for those to be prevented from being transmitted from me to my child. They asked why I didn't come to the clinic, and I couldn't respond. They continued to provide services for me and advised to come back for regular check-ups.
(Participant from Sihlosokuhle Development Centre, 15 September 2016).

The participant's response reflects a lack of awareness of the importance of antenatal check-ups from the time a woman is pregnant. The clinic personnel provided her with an initial set of information on disease transfer from mother to child and the woman was then advised to have regular check-ups. Part of the participant's responses included bad experiences during which their agency was not responded to by medical personnel.

An important finding in the data collected reflects that negligence on the part of hospital personnel seemed to reoccur. This is significant as part of the CCA captures the concept of experiences which are shaped by people's interactions with structures. Part of the women's experiences of the hospital medical personnel is that they are neglected when they arrive to give birth. However, their late arrival may be a factor towards this experience. One cannot simply conclude from this data that the hospital medical personnel is to blame for every death of women or babies. This may be only one factor leading to the mortalities.

Yes, they explained everything to me. When I arrived at the clinic they checked me they took blood samples and urine samples and they told me I was pregnant.
(Participant from Sihlosokuhle Development Centre, 15 September 2016).

Contrary to the bad experiences that other participants offered in the group, the above participant had a better experience which ensures that she received accurate maternal healthcare services. The participant expressed satisfaction with regard to the communication of her pregnancy test procedure.

Theme Nine: Bad service and attitudes

She arrived early at the hospital because she left her home the day before giving birth to get to the hospital on time. It was the process at the hospital which delayed
(Participant from the KwaNyuswa War Room, 15 September 2016).

To further this point of discussion, these negative experiences at hospitals and clinics stand to affect the agency of the pregnant women. Antenatal care attendance in this area is not limited to hospitals and clinics, as there is also a mobile clinic which visits the community members periodically. The comments from the participants based on the mobile clinic reflect other bad experiences with this structure, including a lack of privacy and resources. As mentioned previously, these experiences affect the general perceptions and agency of the community.

The quality of the services provided affects the community women who require maternal healthcare services. In addition, confusion about the link between the clinic and mobile clinic results due to unclear communication and referral systems. Women are left in a position in which they think they cannot secure services from the mobile clinic because the clinic in the community will not attend to them. This originates from a communication problem between the two structures in the healthcare system in Ezinqoleni. An additional issue reflected in the participants' responses is that of the mobile clinic nurse's negative attitudes, which also have an impact on the usage of the mobile clinics by pregnant women.

> *People do know the problem is the way mothers get treated at the hospitals and clinics.*
> (Participant from the Sihlosokuhle Development Centre, 15 September 2016).

> *At the hospital you don't get attended too quickly, you wait with your contractions and this puts the baby's life at risk. They tell you to wait until you feel the contractions even when you are feel them, they tell you to wait.*
> (Participant from the Sihlosokuhle Development Centre, 15 September 2016).

One could argue that the above participant response reflects a lack of understanding of the labour process, as this may happen under circumstances under where the hospital midwives requested the participant to wait before she could give birth. Of notable interest, is that the participant concludes that waiting as she was instructed to do put the baby's life at risk. This participant is disclosing a level of knowledge pertaining to factors which may lead to the death of a baby, and it reflects the extent to which the dangerous acts have not been communicated to this participant.

When I got to the clinic they checked me and said that I'm not yet due to give birth but I felt like something was happening inside so I went back to home, when I got home the cramps got worse than my family hired a car around 7:00pm and I was rushed to the clinic.
(Participant from the Sihlosokuhle Development Centre, 15 September 2016).

A major recurring theme in this data is that of the poor clinic and hospital service. As mentioned previously, the problem is not only with the lack of knowledge about maternal healthcare, it is also that once these pregnant women decide to enact their agency and secure maternity services, they are met by service personnel who offer other women poor service and negative attitudes.

Summary of key findings

Key findings which emerged from the focus group discussions revealed a lack of maternal health knowledge amongst women prior to falling pregnant and during the time of their pregnancy. A few participants only discovered they were pregnant during the course of their first trimester and during this time had no formal knowledge on conception and pregnancy, which led some of the mothers to assume they had the flu or some other sickness as opposed to being pregnant. Further, the fear of HIV testing stemming from stigmatisation affects programmes such as PMTCT , which aim to ensure that the baby is not affected by any diseases that the woman carries.. This finding is also supported by previous research.

Additional key findings reveal that TBAs do not exist in this rural community, and therefore TBAs cannot be listed as a contributing factor to maternal mortalities in KwaNyuswa. However, community caregivers play an important role in the community as they transfer pregnancy knowledge and provide a system of accountability to women by visiting them in their homesteads. In many cases, it seems the community caregivers are more proactive than the pregnant women. This may also be a case of the women receiving the maternal healthcare information at a progressed stage of their pregnancy, meaning the caregivers must communicate information past the women's preexisting pregnancy knowledge which is based on their cultural experiences.

Additional key findings reveal cases of child rather than maternal mortalities in the area, as identified by this group of participants. The issue of transport emerged as a key finding as it was identified as contributing towards maternal mortalities. Besides transport, bad health practitioner attitudes seemed to affect the proactivity of pregnant women in the community. Linked to this were the bad service experiences at the health facilities visited by the pregnant women, which had a negative effect on pregnant women who consequently where inconsistent in their visits to health facilities for maternal services.

In effect, the above-mentioned factors all impact the level of agency of pregnant women and ultimately contribute to the mortalities in the community. This answers the main research question. In terms of Question 1.2 listed above, pregnant women compensate for the apparent lack of healthcare facilities through the agency of the caregivers who provide them with knowledge and support throughout the pregnancy. In addition, the pregnant women commute to the neighbouring hospitals and clinics to secure resources required for the pregnancy. Further, the mobile clinic afforded to the mothers also works as a complementary initiative to ensure that maternal health services reach the pregnant women who live in remote communities such as KwaNyuswa. With regards to Question 1.3, the extent to which lack of access contributes to maternal mortality in KwaNyuswa rural area is revealed through the cases of child mortalities which have been identified by the participants. The researcher here suggests that the extent to which lack of access can contribute to mortalities is determined by the deaths which have occurred consequently. As a key finding the issue of transport to health facilities contributes to the mortalities identified in the KwaNyuswa rural area.

Recommendations

The participant's recommendation for the reduction of maternal mortalities includes using the local War Room as a facility where women can access maternal healthcare services. Ideally, the mobile clinic would station itself at the War Room twice a week, offering clinic services, including the attendance of nurses and provision of medication. Secondly, it was suggested by the participants that the ambulances services should be improved and the number of ambulances serving the area should increase. Thirdly, the municipality should provide a clinic closer to the KwaNyuswa rural area and increase the extent of knowledge amongst community care givers to enable them to identify issues and refer pregnant women

in a timeous manner. Fourthly, the importance of health workers should be recognised in the community, as they have full knowledge and can help women obtain necessary assistance at clinics. Lastly, health workers should educate school-going children on pregnancy in general and more specifically, about the importance of visiting the clinic once they find out they are pregnant.

Chapter 6
Study Conclusions

As a target, which was set in 1995 to be achieved by the year 2015, the fifth Millennium Development Goal has not been achieved. There have been many studies and reports featured in this research inquiry, that have proven this. However, this study's main objective was to understand the perceptions of the community dwellers in relation to the causes of maternal mortalities. The contributing factors as identified in the findings chapter, can be listed as follows; (List key findings here).

The above-mentioned findings were not dissimilar to those findings in previous studies. There is one common thread, which is the context in which these factors exist. The issue of marginality in South Africa is best understood under such circumstances where basic knowledge on maternal health issues is unknown to women who conceive children. As this study and its theories have revealed, knowledge = whether indigenous African or Western – informs the mobility and agency of people .The women in the KwaNyuswa community are affected by a lack of knowledge on maternal care. Culturally, traditional birth attendants (TBAs) were the conduits of knowledge and advice on pregnancy. These attendants also provided support throughout pregnancy and post-birth period. As demonstrated in the literature discussed, on the one hand, traditional birth attendantTBAs have been blamed for mortalities through accusations of practices which neglect safety. Whilst, on the other, , women are also known to understand and trust the TBAs traditional birth attendantbecause they were of shared communal and cultural experiences. In KwaNyuswa, community caregivers have taken up a similar role in that they offer support to pregnant women, in the form of important information and accountability; they ensure that women attend clinic or hospital check-ups during the pregnancy. Although community caregivers do deliver babies, their role of communicating pregnancy knowledge is pertinent to the safety of many pregnancies and deliveries.

Previous research identified potentially related factors contributing to maternal mortalities, and factor contributed by this study is that of medical personnel. The negative experiences identified by the participants of this study indicates that attitude and service delivered by medical personnel have an impact on the consistency of visits to clinics and hospitals by pregnant women. The culture-centered approach (CCA) conceptualises that shared experiences, whether good or bad, build perceptions in a community of people. In the

KwaNyuswa community, the perception of medical personnel is that of mistreating patients and neglecting women in labour. Therefore, negative medical experiences are potentially related to the lack of agency in women in KwaNyuswa and the general attitudes of pregnant towards hospital and clinic visits.

While HIV was not identified as a direct cause of maternal mortalities in the KwaNyuswa community, participants indicated a fear of testing for HIV, which is a necessary requirement to be enrolled in antenatal classes and prevention from mother to child transfer (PMTCT) programmes. Whilst, it is noted that this aspect of the investigation requires further research, this study notes that HIV and the effects on pregnant women may be contributing to mortalities in the community.

Many communities are known to be unresponsive to Western knowledge because cultural practices and beliefs are not considered. This study concludes that the use of caregivers from the community is, therefore, vital to encourage women to participate in their own wellness as conceptualised in the communication for participatory development theory (CFPD). Culture is an important component to consider when communicating information to the community in KwaNyuswa to promote increased agency towards securing services. Further, it highlights the necessity of medical personnel demonstrating cultural sensitivity when dealing with pregnant women from different cultural settings.

The applied theories were pivotal in discussing the literature and findings, but more especially, in assisting the researcher in understanding the phenomena under investigation, namely mortalities within the KwaNyuswa community. The CCA enabled the researcher to engage in the study and interact with the participants from a culture-centric approach. Considering the location of this study, this approach was mandatory as the majority of people are black isiZulu-speaking and the municipality in which the KwaNyuswa community is situated is ruled by tribal authorities. The CFPD approach assisted the researcher explore, understand and make sense of the interactions between caregivers and the pregnant women they assist as stated by the research study participants, and in identifying the importance of the 'same level' or horizontal approach for reliability between the two parties.

Ultimately, the CCA facilitates engagement between the researcher and study participants, which makes for better understanding, opinion generation and flexibility in research. The

researcher is of the understanding, that any study attempting to ascertain issues on the topic of maternal healthcare should consider applying this approach.

Suggestions for further research

The researcher recommends that a quantitative study be conducted to determine the umber of maternal mortalities either specifically in the KwaNyuswa community or within the broader Ezinqoleni Municipality. While HIV was not identified as a direct cause of maternal mortalities in the KwaNyuswa community, in some cases, it prevented women from participating in antenatal care as they resisted being tested for fear of stigmatization within the community. The effectiveness of a programme, such as PMTCT, is dependent on the willingness of mothers to test for HIV, as without testing there is a proven chance of HIV being transferred to an unborn child and the pregnant mother dying from AIDS-related infections. This fear is then a life-threatening barrier to pregnant women and their babies.
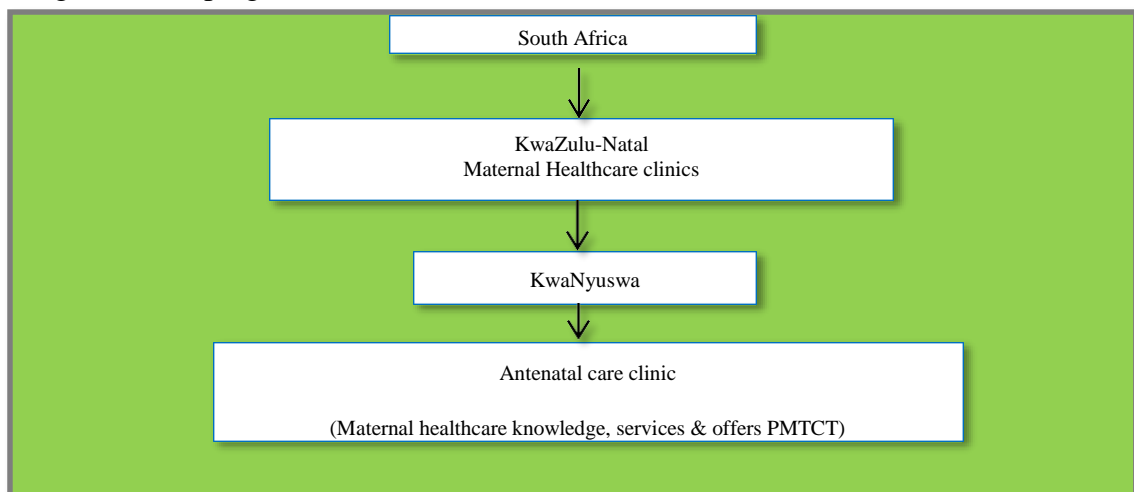

Figure 2.6 A diagram showing the provision of antenatal care services in a clinic which would be situated in the KwaNyuswa rural area. Source: Mkhwanazi, 2015.

The above diagram displays the provision of an antenatal natal clinic through which the maternal healthcare knowledge, services and PMTCT are offered. Offering PMTCT through this model would be aimed at addressing the stigmatisation of HIV-infected women in the community as it would offer a more private facility for HIV testing for pregnant women. Further, the clinic would be more directed towards maternal healthcare services and information to pregnant women, and ideally, would be located within close proximity to the community to service those who cannot access formal maternal healthcare services from clinics and hospitals in distant neighbouring communities and towns. Personnel working at the clinic would ideally have to be from the community itself to breach any cultural barriers in understanding and communicating maternal healthcare services.

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Appendices

Appendix A- Focus group schedule
Focus group guide

Focus Group Interview Schedule
Project Title: Are We There Yet: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Participant Names:

Focus group date: September 2015

Introduction:

My name is Mbali Mkhwanazi.

I am conducting research for my Masters dissertation through the Centre for Communication, Media and Society located at the University of KwaZulu-Natal Howard College. I am here today to discuss with you about the affects of not having access to primary healthcare. I will also ask you questions pertaining to diabetes education in the KwaNyuswa rural area. My research is an investigation of the marginalisation of the KwaNyswa rural area. The topic of my research is Are We There Yet: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

If you choose to participate in today's discussion, it will take approximately an hour and half to complete our discussion. Your participation is voluntary and there is no penalty to you if you refuse to participate. For example, you will not lose your job if you chose not to participate. You will not benefit directly from this research although your participation may contribute to the improvement of health programs in this area. If you choose to participate, you are free to stop the interview at any time for any reason. You are free to ask any questions about this assessment before we start, or during the course of the interview.

You are required to sign a consent form which basically indicates that you are giving me permission to conduct this interview. You do have the option of using a pseudonym if you don't want your name to appear in the transcription and analysis of the interview. If you allow me, I will record our discussion today to ensure that we don't miss any of your responses. This recording will only be available to me. It will be destroyed once the discussion has been transcribed (written down). The transcription will only be available to me. If I use a quotation from you, it will be presented without any identifying information. The purpose of this research is to identify the affects of gaps in healthcare systems and in health communication to cultural communities.

Focus group discussion – Guideline questions:

Topic guideline:

Are We There Yet: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Discussion guideline:

1.   What do you think are the factors that contribute to maternal mortality in the KwaNyuswa rural area?
2.   How do expectant mothers compensate for the apparent lack of healthcare facilities in the KwaNyuswa area?
3.   To what extent does inaccess contribute to maternal mortality in KwaNyuswa rural area?
4.   In your opinion, how can maternal mortality be improved?
5.   How do these factors perpetuate maternal mortality?

Thank you for participating in this study. As a researcher, it is my responsibility to ensure that my findings reach you all.

 If you have any questions concerning this research or your rights as a participant, please contact me on 079 304 5218 E-mail: mkhwanazimbali@gmail.com or my supervisor: Miss Duduzile Zwane on 031 260 1770 E-mail: Zwaned2@ukzn.ac.za

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Appendix B

IsiZulu Version - iFomu Yokwazisa Isivumelwano

Isihloko sesulocwaningo: Are We There Yet: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Umcwaningi: uMbali Mkhwanazi

Igama lozimbandakanyanyo:

Indlela yokuzimbandakanya: Inkulumo yeqembu iFocus

Ngenza ucwaningo lweMasters ngokusebenzisa kwisiKhungo seCommunications, Media and Society eUniversity of KwaZulu-Natal Howard College. Ngilana namhlanje ukuzokhuluma ngemiphumela zokungabinayo indlela yokuthola ukunakekelwa kwezempilo. Ngingathada futhi ukunibuza imibuzo mayelana nesifo soshukela KwaNyuswa. Ucwaningo lwami olokubheka isimo sobandlulo ngo kwezempilo KwaNyswa.

Isihloko somncwaningo yilungelo sempilo: Uphenyo lwezihlelo zempilo Ezinqoleni Municupality.

Uma ukhetha ukuhlanganyela ingxoxo yanamhlanje kumele wazi ukuthi kuzo thatha isikhathi esingange ihora nesigamu sokuthi siqede. Usizo lwenu luyadingeka kodwa ngicela nize ngokuzithandela kwenu. Akekho ophoqiwe. Ngokwesibonelo, angeke uphelewe umsebenzi uma ukhetha ukungahlanganyeli ingxoxo nami. Kungezeka ukuthi inzuzo yalomucwaningo angeke usize wena kodwa kungasiza ngokwenza ngcono izinhlelo zempilo kulendawo. Uma ukhetha ukungahlananyeli ingxoxo, uvumelekile ukuma noma ingasiphi isikhathi na ngokunika yisiphi isizathu. Uvumelekile ukubuza noma iyiphi imibuzo onayo mayelana lenkalo ngaphambi kokuba siqale, noma ngesikhathi sayo ingxoxo.

Into edingekayo ukuthi usayine ifomu lemvumelwano eshoyo ukuthi unginikeza imvemelo yokwenza le-interview nawe. Uvemelekile ukusebenzisa elinye igama uma ungafuni igama lakho livele kwilokhu okulotshiweyo nokuhlahlela kwalengxoxo. Uma ungivumela, ngizoqopha ingxoxo yethu , yanamhlanje, khona singeke siphuthelewe izimpendulo zenu.

Lokhu okuqoshiwe kuzolalelwa yimina kuphela. Izobhujiswa uma ingxoxo seyilotshiwe, seyi bhaliwe phansi ephepheni. Okulotshiweyo nakho kuzobonwa yimina kuphela. Uma ngisebenzisa into oyishilo wena, (quotation) gama ngagama, izokwethulwa ngaphandle kokwazisa ukuthi ubani otheni. Inhloso yalom'cwaningo ukwazisa imiphumela zezikhala ezikhona kwizinhlelo zokunakekelwa kwezempilo nokuxhumana kwezempilo emiphakathini yamasiko.

Isiqondiso:

Are We There Yet: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Discussion guideline:

1.Uma ucabanga kwenziwa yini abantu besifazane abakhulelwe usizo lwempilo bengalutholi laKwaNyuswa?

2.Uma bengalutholie usizo benze njani? Ngabe ikhona enye indela yoku sizakala laKwaNyswa?

3.Uma ningakwazanga ukuthola usizo lwempilo KwaNyuswa niphatheka kanjani?

4.Ngemibono yakho, ukushona kwabantu besifazane ababelethayo kungancishiswa kanjani?

5.Ukungabi khona izindawo zetholampilo kuyandisa ukufa kwabantu besifazane?

Ngiyabonga.

Uma udinga olunye ulwazi ngicela uthinte mina ku079 -304 5218 (iEmail: mkhwanazimbali@gmail.com) noma uthinte umqondisi wami uDuduzile Zwane ku zwaned2@ukzn.ac.za

Noma uthinthe iResearch Office ku:

P. Mohun

HSSREC Research Office,

Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Appendix C

Informed Consent Form   **September 2015**

Research Project: *Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Title of Research Project:	*Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.
Researcher:	Mbali Mkhwanazi
Participant's Name:	
Method of participation:	Focus group discussion

Dear Participant,

I am conducting research for my Masters dissertation through the Centre for Communication, Media and Society located at the University of Kwa-Zulu Natal Howard College. I am here today to interview you about the affects of not having a clinic/hospital nearby your area. My research is an investigation of the marginalisation of the KwaNyuswa rural area. I will also ask you questions pertaining to diabetes education. The topic of my research is *Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

If you choose to participate in this research, it will take approximately 45 minutes to complete our discussion/interview. Your participation is voluntary and there is no penalty to you if you refuse to participate. For example, you will not lose your job if you chose not to participate. You will not benefit directly from this research although your participation may contribute to the improvement of health programs in this area. If you choose to participate, you are free to stop the interview at any time for any reason. You are free to ask any questions about this assessment before we start, or during the course of the /discussion interview.

You are required to sign a consent form which basically indicates that you are giving me permission to conduct this discussion/interview. You do have the option of using a pseudonym if you don't want your name to appear in the transcription and analysis of the

discussion/interview. If you allow me, I will record our discussion today to ensure that we don't miss any of your responses. This recording will only be available to me. It will be destroyed once the discussion has been transcribed (written down). The transcription will only be available to me. If I use a quotation from you, it will be presented without any identifying information. The purpose of this research is to identify the factors which contribute to maternal mortality in KwaNyuswa and women in this area compensate for an apparent inaccess to maternal health.

If you have any questions concerning this research or your rights as a participant, please contact me on 079 304 5218 E-mail: mkhwanazimbali@gmail.com or my supervisor: Miss Duduzile Zwane on 031 260 1770 E-mail: Zwaned2@ukzn.ac.za

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Declaration:

I, …………………………………………………………………….hereby declare that I am fully aware of the research topic and the nature of my participation in the discussion/interview described in this document.

I agree to participate in this research. I however participate as a volunteer and have full rights to withdraw at any stage of my participation with no negative consequences for myself. I also have the rights to refuse to answer questions that I do not wish to answer.

I wish to remain anonymous and request a pseudonym.

YES ☐   NO ☐

_____   _____
Signature of Participant   Date

_____   _____
Signature of Witness   Date

Appendix D

IsiZulu Version - iFomu Yokwazisa Isivumelwano

Isihloko sesulocwaningo	*Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality
Umcwaningi	Mbali Mkhwanazi
Igama lozimbandakanyanyo	
Indlela yokuzimbandakanya	Inkulumo yeqembu iFocus

Igama lami uMbali Mkhwanazi

Ngenza ucwaningo lweMasters ngokusebenzisa kwisiKhungo seCommunications, Media and Society eUniversity of KwaZulu-Natal Howard College. Ngilana namhlanje ukuzokhuluma ngemiphumela zokungabinayo indlela yokuthola ukunakekelwa kwezempilo. Ngingathada futhi ukunibuza imibuzo mayelana nesifo soshukela KwaNyuswa. Ucwaningo lwami olokubheka isimo sobandlulo ngo kwezempilo KwaNyswa.

Isihloko somncwaningo yilungelo sempilo: Uphenyo lwezihlelo zempilo Ezinqoleni Municipality.

Uma ukhetha ukuhlanganyela ingxoxo yanamhlanje kumele wazi ukuthi kuzo thatha isikhathi esingange ihora nesigamu sokuthi siqede. Usizo lwenu luyadingeka kodwa ngicela nize ngokuzithandela kwenu. Akekho ophoqiwe. Ngokwesibonelo, angeke uphelewe umsebenzi uma ukhetha ukungahlanganyeli ingxoxo nami. Kungezeka ukuthi inzuzo yalomucwaningo angeke usize wena kodwa kungasiza ngokwenza ngcono izinhlelo zempilo kulendawo. Uma ukhetha ukungahlananyeli ingxoxo, uvumelekile ukuma noma ingasiphi isikhathi na ngokunika yisiphi isizathu. Uvumelekile ukubuza noma iyiphi imibuzo onayo mayelana lenkalo ngaphambi kokuba siqale, noma ngesikhathi sayo ingxoxo.

Into edingekayo ukuthi usayine ifomu lemvumelwano eshoyo ukuthi unginikeza imvemelo yokwenza le-interview nawe. Uvemelekile ukusebenzisa elinye igama uma ungafuni igama lakho livele kwilokhu okulotshiweyo nokuhlahlela kwalengxoxo. Uma ungivumela,

ngizoqopha ingxoxo yethu , yanamhlanje, khona singeke siphuthelewe izimpendulo zenu.

Lokhu okuqoshiwe kuzolalelwa yimina kuphela. Izobhujiswa uma ingxoxo seyilotshiwe, seyi bhaliwe phansi ephepheni. Okulotshiweyo nakho kuzobonwa yimina kuphela. Uma ngisebenzisa into oyishilo wena, (quotation) gama ngagama, izokwethulwa ngaphandle kokwazisa ukuthi ubani otheni. Inhloso yalom'cwaningo ukwazisa imiphumela zezikhala ezikhona kwizinhlelo zokunakekelwa kwezempilo nokuxhumana kwezempilo emiphakathini yamasiko.

Awudingemali ukuzimbandakanya kulolugcwaningo, kodwa ngicela uhlalewazi ukuthi izinkulumo ezi'rhekhodiwe zingasetshenziswa kwi'projekti. Igama lakho ngeke livezwe kwi 'projekti uma ungathandi livezwe.

Ngiyabonga.

Uma udinga olunye ulwazi ngicela uthinte mina ku079 -304 5218 (iEmail: mkhwanazimbali@gmail.com) noma uthinte umqondisi wami uDuduzile Zwane ku031 260 1770 (iEmail: zwaned2@ukzn.ac.za).

Noma uthinthe iResearch Office ku:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

iFomu Yesivumelwane

Isulocwaningo:

iDECLARATION:

Mina,………………………………….,…………………….ngiyazisa ngokwamukelekile ukuthi nginolwazi oluphelele ngalolu cwaningo nendlela okumele ngizimbandakanye ngayo kulelisu locwaningo oluchazwe kulokhu okubhalwe luleli phepha.

Ngiyavuma ukuzimbandakanya kulelisu locwaningo. Ukuzimbandakanya kwami kodwa kungokuzithandela ngaphandle kokulindela ukuhola okuthize, futhi nginawo wonke amalungelo okuhoxa nanoma yinini ekuzimbandakanyeni kwami ngaphandle kokuthola imiphumela emibi ngalesi senzo. Nginamalungelo futhi okunqaba ukuphendula imibuzo engingatisi ukuba ngiyiphendule.

Ngifisa ukuba ngongenalo igama futhi ngicela ukusebenzisa igama lokuzakhela.

YEBO [ ]   **CHA** [ ]

_____   _____
Igama elisayiniwe lalowo   Usuku
Ozimbandakanyayo

_____   _____
Igama elisayinwo likafakazi   Usuku

Appendix E

Informed Consent Form – Audio Recording   **September 2015**

Research Project: *Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Title of Research Project:	*Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.
Researcher:	Mbali Mkhwanazi
Participant's Name:	
Method of participation:	Focus group discussion

Dear Participant,

I am conducting research for my Masters dissertation through the Centre for Communication, Media and Society located at the University of Kwa-Zulu Natal Howard College. I am here today to interview you about the effects of not having a clinic/hospital nearby your area. My research is an investigation of the marginalisation of the KwaNyuswa rural area. I will also ask you questions pertaining to diabetes education. The topic of my research is *Are We There Yet*: An Investigation of the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.

Please note that:
- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at knowing the challenges of your community relating to resource scarcity, peoples' movement, and effects on peace.

- Your involvement is purely for academic purposes only, and there are no financial benefits involved.

- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at:
Email: mkhwanazimbali@gmail.com
Cell: +27 79 304 5218

My supervisor is Miss Duduzile Zwane who is located at the School of Applied Human Sciences, Howard College campus of the University of KwaZulu-Natal.
Contact details: email: zwaned2@ukzn.ac.za.Phone number: 031 260 1770

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za , Thank you for your contribution to this research.

DECLARATION

I…………………………………………………………………………. (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT   DATE

…………………………………   ………………………………

Appendix F

Dear Sir/Mam'

My name is Mbali Mkhwanazi and I am currently conducting research for my Masters dissertation through the Centre for Communication, Media and Society located at the University of Kwa-Zulu Natal Howard College. My research interest is *An investigation o/ the perceived causes of maternal deaths in KwaNyuswa, Ezinqoleni Municipality.* As the nature of my research is qualitative I will be conducting 3 focus groups with 24 women currently residing in the rural area. These focus groups will take place at the Sihlosokuhle Development Centre located in KwaNyuswa, from the 21st - 23rd September 2015. This study has been granted ethical clearance by the HSSREC Research Office, protocol reference number: HSS/0911/015M.

As a researcher I truly value the genuine interest participants have shown towards my enquiry. I wish to express my appreciation by giving each participant 'a thank you hamper' with various items in it. I am heartily requesting hygiene product donations from your company for each of the participant hampers. The hampers will be given to each of the 24 participants at the end of every focus group.

Should you require further information regarding the study, please do not hesitate to contact my supervisor Miss Duduzile Zwane who is located at the School of Applied Human Sciences, Howard College campus at the University of KwaZulu-Natal. She can be reached through thefollowing,

Email: zwaned2@ukzn.ac.za Phone number: 031 260 1770
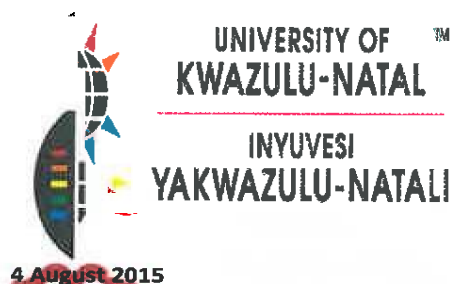
Your assistance will be greatly appreciated.

_____   _____

Mbali Mkhwanazi   Duduzile Zwane "
 (Researcher)   (Supervisor)

Appendix G

UNIVERSITY OF ™
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

4 August 2015

Miss Mbali Slindokuhle Mkhwanazi 210543982
School of Applied Human Sciences
Howard College Campus

Dear Miss Mkhwanazi

Protocol reference number: HSS/0911/015M
Project title: *Are we there yet: An investigation of the perceived causes of maternal mortality in KwaNyuswa, Ezinqoleni Municipality*

Full Approval – Expedited Application

In response to your application received on **13 July 2015**, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. **Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.**

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of **3** years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....
Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Ms Duduzile Zwane
Cc Academic Leader Research: Dr Jean Steyn
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za , mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

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