

UNIVERSITY OF KWAZULU-NATAL

**THE INFLUENCE OF MILLENNIUM DEVELOPMENT GOAL 5 ON MATERNAL
HEALTH IN SOUTH AFRICA: A CASE STUDY OF UMGUNGUNDLOVU
DISTRICT**

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Administration**

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DECLARATION – PLAGIARISM

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ABSTRACT

Since the inception of the Millennium Development Goals in 2000, globally there have been great achievements made in the reduction of mortality in women during pregnancy, childbirth and post-delivery. This is due to the fact that maternal health has been a major focus of the international community. However, in many parts of the world, maternal deaths remain unacceptably high, with wide disparities in progress towards Millennium Development Goal 5. South Africa is amongst the countries that have seen limited progress towards achieving Millennium Development Goal 5, due to the fact that it is the 'epicentre' of the human immune deficiency virus (HIV) infection pandemic. South Africa, as one of the States that adopted the MDGs, needs to adopt New Public Management (NPM) managerial system in order to achieve the goals. Under the auspices of NPM directing, follow up and evaluation are thus stressed, based on a principal-agent contractual and cost-cutting nexus that substitutes former trust in providers and managers of welfare tasks to serve citizens or provide public goods. The study was done in the rural area of Impendle, a Local Municipality in Umgungundlovu District, which has seven Local Municipalities. The sample was drawn from the population of African Zulu males and females, all residing in the area of Impendle. Four themes emerged from the data analysis, namely: understanding maternal health, factors affecting maternal health, community participation in maternal health and programs towards the improvement of maternal health. Lack of access to healthcare facilities is also a major contributor to failure in the achievement of this goal. Lack of access ranges from the fact that some areas have no healthcare facilities at all, while some are too far, which leads to financial constraints. Stigma on HIV and lack of support for teenage pregnancies are some of the challenges faced by women in the area. The involvement of communities, male partners and local stakeholders is important to ensure care and well-being of women and children, thus preventing unnecessary maternal morbidity and mortality, and ensuring positive health outcomes. It was found that while some improvements in general healthcare and HIV were noted, the area of maternal health is not receiving much attention, and as a result, the likelihood of achieving MDG 5 remains a challenge. The recommendations to the study would assist local authorities and decision-makers to ensure that necessary attention is given to maternal health and the attainment of MDG 5, and the decrease in the relatively high maternal mortality rate. In this way, healthy and well-informed communities can work with government for a better future for all.

LIST OF ACRONYMS

| ACRONYM | DESCRIPTION |
|---------|---|
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal care |
| ANC | African National Congress |
| ART | Antiretroviral treatment |
| AUC | African Union Commission |
| CARMMA | Campaign on Accelerated Reduction of Maternal Mortality in Africa |
| CCG | Community Care Giver |
| COC | Combined oral contraceptives |
| CP | Community participation |
| FHT | Family Health Team |
| FP | Family planning |
| GDP | Gross Domestic Product |
| HIV | Human immune virus |
| HPF | Health promotion foundations |
| IUD | Intra-uterine device |
| KZN | KwaZulu-Natal |
| LED | Local Economic Development |
| MDG | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| MTCT | Mother to child transmission |
| MNCWH | Maternal New-born, Child and Woman's Health |
| NDOH | National Department of Health |
| NGO | Non-Governmental organization |

| | |
|--------|--|
| NHI | National Health Insurance |
| NSDA | Negotiated Service Delivery Agreement |
| NSP | National Strategic plan |
| PHC | Primary Health Care |
| PLWHIV | People living with HIV |
| PMTCT | Prevention of mother to child transmission |
| PSP | Provincial Strategic plan |
| SA | South Africa |
| SDG | Sustainable Development Goals |
| SONA | State of the Nation Address |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TBA | Traditional Birth Attendants |
| THP | Traditional Health Practitioner |
| TOP | Termination of pregnancy |
| UN | United Nations |
| UNAIDS | United Nations Programme for AIDS |
| UNDP | United Nations Development Plan |
| WHO | World Health Organization |

LIST OF TABLES

| No. | Description | Page no. |
|-----------|--|----------|
| Table 1.1 | United Nations Millennium Development Goals | 2 |
| Table 1.2 | Sample and sample size | 14 |
| Table 2.1 | Doctrinal Components of New Public Administration | 20 |
| Table 2.2 | Locus and focus of Primary Health care within Public Administration and Governance | 22 |
| Table 3.1 | Numbers of maternal deaths notified in KZN Districts | 40 |
| Table 3.2 | Transforming our world: the 2030 agenda for sustainable development | 42 |
| Table 5.1 | Themes related to Maternal Health | 61 |

LIST OF FIGURES

| No. | Description | Page no. |
|------------|---|-----------------|
| Figure 5.1 | Aspects of Maternal Health given in response to question to explain the concept | 64 |
| Figure 5.2 | Reported response times when calling ambulance services in Impendle | 70 |

TABLE OF CONTENTS

| | |
|---|------|
| DECLARATION – PLAGIARISM | i |
| ACKNOWLEDGEMENTS..... | ii |
| ABSTRACT | iii |
| LIST OF ACRONYMS | iv |
| LIST OF TABLES..... | vii |
| LIST OF FIGURES..... | viii |
| CHAPTER ONE - INTRODUCTION OF THE STUDY..... | 1 |
| 1.1 Introduction..... | 1 |
| 1.2 Background of the study | 3 |
| 1.3 The research problem | 4 |
| 1.4 Research questions | 6 |
| 1.6 Literature review | 7 |
| 1.7 Theoretical framework | 10 |
| 1.8 Research methodology..... | 12 |
| 1.8.1 Research design..... | 12 |
| 1.8.2 Research approaches | 13 |
| 1.8.3 Study site | 13 |
| 1.8.4 Target population..... | 13 |
| 1.8.5 Sample and sample size..... | 14 |
| 1.9 Data collection methods..... | 15 |
| 1.9.1 Semi-structured in-depth interviews | 15 |
| 1.9.2 Focus groups..... | 15 |
| 1.10 Data Analysis..... | 15 |
| 1.11 Ethical considerations | 15 |

| | | |
|---|--|-----------|
| 1.12 | Limitations of the study | 16 |
| 1.13 | Structure of Dissertation | 16 |
| 1.14 | Conclusion..... | 17 |
| CHAPTER TWO - THEORETICAL FRAMEWORK OF NEW PUBLIC ADMINISTRATION | | |
| THEORY AND PUBLIC HEALTH SERVICE DELIVERY | | |
| | | 18 |
| 2.1 | Introduction | 18 |
| 2.2 | New Public Management | 18 |
| 2.3 | Government -based approach to service delivery | 21 |
| 2.3.1 | Primary Health Care Services | 23 |
| 2.3.2 | Department of Health Maternal, New-born, Child and Woman Health and Nutrition Strategic Plan 2012-2016..... | 24 |
| 2.3.3 | Public Administration and Governance..... | 25 |
| 2.3.4 | Programmes focussing on maternal health | 27 |
| 2.3.4.1 | <i>National Health Insurance</i> | 27 |
| 2.3.4.2 | <i>Campaign for Accelerated Reduction of Maternal Mortality in Africa</i> | 28 |
| 2.4 | Achieving Millennium Development Goals through New Public Management..... | 32 |
| 2.5 | Conclusion..... | 33 |
| CHAPTER THREE - REVIEW OF LITERATURE..... | | |
| | | 34 |
| 3.1 | Introduction | 34 |
| 3.2 | Overview | 34 |
| 3.3 | Health Care in South Africa | 35 |
| 3.3.1 | Healthcare during Apartheid Era in South Africa | 36 |
| 3.3.2 | Healthcare during Post-Apartheid Era in South Africa..... | 37 |
| 3.3.3 | HIV in South Africa..... | 38 |
| 3.4 | Millennium Development Goals..... | 39 |
| 3.4.2 | Sustainable Development Goals | 42 |
| 3.5 | Maternal Health Policy in South Africa..... | 44 |

| | |
|--|-----------|
| 3.6 Community Participation in relation to Public Health..... | 46 |
| 3.7 Impact of Tradition and Culture on Maternal Health | 47 |
| 3.7.1 Culture..... | 47 |
| 3.7.2 Traditional Medicine..... | 48 |
| 3.8 Male Involvement in Maternal Health..... | 49 |
| 3.9 Conclusion..... | 50 |
| CHAPTER FOUR - RESEARCH METHODOLOGY | 52 |
| 4.1 Introduction | 52 |
| 4.2 Research Methodology | 52 |
| 4.3 Research Objectives and Research Questions | 53 |
| 4.4 Research design | 53 |
| 4.6 Sample and Sample size..... | 55 |
| 4.7 Data collection methods..... | 56 |
| 4.7.1 Semi-structured in-depth interviews and focus group discussions..... | 56 |
| 4.7.1.1 Planning | 57 |
| 4.7.1.2 Selecting the participants | 57 |
| 4.7.1.3 Constructing an effective research question..... | 58 |
| 4.7.1.4 Implementation | 58 |
| 4.7.1.5 Conducting and analysing data..... | 58 |
| 4.7.2 Document Collection | 59 |
| 4.8 Data Analysis..... | 59 |
| 4.9 Ethical considerations..... | 59 |
| 4.10 Limitations of the study | 60 |
| 4.11 Conclusion..... | 61 |
| CHAPTER FIVE - RESEARCH METHODOLOGY AND RESULTS | 62 |
| 5.1 Introduction | 62 |

| | |
|--|-----------|
| 5.2 Themes emerging from data analysis | 62 |
| 5.3 Understanding maternal health | 63 |
| 5.3.1 Maternal health..... | 63 |
| 5.3.2 Maternal death..... | 65 |
| 5.3.3 Millennium Development Goals | 67 |
| 5.4 Factors affecting maternal health | 68 |
| 5.4.1 Access to Maternal health services | 68 |
| 5.4.1.1 Service availability and access | 69 |
| 5.4.1.2 Emergency services..... | 71 |
| 5.4.1.3 Staff attitudes and quality | 72 |
| 5.4.2 Religion and traditional beliefs | 74 |
| 5.5 Community participation on maternal health | 76 |
| 5.5.1 Male involvement in maternal health issues | 77 |
| 5.5.2 Community health worker support on maternal health | 79 |
| 5.5.3. Political leadership involvement..... | 80 |
| 5.5.4 Community education and information..... | 81 |
| 5.6 Programs towards improvement of maternal health..... | 82 |
| 5.6.1 PMTCT AND CARMMA Strategies..... | 83 |
| 5.6.2 Family Planning..... | 83 |
| 5.6.3 Termination of Pregnancy | 86 |
| 5.6.4 HIV/ STI Education | 88 |
| 5.7 Conclusion..... | 89 |
| CHAPTER SIX - INTERPRETATION OF THE FINDINGS, RECOMMENDATIONS AND CONCLUSION..... | 90 |
| 6.1 Introduction | 90 |
| 6.2 Interpretation of the findings | 91 |
| 6.2.1 Objective 1: Examine evidence for improving women health. | 91 |

| | |
|---|-----|
| 6.2.2 Objective 2: Review progress made on MDG 5 in uMgungundlovu District..... | 92 |
| 6.2.3 Objective 3: Review how uMgungundlovu District citizens are involved in maternal health issues..... | 93 |
| 6.3 Conclusion of the study | 96 |
| 6.4 Recommendations | 96 |
| 6.4.1 Healthcare accessibility | 96 |
| 6.4.2 Information sharing..... | 97 |
| 6.4.3 Relationship between Traditional and Western medicine | 98 |
| 6.4.4 Stigma mitigation..... | 98 |
| 6.4.5 Contraceptive uptake..... | 98 |
| 6.5 Suggestions for further research | 99 |
| 7. REFERENCES..... | 102 |
| 8. ANNEXURES..... | 117 |
| CONSENT | 120 |

CHAPTER ONE - INTRODUCTION OF THE STUDY

1.1 Introduction

Ensuring the health and well-being of expectant mothers has long been the goal of World Health Organization and governments the world over. Internationally, it is acknowledged that a healthy woman who has a healthy pregnancy leads to less birth complications and the birth of healthy babies. However, there are many countries around the world that continue to have very high maternal mortality rates despite international agreement on significantly reducing maternal deaths through the Millennium Development Goals.

In 2000, the United Nations adopted the Millennium Development Goals (MDGs) Declaration. These were eight development-focused goals, the fifth one of which was titled “improved maternal health”. MDG 5 set two targets, first to reduce the maternal mortality ratio (MMR) by 75% by 2015 and secondly to ensure universal access to reproductive health for all women (Gaensbauer, Baker, and Kenny, 2011:260). During recent years, the worldwide MDG focus has progressively emphasized the fact that poor or no progress is being made towards attaining MDG 5 on improved maternal health in sub-Saharan Africa. The South African Health Review in 2010 stated that there were indications that South Africa was not on track to achieve MDG 5 and that maternal mortality had actually doubled since 1990 (Theron, 2012:1).

The MDG targets focus on developmental issues such as poverty, hunger, maternal and child health, communicable diseases, education, gender equality, environmental decay and international partnership (Lomazzi, Laaser, Theisling, Tapia and Borisch, 2014:1). The eight MDGs set targets for levels of achievement for the period of 1990 to 2015 (Bryce, J., Black, R.E and Victoria, C.G. 2013:1). Table 1.1 below lists these MDGs.

Table 1.1 United Nations Millennium Development Goals

| Goal | Description |
|-------|--|
| MDG 1 | Eradicating hunger and poverty |
| MDG 2 | Universal primary education |
| MDG 3 | Promoting gender equality |
| MDG 4 | Reducing child mortality |
| MDG 5 | Improving maternal health |
| MDG 6 | Combating HIV/AIDS, malaria and other diseases |
| MDG 7 | Environmental sustainability |
| MDG 8 | Global partnership |

Adapted from: Global Health Action (Lomazzi *et al.* 2014:2)

The MDGs can be seen as indicators on a lengthy road to global development (Soyeju, 2015:1). As highlighted in Table 1.1 above, there were three important goals related to health that needed to be achieved by 2015. These goals were MDG 4 focusing on reduction of child mortality, MDG 5 addressing improvement of maternal health and MDG 6 on HIV/AIDS, malaria and other diseases. The reality was that only forty nine (49) out of eighty seven (87) states were within range of achieving the poverty reduction target in 2011 (Van der Elst, 2012:140). In order not to abandon the ideals of the development goals, the focus points of MDGs were taken into account in the debate and definition of the next round of goals beyond 2015 known as Sustainable Development Goals 2015 to 2030 (Lomazzi *et al.* 2014:7). The SDGs are an important concept and could help finally move the world to a sustainable trajectory (Sachs, 2012:1).

Over half a million women lose their lives each year from difficulties arising during pregnancy or childbirth. Worldwide the maternal mortality ratio (MMR) in 1990 was 430 maternal deaths per 100 000 live births and in 2005 the rate had fallen to some extent to 400 per 100 000. (Gaensbauer *et al.* 2011:260).

According to UN International Human Development indicators, South Africa's MMR increased from 230 deaths per 100 000 live births in 1990 to 440 deaths per 100 000 live births in 2005 (National Department of Health 2012). Maternal mortality ratio (MMR) is the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births. In the year 2010 it was reported that South Africa's MMR was 310 deaths per 100 000 live births which was higher than that of its neighbouring countries (WHO, 2010). However, it was estimated that the MMR rose from 280 per 100 000 live births in 2008 to peak at 304 per 100 000 live births in 2009 before dropping to 269 per 100 000 live births in 2010 (Dorrington, Bradshaw and Laubscher, 2014:3).

Maternal care is a vital component of primary health care and a free health service for pregnant women in South Africa. Within South Africa, the Maternal and Child Health programme is found in general development policies which are concentrated on meeting the basic needs of rural and urban communities, maximising human resources potential, expanding the economy and spreading its benefits to all South Africans. To fulfil these principles, the then Minister of Health publicised free health care services for pregnant women and children under the age of 6 years in July 1994 (National Department of Health 2015:13).

The focus of this study is primarily on MDG 5-improving maternal health.

1.2 Background of the study

The reasons why few governments in low-income countries have been able to attain high, constant and impartial coverage for interventions proven to decrease maternal and child deaths, vary by setting are not fully understood (Bryce *et al.* 2013:3). According to World Bank (2014), trends in maternal mortality globally, maternal deaths fell by 45% between 1990 and 2013. Although considerable progress has been accomplished in almost all regions, many countries, mainly in sub-Saharan Africa, were anticipated to fail to reach the Goal 5 target of reducing maternal mortality by 75% by 2015. In fact, of all the MDGs, the least advancement has been made towards the maternal health goal (Gaensbauer *et al.* 2011:260). The report on District Health Information System (2014) showed that the target for maternal mortality rate was 38/100 000 live births, but South Africa was reported at 310/100 000 with UMgungundlovu District positioned at 177/100 000.

The saving mothers report 2013-2014 (National Department of Health 2014), indicated that in South Africa the Institutional Maternal Mortality Ratio (IMMR) diminished from 172.22 per 100 000 live births in 2008-2010 to 154.06 per 100 000 live births in 2011-2013, a decrease of 12.6% (Schoon, 2013:3). The term Institutional Maternal Mortality Ratio is used in this section, instead of MMR because the deaths during pregnancy, childbirth and puerperium reported predominantly occur in institutions. Together with HIV/AIDS, obstacles to comprehensive emergency obstetric care hinder the country's ability to achieve MDG5 and effectively reduce child mortality and improve maternal health (National Department of Health 2014).

On a daily basis, approximately 800 women worldwide pass away because of problems during pregnancy and childbirth and 99% of these incidents take place in emerging nations. High rates of maternal mortality and high fertility are found in several low-income states (World Bank, 2014). The UN Secretary-General, Ban Ki-Moon, associates the absence of improvement with lack of resources, focus and responsibility (UN, 2010).

1.3 The research problem

In South Africa, in terms of maternal, neonatal and child health, the focus should be on reaching all people with effective maternal and neonatal care through firming up of primary healthcare services. Most notably, this strengthening should be focused on district hospitals where 25-50% of deaths which occur are as a result of avoidable factors related to the health system. According to the WHO report in 2014, about 50% of maternal deaths occurred in Africa (Theron, 2012:1). Globally, women and girls still suffer and die during pregnancy and delivery, especially in developing countries (World Bank, 2014).

The problem of maternal, new-born and child mortality remains overwhelming globally: 265 000 maternal deaths, 880 000 stillbirths, 1.2 million neonatal deaths and 3.2 million infant and child deaths annually, the vast majority occurring in low-income countries (Buttenheim and Asch, 2012). This is despite the fact that in 2000, all United Nations Member States came together to develop a strategy that was designed to deal with the issue of social ills worldwide. This meeting resulted in the establishment of the eight MDGs described above. These critical economic and social development priorities and targets were to be reached by 2015 (Aibunuomo, 2011:534).

The Countdown to 2015 report suggested that progress toward MDG 5 had been inconstant and largely inadequate (Bryce et al. *in* Sullivan and Hirst, 2011:907). Target 6 of MDG 5 required reduction of maternal mortality by three-quarters between 1990 and 2015 and the evidence showed that South Africa was not on track to achieve MDG 5 and that maternal mortality had actually doubled since 1990 (Theron, 2012:1). Improving health outcomes needs major improvements in the healthcare delivery systems and this would lead to progress in other MDGs because health is at the centre of most of other goals. More resources and change in healthcare policies can accelerate progress (Brende and Hoie, 2015).

Globally reproductive health problems are the principal cause of death amongst women aged 15-44 (Sullivan and Hirst, 2011:901). According to the (Saving Mothers' Report 2011-2013), the top three causes of deaths were non-pregnancy related infections, obstetric haemorrhage and hypertension. Together, these causes accounted for more than two thirds of all maternal deaths (Maartens, Cotton, Wilson and Venter, 2012:27). Over and above the three causes mentioned above, Gaensbauer *et al.* (2011:260) added prolonged obstructive labour and unsafe termination of pregnancy as significant causes of maternal death. It has also been highlighted that the targets for reproductive health were absent before 2007 and are still insufficient in MDG 5. Omissions in MDG 5 are the issues of abortion, a fertility regulation indicator and the availability and use of obstetric services (Fehling, Nelson, and Venkatapuram, 2013).

Even though healthcare services are generally available at minimal or no cost to the client and can be physically accessible in some areas, it has been discovered that these services can be unfriendly, socially demeaning and even abusive to women (Ganle, Parker, Fitzpatrick and Otupiri, 2014:24). Poor clinical assessments, delays in referral, not following standard protocols and not responding to abnormalities in monitoring of patients are some of the most common mistakes made by healthcare providers. Lack of suitably trained doctors and nurses has also emerged as an important contributing factor in maternal deaths (Maartens *et al.* 2012:27).

South Africa is dedicated to reducing mortality and morbidity among women and children. This obligation is echoed in the Negotiated Service Delivery Agreement (NSDA) which was signed in 2010 and which identifies decreases in maternal and child mortality as key strategic

outcomes for the South African health sector (National Department of Health 2012). Government funding increased from R4.5 billion in 2009-2010 to R8.4 billion budgeted in 2010-2011 for expansion of antiretroviral treatment, scaling up of PMTCT and promotion of HIV and TB treatment integration (Mayosi, Lawn, Van Niekerk, Bradshaw, Karim and Coovadia, 2012:6).

Taking into consideration additional policy measures to expand access to those co-infected with TB and women and children with CD4 counts lower than 350, an additional R3 billion was allocated in the budget. At that period, about 920 000 people were on anti-retroviral treatment according to the Minister of Finance, Gordhan (2010:17). Furthermore, according to Gordhan (2014:11), it was reported that R41 billion was spent on HIV and AIDS programmes in the previous five years, and R43.5 billion was budgeted for the next three years.

The Department of Health has a strategic plan in place which recognises priority interventions that will have the highest influence on reducing mortality rates, as well as augmenting gender equity and reproductive health according to Maternal, New-born, Child and Women's Health strategic plan 2012-2016 (National Department of Health 2012). It is clear that some of the maternal deaths could be prevented if the underlying problem is diagnosed early, the initial emergency management provided promptly and timely referral to the appropriate level of care occurs (Theron, 2012:3).

1.4 Research questions

The primary research question sets the foundation and decision of the application of the most appropriate research design (Edmonds and Kennedy, 2013:177). Cresswell (2009:139) states that a research question points to what will be learnt or be answered in the study. This study primarily seeks to understand what the factors are that influence the lack of achievement of MDG5 in the Impendle area of the UMgungundlovu District Municipality. It is only with a thorough understanding of the context in which the problem occurs that we can suggest possible solutions that will have a positive impact on reducing maternal deaths in that area. This study sought to answer the following three questions:

- How has UMgungundlovu District progressed towards achievement of MGD 5 since the inception in 2000?
- What steps have been taken to improve services to women in the UMgungundlovu District?
- To what extent is the community involved in maternal health issues?

1.5 Research objectives

In order to answer the research questions above, the researcher formulated the research objectives. There are three objectives that were proposed for the study as stated below:

- To examine evidence for improvements in women's health.
- To review progress made on MDG 5 in the UMgungundlovu District; and
- To review how the UMgungundlovu District's citizens are involved in maternal health issues.

In order to meet these research objectives, a comprehensive description of the theoretical framework of the Study (Chapter2) and an extensive literature review was undertaken (Chapter 3) in order to establish the context in which the study occurs. These chapters examine the extent to which MDG 5 has been achieved internationally and locally, the commitment of funding for the healthcare of pregnant women, babies and children and also the manner in which Public Management is implemented in the South African context.

1.6 Literature review

South Africa has experienced a compound health transition in the past two decades. Mayosi *et al.* (2012:6) note that mortality worsened between 1990 and 2005, in almost all age groups mainly because of HIV and AIDS. Although progress in MDG indicators is generally insufficient, several aspects could be noted, particularly, mortality of mothers and children younger than 5 years (MDG 4 and 5). Bryce *et al.* (2013:1) state that MDG 4 and 5 are significant for global health as a whole because they signify the mortality endpoints for women and children across specific diseases, nutritional and environmental risk factor and distal elements including inequalities in economic resources and education.

Health plays a vital role in the MDG framework, with three of the eight goals directly and several other goals more indirectly, related to health. However, it has been argued that this focus on maternal mortality, child mortality and specific infections is too limited and an overarching goal of freedom from illness is absent (Fehling *et al.* 2013:1115).

According to the Saving Mothers Report 2011-2013 (National Department of Health 2014), TB is the single most common cause of death in South Africa. There were 384 maternal deaths attributed to TB between 2011 and 2013, which is 26% of all non-pregnancy related infections. It is noted that the number of maternal deaths classified as TB fell from 529 since 2010, a decrease of 24, 6%. The scale up of TB screening at antenatal visit is a factor which likely contributed to this fall (Maartens *et al.* 2012:29). In addition, the life expectancy in South Africa for both men and women has significantly improved and is presently 62 years across genders, which is an increase of eight and a half years since 2005 (Zuma, 2016).

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While pregnancy may often be a period of anticipation accompanied by feelings of maternal love and nurturing, for many women it can also be a period of suffering, ill health and even death (Say *in Phiri*, 2015:1). The Constitution of The Republic of South Africa, 1996, section 27 states that, “everyone has a right to have access to health care services, including reproductive health care”.

Maternal death is the demise of a female while expectant or within 42 days post-delivery, irrespective of the period of the pregnancy, deriving from any cause but excluding accidents or injuries (WHO, 2010:6). Since maternal death represents a major international challenge, it is important that the community at large, especially women, are able to define maternal death and that equality in both power and access to health resources is ensured. In this way monitoring of expectant and new mothers can be done at all levels during this period (Sullivan and Hirst, 2011: 902).

Gaensbauer *et al.* (2011:260) state that complications during pregnancy and childbirth are the prominent causes of death, disease and disability among women of reproductive age in developing countries. On a daily basis at least 1,600 women die from complications of pregnancy and childbirth globally, amounting to about 584,000 women dying each year.

According to the Saving Mothers Report 2008-2011 (National Department of Health 2012) the most usual routes to mothers and women dying during that period were “non-pregnancy related infections, mainly AIDS (50%), obstetric haemorrhage (14%), complications of hypertension (14%), pregnancy related infections (5%), complications of pre-existing medical conditions such as cardiac conditions, and diabetes (9%). In contrast, the Saving Mothers Report 2011-2013 showed that the majority of maternal deaths transpired from cases with prolonged labour and were classified as obstetric haemorrhage 44%, followed by non-pregnancy related infections, mainly AIDS (34,7%), pregnancy-related sepsis 20% and anaesthetic related deaths 12% (Maartens *et al.* 2012:31). This shows that haemorrhage remains a leading cause of maternal death and that there is a significant decrease in deaths due to non-pregnancy related infections.

In 2009, 15 years after the first democratic election and liberation from apartheid, South Africa faced four epidemics: HIV and Tuberculosis (TB); chronic diseases and psychiatric disorders; injuries and violence; and women and child death (Mayosi *et al.* 2012:5). The widespread incidence of HIV and some challenges that were faced by the health system resulted in South Africa being amongst the nations that saw an increase in maternal mortality (Van der Elst, 2012:142).

In his budget speech, Gordhan (2010), the then Minister of Finance stated that there were significant changes in policy and increased budget for the treatment of HIV in pregnant and lactating females since 2009. State finance improved from R4.5 billion consumed in 2009/2010 to R8.4 billion in 2010/2011 for growth of antiretroviral therapy (ART), establishment of the prevention of mother to child transmission (PMTCT) programmes and HIV and TB treatment incorporation (Budget Speech, 2012). In his State of the Nation Address (Zuma, 2009), the President stated that, “all South Africans should know their HIV status” and emphasized that a campaign would be launched in April 2010 to encourage 15 million sexually active individuals to test for HIV and TB.

By June 2011, 14.8 million counselling sittings had been undertaken; 13 million people had been tested for HIV and 8 million tested for TB (Mayosi *et al.* 2010:6). The uMgungundlovu District counselled and tested about 300 000 clients for HIV and TB throughout that period according to District Health Information System (National Department of Health 2012). The

HIV policy turnaround in 2009 led to a massive rollout of HIV testing and treatment for 3.2 million people living with the virus. This contributed immensely to healthier and longer lives for those infected (Zuma, 2016).

The introduction of the National Health Insurance (NHI) in the health structure holds out the prospect of widespread entrance into effective programmes that will prevent disease, fight illness and lead to progress in MDGs 4, 5 and 6 (Mayosi *et al.* 2010: 12). The Minister of Health in 2014 reminded the country that the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) was established by the African Union Commission (AUC) with the aim of reducing Maternal Mortality in Africa, thus achieving MDG 5.

There are three key aspects of the health system that will ensure that the mothers are saved during pregnancy, labour and after delivery. These are having skilled healthcare providers, a healthcare system that is appropriately resourced and a rapid inter-facility emergency transport system (Schoon, 2013). The extent to which these aspects are operational in the Impendle District is further explored in the study.

1.7 Theoretical framework

The theoretical framework that was used for this study is New Public Management (NPM). The components of the NPM as a new paradigm include:

Break up of centralised bureaucracy; wide personnel management; shift to desegregation of units in the public sector, involving breaking up of former monolithic units; unbundling public sector into corporative units organised by products; with developed budgets and dealing with one another at 'arm's length' basis; shift to greater competition in the public sector through term contracts and public tendering procedures; stress on private sector-styles of management practice – involving a move away military style public service ethic to more flexible hiring, rewards and more use of public relations (Nasrullah in Vyas Doorgapersad 2011:238).

Babravicius and Dzemyda (2012:1) concur that the six foundations that reinforce the NPM approach have been identified as decentralisation, privatisation, and orientation of the results of the market mechanism towards the public sector, private sector management practices and participation. Under the auspices of NPM directing, follow up and evaluation are thus stressed, based on a principal-agent contractual and cost-cutting nexus that substitutes former trust in providers and managers of welfare tasks to serve citizens or provide public goods. Thus NPM has also been reflected as the answer to performance failure proved by a traditional bureaucratic model for being hierarchical, sluggish, inefficient and costly (Hood, 1991; Alexander, 2014).

Societies are not called customers, now they are referred to as clients and consumers and there is privatization and commoditization of previous public goods together with portions of scientific knowledge (Elzinga, 2010:309). Subsequent to the altered role of the state and rising demands for good governance worldwide, the NPM paradigm arose to embed a new method into traditional public administration.

This innovative approach was geared in the direction of enhancing competency, output, improved service delivery and accountability (Hughes, 2010). The emphasis of NPM is on outcomes contrasting to the process – which was the angle of traditional public administration (Basheka, 2012:54).

In this competitive world, it is becoming progressively challenging for organizations, both privately owned or in the public sector, to attain their goals and manage risk efficiently. Some reasons for this, is the increasing market globalisation in which operations occur, scantly resources, continuous changes in the business atmosphere and the accumulative challenges to identify and manage risks effectively (Coetze and Lubbe, 2013:45). These changes are essential as a deliberate answer to lack of professionalism, accountability and low economic proficiency shown in public sectors (Boulle, 2011).

In this study this theory is used because MDGs require achievement of numerical performance indicators which is in accordance with the trends of results based management in NPM.

1.8 Research methodology

Methodology refers to the theory of how things are done. Research is also seen as a fixed set of methods to the study of a particular situation in order to achieve a definite solution (McNiff, 2010:8). Methodology means a study of methods, including the philosophical assumptions underlying different methods (Punch, 2016:65). The research methodology undertaken in this study is further described below.

1.8.1 Research design

Research design connects research questions to data, assembles the proposed methods and shows how they will be used to answer the research question (Punch, 2016:89). According to Edmonds and Kennedy (2013:7) research design aims to provide a framework from which specific research questions can be answered while utilizing the scientific method. One example is a case study which can be used to scrutinize factual circumstances to offer the foundation for the submission of ideas (Edmonds, 2013:113). A case study research design was chosen for this study. Case studies are a design of inquiry found in many fields in which the researcher develops an in-depth analysis of a case, often a program, event and activity, process of one or more individuals.

Cases are bound by time and activity and researchers collect detailed information using a variety of data collection procedures over a sustained period of time (Cresswell, 2014:42). According to Yin (2014:10), the case study method is particularly appropriate when the research question starts with: “How?” or “Why?”

Miles, Huberman and Saldaña (2014:28) define a case as a phenomenon of some sort occurring in a bounded context. Swanborn (2010:13) concurs, stating that a case study refers to the study of a social phenomenon where the researcher, guided by an initially broad research question, explores the data and only after some time formulates more precise research questions, keeping an open eye to unexpected aspects of the process by abstaining from pre-arranged procedures and operationalisations.

1.8.2 Research approaches

Research approach refers to the plans and procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation. This plan involves several decisions (Cresswell, 2014:31). There are generally three approaches that are used in research namely: qualitative, quantitative and mixed methods. Quantitative research is empirical research where data are in the form of numbers (Punch, 2016:10). A mixed method on the other hand, is defined as a combination of various aspects of quantitative and qualitative methods (Edmonds and Kennedy, 2013:146).

Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data (Cresswell, 2014:32).

Qualitative research methodology was chosen for the study. This approach was chosen because it has the ability to explore and produce detailed clarifications relating to the researched issue with special focus on understanding and an emphasis on meaning (Edmond and Kennedy, 2013:112).

1.8.3 Study site

The study site is the area of residence where information or data will be collected to meet the needs of the study (Rossman and Rallis, 2012:137). The chosen site for this study was the Impendle Local Municipality, the smallest local municipality in the UMgungundlovu District. The population of the municipality is 34 212 and it is in a deep rural area within the largest district in KZN. UMgungundlovu District as a whole has seven local municipalities and a population of slightly above one million (Stats S A, 2011).

1.8.4 Target population

Target population is the group of people to be sampled. The population may be characterised into different social groupings selected according to the research topic (May, 2011:98). Population refers to all the people or phenomena under study, from whom a sample will be selected for research (Somekh and Lewin, 2011:327). The target population for this study was citizens and clinic managers in the Impendle Local Municipality.

1.8.5 Sample and sample size

A sample is a subcategory of the total population from which data is collected by the researcher (May, 2011:98). Non-probability sampling was chosen for the study where nomination of people depends on the researcher's decision (Edmonds, 2013:16). May (2011:100) state that purposive sampling occurs when a selection is made according to known characteristics. On the other hand, Edmonds (2013:17) suggests purposive sampling means units are chosen with a purpose in mind, in this case the community.

According to Rossman and Rallis (2012:139), sample size denotes the overall quantity of individuals nominated to partake in the study. In this study, the focus was on clinic management and the community at large. There are three health facilities and 34 212 people residing in four wards in Impendle. Clinic managers for the three clinics in the area were chosen as they were deemed to be the main decision-makers regarding the maternal issues in their respective clinics. In each of the four wards 10 community members, a Traditional Health Practitioner and the Ward Councillor were chosen to participate in the study, as well as 2 pregnant women and a clinic manager from each of the three clinics. This breakdown is displayed in Table 1.2 below.

Table 1.2 Sample and sample size

| Area | Number of participants |
|-----------------|--|
| Clinic A, B, C | 3X Clinic Managers |
| Clinic A, B, C | 6X Pregnant women |
| Ward 1, 2, 3, 4 | 4X Ward councillors |
| Ward 1, 2, 3, 4 | 4X Traditional health practitioners |
| Ward 1, 2, 3, 4 | 40X Community members (10 for each ward) |
| Total | 57 |

1.9 Data collection methods

In this study, data gathering methods chosen included semi-structured in-depth interviews and focus group discussions. In-depth interviews were used for the 17 participants and focus group discussions were used to have discussions with the 40 community members.

1.9.1 Semi-structured in-depth interviews

Semi-structured in-depth interviews were used as the primary means of data collection for this study. A semi-structured interview represents an opening up of the interview method to gain an understanding of how interviewees generate and deploy meaning to social life (May, 2011:135). This method was chosen because it uses open-ended questions thus generating answers, which provide rich data (Somekh and Lewin, 2011:62). Interviews were recorded and transcribed, and field notes were also taken during the interviews.

1.9.2 Focus groups

Rossmann and Rallis (2012:189) state that focus groups are generally composed of 7-10 people who are not well-known to one another and have been selected because they share certain characteristics. In this study, a total of 40 people (10 per focus group) were interviewed. The audio-taped data were transcribed and the field notes were also taken during the interviews.

1.10 Data Analysis

Analysis is the act of examining, interpreting, conceptualising, reducing and integrating data, submits Somekh and Lewin (2011:115). According to Rossmann and Rallis (2012:269), analysis is the outline and pattern of identification of detail. In this study, in-depth interviews were scrutinized utilising the thematic analysis, which means to identify themes which emerge from the data and record them as end-products of the study (Edmonds and Kennedy 2013:15).

1.11 Ethical considerations

Punch (2016:31) summarizes the main ethical issues when conducting research as harm, consent, deception, privacy and confidentiality. Israel and Hay (*in* Cresswell, 2014:132) concurs that ethical questions are apparent today in such issues as personal disclosure, authenticity, credibility of the research report and the role of researchers in cross-cultural contexts.

Ethical approval for this research was obtained from the University of KwaZulu-Natal Ethics Committee and a gatekeeper's letter from UMgungundlovu Health District. Informed consent with sufficient information regarding the study was signed by participants so as to ensure an informed decision. Participants used pennames and were advised to keep from public some information deemed to be private; and that they were free to withdraw from the study anytime should they feel the need to do so.

1.12 Limitations of the study

This study has some possible limitations. There are a limited number of research studies on the Millennium Development Goal 5 in the UMgungundlovu District. Prior studies could assist a researcher with information on the current study being undertaken. Secondly, the study was done in one small geographical area so the results are not generalizable. Lastly some transcriptions were done in isiZulu and translated to English.

1.13 Structure of Dissertation

This study is divided into six chapters, which are delineated as follows:

Chapter one: Introduction of the study

It is important to properly introduce a research study. This chapter deals with the key issues that are discussed in the study. It gives background information on the reasons for embarking on the study, and also highlights the problem areas related to the study.

Chapter Two: Theoretical Framework

Theories are developed to clarify, envisage, and understand the phenomena. This chapter will give a structure that will support or hold the study together.

Chapter Three: Review of literature

This chapter looks at the previous studies which are relevant to the issue of maternal health as it relates to the Millennium Development Goal 5. It also discusses other issues that relate to maternal health, including policies and strategies that are concerned with this area of healthcare.

Chapter Four: Research Methodology

This chapter looks at the process and methods that are used to collect data relating to the study. It outlines the approaches, designs, questions and objectives of the study in more detail.

Chapter Five: Research Methodology and Results

This section looks at the findings of the study as they relate to the research methodology that had been used.

Chapter Six: Interpretation of the findings, conclusion and recommendations

This chapter looks at the interpretation, clarification and explanation of the findings, the recommendations thereof and the concluding remarks of the study.

1.14 Conclusion

This chapter has shown how the study seeks to uncover as yet, poorly understood factors that relate to maternal health and MDG 5. The essential elements of the study were introduced and the importance of the study was indicated by highlighting the problem the study seeks to explore. Attention was also drawn to the research questions and objectives of the study. An introductory literature review was presented and the New Public Management theoretical framework was established. The methodology followed for the study was outlined and the data collection methods and analysis briefly explained. Finally, the ethical considerations for and limitations of the study were discussed. In the chapter that follows, the theoretical framework for the study, that of New Public Management, is explained and linked to the research undertaken.

CHAPTER TWO - THEORETICAL FRAMEWORK OF NEW PUBLIC ADMINISTRATION THEORY AND PUBLIC HEALTH SERVICE DELIVERY

2.1 Introduction

In this chapter, the theoretical framework of the study is established and the underpinning theory-New Public Management (NPM) by Hood in 1991 is described in detail. The theory is then contextualised within the South African environment and the government-based approach to service delivery is detailed with reference to local laws, policies and programmes, which focus on maternal health. In addition, the concept of governance and the relationship thereof with public administration is also explored.

2.2 New Public Management

The theory of New Public Management (NPM) was developed by Hood in 1980. This framework was developed to represent a “paradigmatic break from the traditional model of public administration” (Vyas-Doogerpersad, 2011:238). This was seen as important in the advancement of the values of decentralised, democratic and free-market orientated state and was conceived as a model to assist the public sector to achieve the Millennium Development Goals.

Basheka (2012:25) states that ‘administration’ and ‘management’ are concepts that have historically nearly moved side by side, although management factually replaced administration during the 1970s. At that time, it was felt that government administration required adoption of private sector management styles. Elzinga (2010:307) concurs, stating that the last thirty years have seen a growing alliance between public administration and neoliberal styles of governance, motivated by the progression of globalization and privatization. The introduction of NPM doctrines has resulted in a changed focus for academics with the current interest being largely on the management influence on the performance of the public sector. The NPM principles advocate for the replication of private managerial systems in the public sector so as to improve the productivity, efficacy and quality of service delivery (Laegreid and Verhoest 2010:211).

Peters (2010:326) notes that while it is difficult to identify precisely when the shift from public administration to the concept of public management occurred, the phrase NPM has become central to describing and understanding what has been happening in government.

However, according to Louw (2012:93) the NPM grew in popularity during 1979 when Margaret Thatcher took over as Prime Minister in the United Kingdom and introduced her bold plans to decrease public spending in a number of public sector reforms.

Harpen (2011) asserts that neoliberal public administration assumed that the necessities and difficulties within the public sector that needed to be addressed were known and understood. In contrast, NPM assumes that needs and wants will be articulated and fulfilled by the mechanism of market choice.

Hood's (1995) framework is of interest to the study because it looks at public accountability and organisational best practice as being influenced by specified doctrines or components such as hands-on professional management, corporatisation, competition, performance management, private-sector management, output controls and decentralization. When one considers the MDGs, it is clearly not possible to achieve these ambitious goals without all these aforementioned factors coming into play. According to Chaston (2011:17), reform in the public sector implemented under the banner of NPM was seen as increasingly necessary in order to reduce the public sector's share of the Gross Domestic Product (GDP). From inception then, NPM has been viewed as a theory, which purposefully connects private sector management styles and public sector organisations.

NPM is seen to require public sector managers to become responsible for defining strategy for their organizations, utilizing empowerment, expanding participation in decision-making, promoting competition, putting the customer first and fostering the concept of market-oriented government (Chaston, 2011:26). In such a context, this study relating to the public health sector, NPM places emphasis on developing more innovative solutions to ensure quality service delivery.

The MDGs are closely related to service delivery. Over the years, there have been extraordinary initiatives for commercial and social growth within the international community. In low-income states, governments strive for development, which is supported by the establishment of policies and programmes in an attempt to ensure success. Nevertheless, the rapid accomplishment of MDGs in the late 20th Century proved elusive for the majority of the countries (Turner *et al*, 2015:1).

Table 2.1 below lists the doctrines or elements of the New Public Management as described by Hood in the early 1980s and the justification of each of these in the context of public administration practices within the health sector in the study is highlighted.

Table 2.1 Doctrinal components of New Public Administration

| Doctrine | Justification |
|---|---|
| Hands-On Professional Management | Accountability requires clear assignments of responsibility not diffusion of power |
| Performance Standards/Methods | Clearly stated aims, efficiency, and hard look at goals |
| Output Controls | Need for a greater stress on results |
| Decentralizing of Units | Make units manageable and create accountability |
| Competition | Rivalry as the key to lower costs and better standards; contracts as the key to explicating performance standards |
| Private-sector Management | Need to apply proven private sector management tools in the public sector |
| More stress on discipline and frugality in resource use | Need to cut direct costs, raise labour discipline, do more with less |

Adapted from: Hood, 1995.

As noted in Table 2.1 above, private sector management and performance standards are part of the NPM framework. South Africa, as one of the States that adopted the MDGs, needs to adopt this managerial system in order to achieve the goals. Turner (2015:11) stated that the MDGs would be achieved by innovative public-private partnership but also accorded a central role for the state in poverty eradication. Chaston (2011:29) concurred stating that the perspective of the public sector professionals was reinforced by the fact that underlying NPM was the foundational principle of seeking new ways to measure performance.

This is then, used as the basis for determining opportunities to achieve cost savings in public sector expenditure. Therefore, Hood's framework of NPM was useful in the South African context as it gives guidance on the separation of powers between national, provincial, district and local municipality structures and where budget was to be allocated. The same principles of budget allocation apply to provincial departments, especially Department of Health, where the budget is allocated according to assigned targets per district and facility, and according to different programmes. For example, the HIV budget is allocated for programmes such as HIV testing services, Antiretroviral Therapy, Maternal and Child Programme and others.

It has been noted, that there has been great advancement by low-income countries towards attainment of the MDGs, even though the improvement is very inconsistent depending on states, goals and areas (Sachs, 2012: 220). However, Bутtenheim (2013) asserts that despite the stated improvements, maternal, new-born and child mortality is still very high with 265 000 maternal deaths, 880 000 stillbirths, 1.2 million neonatal deaths and 3.2 million infant and child deaths each year, many of these happening in low socio-economic countries. There is thus still a great need to examine service delivery within the health sector and identify ways in which maternal, infant and child health targets can be attained.

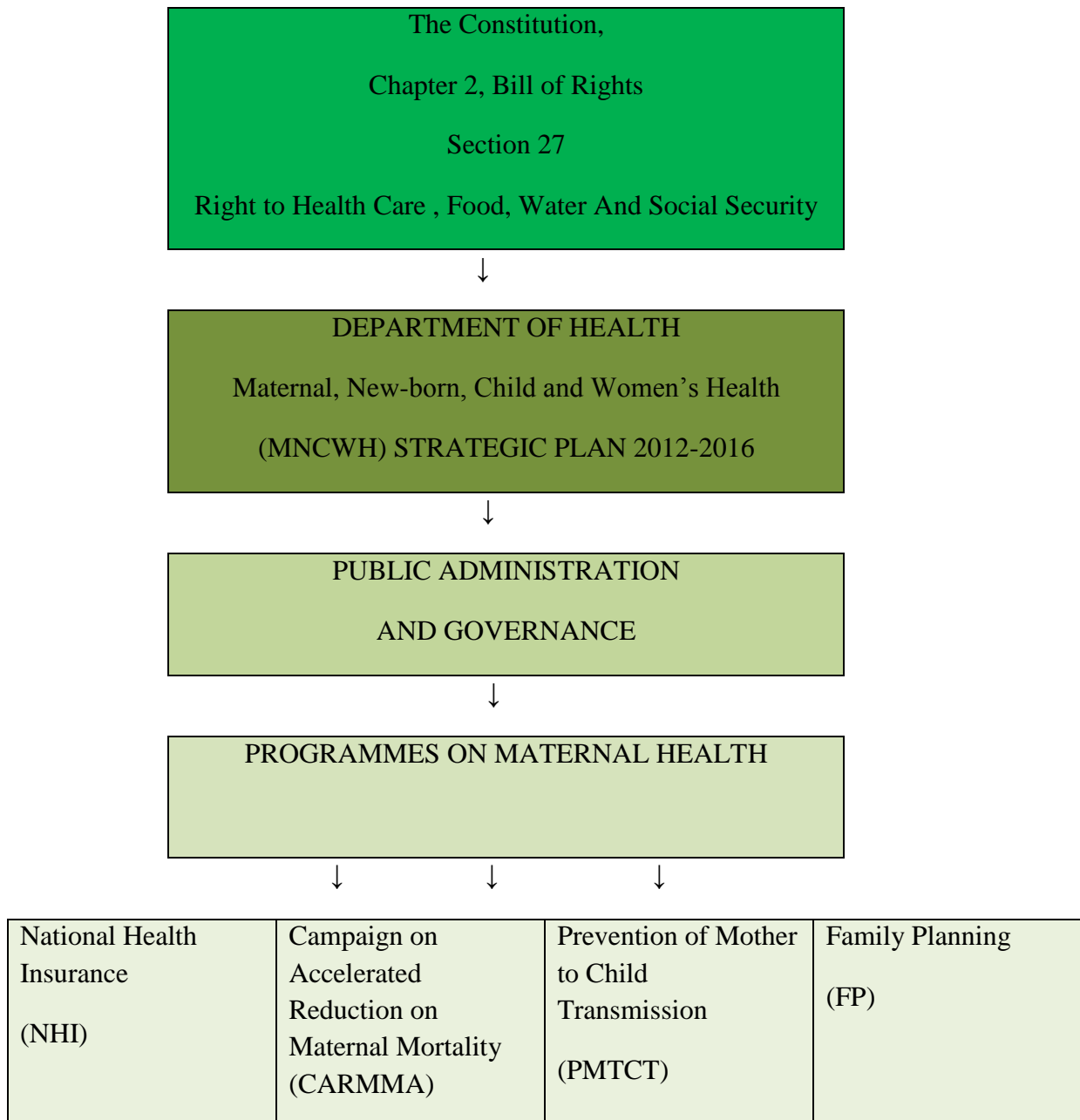
2.3 Government -based approach to service delivery

According to the UN MDG report (2015) since 1990, globally the maternal mortality ratio has decreased by 45 per cent, with the highest reduction being in 2000, when the MDGs were adopted. The international public stood at a significant intersection in 2015, the deadline for MDGs. At that time, the global community had the opportunity to reflect on their accomplishments and at the same time take up new determinations for the future. It is clear maternal health has improved considerably since the implementation of the MDGs. The 45 % reduction in maternal mortality globally between 1990 and 2013 meant a drop from 380 maternal deaths per 100,000 live births to 210 per 100 000.

The situation in South Africa with respect to government provision of health services needs to be understood within these broader global achievements of MDGs. As stated by Naledi Barron and Schneider (2011:18), despite the fact that South Africa spends 8% of the GDP on health and is one of the countries with noted financial stability in the African region, health outcomes are not as positive as may be expected.

In fact, attainment of critical health outcomes is less successful in South Africa than other countries which spend less on health care. The section below looks at how Primary Health Care (PHC) plays a vital role in the improvement of maternal health in the South African region.

Table 2.2 *Locus and focus of Primary Health care within Public Administration and Governance*



Authors' perspective

A discussion of the table follows:

Naledi *et al.* (2011) continue to highlight some of the factors that inhibit the achievement of stipulated outcomes for health care, which include accessibility, quality, inadequate human resources, poor governance and management capabilities and skills. Logie (2015) concurs, stating that underfunding of health resources, unregulated commercialisation and repetition of the same disease programmes by different organisations, some even targeting the same areas, are also factors which inhibit optimal attainment of health outcomes in South Africa.

2.3.1 Primary Health Care Services

The Constitution of the Republic of South Africa, 1996 states clearly that all South African citizens have a right to health care, as stated in Section 27 of Chapter Two. Although PHC services are freely available in South Africa, some people still prefer to utilise paid services within the private sector because they feel public services are not as freely accessible (Olise *in* Chiduben 2012:18). While the right to choose a health care practitioner is acknowledged, the fact that this is precipitated by lack of access to the public health care indicates there is something amiss in the system. Logie *et al.* (2010:1) suggests that health systems in developing states should focus on fairness and equity for both city and rural residents. This is however difficult to achieve due to an apparent lack of resources and or lack of funding and budget allocation, particularly in the South African system.

The concept of PHC has four underlying structures, which are commitment by the politicians, technology, inter-sectoral collaboration and citizen involvement. The use of the term PHC was reported to be used at the beginning to mean first contact of care given to clients at their nearest health facility. Primary health care is the bedrock to achieving the MDGs, therefore communities, including political leaders, need to deviate from the usual practices and focus on effective behavioural change programmes in order to achieve the MDGs as required (Aibunuomo, 2011:529).

The years 2011 and 2012 saw the establishment of legislative and policy changes that, if implemented as planned, would see a drastic change in the health care system in South Africa (Rene and Padarath, 2011). Spending on antiretroviral treatment was accelerated and a new strategic plan was introduced for HIV, sexually transmitted infections and tuberculosis for 2012-2016 (Mayosi *et al.* 2012:6).

According to Bramford (2013), the main purpose for PHC's re-engineering is to improve Maternal, New-born, Child and Women's Health (MNCWH) results. It is envisaged that there would be a district specialist team in each district team. This team comprises an obstetrician, paediatrician, physician, advanced midwife, advanced paediatric nurse and a PHC nurse. There is also a special focus on improving clinical governance in the districts. In addition, school health teams were established to ensure that both health and learning outcomes are improved. Voce *et al.* (2014) are of the opinion that MDGs were attained through three-stream approach to healthcare, consisting of municipal, ward-based outreach teams, integrated school health teams and district specialist teams. Matsoso and Strachan (2015) concur stating that the vision of PHC re-engineering ensures that all citizens of South Africa have better access to care through recruitment of more staff within and outside of healthcare facilities.

2.3.2 Department of Health Maternal, New-born, Child and Woman Health and Nutrition Strategic Plan 2012-2016

As stated by Bramford (2012) the Strategic Plan for Maternal, New-born, Child and Woman and Nutrition (MNCWH) 2012-2016 was launched in 2012 with a special focus on strengthening interventions that may have the highest influence on reducing maternal, new-born and child mortality. The new strategic plan 2017-2022 was still in draft format at the time of this study.

The emphasis of the strategic plan is on refining coverage and ensuring quality and impartial access to package of essential services through the implementation of eight key strategies for achieving improvements. These key strategies are:

- Address inequity;
- Strengthen community-based mncwh;
- Scale up provision of key mncwh at phc and district level;
- Scale up interventions at hospital level;
- Strengthen capacity of health care system;
- Strengthen human resource capacity; and
- Strengthening systems for monitoring and evaluation.

According to the MNCWH Strategic Plan 2012-2016, in as much as MNCWH services are provided by the DOH, different stakeholders have significant roles to play in supporting enhanced health and nutrition including the Department of Social Development, Rural Development, Basic Education, Agriculture and Home Affairs. The MNCWH strategic plan is a holistic guiding document, which acknowledges the multi-faceted approach required to ensure long-term, sustainable maternal health. In this study, the efficacy of the plan in Impendle was considered.

2.3.3 Public Administration and Governance

Since the State is largely responsible for the effective delivery of health care services, issues of administration and governance need to be clarified in the context of this study. As stated by Hughes (2010) the word ‘governance’ originates from the Latin word ‘gubernare’, meaning to steer, direct and rule. Delmon (2011:69) further suggests that good governance endeavours to provide transparency, equal treatment and open communication and competition.

Governance need not essentially be conducted solely by governments. All organisations including private firms, associations of firms, non-governmental organisations(NGOs) and associations of NGOs engage in governance, often in association with governmental bodies but not necessarily. Ultimately, the aim of all such institutions is to create good governance and ensure consistent success of the entity (Keohane and Nyte *in* Hughes 2010:126).

Governance reveals the value system of spiritual collectiveness, inclination towards agreement, meekness, usefulness, co-existence (Ubuntu), faith and belief in the justice of people and everlasting confidence related to a strong belief in the existence of the omniscient, omnipotent and omnipresent greater being as stated in the KZN Citizen Charter 2009-2014. In addition, Laurence, O’Toole and Kenneth (2011:4) state that governance as the concept can be understood in terms of institutions and processes involved in exercising authority in identifiable social systems. This is done following prescribed norms and standards related to those who exercise power and elucidate the methods and procedures of doing so.

Haffeld (2013:47) states that governance post-2015 must deal with the challenge of managing distributed power in networks consisting of self-serving governments, business entities and idealistic organizations in environments where there are inherent power disparities as well as incomplete knowledge in the scientific sense.

Thus governance for the post-2015 era is about influencing the intimate relationship between authorities and other actors in the global network.

It is stated, that the African National Congress (ANC) was obliged to build a new system of government out of the disordered apartheid state. Corrupt and mismanaged Bantustans had to be incorporated into the new state, new municipalities and provinces had to be constituted and the state needed to be democratised and administratively overhauled. At the present time, the performance of SA governance is especially poor at the local level. Municipalities suffer deficiencies in planning, project management and technical capacity among others, submits Plaatjies (2011:26).

Niehof, Rugamela and Gillepsie (2010) state that the mid-1990s saw the emergence of a new parallel interest on the part of a broader group of scholars and programme officers in the specific, collective and commercial environments that underpinned vulnerability to HIV infection. Scholars and programme managers learned how social justice, poverty and inequity conditioned asymmetrical scatterings of the virus in the population and communities at large. The idea of danger relating to certain persons who assumed certain behaviours became better balanced with a broader focus on structural drivers of the epidemic and on social and economic risk environment. The notion of AIDS as an inter-sectoral challenge, not only a health issue, opened the door for many new researchers and development professionals.

Thomas, Hanour-Knipe and Aggleton (2010:144) noted that compound interaction between race, class and geography belies a single political economy of understanding. Migrant labour, an institution rooted in the Nineteenth Century when gold and diamonds were discovered, prevented Africans from settling in urban areas and forced men into long absences from their rural homes. While the male migrant infector model was not the only social model used to understand the contemporary HIV pandemic in SA, it became one of the important ways in which the disease was framed, especially in the early years of the epidemic.

Accountability is very important in ensuring that good governance is undertaken. Unless public administrators are held accountable and responsible for their actions, there will be no improvement in the lives of the citizens of the country. As a result, it becomes vitally important that citizens are empowered to understand their right to justice, systems which perpetuate poverty and the right to access programmes of development in general.

Unless citizens are involved in participative and transparent decision-making, quality service delivery will not be achieved. There is a great need for community and civil society empowerment to build self-confidence and encourage citizens to lead lives of dignity and fulfilment, especially in the African countries where there seems to be lack of good governance (McNeil and Malena, 2010).

Governance is the pillar of every country, be it developed or under-developed. There have been numerous reports of corruption and bad governance in developing countries and this has affected progress on development issues.

2.3.4 Programmes focussing on maternal health

The government of South Africa has initiated several programmes which address the maternal health needs of the country, in an attempt to achieve MDG 5. The programmes mentioned below show the role the government of South Africa has played in order to improve maternal health in the country.

2.3.4.1 National Health Insurance

According to Dunjwa (2015) the Minister of Health, Dr Aaron Motsoaledi announced a 25 member Advisory Committee on NHI, in November 2009. This committee was tasked with advising the Ministry on the formulation and implementation of an NHI policy. In August 2011, the Department of Health released a Green Paper entitled National Health Insurance for South Africa (also known as the 'NHI green paper'). NHI is meant to ensure that all people of the country have accessible, effective and excellent health services. Phasing in of the NHI is proposed to take place over a period of fourteen years and will include significant reforms in service delivery systems. The implementation will ensure widespread access to quality healthcare on a more sustainable and equitable basis than currently exists for the entire population (Mayosi, *et al.* 2012).

As stated by the President of South Africa during the 2016 State of the Nation address (Zuma, 2016), the White Paper on National Health Insurance that was released in December 2015 aims to improve health care for everyone in South Africa. NHI White Paper 2015 states that the South African health system has been described as a two-tiered system divided according to socio-economic lines. NHI will create a unified system by improving equity in financing, reducing fragmentation in funding pools and making health care delivery more accessible and affordable for the population.

A National Health Insurance (NHI) scheme in SA will definitely improve healthcare delivery but may not be able to address other health care issues which affect the world in general. Health promotion is currently regarded as the primary tool by which to ensure equity in health, including community participation in matters related to health and survival. As a result, recent focus has been on resourcing health promotion projects because such projects have greater economic benefits in the long run (Payne, Debbink, Steele, Buck, Martin, Hassinger and Harris, 2013).

2.3.4.2 Campaign for Accelerated Reduction of Maternal Mortality in Africa

Very high rates of maternal and child mortality are reported in South Africa when compared to the rest of the world. The maternal mortality ratio (MMR) in South Africa is 310 deaths per 100 000 live births and the under-five mortality rate is 56 deaths per 1 000 live births according to KZN Maternal Deaths Report 2011-2013 (National Department of Health 2014).

According to the KZN Citizens Charter (2009-2014), CARMMA was launched at Osindisweni Hospital in EThekweni District, KwaZulu–Natal, on Friday 4 May 2012. The operation was established by the African Union and United Nations Population Fund (UNFPA). It is a programme which is inclusive of all African countries under the theme “Africa Cares: No Woman Should Die While Giving Life”. In essence the campaign is directed at reducing the high rate of pregnancy-related deaths in Africa by ensuring that adequate resources are procured and allocated towards sexual and reproductive health services. As stated by Bramford (2013), one of the priorities of CARMMA is to ensure that regions have sufficient dedicated obstetric ambulances so that women can access the services of a skilled birth attendant during labour as well as referral to appropriate suitable care both during and after labour.

The Department of Health Annual Report, states that maternal mortality seems to be slowly but surely falling. The maternal mortality ratio in South Africa in 1990 was estimated at 150/ 100 00 live births. A 75% decrease from this level would result in the MDG 5 target for 2015 to be 38/ 100 000 live births. Sadly, South Africa lacks provable means of counting maternal deaths but the estimated overall maternal mortality for 2007/ 2008 has ranged from 310 to in excess of 700 maternal deaths per 100 000 live births. Although at that time it seemed clear that MDG 5 would not be achieved, there was a notable reduction in maternal mortality showing a 13% reduction in the 2011 data - that is 153 deaths per 100 000 live births overall.

This decrease was noted to be more significant for HIV-positive women, showing that deaths from non-pregnancy related infections remain in the highest single category but showed an astounding 28% reduction in mortality amongst HIV-positive women (National Department of Health 2011).

2.3.4.3 Prevention of mother to child transmission (PMTCT)

The National Department of Health in South Africa stated in 2013 that the provision of antiretroviral treatment (ART) would be a lifelong, permanent commitment to HIV positive patients. In addition, these patients were reminded that they also have an obligation and responsibility to adhere to ARV treatment protocols. Based on the PMTC guidelines (National Department of Health 2013), all HIV positive pregnant women regardless of CD4 count would commence lifelong ART early (Mayosi *et al.* 2012).

The PMTCT programme was established in 2002 in SA and has become the bigger such programme globally with the service available at 2 525 sites country-wide. South African women who require ART are identified early in pregnancy and are either enrolled directly into ART programmes or offered a short- course AZT/3TC post-delivery to avoid the development of resistance to Nevirapine, a drug used in the treatment of HIV in pregnant women (Ramkisson, Coovadia, Hlazo, Coutsoydis, Mthembu and Smit, 2010). Subsequently in 2009, HIV treatment for pregnant women saw increased policy focus with changes in treatment threshold and investment scale-up. Within 10 years of the initiation of PMTCT, 95% of all healthcare facilities were offering the service (Mayosi *et al.* 2012:9).

Horwood, Haskins, Vermaak, Phakathi, Subbaya and Doherty (2010:992) state that interventions for PMTC are crucial in decreasing paediatric HIV infection and consequently child mortality. Early initiation of ART in HIV infected children can result in considerable improvements in mortality rates. However, there is a notable challenge that PMTCT implementation, particularly follow up of HIV-exposed infants, is sub-optimal.

Horwood *et al.* (2010:992) go on to note that the establishment of a PMTCT programme in SA in 2002 also came with challenges, for example, health workers noted an increased workload. However, there was a simultaneous introduction of the non-professional cadre known as lay counsellors who were employed to deal with issues of HIV counselling and testing thus reducing overwork in the professionals. The lay counsellors together with the

professionals were to ensure that HIV-infected women and their babies were identified early and put on treatment.

Ramkissoo *et al.* (2010:316) state that there is no indication that pregnancy quickens the progression of HIV- related infections in asymptomatic women and that they are no different than others in developing HIV- related sickness. However, it is estimated that ART for pregnant women in SA and other low income countries still reaches less than 10% of individuals in need. In 2010, South Africa was one of the four countries to have achieved more than 80% coverage of ART prophylaxis for PMTCT (Mayosi *et al.* 2012:9). The Desktop Review on Reproductive health (National Department of Health 2013) state “there is now an explicit recognition that the health of HIV-positive mothers is essential for the wellbeing of their infants. PMTC services initially had a single goal to prevent vertical transmission. Maternal health needs to be seen in a broader context than preventing maternal mortality.”

2.3.4.4 Family Planning for improved health service delivery

Orner, de Bruyn, Harries and Cooper (2010:44), state that it is clear that the HIV/AIDS epidemic in the Southern African region, mostly affects certain age and gender groups, particularly females of child-bearing age. Therefore, it is very important to ensure that effective sexual reproductive health services are easily available, including access to termination of pregnancy facilities, in order to decrease maternal and child deaths. However, according to Gaensbauer, *et al.* (2011:260), while there has been increased accessibility to family planning services worldwide, there remain challenges in some developing regions. In 2005, the contraceptive prevalence was sitting at 22% in low economic countries showing that there was a great need for marketing of this service in these areas. Dhlomo (2011) the KZN MEC for Health, stated that teenage pregnancy is a key public health concern in South Africa, with more than one-third of South African females having their first child by age 19. Most first deliveries occur to single women and contraceptive use often commences only after a first birth.

Maternal deaths can be reduced if family planning can be available and accessible to all those in need locally and internationally, as stated in MDG 5 (Hulme, 2010). In the Sustainable Development Goals (SDGs), this issue of family planning is addressed as target 3.7, which

declares universal access to sexual and reproductive health including family planning (Theron, 2016:1).

As stated by Sullivan and Hirst (2011:904), MDG 5b aims to attain widespread access to contraceptive and other reproductive services by 2015.

Progress is measured with reference to the number of contraceptives utilised, inability to access contraceptives to those in need, antenatal care visits analysis and teenage pregnancy. It is estimated that from 1990 contraceptive usage had remained at 67% over the years in developed areas and increased from 50% to 62% in low-income countries (Correa, Petchesky and Parker, 2010). According to the Endres (2013:285), the contraceptive prevalence increased to 27% in African countries in 2013. This is still well below the prevalence in developed and other low-income countries.

Patel (2014:1) suggests that sexual reproductive services should be available in all consulting rooms ensuring a 'one stop shop' so that there will be no missed opportunities. This will prevent unwanted pregnancies and consequently reduce maternal mortality. Ramkissoon *et al.* (2010) point out that during antenatal care, HIV positive women are encouraged to use condoms, as well as being informed of other methods that can be utilised over and above that, referred to as dual protection. During antenatal care it is noted that it is important to provide health education to the mothers that will opt for breastfeeding as to which method of contraception is to be used to avoid complications to both the neonate and the mother.

According to Payne *et al.* (2013:119), it has been established through research that illegal abortions contribute to the maternal mortality. Therefore it is of utmost importance that programmes addressing this issue be prioritised both locally and around the world (Ray, Madzimbamuto, Ramagola-Masire, Phillips, Mogobe, Havernkamp, Motana and Mokatedi, 2013:541). Provision of quality service during contraception awareness campaigns and providing a 'one stop shop' for all services integrating family planning, inter-sectoral collaboration and evidence-guided planning are some of the key points that were included in the National Contraception and Fertility Planning Policy and Service Delivery Guidelines and National Clinical Guidelines strategy (National Department of Health 2012). The primary purpose of these policies is the prevention of unwanted pregnancies where different targeted groups, including key populations, are given a chance to choose their choice of contraceptive

method after discussion with health workers. This will in turn lead to a decrease in HIV infections (Patel, 2014:1).

As stated by Ramkissoon *et al.* (2010:316) all women, whether HIV positive or negative, have a right to sexual reproductive health and can decide freely on the method of contraception they prefer to use. Further, they can make a decision as to when to have children and through the PMTCT programme, ensure a significant reduction in the likelihood of mother to child transmission. However, the challenge of health workers' attitudes towards HIV positive women remains unresolved and an area that needs investigation. From the afore-mentioned discussion, it is clear that globally, there is a major role played by women of all races, cultures and religions who give birth to the nations and protect the future generation through leadership (Sullivan and Hirst, 2011:901).

2.4 Achieving Millennium Development Goals through New Public Management

It should be noted that NPM is an international trend, but it has not been adopted in its entirety in all countries. One finds different versions in different countries. These differences have been explained by differences that exist between countries with regard to legal and administrative traditions, political style and cultural determinants Elzinga, (2010:309). A lack of data and good quality statistical analysis poses a serious constraint to timely monitoring, policy development, and the ability to target interventions where they are most needed. While the MDGs are expressed as sector-specific goals, they cannot be achieved in sector silos. The multilateral system can perform better. Becoming "fit for purpose" requires agencies to collaborate on high-level goals, to understand the complementary roles of agencies, and to address weaknesses. The MDG review at the country level has revealed little-known programs worthy of being expanded, and has generated a deeper appreciation of the roles and capabilities of the many institutions in the UN and Bretton Woods system (World Bank, 2015:159)

The selection of goals and targets was determined by the Millennium Declaration adopted unanimously by the member states of the United Nations. Building the database and strengthening the statistical systems of developing countries has required the efforts of many partners over many years. When countries produce statistics to monitor their own development programs, differences in definition and methodology often limit comparability across countries. Whether monitored at the national, regional, or global level, international

monitoring of the MDGs requires indicators that are comparable across countries and over time (World Bank 2015:182). Under the auspices of NPM steering, follow up and evaluation or auditing are thus emphasized, predicated on a buyer-seller or principal-agent contractual and cost-cutting nexus that replaces former trust in providers and administrators of welfare tasks to serve citizens or provide public goods Elzinga (2010:312).

The Millennium Declaration recognises the importance of good governance, of which civil servants are very important considering their role, place and position in administration and in society. It is commonly understood that the successful achievement of MDG targets is closely related to efficiency and effectiveness of the civil service system using NPM approach. In doing so, it is important that the civil service is tuned to professionalism and service orientation (UNAIDS 2014).

2.5 Conclusion

In this chapter, the main reason for the shift from administration to management in public facilities and the use of the New Public Management framework for the study was explained. It was highlighted that for better service delivery in the public health sector, there is a great need for introduction of cost awareness, flexibility and effectiveness. This should lead to better productivity without increased overheads to the government (Elzinga, 2010:309). The centrality of the government of South Africa in healthcare service provision was discussed as were the various programmes that have been put in place to address maternal and reproductive health. From the points discussed in this chapter, it is clear that as much as NPM has its challenges; it is also a bridge that, if used appropriately, can have positive outcomes on maternal health and public health in general. In the next chapter, literature relating to the current study was described.

CHAPTER THREE - REVIEW OF LITERATURE

3.1 Introduction

The primary research questions underpinning the study (highlighted in Chapter One) are used to provide a framework through which the literature is examined, organised, synthesised and summarised. In this chapter, literature relating to Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) will be examined with specific reference to health care provision in South Africa. The South African context as far as HIV/AIDS, traditional health practices and maternal health (as well as community and male involvement in maternal health) are concerned, is described. The chapter therefore outlines the theoretical context in which the study is situated.

3.2 Overview

The international community needed a significant and important technique that would address social issues facing the population. As a result of extensive deliberations, the Millennium Development Goals (MDGs) were established (UNDP, 2011). MDGs are a set of eight goals that were purposely written to be understandable and quantifiable. The focus of these goals is to deal with lack, starvation, disease, issues of education, gender disparity, and environmental ruin. The MDGs aim to encourage universal consciousness of social issues, political answerability, social response and community pressures (Sachs, 2012). The date set for the achievement of these goals was 2015.

The post-MDG era (post 2015) is focused on the achievement of a new set of goals known as the Sustainable Development Goals (SDGs). These will guide international development until 2030. At this point, there have been 17 goals and 169 targets that have been agreed upon (Robinovitch, Stott and Fieldmann (2014:206). These are discussed in further detail later in this chapter.

Bryce *et al.* (2013:3) asserts that mortality amongst females and children can be reduced and eliminated through ensuring availability and access to specific high-quality, focused interventions. Buttenheim (2012:581), on the other hand, states that in many areas and across different populations the uptake of free services as provided by the government is still very low, especially for maternal and child products. This indicates the need to focus equally on programmes, which seek to change behaviours as well as on financial stability to ensure adequate provision of services.

This would be necessary if we seek to achieve MDG 4, which addresses the issue of child health and MDG 5, which focuses on maternal health. In the SDGs, the health goals have been combined into one that is SDG 3, which ensures healthy lives and promotes well-being for all at all ages (Robinovitch *et al.* 2014:206).

Over the past few years, international and national planning and policy discussions have still primarily focused on MDGs. In an effort to achieve these goals they have been amalgamated into the functions of developmental partners and civil society in general and have also been included in the students' curriculum at different stages of education (UNDP, 2016). However, it is clear that there have been a notable underachievement of the MDGs, especially in low socio-economic states, due to operational shortfalls in both First and Third world countries as well as broken promises by some stakeholders (Sachs, 2012).

South Africa has not done well in achievement of health targets in the MDGs but there has been some notable improvements. It is estimated that in South Africa about fifty percent of HIV positive people are females and the prevalence of HIV in the SA populace remains high (Burman, Marota and Peter, 2016). However, much improvement is noted in relation to ensuring that HIV transmission is prevented from mother to child, access to universal counselling and testing services has improved since 2009 and all those who are eligible for treatment are put on antiretroviral medication. Sadly though, many females who are HIV-positive women still experience obstacles in obtaining services for sexual well-being, sexually transmitted infections and sexual reproductive health including antenatal care and counselling (Ramkissoo *et al.* 2010:315).

3.3 Health Care in South Africa

Health is regarded as vibrant, ever changing state enabling individuals to function at any given time, maintains Lippincott (2010:57). Naledi *et al.* (2011:18) assert that health does not merely mean the absence of diseases but is defined as a “resource for everyday life, not the objective of living” with “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity” being fundamentals for its full completion. Hood & Leddy (as cited in Lippincott, 2010:6), concur, using the WHO definition that “health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and or infirmity”.

As such, wellness comprises being hands-on and including individuals in efforts toward a state of physical, psychological and spiritual wellbeing in which they feel and look their best. Cockerham (2011:10) asserts that health is regarded as an accomplishment, something that individuals are supposed to work at to improve their quality of life. Failing to do so could result in chronic diseases and premature death. Hollard-Muter (2012:11) also stresses that health is a social issue and a product of interaction between biology and the physical, socio-economic, cultural and political environment in which one resides and acts. Thus, variances in people's health status come from biological differences and differentials in socio economic status.

The South African healthcare system is divergent in that it offers free primary health care services using first class technology in both the public and private facilities; however the latter is more resourced and caters for people in the middle and upper class (Mayosi *et al.* 2012:5). Public health challenges include an excessive burden of disease such as HIV and Tuberculosis (TB) and a shortage of key medical personnel according to NHI White paper (National Department of Health 2015). The public health system remains the provider of healthcare to the vast majority of people. In general, the health outputs and outcomes have steadily improved over the last 5 years as noted in the KZN Province according to KZN Health Annual Report 2014/15 (National Department of Health 2016).

It is reported that more than 31 million clients attended Primary health care (PHC) facilities while more than 6 million were seen at hospital casualties. 951 462 clients were put on anti-retroviral treatment since the year 2010. One of the outstanding health results is the dramatic reduction in the mother to child transmission rate from 6.8% in 2010 to 1.3% in 2014/15. The maternal mortality ratio in facilities was reduced from 147/100 000 (2013/14) live births to 124.9/100 000 (2014/15) and deaths decreased from 280 to 254 according to KZN Health Annual Report 2014/15 (National Department of Health 2016). In order to understand healthcare in South Africa fully, this chapter investigates healthcare provision during the apartheid years, post-apartheid era as well as the effects of HIV on the people of South Africa.

3.3.1 Healthcare during Apartheid Era in South Africa

The NHI White paper 2015, states that before the 1994 elections for democracy, the health care system in South Africa was unequal, and segregated along race lines. The healthcare

system for the white minority was well-resourced while on the other hand the healthcare system for the black majority was severely under-resourced. The Constitution of the Republic of South Africa, 1996, bans the practice of racial discrimination and guarantees the socio-economic rights of all South Africans equally, including the right to health. Upandhyay, Liabsuetrakul, Shrestha and Pradham (2014:2) agree that health service delivery was indeed affected by the apartheid regime in South Africa. The new administration that came to rule in 1994 had to make a number of changes to rectify inequities thus increasing accessibility to health, primarily in terms of availability and affordability.

According to Ruiters and van Niekerk (2012:41), however, efforts to institute a national health system in South Africa commenced before the transition to democracy. The idea was not only mooted by organizations such as the African National Congress (ANC). In 1942, the former United Party administration established a commission of inquiry that was tasked with investigating the availability of health services to all people of the country and ensuring that there was adequate medical, dental, hospital and nursing care for all.

3.3.2 Healthcare during Post-Apartheid Era in South Africa

KZN Citizen Charter 2009-2014, notes that the community or public is entitled to a healthy lifestyle and environment in certain democratic countries; therefore, it is also the situation in post-apartheid South Africa, where these rights were documented in the 1996 constitution. However Kaiser, (2010) states that as much as there was a significant and notable change in the health care in the post-apartheid South Africa, these were suppressed by the increase in the burden of diseases in the country especially the rise of HIV/AIDS epidemic, strain due to lack of medicines, equipment and shortage of personnel which led to low staff morale and consequently reduced health outcomes. Undeniably, on-going management of HIV and AIDS epidemic is predicted to continue in the next ten years or so, and that will definitely need new funding and new strategies like those professed by the suggested national health insurance system.

Aibunuomo (2011:521) states that the new administration that took over in 1994 took numerous steps to ensure that everyone had access to primary healthcare services through building of more than 1 300 clinics in areas that were previously disadvantaged. This development assisted to improve service delivery by ensuring greater access in more geographic regions.

Naledi *et al.* (2011:18), agrees stating that from 1994-1999 there was major health system reorganization. The reorganisation began with the amalgamation of fourteen health departments that were previously separated along racial lines, into one national system and the simultaneous provision of free services in clinics and hospitals, firstly for pregnant women and children under six years but later for everyone.

3.3.3 HIV in South Africa

South Africa has the highest number of HIV infected individuals globally and the country accounts for a massive 35% living with HIV while 32% were newly infected in 2007 (UNAIDS 2012). Deegan (2011:218) states that the first record death from HIV/AIDS associated infection in South Africa was in 1982; by the mid-1990s the number of recorded cases had reached 10,000 while by 2006 the infection affected 19.95 per cent of the population.

Deegan (2011:218) points out that:

“President Mbeki was considerably ambivalent regarding the scale and potency of the pandemic together with the impact the disease would have on the socio-political environment of the country. He questioned the scientific evidence that linked HIV to AIDS and appointed a commission to investigate various aspects of the disease namely: the nature and causes of immunodeficiency and the reasons why AIDS was largely heterosexual in Africa. Mbeki’s views that AIDS resulted from poverty and malnutrition and his refusal to give anti-retroviral treatment to pregnant women created tensions within the country and the African National Congress (ANC)”.

However, when the anti-retroviral therapy (ART) was introduced in 2004, there was hope that life expectancy would increase and that the disease load was going to decrease (Naledi *et al.* 2011:19). This also ensured the reduction of stress for healthcare workers, who then had hope that their clients were taken care of, and would not die as was happening before ART was available in South Africa.

Vawda and Variawa (2012) stressed that at that time (up to 2012) South Africa had the largest ART programme globally. However, only three years earlier, at the end of 2009, the WHO guidelines stated that only about 37% of SA’s HIV infected individuals were getting ART.

This could largely be credited to the lack of a trained workforce, insufficient supply or stock outs of ART and lack of access to treatment points. While the access to ART has improved greatly, Dekeda *et al* (2014:1614) point out that the “need for a high level adherence to antiretroviral treatment has remained a major hurdle to achieving maximal benefit from its use in pregnancy”. This once again speaks to the need to change established behaviours in society to improve health outcomes.

Perez, Ayo-Yusuf, Kofman, Maker, Mokonoto, Naidoo, Rendal-Mkosi and Sallojee (2013:147) state that SA has low life expectancy of 55.3 years for men and 60 years for women. This is due to numerous factors including poverty and underdevelopment, the rising problem of non-communicable and chronic diseases; increasing degrees of injury and HIV/AIDS. However, three years later, according to the State of the Nation Address (Zuma, 2016), the life expectancy of South Africans had improved drastically for both males and females and is presently 62 years across genders, showing an increase of eight and a half years when compared to 2005.

According to the HIV/AIDS, STI and TB (HAST) Provincial Strategic Plan (PSP) 2012-2016 (National Department of Health 2012), KwaZulu-Natal Province has the highest weight of disease related to poverty in the nation, including HIV/AIDS, STIs and TB. The estimated number of people living with HIV (PLWHIV) is 1 622 870 which is 15.8% of the total population.

In 2014, UNAIDS came up with threshing reports pointing towards ending AIDS. One of the reports is Fast Track, which is an all-encompassing determination agreed on at the International AIDS conference in 2014 known as Vision 909090. The vision is that 90% of people know their HIV status, 90% of those who are HIV positive are put on treatment and 90% of those on treatment have viral load suppression (Burman, Marota and Peter, 2016). Without these proposed interventions, it is foreseen that the HIV epidemic will continue to overtake the response thus resulting in the long-term requirement to continue extensive HIV treatment and increasing imminent budgets (UNAIDS, 2012).

3.4 Millennium Development Goals

Van der Elst (2012:137) defines Millennium Development Goals (MDGs) as “time bound and quantified targets for addressing extreme poverty in its many dimensions income

poverty, hunger, disease, lack of adequate shelter, and exclusion while promoting gender equality, education and environmental sustainability”.

In 2012, Cohen (2012:178) stated that it looked like South Africa would not be able to attain some of the MDGs, especially MDG 4 and 5, in spite of the great steps that had been taken and progress that had been achieved in other goals.

According to the National Strategic Plan (NSP) Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), woman and child health will still be significant even in the post-2015 era, with extension in MDG targets. The focus of government, including and especially local government, should be on women and children with all stakeholders being able to detect challenges early, identify groups at risk and refer them accordingly.

Fehling *et al.* (2013:1110) state the improvement of MDGs in different regions has varied from area to area. When looking at the population globally, it is estimated that 15, 5% of the people experience hunger and the number of child and maternal deaths have not decreased. There have been some questions around the issue of the formulation of MDGs and the structure thereof. Oya (2011) believes that the WHO played a critical role in formulation of the goals relating to poverty alleviation. Sachs (2012) states that it is clear that these goals were established by the First World countries as only 22% of the global parliaments were involved. This could explain the reason developing countries are struggling to achieve the goals, as their particular contexts were not taken into account during formulation.

Malaudzi, Phiri, Peu, Mataboge and Mogale (2016) state that South Africa is mostly dependent on donors for programmes related to HIV and Maternal, Child And Women’s Health (MCWH). As a result, it becomes difficult to be proactive with issues that relate to the epidemic because the donors focus on one specific issue at a time and the funding is conditional. This is the likely reason why the country is reactionary, even to outbreaks. Despite this, Bryce *et al.* (2013) state that decline in maternal mortality has been noted over the years, from 400 000 to 275 000 due to some significant interventions that need to be strengthened in future, including PMTCT, CARMMA and family planning programmes. Burton (2013:520) agrees, stating that South Africa has performed well on indicators relating to sexual reproductive health with 97% of females having access to antenatal care and 90% delivering their babies in health care facilities.

Much has been claimed for women's autonomy and for girls' schooling as a way of enhancing that autonomy as well as improving reproductive health outcomes and reducing unwanted pregnancies. Educating women influences some aspects of child health behaviour, such as the child's nutrition, much more than it affects behaviours such as how quickly a woman consults a medical practitioner (Bhatti and Jeffrey, 2012:159).

3.4.1 Maternal Mortality in KwaZulu-Natal

The study looked at maternal mortality trends in KZN over a period of three years as indicated in Table 3.1 below.

Table 3.1 Numbers of maternal deaths notified per KZN District.

| District | Maternal Deaths | | | |
|---------------|-----------------|------|------|-----------|
| | 2011 | 2012 | 2013 | 2011-2013 |
| Amajuba | 14 | 7 | 11 | 32 |
| EThekwini | 124 | 114 | 103 | 341 |
| ILembe | 12 | 11 | 20 | 43 |
| Harry Gwala | 13 | 14 | 11 | 38 |
| UGu | 22 | 20 | 23 | 65 |
| UMgungundlovu | 49 | 59 | 29 | 137 |
| UMkhanyakude | 10 | 10 | 03 | 23 |
| UMzinyathi | 12 | 7 | 7 | 26 |
| UThukela | 17 | 23 | 16 | 56 |
| UThungulu | 58 | 53 | 33 | 144 |
| Zululand | 20 | 8 | 22 | 59 |
| Total | 360 | 326 | 278 | 964 |

Adapted from: KZN Maternal deaths report 2011-2013

From the above statistics, it can be seen that the trend is a stable, but modest decline in maternal mortality across the triennium. Nevertheless, not all districts have followed this steady decline. Of particular concern is iLembe District, where the maternal mortality increased distinctly in 2013. Referral arrangements for regional and tertiary level services should be taken into consideration when relating the maternal mortality in different districts. For instance, it is anticipated that UThungulu and UMgungundlovu Districts have a higher maternal mortality than other districts as they each provide regional obstetric services for two neighbouring districts as well as their own. Harry Gwala, UMkhanyakude, UMzinyathi and Zululand Districts, on the other hand, have only district hospitals and are expected to refer regional level cases to nearest districts. It is therefore, expected that these four districts would have lower maternal mortality than the others. The maternal mortality of over 100 per 100,000 in Harry Gwala and Zululand are therefore of concern according to KZN Maternal Deaths Report 2011-2013 (National Department of Health 2014).

3.4.2 Sustainable Development Goals

According to the UN Secretary General at the time (2011), there is a need for the development of a set of new sustainable development goals that will continue where the MDGs took off and failed. Haffeld (2013:43) states that the Sustainable Development Goals (SDGs) necessitate an innovative and balanced strategy, which is different from the existing policy tools in complicity as a friendly approach. MDGs will still be relevant post 2015 era despite the introduction and formulation of SDGs, which focuses on sustainability, thus complementing the MDGs.

The United Nations Conference on Sustainable Development, Rio+20, in 2012 formulated the idea of the SDGs with an aim to promote and cover three focus areas of sustainable development, that is, environmental, social, and economic. The SDGs substitute the MDGs, which was a 15-year agenda that started in September 2000. The 2030 Agenda contains 17 new SDGs that will direct policy implementation and budgeting for 15 years to come (UNDP, 2015). The debate on choice of indicators for the SDGs was problematic because of the varying notions of what the SDGs should be – or whether there should be something else like a broad health system strengthening approach as endorsed by the WHO. The concept of universal health coverage was mooted following the 2012 UN Secretary –General’s High-Level Panel Report, mandated by the 2010 United Nations MDG Summit.

Despite this confusion, there is difficulty in that there is currently: “no single, universally accepted definition or assessment metrics for sustainable development... [and] no international agreed sustainable development indicators that would help monitor progress” Haffeld (2013:44). Table 3.2 below shows a list of the Sustainable Development Goals as recommended by the United Nations.

Table 3.2. Transforming our world: the 2030 Agenda for Sustainable Development

| Number | Sustainable Development Goal |
|---------|---|
| Goal 1 | No poverty |
| Goal 2 | Zero hunger |
| Goal 3 | Good health and well-being |
| Goal 4 | Quality education |
| Goal 5 | Gender equality |
| Goal 6 | Clean water and sanitation |
| Goal 7 | Affordable and clean energy |
| Goal 8 | Decent work and economic growth |
| Goal 9 | Industry, innovation and infrastructure |
| Goal 10 | Reduced inequalities |
| Goal 11 | Sustainable cities and communities |
| Goal 12 | responsible consumption and production |
| Goal 13 | climate action |
| Goal 14 | Life below water |
| Goal 15 | Life on land |
| Goal 16 | Peace and justice |
| Goal 17 | Partnerships for the goals |

Adapted from: UNDP 2015. Resolution adopted by the General Assembly on 25 September 2015

As highlighted above, SDG 1 focuses on no poverty and SDG 2 addresses zero hunger and SDG 6 focuses on clean water and sanitation. These goals are all connected to SDG 3 in that they contribute towards the health and well-being of the citizens. Combining efforts towards these SDGs would ensure that premature deaths are avoided and health care for all ages is improved, according to Robinovitch *et al.* (2014:206). As noted above SDG 3 focuses on health and well-being for all citizens. This includes a pledge to end HIV/AIDS, tuberculosis, malaria and other communicable diseases by 2030, and includes provision of medicines and vaccination for everyone (UNDP, 2015).

3.5 Maternal Health Policy in South Africa

Policy is defined as “prudence or wisdom in the management of affairs” (Singer and Erickson, 2011:95). On the other hand, Howlett, (2011:16) defines policy simply as what government chooses to do or not to do. Roberts (2010:62) asserts: “Imagine a society in which the legitimacy of government, its institutions, procedures, laws, decisions, office holders and policies is held to rest at least indirectly upon the consent of those it governs”.

South Africa has numerous robust policies on maternal and reproductive health and the highest per capita spending on health compared to other African countries. However, the policies and spending have not yielded the expected result of maternal mortality reduction. There is a great need to make this obligation a reality for women by ensuring that the reproductive health policies that South Africa has, are carried out according to CARMMA strategy (National Department of Health 2012). Bamford (2013) concurs, stating that in the last few years there have been a number of national assurances and interventions focussing on improving maternal, new-born and child health. In SA, declines in maternal and child mortality rate are pointed out in Negotiated Service Delivery Agreement (NSDA) as one of the four strategic outcomes for which the Health Sector must account. The crucial point to ensure advancement in maternal, neonatal and child survival is to ensure every mother, new-born and child is informed of the available health services, in all districts (WHO, 2010).

Kvernflaten (2013:3) states that “We live in a world that is, more than ever, shaped by global ideas” where policy choices and programmes progressively come from actors such as the World Bank, UN agencies, international non-governmental organizations (NGOs), global health initiatives and foundations, and national policy has been intensely impacted by the propagation of external policy expectations.

It is clear that international health policies are restrictive in relation to the countries' capability to govern and develop their own national health priorities and health systems, but expected to conform to the worldwide scene. Global goals like the Millennium Development Goals (MDGs) have been criticised for their "one size fits all" targets and for their reinforcement of a donor-centric view of development.

Bayley, Rao, Szreter and Woolcock (2011:1), assert that there is now a general agreement through social sciences and between development policy-makers that organisations have a significant role to play in relation to wealth and poverty of countries. Since the adoption of the MDGs in 2000, of which goal 4 and 5 aim to improve maternal, new-born and child health, one policy action area felt to be of particular importance to the reduction of maternal and neonatal mortality is to increase the proportion of women accessing and using skilled maternal health care services.

This is especially so during delivery, which should be done with skilled health professionals in attendance, submits Burton (2013). However MDG 5 on improving maternal health has been criticised focussing too much on skilled employees at birth (Kvernflaten, 2013) and not about the all-inclusive approach desirable to accomplish its maternal and reproductive health agenda.

As stated by Ramkisson *et al.* (2010:316) more than half of the people infected with HIV in South Africa are woman and there have been significant developments to intensify admission to counselling and testing, prevention of mother to child transmission of HIV and antiretroviral therapy. Despite these efforts, HIV-infected woman still experience challenges of transmitted infections, access to family planning and contraception, pregnancy, delivery, infant feeding, psycho-social support, counselling and treatment. Worldwide, higher rates of HIV infection occurs in women due to socio-economic, cultural and physiological reasons.

Ray *et al.* (2013:538) posit that there is an emerging predominance of indirect causes, mainly linked HIV and non- pregnancy related infection that leads to maternal deaths. As a result, there is a need for drastic changes in the approach being adopted to avert these deaths. An ill-functioning health system has compromised determinations to improve health in low income countries, even in those well-resourced, middle- income nations like SA and Botswana.

An attitude of frequent quality development through regular audits and the implementation of resolutions thereof are critical for a strengthened health system. Prevention of maternal mortality in regions with a high HIV prevalence necessitates skills development for the management of childbirth, prevention of haemorrhage and sepsis and early identification of hypertension.

3.6 Community Participation in relation to Public Health

Aibunuomo (2011:530) posits that community refers to a local situation implying closeness and which may be characterized by a neighbourhood. At the same time, it implies people who share common challenges and goals. Under this definition, health workers are classified as a community by the virtue of the pressing issues they have in common, one of which is attainment of the MDGs. Community therefore involves reaching consensus on a common end and the regulation of activity in view of that goal.

Juta, Moeti and Matsiliz (2014:1113), note that the principle of community participation (CP) entails an understanding that those who are affected by a decision need to be part of the decision making process. The reason for this is that lack of involvement can lead to unsatisfied and frustrated citizens, which should be avoided by a state wishing to provide efficient services to its citizens. Further, CP should contribute to development efforts in communities by empowering community members, implementing poverty alleviation strategies and fostering partnerships between stakeholders.

According to Kondlo (2010:384), South Africa has a very useful tool for strengthening democracy in the form of the *izimbizo* (public forums) but that this tool is not being utilised appropriately. In fact, the *izimbizo*, in their present form, are a travesty of the good. This is primarily because they are usually a top down strategy due to the fact that government employees and political principals impose their opinions at these forums instead of listening to the people on the ground.

The status quo at these forums needs to be changed if the government wishes to make significant progress in achieving the SDGs. As McNeil and Malena (2010:64) state, citizen participation increases the sustainability of local level development projects and improves community skills to analyse and prioritise problems. It also ensures that previously disadvantaged individuals, especially women and youth, are included in both allocation of resources and in decision making concerning issues relating to their life and future.

3.7 Impact of Tradition and Culture on Maternal Health

According to Moshabela, Zuma and Bernard (2016:86), South Africa is regarded as being unanimous in diversity yet the rich diversity of culture, race, language, ethnicity and religion presents challenges for the country's social dynamics. Malunga (2012:3) affirms this by saying the African cultural heritages suffered from a culture of non-documentation. African culture was passed on from generation to generation through oral instruction, stories, mythologies, rituals, ceremonies and customs. With increasing exposure to the other cultures which are well documented and actively promoted by their owners, the African cultures has been increasingly weakened, leading to confusion, doubts and misunderstanding among modern generations of Africans. African traditional cultures have generally failed to consciously analyse and adapt to changing environments.

3.7.1 Culture

Crowder (2013:107), states that, a culture is a set of beliefs and values that is held in common by a group and that identify it as a group. For a culture to exist "there must be a shared vocabulary of tradition and convention". People are intimately identified with the language, culture and values in which they are brought up with, and in which they live. According to Bacote (in Lippincott, 2010:130), culture is defined as the information, confidence, art, ethics, rules, customs and any competencies and habits learned by humans as members of a community.

Lippincott (2010:7) further explains culture as learned outlines of conduct, principles and standards that are shared by a particular group of people. Knowing the cultural and social implications that specific circumstances have for patients will assist the health worker to avoid imposing his/her own value system when the patient has a different point of view.

Cockerham (2011:115) agrees that culture has a crucial role in the way well-being and illness is seen by a population. Cultures are standards for life that have been handed down from one generation to the next in the form of philosophies, customs, behaviours and traditions including aspects such as foodstuff, clothing, automobiles and various other items. According to Niehof *et al.* (2010:2), women usually occupy an inferior position in the households, which negatively influence their negotiating influence in sexual relations.

This makes women to become vulnerable and victims during promiscuous behaviour. Women with low level decision-making autonomy in the household are not only at risk of being infected by their partners but may also find it difficult to translate health enhancing knowledge into preventive action, argues Niehof *et al* (2010).

As stated above, culture is closely related to traditional practices and Moshabela *et al.* (2016) state that in South Africa there is a notable pattern of using the traditional health system, comprising both indigenous and religious sectors. However, there is no collaboration between donor-driven programmes for MDGs and traditional practices, leading to misunderstanding between western and traditional practises in the country (Malaudzi *et al.* 2016).

3.7.2 Traditional Medicine

As stated by Mbatha (2010:265), most people (as high as 80%) in low income countries, especially on the African continent, still use traditional healthcare for issues relating to their health needs. Traditional healers are represented by a plethora of practices that include herbalism and spiritualism, with a range of practitioners who call themselves diviners, priests and faith healers among other terms. In South Africa alone it is estimated that 70% of people utilise the services of Traditional Health Practitioners (THPs) before consulting the health facilities, despite this fact, there are no clear lines of communication between the Western health workers dealing with MCWH and the Traditional medicine especially as this is the first line of health care (Malaudzi *et al.* 2016).

Moshabela *et al.* (2016:85) state, that Traditional Health Practitioners in South Africa are increasingly acknowledged as essential providers of health care and the National Department of Health is taking firm steps towards the formal regulation of THPs. However tensions continue to dominate the landscape of research and policy debates on the role and practices of THPs, particularly with respect to historical injustices, gaps in scientific evidence, mistrust on the part on biomedical practitioners and toxicity of medicines. The SA Health review 2016 report that progress in relation to the effective operation of Traditional Health Practitioners Council has been slow. A necessary step was taken in November 2015, with the publication of draft regulations relating to the Traditional Health Practitioners Act 2 (22 of 2007).

The proposal states that a student in divination or herbalism must be at least 18 years of age, and a student in traditional birth attendant practice or traditional surgery (circumcision) should be 25 years old at registration in order to practice.

Violari and Cotton (2008) state that in order to achieve the SDGs, there is a great need for integration and collaboration between traditional and western medicine in the fight against HIV/AIDS and overall strengthening of the health care system. It is estimated that there are 150 000 to 200 000 traditional healers in SA with the healer to population ratio estimated at 1:200. A careful examination of the role of healers in SA in the management and prevention of HIV/AIDS will provide valuable information. There is also a need to train traditional birth attendants on health procedures with new born, submits Mbatha, (2010:269).

South Africa will need to pay special attention to the issue of traditional medicine, firstly because it is clearly being preferred as the first option of health care in many regions and secondly, because participative decision-making and training between the western and traditional medicine can result in improved achievement of health goals.

3.8 Male Involvement in Maternal Health

Cultural and gender norms in low-income countries allow men to have dominion over women. This renders it difficult for females to make decisions relating to sex, use of condoms, clinic visits, family planning and sexual reproductive health as they fear rejection and gender-based violence from their partners should they not agree. In some instances females are unable to access HIV testing services and antiretroviral treatment because their partners do not allow them to have access thereto, argues Van der Berg, Brittain, Mercer, Peacock, Stinson, Janson and Dubeka, (2015:2).

According to Ganle *et al.* (2014), young women and teenagers perceived that the husbands are most influential in decisions relating to whether the wife should attend antenatal and/or delivery care. On the other hand, older women between the ages of 25 to 34 take their own decisions relating to whether to utilise antenatal care services or not. This however differs among countries and is greatly dependent on culture and health systems. Nesane, Maputle and Shilubane (2016) concur, stating that males often dictate to women, as they consider themselves to be the head of the family. This sometimes extends to telling them, whether or not to use family planning services, how to dress, what and when to eat and allocation of transport money and time to utilise the health facility.

Van der Berg *et al.* (2015:3) state that men do not want to attend HIV testing and sexual reproductive health services because these are perceived as being ‘woman’s affairs’. Men do not accompany their partners to antenatal care services stating that culture does not allow men to attend clinics because they are seen as weak. Over and above this, policies in Southern Africa and other low-income countries have placed focus and emphasis on women as being the champions in the fight against maternal and child deaths thus excluding men, leading them to feel they have no role to play. This is most unfortunate for the countries concerned. While these policies have had a positive impact and are effective in many ways they have nonetheless unintentionally excluded the role males and couples can play in reducing maternal and child mortality.

As stated by Sullivan and Hirst (2011:907), gender inequality resulting in repeated child bearing and violence towards women, poor sexual and reproductive health education, poor service delivery and inaccessible services, all increase the potential for maternal, infant and child death. Meanwhile insufficient, unpredictable funding and inaccurate, outdated evaluation methods prevent provision of effective, targeted programs. These challenges are frequently compounded by additional social, political and environmental factors. It is clear that gender norms still play a crucial role in health service provision and acceptance because women still have greater challenges in accessing social and reproductive services than their male counterparts, maintains Aibunuomo, (2011:539).

Therefore, it is important to overtly ensure the involvement of men in all activities and programmes that affect women and children in order to get buy-in and support that is required to decrease maternal and child mortality.

3.9 Conclusion

It is clear that MDGs would not have been met by 2015 as planned in 2000 but there have been some improvements throughout the world. The HIV epidemic has affected progress on most of the MDGs especially MDG 5, as it is reported that most deaths that took place were related to HIV. Maternal Mortality is reported to have been reduced in most of the countries including the Sub-Saharan Africa. The post-2015 agenda will have to be inclusive of all health-related goals. Sexual Reproductive Health needs to be strengthened especially in the low-income regions.

This chapter has provided the context for the study by placing the study within the context of the South African healthcare system in a post-apartheid country. The inherited challenges associated with the transition from a segregated to a united country were explained and the impact of the legacy of that era was described. The role of the Millennium Development Goals and Sustainable Development Goals in achieving improved health outcomes for women and children was explained. Consideration was given to how culture and tradition, especially in relation to Traditional Healthcare Practitioners and male involvement in general, impact on the attainment of these goals. In the chapter that follows the research methodology adopted in undertaking the study is described.

CHAPTER FOUR - RESEARCH METHODOLOGY

4.1 Introduction

This chapter expounds on the detailed research methodology adopted in the study, which , includes the research design sampling strategy, population and target population, sample and sample size, data collection instruments, in-depth interviews, document collection, data analysis, ethical considerations and possible limitations to the study. These were discussed in detail in the sections that follow.

4.2 Research Methodology

Methodology refers to the overall rationality and theoretical viewpoint of a study. Different methodologies reflect sets of ontological and epistemological suppositions. Research methodology is important because it gives guidance when choosing research approaches (Long 2014:428). There are generally accepted to be two broad categories of research methodologies namely; quantitative and qualitative which are used to inform data collection, analysis, interpretation and validation (Creswell, 2014:5). However, according to Lund (2012:156) there are three methodological categories, that is, quantitative, qualitative and mixed method. Long (2014:429) connotes that quantitative research involve measurements and statistics, whereas qualitative research employs observations and interviews. Mixed method on the other hand combines both the aforementioned methods.

The qualitative approach was adopted for this study, which included the utilisation of primary and secondary data. These took the form of in-depth interviews and document collection (journals, government circulars and policy documents) respectively in order to explore the issues related to causes of maternal deaths and community involvement in maternal health issues in UMgungundlovu District as they relate to the research question and objectives of the study.

In qualitative research, the focus is on exploring the phenomena from the perspective of participants, while also investigating their behaviour and perceptions in order to get sense of how the participants express themselves in relation to the issue at hand (Lapan, Quartaroli and Remiers, 2012:3).

According to Cresswell (2014:4), the qualitative approach tends to search and comprehend the meaning persons and groups attribute to social problems. Taylor, Bogdan and De Vault (2015:7) concur that “qualitative research refers in the broadest sense to research that produces descriptive data – people’s own written or spoken and observable behaviour”. However, O’Leary (2014:131) argues that the qualitative research methodologies are sometimes maligned for not reaching standards of credibility because occasionally it can be influenced by the researchers’ opinions.

According to Fossinger and Morrow (2013:75), qualitative tactics heighten the connection and discussion between researchers and participants in their communities thus empowering citizens to voice their opinions and views freely. McCusker and Gunaydin (2015:542) on the other hand states that qualitative research is characterized by appreciating some characteristics of social life, and the way the community identifies and perceives a certain issue. This study suits the qualitative approach in that it will explore the “Why? How?” of the phenomena thus ensuring that a comprehensive understanding is reached.

4.3 Research Objectives and Research Questions

The primary objectives of the study are to investigate evidence in improving maternal health services, review progress made on MDG 5 and establish the role being played by the community to improve maternal health in UMgungundlovu District.

Cresswell (2014:139) states that “a research question points to what will be learnt or be answered in the study”. The research question is the main question, issue or argument that was explored in a study and serves as a focal point for the paper (Wheldon and Alhberg 2012:155). Brynam (2015:7) concurs that a research question is a question that provides an explicit statement of what it is the researcher wants to find out about. Qualitative method was found to be suitable for this study because it assisted the researcher in obtaining detailed information about the participants’ insights and experiences as related to the objectives of the study.

4.4 Research design

The particular design of a study must be suited to the aim of the study. In this study, the aim is to ascertain the extent to which the UMgungundlovu District is achieving the progress in addressing MDG 5 (see Chapter Two).

For this reason, the case study design was chosen. According to O’Leary(2014:194) a case study is a method of studying elements of our social fabric through comprehensive description of a single situation or a case. Yin (2014:16), describes a case study as a pragmatic investigation that explores a current phenomenon in complexity and within its actual world framework, trying to lighten a choice or set of decisions. Thomas (2011:3) concurs stating a case study method concentrates on one thing, looking at it in detail, not seeking to generalise from it.

A case study is a process in which detailed consideration is given to a particular group, and enables the researcher to develop a comprehensive analysis of a case (Creswell, 2014:14). A case study investigates a contemporary phenomenon in its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident (Yin 2014:2).

This study is therefore well-suited to the case study design as the purpose is not to obtain generalised results, but rather to understand the reasons for the phenomenon being experienced in this one geographical area (Yin, 2012:21). The design enabled the researcher to build good rapport with the research subjects and provided flexibility to re-examine data or follow up with participants should it be necessary to do so.

4.5 Target population

This is the population to be investigated, and about which conclusions are to be drawn. Such a population need not necessarily consist of people, but people are needed to provide responses (Bethlehem, Cobben and Barry, 2011:26). The study was done in the rural area of Impendle, a local municipality in UMgungundlovu district. As stated in chapter one UMgungundlovu has seven local municipalities. The sample was drawn from the population of African Zulu males and females, all residing in Impendle local municipality.

This local municipality has four wards and three health facilities as mentioned in chapter one. In total fifty seven participants were interviewed for the study. The ages of the participants in the sample ranged from 15 to 60 years. The sample included eight women who were pregnant at the time of the interview three healthcare providers, four traditional healers, three political ward councillors and forty community members. All the participants except for two healthcare workers indicated that they had been born and grew up, and were still living in Impendle area, UMgungundlovu District.

No real names of participants were used except that pennames were allocated to them to ensure anonymity is maintained throughout the study. The private rooms for interviews were prepared beforehand and there were minimal disturbances, such as noise, because in some areas such as clinics consulting rooms were used, and as a result, nurses could come in to fetch some documents.

4.6 Sample and Sample size

A sample is subset of the identified target population usually with the implication that the subset resembles the population closely on key characteristics (Sapsford, 2011:7). Ingham - Broomfield (2011:48) states that subjects of survey research may be called participants, informants or subjects. Samples may be selected using purposive or random sampling methods. Census sampling and purposive sampling were used. Census sampling means selecting all units in a group (Silverman 2011), in this study, the participants were chosen on the basis that they were the citizens of the Impendle Local Municipality. Purposive sampling means units are chosen with a purpose in mind; in this case the employees in the clinics of the area, the healthcare providers chosen were the ones dealing with maternal health issues in their respective areas (Babbie and Mouton, 2011:178).

Non-probability sampling was chosen for a study where nomination of people depends on the researcher's decision. The sample for this study comprised the maternal health clinic managers, ward councillors, pregnant women and traditional health practitioners. In this study, the focus was on health management and the community at large.

The participants that were selected for the study were three clinic managers, representing three wards out of four, because there are only three clinics in the area, the four ward councillors were selected but only three participated in the study and four traditional health practitioners, one representative from each ward representing the four wards. The researcher aimed to interview fifteen pregnant women but only seven ended up being selected on a first come first served basis, that is, the researcher selected the first two clients in two clinics and three on the third one, who attended the antenatal clinic on that day. Four focus groups were conducted, with ten community members per group, totalling forty participants. This selection process ensured that all the wards were represented in the study, so that different views could be recorded and compared. The total number of participants was fifty seven.

4.7 Data collection methods

The data collection process includes gathering and measuring of information by means of unstructured or semi structured observation and interviews, documents and visual materials in order to answer significant questions and evaluate outcomes (Creswell 2014:189). The researcher selected to use three qualitative research techniques because they are in line with the selected methodology. These permitted the researcher to access the views and experiences of participants in the study. The three methods used in the study are the semi- structured in-depth interviews, semi-structured focus group discussions and document collection. Each interview lasted between 30 and 40 minutes. All interviews were recorded using a voice recorder, and later, transcribed verbatim.

4.7.1 Semi-structured in-depth interviews and focus group discussions

According to de Vos, Strydom, Schulze and Patel (2011:342), an interview is a social liaison intended to interchange data or facts amongst the participant and a researcher. The first stage of the interview process is the briefing of the interviewers to ensure standardised performance within a framework of apparently natural behaviour, there is also a need to think about how the interview will be managed (Sapsford, 2011:126), although this was not necessary for this study as the researcher was the only interviewer.

Fossinger and Morrow (2013:75) further state that the interview decorum should be critiqued for the validity of cultural perceptions, significance to participants, capability to offer rich explanation, and suitability to participants' educational standard and language. Cresswell (2014:190) agrees stating that interviews comprise unstructured and normally few open ended questions, with an aim to prompt expression of views and opinions. In the semi structured in-depth interviews, the researcher engages through face-to-face or telephonic interviews with the participants (Richard, 2010).

Semi-structured in-depth interviews were selected for data collection from three clinic managers, three ward councillors, seven pregnant women and four traditional health practitioners comprising a total of fourteen participants. The researcher collected data using tape recorders and took down detailed field notes. Permission to use the tape recorder was sought from each participant. This process was designed specifically to collect data on factors relating to MDG 5 processes over a period of two to four weeks.

A focus group is a collaboration of group opinion resulting from an interaction and discussions between participants in order to gain information about a specific issue (Arthur, Waring, Coe and Hegdes, 2012:186). These deliberations were used precisely to draw upon the participants' attitudes, feelings, beliefs, experiences, and reactions on maternal health issues. The researcher selected and conducted these discussions to ten members from each of the four wards. A total of forty community members were interviewed over a period of two weeks. The researcher used tape recorders and took down detailed field notes to record the collected information. O'Leary (2014:221) states that following steps should be observed during the interview process:

4.7.1.1 Planning

This process can help make or break the process and can either alleviate or exacerbate the problematic circumstances that could potentially occur when conducting the data collection. According to O'Leary (2014:219) before the interview, the researcher must dress appropriately, be prompt, choose the right approach and be modest. Knowing the target population, the researcher's role and the potential language or cultural barriers is also important. In this study, the planning process started with the researcher communicating with the healthcare providers and the municipal structures requesting appointments and the venues for conducting the interviews. The researcher ensured that the dress code is appropriate especially because the study was done in the rural area.

4.7.1.2 Selecting the participants

According to DiCicco-Bloom and Crabtree (2012:317) the selection of participants should be fairly homogenous, meaning there need to be certain key characteristics of the participants that are the same while others are not the same and the group should share similarities related to the study. For in-depth interviews, the participants are founded on iterative progression known as purposeful sampling that pursues to exploit the complexity and effectiveness of data to address research questions. In this study, the participants were selected on the basis that they are the citizen of Impendle Local Municipality or the employees of the area for the healthcare providers.

4.7.1.3 Constructing an effective research question

This involves conscripting and reworking on the questions and to think about themes and restrictions that might be challenging during the discussion (O’Leary, 2014:222). Utilising the research questions to guide your questions implies that the researcher has done a detailed evaluation of the literature and that he/she recognizes what other scholars say about the people being studied (Jacob and Ferguson, 2012:2). In this study, the researcher drafted the interview questions ensuring that they are in line with the research question and objectives of the study.

4.7.1.4 Implementation

According to O’Leary (2014:226) there is a need during the implementation process to continually check if the tape recorder is still functional, ensure only one question is asked at a time, the researcher should be neutral, ensuring that the interview is focussed. The researcher ensured that the tape recorders were fully charged at all times.

4.7.1.5 Conducting and analysing data

The interpretation of data is done through a generated system where responses are coded and quotes are noted in order to come up with a sense or meaning of the data collected (Sauro, 2013:302). O’Leary (2014:224) posits that the researcher needs to align what has been uncovered and assemble the data into segments of information, and state that the challenge of working across one or more interviews is to draw out themes both expected and unexpected. The data needs to be collated as soon as possible. Data transcription was done at the end of each interview. The audio tapes were very essential during transcription of data. The questions were asked using IsiZulu and the researcher did not find any difficulty in translating the collected data into English as she is used to converting materials from IsiZulu to English.

4.7.2 Document Collection

According to Greener (2011:78), document collection includes going through volumes of paperwork or computer files to get an understanding of what is being studied.

Different documents speaking to maternal health issues and MDG5 was collected such as annual reports, District Health Information System, internet, leaflets, literature review and circulars in order to obtain information available on these issues. In this study, the document collection was related to documents that were specific to the area of study, that is, UMgungundlovu District maternal health issues.

4.8 Data Analysis

Qualitative data analysis is the non-numerical scrutiny and clarification of observations and interview transcripts with the aim of determining fundamental connotations and patterns of relationship (Babbie and Mouton, 2011:391). Lapan *et al.* (2012:98), assert that analysis of qualitative data progresses through classification of ideas, themes, topics, content and activities relevant to the study. According to Fowler (2014:1), the main way of collecting information is by asking people questions and their answers constitute data to be analysed.

In this study, in-depth interviews will be scrutinised utilising the thematic analysis, that is, the classification of themes collected from the data and the recordings. Documents will be evaluated using content analysis, which implies coding and categorising data in order to make sense of the data composed and to produce highlights. The researcher will categorise and edit the data to generate comprehensive results.

4.9 Ethical considerations

Creswell (2014:92) states that researchers must protect participants and establish trust with them, uphold the honour of research, and guard against misconduct and indecency that might reflect negatively on their institutions. According to Neuman (2012:145) ethics means integrities, consciences, principles, dilemmas, and conflicts that need to addresses that may arise due to proper or improper manner in which research is conducted research including its legitimacy.

Ingham-Broomfield (2011:49) states that consent should be obtained before the study begins. The researcher is obligated to reflect on the consequences of the proposed study for the participants and individuals and community at large.

Ethical approval for this research was obtained from the University of KwaZulu-Natal Ethics Committee and a gate keeper's letter was received from the UMgungundlovu Health District.

The researcher gave all participants a written declaration that research ethics would be practised. It was also explained to the participants that ethical issues, such as the right to participate voluntarily and the right to withdraw at any given time, would be ensured at all times. All the participants were required to sign an informed consent letter which contained information about the study which enabled them to make an informed decision about participating.

The participants were informed that certain information deemed to be private would not be included in the final dissertation to ensure anonymity and confidentiality. The participants were well-versed of their right to withdraw from the study should they feel the need to do so, as well as their right to voluntarily respond to a question(s) or to decline to answer should they prefer not to.

The researcher used a tape recorder and detailed field notes for semi-structured in- depth interviews and focus group discussions. Permission to use the tape recorders was acquired from the participants after explaining that the use of such equipment would ensure the authenticity of the research undertaken.

4.10 Limitations of the study

As with all case studies, the research reported here has certain limitations. This is because the study did not aim to deliver statistically significant, generalizable findings, but rather sought to describe the lived experiences and perspectives of matters about maternal health, of a small rural community. The findings can therefore not be generalised and should be contextualised within the Impendle region.

It could be argued that the study would benefit from the inclusion of more community members or professional stakeholders working in the area of maternal health. It could also be expanded to other study areas. This would offer a more detailed description of prevalent perspectives on maternal health, which would be of further assistance to local and provincial government when planning intervention strategies, which target improved maternal health.

4.11 Conclusion

This chapter provided detailed explanations of the design, methods, approaches and processes that were used during this study. It clearly states the designs and sampling techniques that were utilised including the process of data collection and analysis and why these were chosen. The information discussed was applied to rural Impendle in the UMgungundlovu District in an effort to answer the research questions posed in Chapter One. The importance of protecting the participants in, and the ethical principles followed for the study were made clear and the limitations of the study were highlighted. The chapter which follows describes the findings of the research and discusses the analysis of these findings.

CHAPTER FIVE - RESEARCH METHODOLOGY AND RESULTS

5.1 Introduction

In the previous chapter, the researcher discussed the research methodology which was adopted to conduct the study. In this chapter, the research findings are presented, as they were drawn from the qualitative data from in-depth interviews and focus group discussions. The main purpose of the study was to explore the understanding of the influence of MDG 5 on maternal health issues in the rural community of Impendle under UMgungundlovu District in KwaZulu-Natal. The chapter outlines certain crucial findings of the study.

5.2 Themes emerging from data analysis

Four themes emerged from the data analysis, namely: understanding maternal health, factors affecting maternal health, community participation in maternal health and programs towards the improvement of maternal health. These themes were then further classified. Table 4.1 indicates the themes and their classifications.

Table 5.1 Themes related to maternal health

| Themes | Classification |
|---|---|
| 5.1.1 Understanding maternal health | 5.1.1.1 Maternal health 5.1.1.2 Maternal death 5.1.1.3 Millennium Development Goals |
| 5.1.2 Factors affecting maternal health | 5.1.2.1 Access to maternal health 5.1.2.2 Religion and traditional beliefs |
| 5.1.3 Community participation on maternal health | 5.1.3.1 Male involvement 5.1.3.2 Community health workers 5.1.3.3 Political leadership 5.1.3.4 Community education and information |
| 5.1.4 Programs towards improvement of maternal health | 5.1.4.1 PMTCT and CARMMA 5.1.4.2 Family planning 5.1.4.3 Termination of Pregnancy |

A discussion of the salient themes follows:

5.3 Understanding maternal health

Discussions and interviews with participants showed a similar understanding of maternal health issues among all participants. It was quite clear that most participants were in agreement that maternal health should be considered a priority and that pregnant women should be taken care of. The questions sought to ascertain how much knowledge the participants had on maternal health, maternal death and related Millennium Development Goals.

5.3.1 Maternal health

All participants were asked to define maternal health in order to gain insight into their understanding of the term. As defined in Chapter Two, maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. This question was generally not answered as required; as participants mostly focused on the expected behaviour of a pregnant woman.

“Maternal health is the health of a pregnant woman until delivery.” N3

“It is the health of a woman during pregnancy and labor.” N2

The general feeling was that a pregnant woman should be healthy, eat well, get some rest and attend the clinic as required, as highlighted below.

“Go to clinic as soon as you suspect pregnancy to start ANC. Mothers need to take care of themselves during pregnancy, eating the right food, avoiding alcohol and drugs, getting enough rest and being treated well in the family. Other people wait until they come for delivery, having not attended the clinic.” F3

“Mothers need to take care for themselves during pregnancy, eating the right food and getting enough rest.” F4

Some participants expressed concerns and stated that the pregnant women should do HIV tests.

“Taking bloods for diseases including HIV, as these will assist in delivering a healthy baby. Doing tests and starting treatment. There is a need to eat healthy food. Are we talking about girls or women? There’s a difference because our children hide pregnancy using belts to tighten the abdomen thus not attending clinic in time.” F1

From the statement below, it can be said, that while many participants spoke of healthy living during pregnancy, some participants were more focused on things that a pregnant woman should avoid during this period. Participants were very clear that a pregnant woman should avoid alcohol, drugs and over the counter medications. Others stated that if a woman is pregnant she must answer questions truthfully at the clinic regarding the things that she is consuming during pregnancy. There were some arguments though when it came to the issue of *izihlambezo* (a traditional herbal medicine that is believed to cause induction of labor thus preventing prolonged labor). While some participants felt like *izihlambezo* should be avoided during pregnancy, others were adamant that *izihlambezo* should be consumed during pregnancy.

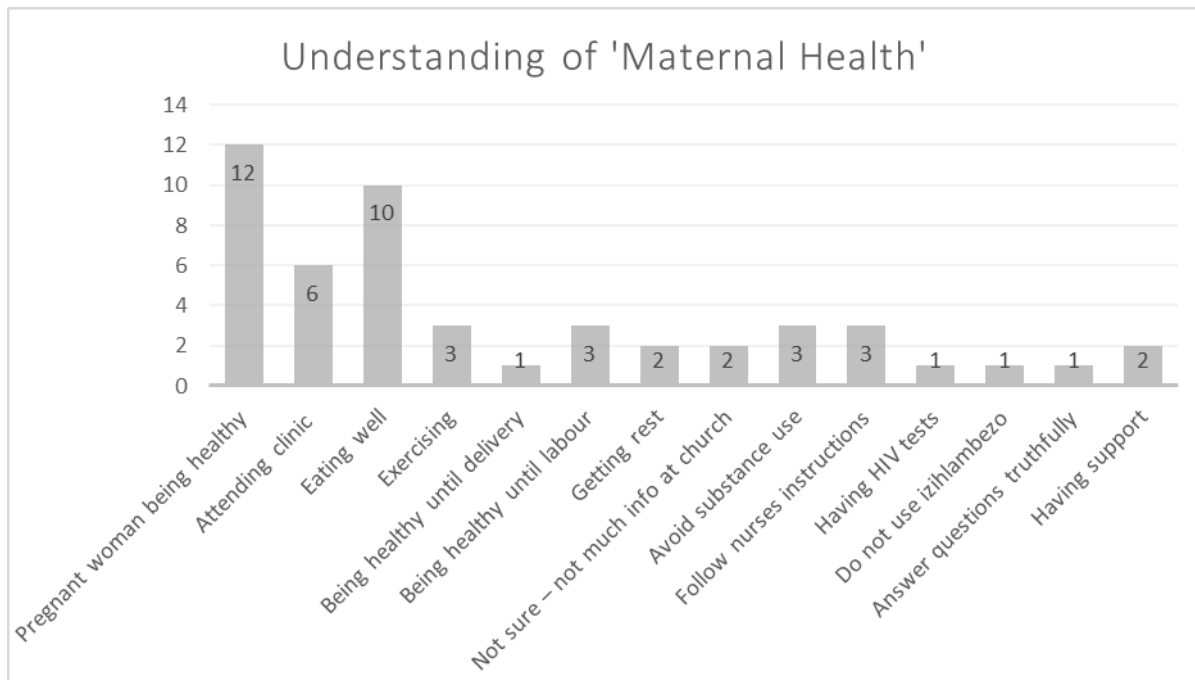
“The pregnant woman should avoid using alcohol, drugs and medicines that are not prescribed by the nurses at the clinic like izihlambezo.” F2

For some participants, the focus was not only on the pregnant woman but also on the unborn child. Participants stated that if the mother takes care of herself during pregnancy, the child will also be healthy following delivery.

“Maternal health means to live healthy life for baby and for herself. Child may be unhealthy during delivery and after birth if the mother did not care for herself.” C1

Figure 4.1 below indicates the aspects of maternal health that were mentioned by study participants. It can be seen from the discussion that most participants consider maternal health concerns to cease at the time of birth. It was of concern that of the behaviours mentioned by the 21 participants; only 6 participants felt that attending clinic was an essential aspect of maternal health and wellness.

Figure 5.1: Aspects of maternal health given in response to question to explain the concept.



5.3.2 Maternal death

As explained in Chapter Two, maternal death is the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The study showed that participants generally do not understand the term maternal death. Participants were talking about death during pregnancy and a few of them made reference to death during or up to labour. No participants mentioned that it is the death of a woman up to 42 days after delivery, while 20 of the 21 participants mentioned death of a pregnant woman and only 7 mentioned death during or shortly after labour.

“It is a death of a woman during pregnancy, labour and immediately after delivery.” N2

“Maternal death is a death of a woman during pregnancy and delivery.” F2

Some participants were more focussed on the fact that maternal deaths occurs mostly to teenagers because their bodies are still young, thus could experience health and risk challenges. It was also indicated at times, that teenagers hide their pregnancy from parents and teachers until it is too late to obtain assistance from the clinic. The participants indicated that most teenagers find ways to conceal their pregnancies which could lead to complications.

“Dying of teenage mothers because they are young and don’t know what they are doing. It also means dying during labour. Some people die because of taking wrong things during pregnancy.” F3

“It happens especially to teenagers because they hide pregnancy thus avoiding ANC leading to death. They hide from parents.” C1

“Ambulance delays, clinics too far. Hiding pregnancy like me, I was afraid to tell my grandmother and that teachers will see me at school so I have been hiding it. I was also scared that nurses will scold me. I only started clinic at 8 months, I am 9 months now. They found that I have high blood pressure.” P6

While most participants tried to define maternal death, for many, the focus was more on the causes of mortality. Participants reported instances whereby abuse of their bodies caused by alcohol intake could lead to deformities and death of unborn children. Diseases like HIV and high blood pressure was indicated as one of the major causes of maternal deaths.

“Alcohol in this area is seen consumed by females too much. Delay in taking medicines or taking wrong medicines during pregnancy which will then interfere with the normal process. Being a teenager is a risk because the body is still young. People attending the clinic late leads to missed opportunities.” C2

“Not eating well, high blood pressure, diseases which could have been detected early if she attends clinic.” T1

Interviews also revealed that ambulance delays and the distance to clinics were some of the causes and contributory factors of maternal deaths. There was an indication that emotional trauma, especially for teenagers who are young and not ready for the additional responsibility of being a parent, may also lead to deaths.

“Some of them take Izihlambezo not as instructed. Some are not educated enough on how to handle pregnancy. Not done tests. If you not taking treatment as required or you don’t want to be put in the delivery position as instructed by nurses during labour you may die. Stress due to challenges at home or separation from partner.” F2

“Maternal death can be due to High BP leading to dizziness and collapse. Transport or ambulance delays leading to death. Emotional trauma which may be due lack of support. Teenager might lack knowledge of what to do during labour.” C3

In addition, it was revealed, that stress and emotional trauma were noted among pregnant teenagers due to fear of their teachers, nurses and parents. The discussion revealed that some teenagers hide their pregnancies until it is too late to receive treatment to prevent diseases and reduce complications. It was clear that the focus of the participants with respect to maternal death is on the pregnant mother, while the possibility that a woman may die after child birth is not seen as related to ‘maternal death’ or posing a high health risk.

5.3.3 Millennium Development Goals

As stated in Chapter Two, MDGs are a set of eight goals that are easily understandable and which were established to deal with poverty, starvation and diseases, as well as issues of education, gender disparity and environmental ruin. The MDGs assist to encourage universal consciousness of social issues, political answerability, social response and community pressures (Sachs, 2012). South Africa is a global leader in the fields of HIV and TB, with the world’s largest antiretroviral treatment programme and an approach to the response that is multi-sectoral, built on the synergistic collaboration of government, civil society and the private sector. The most important level of leadership that need to be strengthened is at community level. Wards or groupings of wards constituting well-established towns, villages or townships must be empowered to lead. Basically for the healthcare sector to improve and diseases to decrease in communities, there is demand for empowered leadership in all spheres of government(national, provincial and local) as well as communities, the private sector, organised labour, civil society, academics, researchers and most importantly healthcare users National State (National Strategic Plan 2017-2022).

Interviews with people of Impendle including, political and general leadership of the area suggested that while the MGDs were established some 15 years ago, they are still not clearly understood by the community at large. Some participants reported having heard about it on the radio or television but were unable to give details on what exactly the MDGs entail. None of the participants were able to list all the MDGs when asked if they knew any, although some were able to mention poverty and HIV reduction. Only one participant was able to mention specifically that MDG 5 speaks of maternal health.

“Not fully understand it, there’s a need to fulfil some goals. The government say they need to fulfil some things. The MEC for health also talks about it, to say the department of health should move from this level to the next.” C1

“It talks about what government does to prevent poverty in the community and protection of mothers and children. MDG 5 talks about prevention of death of mothers and their children. Not able to actually list them.” N1

A total of 12 of the 21 participants (57.1%) stated that they had no idea what the MDGs were or had never heard of them. The remaining participants generally associated MDGs with HIV and other diseases.

“No one ever told us about MDGs. Who was supposed to tell us?” F1

“I have never heard of it.” P1

“I think those are goals to fight poverty and diseases. Don’t know how to list them.” N2

Generally, the MDGs were poorly understood by all participants and as a result the significance of the goals in terms of achieving improved maternal health was similarly not understood. Overall, participants displayed a very basic understanding of maternal health and it was clear that the majority had limited access to more in-depth information on the topic.

5.4 Factors affecting maternal health

Whilst asking the participants about the concept ‘maternal health’, many described health or lack thereof, in terms of the factors that result in a pregnant woman being either healthy or unhealthy. In this section, the main factors that were identified by participants are further explored.

5.4.1 Access to Maternal health services

For women to have the ability to access and utilise maternal care services, there must be adequate supply of these services. In South Africa, maternal health services are available free of charge in public health facilities, including primary health care. This does not, however, mean that all expectant mothers have access to these services due to various barriers to access. A discussion follows of the various aspects.

5.4.1.1 Service availability and access

Interviews with the community revealed that access to health care services is inadequate in Impendle local municipality. The interview data showed that out of four (4) wards in the area, there are only three (3) primary healthcare facilities with 14 out of the 18 participants interviewed (77%) mentioning that accessing the clinic is difficult due to distance and lack of transport. In addition, there is no hospital in the area and only one (1) of the clinics is open 24 hours a day, with other clinics closing at 16h00.

Over half of the participants (10/18) cited the lack of access to health care services after hours and over weekends as an area of concern in service provision. The third major challenge that was indicated by participants (9/18) was the fact that the queues are very long in health facilities especially at the Gomane clinic due to its being more accessible in terms of operating hours and being the only health facility in town. It may be that when people go to town for shopping, they attend the clinic on the same day resulting in longer queues

“There are long queues leading to people going back home without being assisted because of the taxis that are leaving the area at a certain time. Some people sit at the clinic from 07h00 to 19h00. Few clinics for the big population, the area of IMpendle has four wards with three clinics. Only one clinic opens 24 hours. We also have staff shortages leading to sitting whole day at clinic. There’s still stigma on HIV in this area so people are afraid to test and disclose. Sometimes people anticipate long queues at clinics and decide to stay at home until it is too late to be treated.” C2

“The clinic is too far, that is also one of the reasons I delayed because my grandmother had no money for transport to the clinic so I had to wait for her payday. There’s no ambulance in this area.” P6

As was highlighted above the issue of transport was regularly mentioned as a barrier to accessing services. It was stated, that if a pregnant woman was in labour, people try to hire private cars to get to Gomane clinic, instead of waiting long hours for the ambulance.

It was interesting to note that the issue of stigma around HIV is seen as one of the reasons pregnant women choose not to attend the clinic. Participants indicated that due to stigma in the area of Impendle, people sometimes do not go to clinic especially pregnant women because they will be required to test for HIV. Previously the HIV unit was separate from other facilities in all the clinics in the area, so it was obvious to all when you were seeking

services related to HIV leading to assumptions and rumours. However, that has changed and all services are provided in one space, a comprehensive service.

“The transport is very expensive to take people to clinics, ambulance not on site. There are long queues at clinics. Stigma on HIV prevents people from going to clinic especially pregnant women because they will be tested. Some people still believe that they are being bewitched when they are sick. Clinics don’t open on weekends.” C3

“There has been some improvement because the HIV Unit is no longer a stand-alone clinic. Clinics close at 4pm thereafter you have to hire transport to go to PMB or Gomane. We have no clinic around; we hire transport or take taxis to clinic.” F4

The concerns raised by participants are backed up by available data on services in the area. These show that the distribution of services, in terms of healthcare facilities is insufficient. For instance ward four (4) is a big area, but there is no healthcare facility. The people from this area have to take taxis or hire private vehicles in order to go to a clinic. In addition, another participant stated that despite staying near the clinic in ward two (2), during the rainy season when the river is full, she and others that stay in that area are unable to cross the river. They are then forced to take a taxi to Gomane clinic, which is further away from her area of residence.

“Transport to go to Gomane for a woman in labor is between R40 to R60 from here. Ambulance takes long to arrive. If you are near your time of delivery, it’s better to go to areas in town where there are many clinics and hospitals. Clinic here close at 4pm. No money for pregnant woman to take a taxi to Gomane or Pietermaritzburg for delivery.” T1

“The clinic closes early at 16h00, even earlier on Fridays. Have to hire a car which cost about R300 or more to take you to other clinics at night. There are long queues at clinics. There is shortage of medicines and staff. There is an issue of breach of confidentiality by HIV counsellors. Exclusion of HIV services from other areas leading to stigma. Some people don’t want to go to the clinic because they will be required to test for HIV; as a result they just stay at home. People are not forced to test but nurses say it is easier if it is done so as to know exactly what to treat. I stay on the other side of the river, so if the river is full I cannot access this clinic; I have to take taxis to Gomane, which is accessible but very far from here.” F1

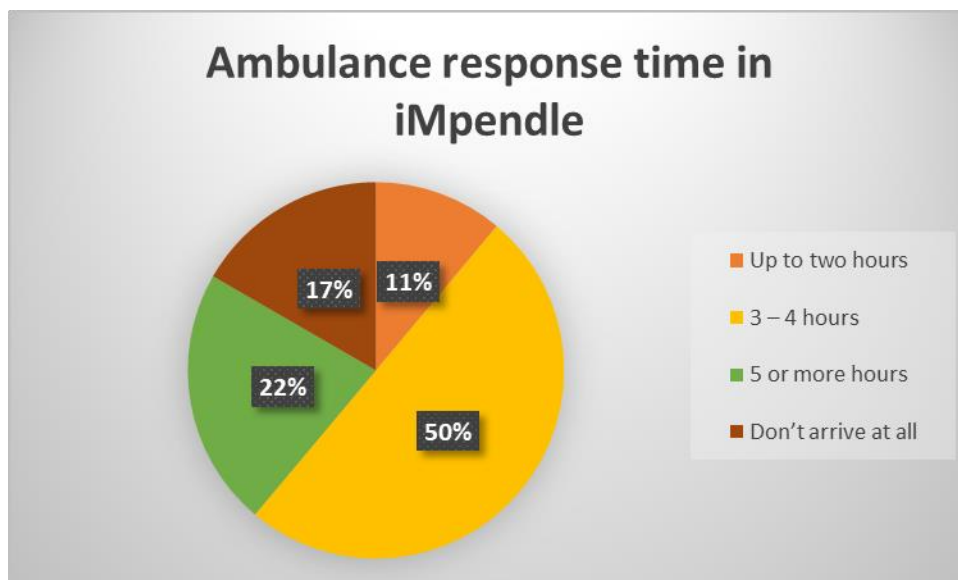
Participants indicated that the people of Impendle are dissatisfied with the lack of health care services in their area. They stated that due to the health care facilities being a long distance from their areas of residence they feel as though they are paying for health services because they are frequently required to hire private cars to get to the nearest, twenty four hour health care facility or are required to go to a private doctor or pay to travel to Pietermaritzburg for ultrasound or x-rays.

Two participants further indicated that sometimes there is no medication at the clinics in Impendle and a person may wait at the clinic the whole day, only to be told that the medication they require is out of stock.

5.4.1.2 Emergency services

Interviews revealed that there is no emergency service base in the area, so when there is an emergency, people reported waiting from two (2) to eight (8) hours for an ambulance to arrive. Interview data also revealed that sometimes the ambulance does not arrive at all (3 participants stated this), especially if the weather is inclement, because the roads are bad. Figure 5.2 below reveals the responses given when asked how long an ambulance takes to arrive.

Figure 5.2: Reported response times when calling ambulance services in Impendle.



Not one of the participants was aware of obstetric ambulances that are specially designed for pregnant women. One may assume therefore that such services are not available in Impendle.

“I have never heard of an obstetric ambulance. It usually takes up to 4hrs, sometimes you can even deliver whilst waiting for one. Sometimes they get lost because we have no straight addresses; we use the nearest landmarks like shops.” P1

“No idea of obstetric ambulance. The ambulance takes more than three hours to arrive. Sometime it takes whole day especially if they know it is a pregnant woman. People deliver before it arrives. My child was in labour, it was raining so the ambulance people said they are unable to reach the area, we had to hire a car to take her to the clinic. At one point, there was snow in the area, the clinics were closed as there were no nurses, my daughter in law was in labour, the car had to rush her to Edendale hospital but we ended up going to Songonzima clinic which is on the way, because it was time for delivery, we couldn't reach Pietermaritzburg, both her and the child were healthy.” F3

“I have never heard of obstetric ambulance. The ambulance takes more than three hours to arrive in this area because it is far.” C1

“Not aware of an obstetric ambulance. The ambulance takes a very long time, even a whole day sometimes.” T2

Furthermore, some participants indicated that sometimes deliveries still take place at home in the area of Impendle due to the fact that ambulances take a long time to arrive or sometimes due to premature labour.

5.4.1.3 Staff attitudes and quality

Some participants reported that they were scolded by nurses for not coming to the clinic early in their pregnancy or for not attending antenatal care classes (ANC). Mention was made by 4 participants, of the lack of staff at the clinics and the poor attitude of staff towards the community. This was confirmed in the interviews with health care providers as they too mentioned that there is a shortage of staff leading to staff being overworked. In Gomane, clinic the issue of overcrowding (leading to long waiting times and lack of proper service) was also stated by the health care providers and this was cited as being due to the fact that it is the only twenty four hour (24) clinic in the area. According to health care providers, most people prefer Gomane clinic over the other clinics, ostensibly because they receive better care and have better access due to operating hours. Gomane is also the only clinic that provides full maternal services, that is, having a functional maternity ward. However, despite having

the facilities, it was stated that even the Gomane clinic does not have an advanced midwife or a 24-hour medical doctor service.

“Only one clinic open 24 hours but it is far for most people. We are fortunate that the 24 hour clinic is in our area but it is always full. If there is a delivery though, all nurses leave their stations and attend to that person, leaving all other clients stranded, but if you go there, to labour ward you find them just talking, only two people will be delivering the baby. Nurses sometimes are just plain careless, few weeks ago a young pregnant woman collapsed at home, was sent to clinic, where she was given only glucose and sent back home, she collapsed again at night and was referred to me (Traditional Health Practitioner), I advised them to take her to hospital, a car was hired and she was taken to Edendale hospital where she was admitted for two weeks.” F3

It is important to understand barriers to health care services in order to improve the quality of health care. The participants stated that the quality of maternal health care offered at health care facilities in Impendle was not the standard that is expected. There was a mention that Gomane clinic does not have an ultra sound or x-ray machines, so if there is a need for these services the clients are referred to Edendale hospital in Pietermaritzburg, which costs a lot of money. When asked what they would like to see improved to ensure quality of care, participants mentioned having an ambulance base in the Impendle area, all three clinics having maternity wards, opening longer hours and having enough staff to provide services.

“The government should hire more nurses, there are so many nurses who were trained but are sitting at home without work yet we are told there is a shortage.” T4

“People like to come to this clinic, even those staying near Mahlutshini and Nxamalala clinics prefer to come here. We have no advanced midwife on site. We have to phone Edendale Hospital in case of there is an emergency. There is no ultrasound on site, as a result, people are referred to hospital or if they have money they can go to the private doctor. No doctors on site during the 24 hour service time. There are staff shortages. There is no laboratory on site, blood results delays from Edendale making it difficult to treat the pregnant woman early for some diseases.” N1

Interviews with health care providers revealed that nurses are trying their best to perform their duties in spite of the fact that there are many challenges facing the healthcare system.

Health care providers stated that there is insufficient equipment and shortage of trained staff. At times, this shortage leads to mistakes in medical service provision due to staff being overworked (as results are tired and rushing) or not having the necessary skills to provide the kinds of services requires. This is especially true when dealing with complications during pregnancy or labour.

“Although I am trained as a midwife but I cannot handle difficult or complicating cases. No equipment or resources for maternity services. There is shortage of staff leading to mistakes at times due to people being overworked. Roads toward the clinic are very bad; muddy gravel, leading to ambulance delays, if it is raining ambulance has difficulty coming here. Too much programmes, you cannot focus because everyone is coming with a new guideline or introducing a new programme.” N2

In addition, some healthcare providers mentioned that due to staff shortages it is very difficult to attend training workshops because that would mean an even greater workload for the staff remaining behind. Interview data also revealed due to healthcare providers being overworked and the resultant stress causing illness, many staff members are frequently on sick leave, again resulting in more challenges for others.

5.4.2 Religion and traditional beliefs

Religion and tradition plays a vital role in the lives of communities especially in rural areas. In Impendle participants indicated that there are some religions which do not allow their members to attend healthcare facilities. The deliveries of babies are done by the elders of the church who are not trained but who do it from experience, having had children themselves. It was also stated that some religions believe in the use of holy water instead of the use of western medications. Amabhidiya is a religious organization or church that has its origins in Impendle local municipality; these congregants are known for wearing red robes. They are believed to use prayer for sickness and do not allow the church members to go to the doctors, clinics and hospitals.

“I am not allowed to go to clinic. I wouldn't be pregnant if I attended clinic for prevention. We are not allowed to attend clinic or take any medication. Some people go to clinic but we are not allowed. We don't use anything except for prayer.” P2

“We are not allowed to go to hospital; deliveries are done by woman inside church. I had a challenge of bleeding on my second child and it was too painful. The child was also bleeding on the umbilicus. Our religion doesn’t allow injection and pills. I decided to come to clinic for this child since the last one had challenges.” P5

“Amabhidiya don’t attend clinic. They don’t even immunise their children. There are those who believe in holy water thus they do not attend the clinic. Sometimes the child has rash but won’t be taken to clinic instead will be smeared by some holy oil. We are seeing Amabhidiya coming to clinics now even though they are still not allowed.” F3

One participant, a teenager, indicated that the reason she hid her pregnancy was because she was a youth member at church so she was afraid to disappoint her pastor and the congregation. In this way, the expectation of religious doctrine can also be seen to affect maternal health negatively.

“I was in the youth at church and that is why I had to hide my pregnancy because I was afraid they were going to chase me away from the group. I have actually disappointed my Pastors.” P6

However, during the interviews, the religious beliefs of the Amabhidiya were the most frequently mentioned. Due to the fact that there is a mission of Amabhidiya in Impendle and many members live in the area, the entire community is aware of their beliefs and practices, particularly concerning not being allowed to attend the health care facilities and relying on prayer for healing.

Traditional practices also impacted on maternal health. During the interviews participants, including the health care providers, indicated that the use of *izihlambezo* was a usual practice in Impendle. It is believed that *izihlambezo* should be taken to ensure optimal delivery of the child. Traditionally, this medicine is taken few weeks before delivery, to ensure its effectiveness. Five (5) out of six (6) pregnant women interviewed indicated that they were taking *izihlambezo*. The other one indicated that she was not taking it but she is aware of it. All four (4) traditional health practitioners stated that there were no side effects on taking *izihlambezo*, as long as they are taken as instructed.

“Izihlambezo. It is drunk near delivery I started it some weeks ago because it was said I needed to take it before delivery to make things easy. I was given by Granny’s friend, a traditional healer.” P6

“Izihlambezo. It is safe to take. These were taken some years ago even before the Western medicines. People never got sick because of it instead it helps them to be strong and well during delivery.” T4

“Izihlambezo. It is used to clean the uterus thus making it faster to deliver. Decrease period or intensity of pain during labour. Should be taken as instructed otherwise can cause problems.” F3

When asked about the issue of traditional birth attendants (TBAs) in Impendle, there was unanimous agreement that there are no longer any practicing TBAs in the area. Four of the participants mentioned that in years gone by there were TBAs but they no longer practise due to diseases like HIV. However, three participants mentioned that in emergencies, some of the former TBAs may still try to assist.

“There are people who used to deliver people at home. They were doing a great job but with all these diseases in recent times they have stopped the practice. They are still out there but they are doing other side of traditional medicines not delivery.” T2

It was interesting to note that some participants stated that lately there are some members of Amabhidiya, especially pregnant women and/or children who go to the health care facilities and seek medical assistance, ignoring the church’s instruction.

5.5 Community participation on maternal health

Communities are engaged as either passive or active recipients of health services. Empowered communities are engaged through a capacity-building process to plan, implement, and evaluate the quality and provision of services as required. In the area of Impendle, however, there was a general feeling that the community has not been involved in maternal health issues. Participants complained that there were no awareness campaigns or even booklets or pamphlets relating to maternal health available.

5.5.1 Male involvement in maternal health issues

Interview responses indicated that participants feel that there is a role for men to play in maternal health issues. It was interesting to note that 18 out of the 23 participants mentioned that male figures should be involved in the pregnancy in some way while only 11 mentioned the role of the other female figures in the process. Further male participants indicated that primarily, men should give financial support to pregnant women, so that they can buy the food that they crave and need to maintain a healthy pregnancy. Only one participant mentioned that the men should assist with house hold chores when the woman is pregnant so that she can get enough rest. It would appear that the general feeling is that men should be involved and that their involvement is primarily to ensure that the pregnant woman is financially supported.

It was interesting to note that two participants made it clear that it is not the place of males to attend the clinic or delivery with his partner as this is not culturally accepted. In this regard, participants felt that women should support each other more closely because they have been through pregnancy themselves, they know what to do.

“All females should be involved; they are ones who become pregnant. Males can be involved also for support. Males are not supportive though, the minute you become pregnant they leave you.” P4

“Men must buy food as craved by pregnant woman. Men should allow women to rest and assist them with household chore. Men must just give money as needed. A man must not have sex with a pregnant woman after seven months to avoid bad omen that might happen to both the mother and the child.” F3

“Males can play a role to teach even neighbours children how to behave. Grandfathers can support children.” P1

Two participants (both pregnant women) mentioned that too often men refuse to take responsibility after impregnating a woman and frequently abandon a woman once she falls pregnant. The issue of cohabitation was also raised by a councillor in one of the wards. She stated that people from that one particular village were not placed by the INkosi of the area as is the custom of Impendle, but the sites were bought from someone in the community. As a result, these people do not want to conform to the accepted practices of the area; they are an

isolated community, living a different life and in that area, the roles of men and women are confused.

“An ideal family composition refer to a family with Father, Mother and Children, it does not happen at all times. Boys impregnate girls and leave them, sometimes to go to find work and never come back.” P1

“There is one village in this ward where there is a lot of cohabitation leading to lot of pregnancies.” C2

“The father of the child does not give support. In my case he moved away from here to live with his relatives in Durban, he has started a new school. My grandmother supports me, my parents passed away when I was still in Primary school.” P6

It was also stated that staff at clinics including nurses and doctors as well as the community at large, can play a major role in supporting a pregnant woman, although some community members were sceptical as to the extent of the involvement. The reason given for the scepticism was that if a member of the community tries to assist or insists that people go to the clinic or even shows some interest in their pregnancy, the pregnant woman or her family may suspect that you wish to bring harm to the woman or her child. The suspicion is influenced by traditional beliefs regarding witchcraft.

“The whole community needs to push pregnant women to go to clinic. Clinics should also be open till late especially for pregnant people.” C1

“No information on how we can be involved. Can't answer questions when asked by people on the ground because you don't know anything yourself. If you get too involved it is believed you want to bewitch the pregnant person, so if the child dies, they will point at you.” F4

It was clearly indicated, that males have a role to play and it was mentioned that grandfathers, fathers, partners and/or husbands should be available and visible during this period.

The family composition that is seen in the area of Impendle is generally the traditional nuclear family consisting of a father, a mother and children. There were some participants who mentioned that grandparents live in the same house. Participants further indicated that

even if the father is working in town (either in Pietermaritzburg or Durban), they come back home frequently.

5.5.2 Community health worker support on maternal health

Interviews with healthcare providers indicated that Impendle has a total of seventy one (71) community health workers known as Community Care Givers (CCGs). These are distributed to all four (4) wards in the area, and they are paid a stipend by the Department of Health. Their main duties are to visit households, do disease profiling and report back to the health facility on the issues found in the community. Interviews with participants who are not healthcare workers revealed that the CCGs do not have enough information on maternal health issues. All the respondents indicated that they do not feel the CCGs gave enough information on maternal health issues.

They did however, indicate that they provide useful information on healthy eating and encourage pregnant women to attend the clinic as they are supposed to.

“The CCGs ensure that pregnant women visit the clinic as required. They encourage mothers to go for testing.” P7

“CCGs have no pamphlets; they attended some HIV workshop where they distributed information but it was specific to HIV only not maternal health.” C1

“They tell us to attend clinic, give us a list of food we are supposed to eat and encourage us to take treatment.” P2

“There is not much being said on maternal health issues by CCGs; mostly they talk about HIV.” F2

According to health care providers who were interviewed, there is also a group of nurses who work with the community. They are called Family Health Teams (FHTs), and are supposed to work closely with the CCGs in identifying and even treating minor ailments in the community. However, instead of four teams, covering all four wards, there is only one team in Impendle, covering the whole area. This is a result of the shortage of nurses. This was confirmed with three participants (who are not health care providers) specifically mentioning the lack of monitoring of the CCGs as problematic. Overall, the majority of participants

stated that they were not sure whether CCGs had information or had never heard CCGs discussing maternal health issues.

“CCGs refer people to clinics who are sick. They are overworked because everything is done by them. Very few nurses are seen going around the households and community, mostly it’s CCGs.” T1

“I don’t even know what they say about pregnancies. They don’t have pamphlets on this issue; they give pamphlets on HIV and TB, but nothing on maternal health. Some of them don’t want to work, they are lazy, and someone needs to follow them up.” F4

Interview data revealed that part of the work of CCGs is to do home pregnancy testing. Those who find out that they are pregnant from these tests are immediately referred to the nearest health care facility for further care and support. It was further stated, that CCGs encourage pregnant woman to plant vegetable gardens so as to it healthy during their pregnancy. Participants indicated that CCGs promote cleanliness in the homes, ensuring that pregnant women take care of themselves and perform blood tests for HIV at the clinic in order to start treatment early should a person be HIV positive.

5.5.3. Political leadership involvement

The interviews with political leadership indicated that they too do not have sufficient information on maternal health. All three ward councillors indicated that they would like to be involved in maternal health and other health issues in general. They further advised that they had no information and that they have never seen pamphlets with information about maternal health matters. Workshops are done on HIV and TB but no such training is provided on maternal health.

Councillors who participated in this study were also not aware that there are obstetric ambulances in uMgungundlovu district. This indicated that information on services to the community is not well communicated to the grassroots political leaders in the wards. When asked what the causes of maternal death in Impendle area are, the councillors mentioned that they do not have specific information but they felt that disease and alcohol consumption played a contributory role. One councillor mentioned that she is working with a Non-

Government Organization to create awareness about teenage pregnancy but pointed out that there are no pamphlets on this issue.

“Alcohol in this area is seen consumed by females too much. Delay in taking medicines or taking wrong medicines during pregnancy which will then interfere with the normal process. Being a teenager is a risk because the body is still young. Attending the clinic late may also lead to missed opportunities.” C2

Political leaders stated that there is a need to be provided with introductory on maternal health issues so that they are able to disseminate that information to citizens in their wards. Mention was also made that there are no youth friendly services in the area, neither from the local municipality nor from the provincial departments.

It was mentioned that such services would contribute to ensuring that the youth stay out of trouble by becoming involved in constructive activities after school and during school holidays. Health care providers similarly agreed that there were no such youth-friendly services in the clinics either because of staff shortage.

During the interviews, the political leadership also mentioned that the Local Economic Development (LED) office in Impendle is not functional, this despite high levels of unemployment and poverty in the area leading to social ills including teenage pregnancy. This is, according to the councillors, one of the leading factors driving the prevalence of social ills in Impendle, including teenage pregnancy.

5.5.4 Community education and information

Interviews and discussions indicated that there was very little to no information on maternal health in the area of Impendle, whether through health care facilities or non-government organisations. There are no pamphlets or posters on maternal health. Some participants indicated that the only information that is publicly available is on HIV and Drugs.

“There is no information available on maternal health. No pamphlets or posters.” F3

“As traditional health practitioners, we have been trained on HIV and TB. We were never trained on maternal health issues as a result we have no knowledge.” T1

“There’s nothing that I have that is specific to maternal health issues. The focus has been on HIV and drugs with the campaigns that we have had in the past.” C3

As much as there seems to be no information on paper, some participants mentioned that health education is given at the clinic during the waiting periods in the morning.

“We are given health education at the clinic regarding diet, living healthy and resting.” P6

Participants indicated that they only get information on diet, exercise and importance of blood tests for HIV and other diseases when they visit the clinic. Some participants especially community members and political leadership stated that they would like to be involved in maternal health issues but need to be given information. It was clear from the interviews conducted, that the people of Impendle have limited access to information on maternal health.

5.6 Programs towards improvement of maternal health

There are many programs that have been established to curb the scourge of HIV and improve maternal health in South Africa, specifically in the uMgungundlovu district. Interviews with the participants indicated that there is some knowledge of these programs but no clear understanding of what resulted from the establishments including mention of PMTCT and family planning. Maternal health is further compromised by the lack of advanced midwives, an obstetrician and or a 24-hour general practitioner. Health care participants mentioned that if there is a complication during delivery they have to phone Edendale hospital to speak to a doctor on call for advice.

“I wish to have in-service training on maternal health. There is a great need to employ advanced midwife who will be responsible for complicated cases. Currently we phone the hospital for advise those cases are referred to Edendale hospital which is about 65km from here. Sometimes you don’t know what to do while waiting for the ambulance which delays at times.” N1

Some healthcare providers indicated that even though they are working in the maternity department, they do not have sufficient information or training especially pertaining to recent advancements in maternal health.

5.6.1 PMTCT AND CARMMA Strategies

Despite the challenges that have been detailed above, healthcare providers all felt that the Department of Health is doing as much as it can to improve maternal health in difficult circumstances. Health care providers stated that programmes like PMTCT, CARMMA, Mom Connect (an SMS-based reminder and information sharing system) and home pregnancy testing have ensured that both maternal and child health has improved.

“Yes. Programmes like PMTCT. People are educated to attend clinic, skilled nurses available, there are radio slots on maternal issues.” N1

“Yes. Many programmes in place like PMTCT and CARMMA, Pregnancy testing in communities done by CCGs.” N2

“Yes. Mom connect programme (sms system) which give pregnant woman information and remind them on their clinic appointments. Ambulance rush when a person is in labour. Not aware of obstetric ambulance. Community health workers do home pregnancy test and refer clients to clinic immediately should they be pregnant.” N3

However, responses from other participants were not as positive about the efforts of government in terms of health care provision thus far. They indicated that while a lot has been done there are still challenges that needed to be addressed in the health care system especially in the area of Impendle like the issue of shortage of clinics and staff. There were a few participants who felt that the Department of Health has not done anything to improve maternal health in the area.

5.6.2 Family Planning

One of the targets of MDG 5 is to achieve universal access to reproductive health, which includes family planning. The general feeling during interviews was that participants understood family planning (FP) to mean the use of contraceptives. Only a few participants mentioned that the purposeful planning to have or grow a family, even before becoming pregnant. This indicated that there seems to be a very limited understanding of family planning and reproductive health.

In as far as contraceptives are concerned, most participants were able to list a few types of contraception used. The most regularly mentioned methods were injections, pills and

Implanon. Participants indicated that there is widespread awareness that family planning services are available free of charge in health care facilities but added that there are some myths in the community regarding the use of contraceptives. As a result of these myths, people are not keen to use contraception.

“People are clear on contraception but they don’t use it negatively affects libido. The results show that they do not use contraception.” C2

“Some women cite that contraceptives make them fat. Others complain that it affects libido, so they rather not take it. Some teenagers are becoming pregnant on purpose, because of peer pressure.” N2

“FP means planning with your partner whether you want to have a baby at that time or in future. People don’t want to use condoms because they say it feels wrong. These condoms are not of good quality, they burst easily. These services are easily available I don’t know why people do not want to uses it.” F4

Condoms were also mentioned as a contraceptive measure that is often spoken about and that they are easily accessible, being available in healthcare facilities, shops, and traditional courts. However, despite them being available widely, they are not used. Health care providers indicated that teenagers come to the clinic to do a pregnancy test and if told that they are negative and offered contraception, they refuse to take it. They will come back again in a few months pregnant.

“You see someone who is not married having sex without protection. Our children do not want to use condoms, we tell them as parents, even bring condoms home to their rooms but they don’t take them, you still find it lying there. Many teenagers in high school having sex and babies are seen here on daily basis, they don’t want to listen to elders. We tell them it is either the grave or the condom, they just laugh because I am an on old man. I am working with schools on teenage pregnancy project, there's a notable drop in pregnancies since the project of awareness started. There are myths on condoms and injections, they say condoms burst and injection causes lower libido. It is easier to teach children that are in school about pregnancy, the challenge is how to reach youth out of school.” F1

“Teenagers are mostly pregnant around this area, school nurses offer contraceptives but students refuse. A 13 or 14 year old come to the clinic to do pregnancy testing, if negative they are offered contraceptives but they refuse and come back a month or two later pregnant. It means they purposely become pregnant.” N1

Although not widely reported, some participants indicated that due to high unemployment and poverty rates, some people avoid the use of contraceptives so that they can become pregnant in order to access the child support grant.

Other factors which negatively impacted on good family planning practices mentioned by the participants include unprotected sex and multiple sexual partners as a result of excessive alcohol. In addition, it was also mentioned that some people become pregnant even if they are using an injection, therefore, there are those who do not see it being useful as a result of this failure.

“Family planning means having a planned baby with your spouse. However due to unemployment rate we see people getting pregnant to receive social grants. We also see the rate of sugar daddies and blessers go up in our area.” C3

“Not using condoms. There are people who drink alcohol then sleeping around, resulting in pregnancy. Some become pregnant even if they are using injection. These are seen a lot in this community.” F2

Some of the young participants mentioned that it would have been easy to access family planning services if the contraceptives could be available in schools. They said that healthcare workers come to school and talk about contraceptives but they do not bring anything with them and the school children are told to go to the clinic. However, the children are not able to go to the clinic as they do not have transport money. The interviews with the health care workers concur with the sentiment of the young participants. They explained that the difficulty is the Department of Basic Education does not allow the provision of contraceptives in schools including, condoms.

“If FP can be done at schools it will be easier because sometimes we do not have money to go to clinic. We were given health education one day and they talked about pills, injections and implanon but they did not bring the injections they were just talking.” P6

Ukusoma (non-penetrative sex) was also mentioned as one of the prevention strategies that have been used for a long time to prevent pregnancy and diseases. Abstinence was also mentioned; with participants explaining that they feel like the message on abstinence is losing momentum and therefore should be revived. Many participants mentioned that it is mostly school children who become pregnant because they do not want to listen to their parents and having messages on abstinence coming from other sources will lead to a decrease in the number of pregnancies.

5.6.3 Termination of Pregnancy

In South Africa, the termination of pregnancy (TOP) was legalised in 1998. However, illegal abortions are still widespread and are one of the causes of maternal death in the country. Interview discussions revealed that participants have limited knowledge on the availability and accessibility of TOP services in the uMgungundlovu district.

The general feeling was that abortion is the killing of an innocent child. Some participants indicated that it is the plan of God to allow a person to be pregnant, so if a person terminates, he is fighting against God.

“Mmhhh.. It is not a nice thing to talk about, if a person is pregnant, it is God’s plan. In the Zulu culture there supposed to be a traditional ceremony when a child dies, so what to do with the aborted one. It’s okay only if you have been raped. The soul belongs to God. Some people drink some backstreet stuff to abort. Sugar daddies tell young women to do abortions. Not sure where it is done legally.” F1

“That is killing of an innocent soul is against my belief. Have no idea where it is provided. People will never ask me where it is provided; I do not want to be involved in that. This angered me the minute it was legalised, I can refer them to a doctor if it comes to it.” C2

“Don’t agree with the issue of abortions but people have reasons for doing it like rape. Our church does not allow it also because God is the giver of life.” P6

Most participants indicated that they have no idea where the TOP services are provided and went so far as to state that they would not refer a person for that service, since it is against their belief. A few participants indicated that TOP is done in hospital in Pietermaritzburg but had no idea which one.

“I can’t be part of that. I can’t refer people for it. I don’t even know where it is done.” C3

“It is a difficult topic to think about, we should encourage people to go for family planning rather than abortion. Abortions are an abomination in the society. Young people should not do it; they must bear consequences of not listening to parents. Services are provided in clinics but not in Impendle. Other services are advertised in the posters in the streets. No one should do abortion rather give child for adoption. It is the right of a person to do it.” F3

It was interesting to note that some participants indicated that TOP can be acceptable when done due to circumstances like rape or if the growing child has some deformities as revealed by ultrasound. The majority though, felt that a woman must not use termination of pregnancy as a method of contraception; they must keep the baby if they did not use proper contraceptives in time.

“I am totally against it because God created that child with a purpose. A person can choose to do it depending on the circumstances, like if the father of the child leaves you and you have no support at home. It is an innocent soul. It is done in Hospitals in Pietermaritzburg.” F4

“It is wrong because there are other ways to prevent pregnancy. So if pregnant, keep the child.” P4

Some participants indicated that there are illegal abortions that are taking place in some areas. These abortions happen when the pregnant woman is given illegal medicines to ingest, leading to labour pains and abortion. It was noted that there are often posters on the streets which advertise termination of pregnancy services but the service providers are unknown.

“Not a good thing to have an abortion. It is done in towns. Backstreet abortion is done in some areas. Some people get medicines to do it from people who know how to do it.” P1

“It is killing of a child. We see adverts on papers and on streets. It’s done due to rape.” P5

Health care providers interviewed indicated that TOP is not done in any of the facilities in Impendle because there are no resources for it and nurses are not trained to perform it. In one facility the nurse said that about three or four people require that service per month while another facility stated that about four or five people request it per year. These women are referred to Pietermaritzburg. One health care provider indicated that she had no idea, which

facilities provide the service, while the other two indicated that it is done in Edendale and Northdale hospitals.

This strategy was established in order to ensure that women are empowered to make decisions about their lives and future but it would appear that the community of Impendle is generally so opposed to TOP for religious or cultural reasons that they either refuse to refer people for safe legal abortions or do not even know where the services are provided.

5.6.4 HIV/ STI Education

During the interviews, some of the participants revealed that they thought maternal deaths can be due to HIV. The general feeling was that STIs can not cause any harm to maternal health. Gonorrhoea was mentioned frequently as one of type of STI but it was also noted that the disease is no longer prevalent. Participants were generally able to indicate what some of the common symptoms of STIs are.

It was worrying to note that some participants mentioned that some STIs, most notably pubic lice, result from bewitchment. This indicate that traditional beliefs may still have a negative effect on sexual behaviour if it is believed that the cause of STIs is an external entity over which one has no control. During the interviews, some respondents also mentioned that STIs are curable except for HIV.

“It results from unsafe sex. It’s called drops. It also caused during witchcraft when a partner drink some concoction that will ensure that another person does not sleep around but sleep with him only (ilumbo).” F1

“Having discharge in your private parts due to unsafe sex, not using a condom. Can be done through bewitchment by a partner if he suspects you are cheating, especially lice. HIV is also an STI.” F4

Apart from bewitchment, other causes of STIs mentioned were be unsafe sexual intercourse (not using a condom) and having multiple partners.

“You get it through sexual intercourse with multiple partners or if your partner cheats. It can be sores in private part or drops.” T1

“I have attended HIV Campaigns which also include STI awareness. Many people are unemployed in the area as a result young people have sex with older people to get some money for the food and stuff like that.” C1

It was noted again that due to high unemployment and poverty rates in the area, some girls and women use sex as a commodity in order to get money to buy daily necessities.

It was clear that most participants have some knowledge of HIV as they mentioned that they have been trained about HIV and some have attended workshops. It was mentioned that HIV is often the focus of discussions during meetings and campaigns.

5.7 Conclusion

This chapter discussed the data obtained during interviews that were conducted with various community members from the Impendle local municipality in UMgungundlovu district. The themes which emerged from the interviews and focus groups indicate that within the community there are several programmes related to maternal health but that community involvement in their development is minimal. There is little understanding of ‘maternal death’ and the MDGs. It also emerged very clearly that there is a dire lack of access to healthcare services generally and this seems to be exacerbated when it comes to maternal health services. Other issues which emerged are the lack of information about maternal health available in the community and the impact that religion and tradition have on the efforts to improve maternal health outcomes. Overall, the results indicate that there are many challenges related to maternal health in the Impendle area, which could negatively impact the attainment of the targets of MDG 5. In the final chapter, the interpretation of these findings is unpacked and recommendations made based on the interpretation. The report on this study is then concluded.

CHAPTER SIX - INTERPRETATION OF THE FINDINGS, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

Gender equality and female empowerment have now been recognized as important development objectives both in themselves and as keys to the achievement of other health and development, objectives, such as reducing maternal mortality and preventing the spread of HIV. When women flourish, society flourishes. Much evidence now exists that when women are empowered with resources, they invests not only in themselves but also in their families. A woman may have overcome many challenges in being able to leave her home without a companion or in having the funds to travel to the clinic, only not to get the service she requires (WHO, 2013). In South Africa there is a public health care service, which is provided free of charge to all. The government has ensured that, in particular, healthcare for women and children is free in order to prevent many challenges that are faced by this population and to empower them to make decisions related to their own lives and health. However, studies have shown that maternal health services are hindered by affordability and availability barriers in some areas. Without access to healthcare services, many people would die, including pregnant women and children. This study aimed to expound on three main objectives: to examine evidence for improving women's health, to review progress made on MDG 5 and to review how UMgungundlovu District citizens are involved in maternal health issues. The theoretical framework was contextualised within the New Public Management paradigm in order to understand the processes that are followed in organisations to achieve the targets that have been set, in this case MDG targets. This study was based on the sample of one rural local municipality in UMgungundlovu District namely Impendle.

Chapter Five described the findings from the interviews conducted; whilst this chapter further discusses those findings and provides some concluding remarks and pertinent recommendations arising from the study.

6.2 Interpretation of the findings

The formation of MDGs has seen a substantial improvement in health and the well-being of people in numerous countries. However, there are still challenges in some countries towards achieving MDG 5 on maternal health improvement especially within sub-Saharan Africa. This was highlighted in Chapter Two of the study. Below is the interpretation of the findings according to the objectives of the study.

6.2.1 Objective 1: Examine evidence for improving women health.

Healthcare access was a major concern for the community of Impendle because they believed that they are being neglected due to the fact that they do not have adequate healthcare services in the area. Currently there are only three clinics available and of those only one is open 24 hours a day. Furthermore, there is no hospital in the area.

Both the community and the healthcare providers also noted that there is a shortage of staff in the healthcare facilities especially with respect to posts for doctors and professional nurses. Participants also perceived that the government is not doing enough to ensure that more healthcare providers are employed and are available at the facilities within the community.

In addition to general access to medical services being of concern to the community, participants noted that it would appear that maternal health is not a priority for the government in the area of Impendle. “A maternal death may be a number in a country’s statistics, but it is a devastating event for everyone touched by it” (Lawson and Falush, 2012). The participants indicated that deaths occur in the area because there is only one healthcare facility that has facilities to perform deliveries and that is a cause of ill health and mortality.

Moreover, participants viewed the quality of the care provided within the healthcare system as being below standard. Their perception of quality care is focused on having all the necessary resources available in healthcare facilities. These resources as highlighted by participants include having sufficient staff, equipment and clinics and having a hospital and having ambulance base in the area.

In addition, transport to healthcare facilities at night was flagged as an issue by participants especially because of the challenges with ambulance delays. The participants noted that at night and during weekends, women in labour and sick people have to hire private transport to

the only twenty four hour healthcare facility available in Impendle. The participants stated that this is very costly and results in additional stress for a community that is already economically impoverished.

6.2.2 Objective 2: Review progress made on MDG 5 in uMgungundlovu District

The MDGs were adopted by different countries including South Africa in the year 2000 yet the study revealed that within Impendle there was limited information and knowledge on these goals. Participants were either not aware of the MDGs at all or had only heard about them in the media. None of the participants were able to list all eight goals and those who were able to list a few MDGs, emphasized poverty and HIV. The participants in the study were asked to answer some specific questions related to maternal health issues and the researcher documented all the responses. When asked about the MDGs, roughly 85% of the participants were not clear on the subject including MDG 5, which was the focus of the study. It was clear that the issue of maternal health and by extension, MDG 5, is not being discussed in their community meetings or during the awareness campaigns taking place in the area. When discussing the challenges experienced in the Impendle community as far as maternal health matters are concerned, poor access to healthcare services and lack of support during pregnancy were cited as some of the issues that lead to severe ill health and deaths in the area.

Participants viewed the quality of the care provided within the healthcare system as being below standard. Their perception of quality care is focused on having all the necessary resources available in healthcare facilities. These resources as highlighted by participants include having sufficient staff, equipment and clinics and having a hospital and having ambulance base in the area.

There are three healthcare facilities in the area of Impendle, but only one provides maternal health services. The other health facilities were reported by both healthcare providers and community members as being inadequately resourced to provide the necessary services. Participants noted that there were no labour wards or maternity rooms in these clinics and as a result women in labour would travel to the one clinic that has a maternity ward. While antenatal care services are available in all healthcare facilities, maternal health service in terms of service delivery is not easily accessible for those in need of it. The participants noted

that there are no ultra sounds or x-rays machines in the area at all and as a result pregnant women are referred to the Pietermaritzburg region for these services.

The lack of emergency services in the form of an ambulance base, and the resultant delays in the arrival of ambulances when called, was another challenge cited by participants. It was noted that women in labour sometimes wait for such an extended period for the ambulance to come to their assistance that they deliver at home while waiting. The study revealed that emergency personnel are hampered in their duties when the weather is inclement because the roads are inaccessible in those conditions. None of the participants, except for one healthcare provider, were aware of the obstetric ambulance that is specifically available for pregnant women. The participants cited that the presence of an ambulance base in the area would contribute to improvement in maternal health and the health of the community in general.

Contraceptives are available in all healthcare facilities in the area as mentioned by participants. The challenge however, is that some women do not want to use it because they are of the view that the use thereof has negative effects on their bodies. Condoms are available in both healthcare facilities and non-health facilities including spaza shops, petrol stations and taverns, however, people do not use them. Furthermore, participants stated that some women do not want to use contraceptives because they want to become pregnant in order to access child support grants.

The termination of pregnancy (TOP) services in South Africa is legal. However, there is evidence to suggest that there are some women who still choose unsafe abortions to terminate pregnancy. Interviews in this study revealed that there are some barriers in accessing legal TOP legal services. The study revealed that the barriers to access include the lack of information about the facilities, which these services are done and stigma toward the service and service providers performing the service. Some participants stated that they did not want to be involved in abortions nor refer people for the service due to their religious or cultural beliefs.

6.2.3 Objective 3: Review how UMgungundlovu District citizens are involved in maternal health issues.

Information on maternal health issues was cited as another challenge because the participants pointed out that there are no pamphlets or any other form of materials that speak to this issue.

The only information which the participants mentioned was that information shared by the healthcare providers during the morning healthcare education sessions in the waiting area at the clinic. The lack of information to the community was clear as the participants were not sure of the definitions of both maternal health and maternal death. This is of concern as the lack of understanding of key concepts may result in a lack of effective management of maternal health in a holistic manner.

HIV stigma was cited by the community as another challenge that is still noted in some villages around Impendle. It was cited as the reason why some people especially pregnant women do not want to go to healthcare facilities during their pregnancies because they fear that they would be required to go for HIV testing. Until recently, the health facilities had separated HIV departments from other services.

The participants were of the opinion that the integration of HIV services into the mainstream with all other services, might contribute to reducing the stigma of the pandemic. In addition participants highlighted that there is a need for continued community awareness campaigns on HIV and stigma mitigation.

According to the respondents, there is a challenge of negative staff attitudes from some of the healthcare providers. However, it was noted that there is much improvement on this issue since establishment and involvement of clinic committees, and the presence of suggestion boxes within facilities. Reports of bad attitudes from staff are attended to by both the community representatives and the healthcare management as soon as it is reported and dealt with accordingly.

Teenage pregnancy was cited as a further challenge in the area. Some participants felt that this is due to the fact that teenagers do not want to listen to the elders, while others cited the fact that there is no access to contraceptives and family planning services in schools. Participants also mentioned that school health nurses, merely talk about contraceptives when they visit schools, but they do not bring contraceptives with them as they are not allowed to do so. Teenage pregnancy was cited as one of the causes of maternal death because young girls hide their pregnancy from parents and teachers until it is too late to start antenatal care.

Furthermore, there is notable challenge of women being abandoned by the men who impregnate them, neither supporting them during pregnancy nor once the child is born.

Participants felt that men should ensure that they support their partners financially and help them with household chores during pregnancy and after delivery.

Participants mentioned that it is important for political leadership to be involved in maternal health issues. They suggested that there should be information sharing between healthcare service providers and political leadership in the area so that they can work together to ensure that all people are aware of these maternal health issues through targeted awareness campaigns.

Another aspect that was raised by the participants in the area of Impendle was the effect that religion has on maternal health in the area. Participants had concerns regarding the fact that some religions in the area do not allow their members to attend healthcare services, including pregnant woman and children.

These religions rely on prayer and or holy water and not medicine, and the deliveries are done by untrained women in the church. Participants felt that this practice might also lead to an increase in maternal and child deaths. The use of *izihlambezo* was seen as an important aspect of ensuring a smooth uneventful delivery and was accepted by several participants.

However, there were some participants who opposed the use of *izihlambezo* during pregnancy stating that it might lead to sickness of both the mother and the child. It was found that most pregnant women in the area use *izihlambezo* during pregnancy, and they have not experienced any negative effects. The use of holy water was also noted as being a practice that takes place in the area instead of going to the clinic. People drink water from the church which is believed to result in a healthy mother and child.

Another aspect that emerged from the study was the fact that there are no longer practicing traditional birth attendants in the area due to the rise in HIV and other diseases. This situation resulted in those birth attendants being afraid of conducting deliveries outside the healthcare facilities. However, though not practicing, the traditional birth attendants do still occasionally assist when there are emergencies like home deliveries due to ambulance delays or any other reason.

The traditional health practitioners that were interviewed stated that they are referring clients, especially pregnant women to healthcare facilities by giving them referral slips but the healthcare providers do not return the slips for continuum of care. The traditional healthcare

practitioners stated that they would like to have a relationship with the Western healthcare providers in order to ensure that clients receive holistic care and are given a chance to choose their preferred type of service, be it Western or Traditional or a combination of the two.

6.3 Conclusion of the study

This study sought to describe the influence of Millennium Development Goal 5 on maternal health in the Impendle area of UMgungundlovu District. The aim was to understand the lived experiences of community members pertaining to maternal health as well as their understanding of maternal health and matters related thereto. It was found that while some improvements in general healthcare and HIV were noted, the area of maternal health is not receiving much attention and as a result, the likelihood of achieving MDG 5 is slim. The recommendations to the study will assist local authorities and decision makers to ensure that necessary attention is given to maternal health and the attainment of MDG 5 and the decrease in the relatively high maternal mortality rate. In this way, healthy and well-informed communities can work with government for a better future for all.

6.4 Recommendations

Healthcare service delivery in South Africa has improved drastically and several steps have been taken to address inequalities and improve access. However, this study revealed that there are some areas within the healthcare system in the Impendle that remain a challenge. There is evidence that there is a great need to ensure further improvement in healthcare service provision in the rural areas of uMgungundlovu. This study came up with the recommendations that are listed below.

6.4.1 Healthcare accessibility

The greatest theme emerging from the data obtained for this study is that of health services being inaccessible, for various reasons as described in 6.2 above. One of the barriers to access is transport, and it is thus recommended, that a dedicated obstetric ambulance service be based in Impendle. This will ensure that ambulance delays for pregnant women in labour are minimized and that the community is not required to use the little money they have to pay for private transport to hospital. Another barrier to accessing healthcare services and which impacts negatively on the quality of care in clinics around Impendle is the shortage of staff, especially doctors and advanced midwives.

The suggestion in this regard is to employ more of such staff members especially to have one local advanced midwife to deal with the complicated pregnancies as well as a medical practitioner stationed in the area 24 hours for emergencies.

This will also reduce the expensive transport costs to Pietermaritzburg for more specialist interventions and after hour's services. In addition to improving access, such intervention will also make the workload for current staff more manageable, thereby improving staff attitudes and ultimately, improving the quality of care.

Apart from human resource requirements to improve access to healthcare, there is also a need to understand the other resource constraints, which affect access and quality of healthcare in the area of study. In this regard, it is proposed that an audit be done with specific focus on the availability of equipment, medicine and infrastructure resources minimally required to ensure quality maternal healthcare to the women of Impendle.

6.4.2 Information sharing

Another prominent theme that emerged was the lack of information and poor understanding of maternal health. This was apparent in that most participants were unable to say much about the MDGs and ascribed maternal health as focused only on the pregnant woman. In order to arrest this ignorance on this important matter in Impendle, it is recommended that a multi-pronged information sharing strategy be devised and implemented. This strategy could include production of pamphlets, training of community and so on. Such an approach should ensure that men, religious and cultural groupings and both traditional and western healthcare practitioners are included to ensure a holistic strategy to improve understanding of maternal health. Such engagement between all community stakeholders is important for the improvement of maternal health and promoting a supportive environment where women are able to confide and get the necessary care. The establishment of three national committees (maternal, perinatal and child mortality) reporting directly to the Minister of Health has been a step forward in increasing the profile and coordinated action for maternal, neonatal and child health linking national mortality audit data to action and transferring lessons learned in one province to others Mayosi *et al*, (2012). New social media and information technology have given the world an unprecedented opportunity for inclusive, global scale problem solving around the main sustainable development challenges. The pathways to sustainable development will not be identified through top-down approach, but through a highly

energized are of networked problem solving that involves the world's universities, businesses, non-government organizations, governments and especially young people, who should become experts and leaders of a new and profoundly challenging era (Sachs, 2012).

6.4.3 Relationship between Traditional and Western medicine

A further suggestion related to sharing of information is to build an inclusive and responsive referral system between traditional healers and western healthcare practitioners. Data indicated that many clients in rural areas prefer to start with traditional consultation before going to the next level of care. Thus to ensure holistic, complementary maternal care, a strengthened relationship between these two health systems needs to be created. Traditional healers and traditional medicine has a crucial role to play in building the health system in South Africa and strengthening and supporting the national response to HIV and AIDS. There is therefore a need for urgent investment and support of traditional healers and traditional medicine, not only by government but also by civil society and the private sector (Mbatha, 2010)

6.4.4 Stigma mitigation

A further recommendation from this study is to devise strategies that will address the negative stigma associated with termination of pregnancy and HIV. These strategies may include discussions with political and religious leaders, school presentations and printed literature. In one study, it was found that HIV status was more likely to be missing for women who died in general, and death rates in women with unknown HIV status were higher than those in women whose HIV status was known, suggesting that the prevalence of HIV infection in women whose HIV status was known underestimated overall prevalence (Hsu, Berman and Mills, 2013). The South African National Department of health has therefore embarked on an expanded combination prevention approach as a contribution to achieving the global ambition of ending AIDS using the 909090 strategy (Burman, Aphané and Dolobelle, 2016). Caution should also be exercised in the area of TOP since it was clear from the data that the topic is not well received in the community of Impendle.

6.4.5 Contraceptive uptake

The seemingly low uptake of contraceptive use was identified as concerning in Impendle, as was the high rate of teenage pregnancy. It is proposed that the Department of Basic

Education, the Department of Health and the community at large need to discuss the possibility of allowing access to contraceptives in schools. This will enable girls to be empowered to plan pregnancies and access family planning services more conveniently. Across the globe, women often struggle to meet their reproductive health needs. While their needs may vary according to where they live and their stage of life, women would all benefit from improved prevention methods for reproductive health, therefore fast tracking the development of Multipurpose Prevention Technologies (MPTs) will empower women to prevent two or more SRH risks (Schelar, Polis, Essam, Looker, Bruni, Chrisman and Manning, 2015).

These recommendations emerge from the barriers to healthcare that was expressed by various members of the community in Impendle. Should they be adopted there is likely to be significant improvements in access to maternal health services as well as to information regarding maternal health. This will greatly assist the uMgungundlovu District to move closer to achievement of MDG 5.

6.5 Suggestions for further research

There is a continuing global commitment to reduce the unacceptably high maternal death rates in low to middle-income countries. Progress towards this goal in South Africa demands national coordination and cooperation with the major role players in provision of health services, addressing causes of maternal and perinatal deaths and in making available clinical management protocols to ensure that high quality health services are rendered (National Department of Health 2015).

Maternity care is an integral component of primary health care and a free health service for pregnant women. Within South Africa, the Maternal and Child Health programme is located in general development policies, which are focused on meeting the basic needs of rural and urban communities, maximising human resources potential, enlarging the economy and spreading its benefits to all South Africans.

Improving quality of antenatal and postnatal care and using health information to follow up on patients can contribute to reducing unnecessary deaths (National Development plan 2030). The National Strategic Plan for HIV/AIDS, TB and STI aims to accelerate the decline in HIV-related mortality and to reduce TB mortality by 50%. Reaching these goals will require

attainment of 90-90-90 strategy for HIV and TB; increasing STI detection and treatment by 50%. To accomplish these aims, South Africa will have to increase proportion of people living with HIV who know their status from 60% to 90%, consistent with the 90-90-90 approach, increase TB case detection from 68% to 90%, strengthen diagnosis of STIs, increase antiretroviral treatment coverage from 53% to 81%, provide holistic, patient-centred support and promote innovation (National Strategic Plan 2017-2022).

The findings and conclusions drawn in this study emanated from analysis of interviews conducted with various role players within each of the 4 wards of the Impendle area. It has provided us with a detailed description of the experiences and perspectives around maternal health in this one area and provides some important recommendations on how to improve service delivery in the area for the attainment of MDG5. However, to further expand on the findings of this study, the following areas of research can be undertaken to ensure a more comprehensive overview of challenges and opportunities, which exist with respect to improved maternal health services:

- 6.5.1 Using the findings of this study, devise and implement a programme, which focuses on dissemination of information on the MDGs and sustainable development goals in general. The prevalent understanding of the community with regards to development goals after the implementation of the programme can be compared to the data from this study and analyzed for effectiveness.
- 6.5.2 Studies which seek to understand the prevailing relationship between traditional western medicine and report on how to optimize this relationship for the benefit of the patient.
- 6.5.3 Comparative studies in other settings such as rural wards in another province or urban areas within the uMgungundlovu municipality would also provide valuable insight into the particular experiences and perspectives of persons in various areas.

This study has provided the necessary starting point from which to launch further research into maternal health and associated services in South Africa. It is hoped that this and all associated research in this field will ensure that girls and women are more enlightened about maternal health and that the necessary, quality services are increasingly made accessible.

There is a continuing global commitment to reduce the unacceptably high maternal death rates in low to middle-income countries (LMIC). Progress towards this goal in South Africa demands national coordination and cooperation with the major role players in provision of health services, addressing causes of maternal and perinatal deaths and in making available clinical management protocols to ensure that high quality health services are rendered.

Maternity care is an integral component of primary health care and a free health service for pregnant women. Within South Africa, the Maternal and Child Health programme is located in general development policies, which are focused on meeting the basic needs of rural and urban communities, maximising human resources potential, enlarging the economy and spreading its benefits to all South Africans.

7. REFERENCES

- Aibinuomo, F.A. (2011). Primary Health Care (PHC) as the bedrock of the MDGs: community sensitization, mobilization and education on communication for positive health change. Department of Adult Education, Ibadan, University of Ibadan. 19(1): 529-542.
- Alexander, L. (2014). The Ontology of Consent: The analytic philosophy, 55(1): 102 – 133.
- Arthur, J., Waring, M., Coe, R and Hegdes, L. (2015). Research Methods and Methodologies in Education. London: Sage Publication Ltd. United Kingdom.
- Babbie, E and Mouton, J. (2011). The Practice of Social Research. Cape Town: Oxford University Press.
- Babravičius, J and Dzemyda I. (2012). Public policy and administration, 11(2): 2012.
- Basheka, B.C. (2012). The Paradigms of Public Administration Re-Examined: A reflection. Uganda Management Institute, Kampala, Uganda, 47(1): 200-287.
- Bayley, C.A., Rao, V., Szreter, S and Woolcock, M. (2011). History, Historian Development Policy., UK. Manchester University Press.
- Bethlehem, J., Cobben, F and Barry, B. (2012). Handbook of non-response in Household Surveys. 2012. Hoboken, NJ, John Wiley & Sons Inc.
- Bhatti, F and Jeffery, P.R. (2012). Education outcomes and poverty: A re-assessment. Routledge, 711 Third Avenue, New York, NY, 10017.
- Bramford, L. (2013). Maternal, New-born and Child Health. National Department of Health, School of Health Systems and Public Health, University of Pretoria, SAHR 2012/13
- Brende, B and Hoie, B. (2015). Towards evidence-based, quantitative Sustainable Development Goals for 2030. The Lancet, 385: 206 - 208.
- Bryce, J., Black, R.E and Victoria, C.G. (2013). Millennium Development Goals 4 and 5: Progress and Challenges. *BMC Medicine*, 11:225.
- Brynam, A. (2015). Social Research Methods. USA. Oxford University Press.

- Boulle, L. (2011). *Globalisation and Governance*. Cape Town, South Africa.
- Burman, C.J., Marota, A and Peter, D. (2016). Weak signal detection: A discrete window of opportunity for achieving ‘Vision 90 90 90’?, *SAHARA-Journal of Social Aspects of HIV/AIDS*, 13(1): 17 – 34.
- Burton, R. (2013). Maternal Health: There is a cause for optimism. *South African Medical Journal*, 103(8): 520-521.
- Buttenheim, A and Asch, D. A. (2013). Behavioral Economics: The Key to Closing the Gap on Maternal, Newborn and Child Survival for Millennium Development Goal 4 and 5. *Maternal Child Health Journal* 17(4): 581-585.
- Campaign for Accelerated Reduction of Maternal Mortality. (2012). ESR Review: *Economic and Social rights in South Africa*, 13(3): 17-18.
- Chaston, I. (2011). *Public sector management: mission impossible?*. New York, Palgrave Macmillan.
- Chidubem, M.E. (2012). *Formats for storytelling by Care givers for sharing knowledge in home base care*. Cape Peninsula University of Technology.
- Cockerham, W. (2011). *Social Cause of Health and Diseases*. UK. Polity Press.
- Coetze, G.P and Lubbe, D. (2013). The risk maturity of South African private and public sector organisations. *Southern African Journal of Accountability and Auditing Research*, 14 (1): 45 – 56.
- Cohen, J.L. (2012). *Globalization and Sovereignty: Rethinking legality, legitimacy and Constitutionalism*. Cambridge University Press, Cambridge United Kingdom.
- Creswell, J.W. (2009). *Research design: Qualitative, Quantitative and Mixed Methods approaches*. Los Angeles:-Sage Publication.
- Cresswell, J.W. (2014). *Research Design: Quantitative, Qualitative and Mixed Method Approaches*. United Kingdom. Sage Publication Ltd.

Correa, S., Petchesky, R and Parker, R. (2010). *Sexuality, Health and Human Rights*. USA:- Routeledge.

Crowder, G. (2013). *Theories of Multiculturalism: An Introduction*. Cambridge United Kingdom:- Polity Press.

Deegan, H. (2011). *Politics in South Africa 2nd Edition*. England:-Pearson Education Limited.

Dekeda, K.F., Vellem, N.M., Ntshontsho, N. and Goon, D.T. (2014). Knowledge and use of antiretroviral treatment among pregnant women attending health centres in Amathole District, Eastern Cape Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, 20(4:2), 1613-1620.

Delmon, J. (2011). *Public Private Partnership projects in Infrastructure; An essential guide for policy makers*. USA:-Cambridge University press.

De Vos, A.S., Strydom, H., Schulze, S. and Patel, L. (2011). *The sciences and the profession. Research at the grass roots for the social sciences and human service professions*. 4th ed.: JL Van Schaik Publishers, South Africa.

DiCicco-Bloom, B and Crabtree, B.F. (2012). The Qualitative Research Interview. *Backwell Publishing Ltd. Medical Education*; 40: 314-321.

Dhlomo, S. 2011. Progress report on key health service delivery initiatives. KwaZulu-Natal Provincial Legislature. September 2011.

Dorrington R.E., Bradshaw D and Laubscher R. (2014). *Rapid Mortality surveillance report 2012*. Cape Town: South African Medical Research Council.

Dunjwa, M. (2015). *National Health Insurance (NHI) Pilot Districts: progress report by Minister of Health*.

Edmonds, W. A and Kennedy, T.D. (2013). *An applied reference guide to research designs: Quantitative, qualitative, and mixed methods*. Los Angeles, CA:-Sage Publication.

Elzinga, A. (2010). New Public Management, science policy and the orchestration of university research-academic science the loser. *The Journal for Transdisciplinary Research in Southern Africa*, 6(2): 307-332.

Endres, J. (2013). *Africa Survey: Africa in Figures*. Good Governance Africa. Johannesburg, South Africa:-Oxford.

Fehling, M., Nelson, B.D and Venkatapuram, S. (2013) Limitations of the Millennium Development Goals: a literature review. *Global Public Health*, 8(10): 1109 – 1122.

Fossinger, R and Morrow, S.L. (2013). Towards best practises in Quantitative, Qualitative and Mixed Methods Research: A social justice perspective. *Journal for Social Action in Counselling and Psychology*. 5(2): 69-82.

Fowler, J.F. (2014). *Survey Research Methods*. Applied social research methods 5th ed. United Kingdom:- Sage Publication.

Gaensbauer R., Baker, P.N and Kenny, L.C. (2011). Saving mothers lives: progress in achieving Millennium Development goal 5. *The Obstetrician & Gynecologist*, 13:259-262.

Ganle, J.K., Parker, M., Fitzpatrick, R and Otupiri, E. (2014). A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. *BMC Pregnancy and Childbirth*, 14:425.

Gordhan, P. (2010) *Budget speech*. Republic of South Africa. 17 February. Available at <http://www.info.gov.za>, [Accessed on 19/07/2011]

Gordhan, P. (2012) *Budget speech*. Republic of South Africa. Feb 22. Available at <http://www.info.gov.za>.

Greener, I. (2011). *Designing Social Research: A guide for the bewildered* 1st ed. London:- Sage Publication.

Haffeld, J. (2013). Sustainable development goals for global health: facilitating good governance in a complex environment. *Reproductive Health Matters*, 21(42):43-49.

Harpen, C. (2011). Public Management, New. *International Encyclopedia of the Social & Behavioral Sciences*.

Hollard-Muter, S. (2012). Literature review on Maternal Health, Soul City. *Women's Health Project*, University of the Witwatersrand, Johannesburg.

Hood, C. (1991). The New Public Management' in the 1980s: Variations on a theme. *Accounting, Organizations and Society*, 20(3): 93 – 109.

Horwood, C., Haskins, L., Vermaak, K., Phakathi, S., Subbaya. R and Doherty, T. (2010). Prevention of mother to child transmission of HIV (PMTCT) programme in KwaZulu –Natal, South Africa: an evaluation of PMTCT implementation and integration into routine maternal, child and women's health services. *Tropical Medicine and International Health*, 15(9): 992-999.

Howlett, M. (2011). *Designing Public Policies: Principles and Instruments*. New York:- Routeledge.

Hughes, O. E. (2010). *Public management and administration: an introduction*. New York:- Palgrave.

Hulme, D. (2010). Lessons from the making of the MDGs: human development meets results-based management in an unfair world. *Ids Bulletin-institute of development studies*, 41 (1):- 15-25.

Ingham-Broomfield, I. (2011). A nurse's guide to mixed methods research. *Australian Journal of Advanced Nursing*, 33(4): 46-52.

Jacob, S. A., and Ferguson, S. P. (2012). Writing Interview Protocols and Conducting Interviews: Tips for Students New to the Field of Qualitative Research. *The Qualitative Report*, 17(42), 1-10.

Juta, L.B., Moeti, K.B and Matsiliz, N. S. (2014). A Community participation in South Africa: an assessment of the N2 Gateway Housing Project in Langa/Joe Slovo Township. *Journal of Public Administration*, 49(4): 1113-1125.

Kaiser, H.J. (2010). An overview of Health and health care in South Africa 1994 – 2010: priorities progress and prospects for new gains, 24 – 26 .

Kondlo, K. (2010). Making Participatory Governance work - re-inventing izimbizo forums in South Africa. *Journal of Public Administration*, 45(2): 384 – 395.

Kvernflaten, B. (2013). Meeting targets or saving lives: Maternal Health Policy and Millennium Development Goal 5 in Nicaragua. *Reproductive Health Matters*, (13)4: 283-427.

KZN Citizen Charter. 2009 -2014. Affirming our commitment to service excellence. The Office of the Premier, KwaZulu-Natal.

Laegreid, P and Verhoest, K. (2010). Governance of Public sector organizations: proliferation, autonomy and performance. New York :-Palgrave Macmillan.

Lapan, SD., Quartaroli, M.T and Riemer, F.J. (2012). Qualitative Research: An Introduction to Methods and Designs 1st Edition. San Fransisco:-John Wiley & Sons.

Lawson, D.J and Falush, D. (2012). Population identification using genetic data. *Am. Rev. Gennon and Hun. Genet* available online before publication @ <http://www.annualreview.org>.

Laurence, J., O'Toole, Jr and Kenneth, J, M. (2011). Public Management: Organization, Governance and Performance. New York:-Cambridge University Press.

Lippincott, W. (2010). Textbook of Medical and Surgical Nursing. Lippincott Williams & Wilkinns publishers, 11th edition, 530 Walnut Street, United States of America:-Philadelphia, PA.

Logie, D.E., Rowson, M., Mugisha, N.M and McPake, B. (2010). Affordable Primary Health Care in low-income countries: Can it be achieved? *Sabinet, 2 (1): African Journal Primary Health Care Family Medicine*. 2010(1): 246-248.

Lomazzi, M., Laaser, U., Theisling, M., Tapia, L and Borisch, B. (2014). Millennium Development Goals: how public health professionals perceive the achievement of MDGs. *Global Health*, 7:24352.

Long, H. (2014). An empirical review of research methodologies & methods in creativity studies (2003-2012). *Creativity Research Journal*, 26(4): 427-438.

Louw, V.N. (2012). From Public Administration to Governance: science or ideology. Department of Public Administration and Management University of South Africa, *Journal of Public Administration* 47(1): 88-101.

Lund, T. (2012). Combining Qualitative and Quantitative Approaches: Some arguments for Mixed Method. *Scandinavian Journal of Educational Research*, 56(2): 155-165.

Maartens G, Cotton M, Wilson D, Venter F. (2012). Handbook of HIV Medicine. 3rd ed. Cape Town: Southern Africa:- Oxford University Press.

Malaudzi, F.M., Phiri, S.S., Peu, D.M., Mataboge, M.L.S and Mogale, R.S. (2016). Challenges experienced by South Africa in attaining Millenium Development Goals 4, 5 and 6. *African Journal PRM Health Care Family Medicine* 2016; (8)2:947.

Malunga, C. (2012). Power and Influence: Self -Development lessons from African Proverbs and Folktales. USA:-University Press of America.

Matsoso, M.P and Strachan B. (2015). Human Resources for Health for South Africa: HRH Strategy for Health Sector 2012/2013 -2016/17.

May, T. (2011). Social Research: Issues, Methods and Process 4th Edition. Maidenhead, Berks: Mc Graw-Hill:-Open University Press.

Mayosi, B.M., Lawn, J. E., Van Niekerk, A., Bradshaw, D., Karim, A.S.S and Coovadia, H.M. (2012). Department of Medicine, Groote Schuur Hospital, University of Cape Town, South Africa.

Mbatha, B. (2010). Traditional healers and HIV and AIDS prevention and care in South Africa: the case of Mahlabathini District in KwaZulu-Natal. *Indilinga African Journal of Indigenous Knowledge Systems*, 9(2): 265-273.

McCusker, K.and Gunaydin, S. (2015). Research using Qualitative, Quantitative and Mixed Methods & Choice based on research. *Perfusion Journal*, 30(7): 537-542.

McNeil, M and Malena, C. (2010). *Demanding Good Governance: Lessons from Social Accountability Initiatives in Africa*. The International Bank for Reconstruction and Development, Washington DC:-World Bank.

McNiff, J and Whitehead, J. (2010). *Action Research: Principles and Practice* (2nd edition) London:-Routledge Falmer.

Miles, M. B., Huberman, A. M and Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd edition.). California:- Sage Publication.

Moshabela M., Zuma, T and Bernhard G. (2016). Bridging the gap between Biomedical and Traditional Health Practitioners. *South African Health Review*, 2016.

Naledi, T., Barron, P and Schneider, H. (2011). Primary health care in SA since 1994 and implications of the new vision for PHC re-engineering. *South African Health Review*, 17-28.

National Development Plan. 2030. Our Future-make it work. National Planning Commission. Department of Presidency, RSA.

National Department of Health. (2011). *Annual report*. Department of Health. South Africa.

National Department of Health. (2012a). *Saving Mothers Report 2008-2011*. Fifth Report on Confidential Enquiries into Maternal Deaths in South Africa. Department of Health, Pretoria.

National Department of Health. (2012b). *District Health Information System*. South Africa.

National Department of Health (2012c). *National Contraception and Fertility Planning Policy and Service Delivery Guidelines*. Department of Health, Republic of South Africa.

National Department of Health. (2012d). *South Africa's National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)*.

National Department of Health. (2012e). *Strategic Plan for Maternal, New-born, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 –2016*.

National Department of Health, (2013a). *Saving Mothers Report 2011-2013*. Sixth Report on Confidential Enquiries into Maternal Deaths in South Africa. Department Of Health, Pretoria.

National Department of Health . (2013b). *Desktop Review on Reproductive Maternal and Child Health (RMCH) in South Africa*.

National Department of Health (2013c). *National consolidated guidelines for The Prevention of Mother to Child Transmission of HIV*. Department of Health, Republic of South Africa.

National Department of Health. (2014). *KwaZulu-Natal Maternal Deaths report 2011-2013*. South Africa.

National Department of Health. (2015a). *Guidelines for Maternal Health in South Africa*. Department of Health, Pretoria.

National Department of Health. (2015b). *National Health Insurance for South Africa. Towards Universal Health Coverage*. Government Gazette, 11 December 2015.

National Department of Health. (2015c). *KZN Annual report 2014/15. Department of Health*. South Africa.

National Strategic Plan. (2017) South African National Strategic plan on HIV, TB and STIs 2017-2022, Draft.

Nesane, K., Maputle, S.M and Shilubane, H. (2016). Male partners views of involvement in maternal healthcare services at Makhado Municipality clinics, Limpopo Province, South Africa, *African Journal Primary Health Care Family Medicine* 8(2): 929.

Neuman, W.L. (2012). *Social Research Methods: Qualitative and Quantitative Approaches*, 7th Edition. New York:- Pearson Allyn & Bacon.

Niehof, A., Rugamela, G and Gillepsie, S. (2010). *AIDS and Rural Livelihoods, Dynamics and Diversity in Sub Saharan Africa*. Dunstan House, London EC1N, UK:- Earthscan LTD.

O' Leary, Z. (2014). *The essential guide to doing your research project*. United Kingdom: - Sage Publication.

Orner, P., de Bruyn, M., Harries, J and Cooper, D. A. (2010). Qualitative exploration of HIV-Positive pregnant women's regarding abortion in Cape Town, South Africa. *Journal of Social Aspects of HIV/AIDS*, 7(2): 44-51.

Oya, C. (2011). Africa and the Millennium Development Goals (MDGs): What's wrong and what's missing. *Revista De Economia Mundal*, 27:-19-33.

Patel, M. (2014). Contraception: Everyone's responsibility. *South African Medical Journal*, 104(9): 644.

Payne, C.M., Debbink M.P., Steele, E.A., Buck, C.T., Martin, L.A., Hassinger, J.A and Harris, L.H. (2013). Why women are dying from unsafe abortion: Narratives of Ghanaian abortion providers. *African Journal of Reproductive Health*, 17(2): 118-128.

Perez, A.M., Ayo-Yusuf, O.A., Kofman, K., Maker, A., Mokonoto, D., Naidoo, P., Rendal-Mkosi, K and Sallojee, Y. (2013). Establishing a Health Promotion and Development Foundation in South Africa. *South African Medical Journal* 2013; 103(30):147-149.

Peters, B.G. (2010). The politics of bureaucracy: an introduction to comparative public administration, (6th edition). New York:- Routeledge.

Phiri, T.M. (2015). Male partner support among young unmarried pregnant women in Durban. Unpublished University of KwaZul-Natal, Durban. Masters Thesis.

Plaaityjies, D. (2011). Future Inheritance: Building State capacity in Democratic South Africa. Jacaranda Media (Pty) LTD, 10 Orange Street, Sunnyside, Auckland Park, South Africa.

Punch, K. F. (2016). Developing Effective Research Proposals 3rd edition. London & Thousand Oaks CA:- Sage Publications.

Ramkisson, A., Coovadia, H., Hlazo, J., Coutsooudis, A., Mthembu, P., Smit, J. (2010). Options for HIV-Positive women. *South African Health Review*, Health Systems Trust.

Ray, S., Madzimbamuto, F.D., Ramagola-Masire, D., Phillips, R., Mogobe, K.D., Havernkamp, M., Motana, M., Mokatedi, M. (2013). Review of causes on maternal deaths in Botswana in 2010. *South African Medical Journal* 2013; 103(8):537-542.

Rene, E and Padarath, A. 2011. Editorial. *South African Health Review*.

Republic of South Africa.1996. The Constitution, Act No 108 of 1996. Pretoria: Government Printers.

Richard, M. R. (2010). *Old Advice for New Research*. Online publishing: Springer Science & Business Media. University of California, Santa Barbara, CA, 93106-9660, USA.

Roberts, A. (2010). South Africa: A patchwork quilt of Patriarchy. *Skills at Work: Theory and Practise Journal*, 3(59-69). SA ePublication Journal Collection.

Robinovitch, S.N., Stott, V and Fieldman, F. (2014). Towards evidenced-based, quantitative Sustainable Development Goals for 2030. *Lancet* 2014; 385:205-8. Simon Fraser University, Burnbay, Canada.

Rossmann, G.B. and Rallis, S.F. (2012). *Learning in the Field: An introduction to Qualitative Research*. 3rd Edition. Los Angeles: - Sage publication.

Ruiters, G and van Niekerk, R. (2012). *Universal Health Care in Southern Africa*. South Africa: - University of Kwazulu-Natal Press.

Sachs, J.D. (2012). From Millennium Development Goals to Sustainable Development Goals. *Lancet* 2012; 379:2206-11. Earth Institute, New York, USA: -Columbia University.

Sapsford, R. (2011). *Survey Research*. United Kingdom:- Sage Publication.

Sauro, J. (2011). *A practical guide to measuring usability*. Denver, Colorado.

Schelar, E., Polis, C.B., Essam, T., Looker, K.J., Bruni, L., Chrisman, C.J. and Manning, J. 2015. Multipurpose prevention technologies for sexual and reproductive health: mapping global needs for introduction of new preventive products. *Elsvier* incl. <http://dx.doi.org/10.1016/j.contraception.2015.09.002>

Schoon M G. (2013). Impact of inter-facility transport on maternal mortality in the Free State Province. *South African Medical Journal* 103(8):534-537

Silverman, D. (2011). *Qualitative Research* 3rd edition. Sage Publication Ltd. United Kingdom.

Singer, M and Erickson, P.I. (2011). *A Companion TO Medical Anthropology*. John Wiley and Sons Ltd. 350 Main Street, Malden, MA 02148-5020, USA.

- Somekh, B and Lewin, C. (2011). *Theory and Methods in Social Research* (2nd edition). London & Thousand Oaks CA:- Sage Publications.
- Soyeju, O. (2015). Making a Case for a Development-Driven Approach to Law as a Linchpin for Post- 2015 Development Agenda. *PER/PELJ* 2015(18) 2.
- Statistics South Africa. (2011a). Quarterly labour force survey-quarter 3, Statistical release P0211.
- Statistics South Africa. (2011b). Mid-year population estimates, Statistical Release P0302.
- Sullivan, T.R and Hirst, J.E. (2011). Reducing Maternal Mortality: A Review of Progress and Evidence- Based Strategies to Achieve Millennium Development Goal 5. *Health Care for Women International*, 32:901-916.
- Swanborn, P. (2010). *Case Study Research: What, why and how?* London:- Sage Publication.
- Taylor, S.J., Bogdan, R and De Vault, M. (2015). *Introduction to qualitative research methodology: a practical guidebook and resource..* Hoboken, N J:- John Wiley & Sons Inc.
- Theron, G.B. (2012). The C in CEmOC. Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Stellenbosch University, Tygerberg, South Africa.
- Thomas, G. (2011). *How to do your Case Study: A guide for students & Researchers..* United Kingdom:- Sage Publication.
- Thomas, F., Hanour-Knipe, M and Aggleton, P. (2010). *Mobility, Sexuality and AIDS.* Routledge, 2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN, USA.
- Turner, M., Hulme, D and McCourt, W. (2015). *Governance, Management & Development: making the state work, second edition.* New York, NY 10010:- Palgrave Macmillan.
- UNAIDS Case Study. (2012). Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS 20 Avenue Appia I CH-1211 Geneva 27 Switzerland.

UNAIDS. (2014). “World AIDS Day 2014 Report - Fact sheet”, available from <http://www.unaids.org/en/resources/campaigns/World-AIDS-Day-Report-2014/factsheet>.

United Nations. (2010). MDG Summit, New York, 20-22 September. <http://www.un.org/en/mdg/summit>

United Nations .(2011). *Sustainable development in the 21ST century: Implementation of Agenda 21 and the Rio principles*, detailed report on implementation of Agenda 21, Department of Economic and Social Affairs, New York, December.

United Nations. (2015). Millennium Development Goals Report, New York.

UNDP (2011): Human Development Report Equity and Sustainability: A better future for all. United development programme; 2011.

UNDP (2015): Transforming our world: the 2030 Agenda for Sustainable Development

UNDP (2016): Policy and programme brief, UNDP support to the implementation of the 2030 agenda for sustainable development January 2016, One United Nations Plaza, New York, NY, 10017, USA.

Upandhyay, P., Liabsuetrakul, T., Shrestha, A.B and Pradham, N. (2014). Influence of family members on utilization of maternal health care services among teen and adult pregnant women in Kathmandu, Nepal: a cross sectional study. *Reproductive Health* 2014, 11:92 doi: 10.1186/1742-4755-11-92.

Van der Berg, W., Brittain, K., Mercer, G., Peacock, D., Stinson, K., Janson, H and Dubeka, V. (2015). Improving Men’s Participation in Preventing Mother to Child Transmission of HIV as a Maternal, Neonatal, and Child Health Priority in South Africa. *PLoS Med* 12(4):e1001811.doi:10.1371/journal.pmed.1001811.

Van der Elst, H.J. (2012).The effectiveness of the Millennium Development Goals (MDG) as global paradigm shift for poverty eradication in sub-Saharan Africa. *The Journal for Transdisciplinary Research in Southern Africa*, 8(1) 134-153.

Vawda, Y.A and Variawa, F. (2012).Challenges confronting health care workers in governments’ ARV roll-out: rights and responsibilities. *SA e-Publications* 2012:15 issue 2 486-519. ISSN 17273781.

Violari, A and Cotton, M.F. (2008). Early Antiretroviral Therapy and Mortality among HIV-infected infants. *New English Journal Medicine* 2008; 359:2233-2244, November 20, 2008 DOI: 10.1056/NEJMoa0800971.

Voce, A., Bhana, R., Monticelli, F., Makua, M., Pillay, Y., Ngubane, G and Kauchali S. District Clinical Specialist Teams. *S A e-Publications* 2013/14. pg 45-58, ISSN 10251715.

Vyas-Doorgapersad, S. (2011). Paradigm shift from New Public Administration to New Public Management: theory and practice in Africa:*Td The Journal for Transdisciplinary Research in Southern Africa*, 7(2) 235-250.

Wheldon, J and Ahlberg, M.K. (2012). *Visualizing Social Science Research: Maps, Methods & Meaning*. United Kingdom:- Sage Publication.

World Bank. (2014). *World Development Report. Risk and Opportunity. Managing Risk for Development*.

World Bank Group. (2015). *Global Monitoring Report 2014/2015: Ending Poverty and Sharing Prosperity*. Washington, DC: World Bank. doi:10.1596/978-1-4648-0336-9. License: Creative Commons Attribution CC BY 3.0 IGO

World Health Organization. (2010a). *Guidelines on HIV and infant feeding 2010: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence*. Geneva.

World Health Organization. (2010b). *World Health Report*. Geneva: World Health Organization.

World Health Organization. (2012). *Trends in Maternal Mortality: 1990 to 2010: estimates* Developed by WHO, UNICEF, UNFPA and the World Bank. Geneva: World Health Organization.

World Health Organization. (2013). *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of intimate Partner Violence and Non-Partner Sexual Violence*. Geneva. Switzerland.

Yin, K.R. (2014). *Case Study Research Design: Design & Methods* 5th Edition. United Kingdom:- Sage Publication.

Zuma, J.G. (2009). *State of the Nation Address*. Republic of South Africa. Available at <http://www.info.gov.za> [Accessed on 19/10/2011].

Zuma, J.G. (2016). *State of the Nation Address*. Republic of South Africa 11 February. Available: <http://www.info.gov.za>[accessed on 03/03/2016].

8. ANNEXURES

| Annexure | Description |
|------------|-------------------------------------|
| Annexure 1 | Ethical clearance |
| Annexure 2 | Consent form |
| Annexure 3 | Interview schedule |
| Annexure 4 | Language practitioners' certificate |
| Annexure 5 | Turnitin originality report |



01 February 2016

Ms Sthembile Dlamini (213574512)
School of Management, IT & Governance
Westville Campus

Dear Ms Dlamini,

Protocol reference number: HSS/0078/016M

Project title: The influence of Millennium Development Goal 5 on Maternal Health in South Africa: A case study of Umgungundlovu District

Full Approval – Expedited Approval

In response to your application dated 18 January 2016, the Humanities & Social Sciences Research Ethics Committee has considered the above-mentioned 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 Shanika Singh (Chair)

/s/

cc: Supervisor: Professor K Raga and Dr M Subban
cc: Academic Leader Research: Professor Brian McArthur
cc: School Administrator: Ms Angela Pearce

Humanities & Social Sciences Research Ethics Committee

Dr Shanika Singh (Chair)

Westville Campus, Govan Mbeki Building

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Website: www.ukzn.ac.za



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville



UNIVERSITY OF KWAZULU-NATAL
WESTVILLE

Dear Respondent,

Master of Public Administration (MPA) Research Project
Researcher: Sthembile Promise Dlamini (083 750 0716)
Supervisors: Prof K Raga (raga.kishore@gmail.com) and Dr. Mogie Subban
(subbanm@ukzn.ac.za)
Research Office: Mariette Snyman (031 260 3039) snymanm@ukzn.ac.za

I, Sthembile Promise Dlamini an (MPA) student, at the Westville Campus, of the University of Kwazulu Natal. You are invited to participate in a research project entitled the influence of Millennium Development Goal (MDG) 5 on Maternal Health in South Africa: A case study of UMgungundlovu District. The aim of this study is to explore the influence of MDG 5 strategy on maternal health issues in UMgungundlovu District.

Through your participation I hope to inculcate a clearer understand of the issues and challenges relating to maternal health. The results of the survey are intended to contribute to the improvement of maternal health in UMgungundlovu District.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no repercussions. There will be no monetary gain for participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained of each respondent as well responses provided.

If you have any questions or concerns about completing the letter of consent about participating in this study, you may contact me or my supervisor at the numbers listed above.

The interview should approximately 20-30 minutes. I hope you will avail yourself to the study.

Sincerely

Researchers 'signature _____
Date _____

On separate page

CONSENT

I..... (Full names of participant) hereby confirm that I understand the contents of this document, the nature of the research project, and 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

.....



Name of Candidate

Dlamini Sthembile Promise
213 574 512

Proposed Degree

Master of Public Administration

The influence of Millennium Development Goal 5 on Maternal Health in South Africa: A case study of UMgungundlovu District.

**SEMI-STRUCTURED IN-DEPTH INTERVIEWS
RESEARCH TOPICS**

1. Maternal Health
2. Maternal Death
3. Millennium Development Goal 5
4. The Major Causes Of Death
5. Who Is At Greater Risk Of Dying
6. Primary Obstetric Causes Of Maternal Deaths
7. Number Of Women Who Attend Prenatal, Antenatal Care And Post Natal Care
8. Number Of Women Who Deliver In An Institution
9. Number Of Women Who Have A Skilled Attendant At Birth
10. Knowledge Of Sexual And Reproductive Rights
11. Family Planning Counselling, Information, Education And Communication
12. Importance Of Improving Maternal And Reproductive Health
13. Departments Response To Maternal Health
14. Civil Society And Other Stakeholders Role
15. Adolescent Sexual And Reproductive Health
16. Contraceptive Use, Fertility And Infertility
17. Termination Of Pregnancies
18. STIS and HIV/AIDS
19. Violence Against Women And Girls
20. Barriers To Seeking Health Care At Community, Household And Individual Levels
21. Barriers To Providing Optimum Maternal Care At Health Service Level



Name of Candidate

Dlamini Sithembile Promise
213 574 512

Proposed Degree

Master of Public Administration

The influence of Millennium Development Goal 5 on Maternal Health in South Africa: A case study of UMgungundlovu District.

**SEMI-STRUCTURED FOCUS GROUP DISCUSSIONS
RESEARCH TOPICS**

1. Maternal Health
2. Maternal Death
3. Millennium Development Goal 5
4. Reasons For Women's Deaths
5. Unplanned And Unwanted Pregnancies
6. Termination Of Pregnancy/ Abortions
7. Family Planning
8. Sexually Transmitted Infections (STIS) and HIV/1B
9. Prenatal, Antenatal And Postnatal Care
10. Ambulances/ Emergency Care
11. Community Involvement
12. Community Access To Health Facility
13. Expectations/Experiences And Perceptions Of Quality Of Care
14. Role Of Community Care Givers And Outreach Teams
15. Sociocultural Factors
16. Maternal Age
17. Marital Status
18. Ethnicity And Religion
19. Family Composition
20. Mother's Education
21. Gender Roles And Responsibilities
22. Traditional Beliefs And Medicines

Language Practitioner/Specialist: Language in Education

T. Reddy

B.A. ; U.E.D. (Natal); B.A. Hons. (UNISA); M.A. (Linguistics); Cert. in TRSOL. (Pittsburgh, USA);
Fellow English Spelling Board (Int.) UK
Tel (h) : 031 564 6975
Cell : 083 784 6975
e-mail : tcdreddy@gmail.com

To whom it may concern

Date : 27 02 2018

Re : Language Practitioner Report

Student : Sihemile Promise Dlamini

Dissertation : The influence of Millennium Development Goal 5 on Maternal Health in
South Africa : A case study of uMgungundlovu District

I have had the pleasure of reading the above dissertation submitted in partial fulfilment of the requirements for the Masters degree in the College of Law and Management Studies in the School of Management, Information Technology and Governance at the University of Kwa-Zulu Natal and found the language usage fluent and free of any grammatical inaccuracies.

The work has been read for punctuation, fluency and congruency, and meets the language and stylistic writing at this postgraduate level.

I deem the dissertation acceptable for final admission.

Regards

T Reddy



