

**WOMEN'S EXPERIENCES OF MATERNAL AND CHILD HEALTH (MCH) AND
FAMILY PLANNING (FP) SERVICES: A CASE STUDY OF CATO MANOR IN
KWAZULU-NATAL**

By

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DECLARATION

I hereby declare that this dissertation is my original work. Any work done by other persons has been properly acknowledged in the text. This dissertation has not been submitted for any other degree or examination at any other university.

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ABSTRACT

The increasing recognition that millions of women and children die every year as a consequence of the poor health of the mother coupled with inadequate care before, during, and after delivery, has highlighted the importance of seeking women's views of health services in order to contribute to improving women's health. In order to shed more light on women's views of health services, this study explores women's experiences of MCH and FP services in Cato Manor in KwaZulu-Natal. The study looked at a number of factors including knowledge of reproductive health services and interpersonal relations between women and health providers.

In-depth interviews with service users and CBHWs as key informants were used to obtain information for the study. The results suggest that the majority of the MCH service users expressed overall satisfaction with the services. Discontent mainly rose from lack of contraceptive counseling and the long waiting times at the clinic. Thus, suggestions to improve service delivery included increasing contraceptive counseling especially with regard to the range of methods and their side effects. The study also argued for sustainable improvements in women's health and increasing involvement of men in ensuring positive reproductive health outcomes for women.

LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CBHWs	Community Based Health Workers
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IUD	Intra Uterine Device
MCH	Maternal and Child Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
VCT	Voluntary Counseling and Testing

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CHAPTER ONE

INTRODUCTION

1.1. Background

For women of reproductive age, pregnancy and childbirth are the leading causes of death, disease and disability, accounting for at least 18% of the global burden of disease in this age group (WHO, 1998). Although the suffering and death of women while giving birth is a sufficient cause for action in itself, there are also other significant social and economic considerations. According to the World Health Organisation (WHO), families lose the contribution of the woman to household management and provision of care for children and other family members; the economy loses her positive contribution to the workforce; the community loses a vital member whose unpaid labour is often central to community life; children suffer most when a mother dies, surviving children are three to ten times more likely to die within two years than children who live with both parents; motherless children are likely to get less health care and education as they grow up. It is also important to note that women's wages and work within the home is increasingly becoming more important. The social and economic contributions highlighted above are dependent on women staying healthy through accessing antenatal, postpartum and delivery care, along with FP (WHO, 1998).

Every year over four million babies less than one month of age die, most of them during the critical first week of life; and for every newborn who dies, another is stillborn (WHO, 2003). Most of these deaths are a consequence of the poor health and nutritional status of the mother coupled with inadequate care before, during, and after delivery. Unfortunately, the problem remains unrecognized or - worse - accepted as inevitable in many societies, in large part because it is so common (WHO, 2003). It is for this reason that reproductive and sexual health care including family planning (FP) services and information is recognized not only as a key intervention for improving the health of women and children but also as a human right. All individuals have the right to access,

choice, and the benefits of scientific progress in the selection of FP methods (WHO, 2005).

The benefits of investing in sexual and reproductive health are economic, social and psychological. Care during the antenatal period improves a range of health outcomes for women and children (WHO, 2003). When women present for antenatal care early in pregnancy, it allows enough time for essential diagnosis and treatment regimens such as treatment of sexually transmitted infections (STIs) and management of anaemia. There appears to be a consistent link between use of antenatal care and delivery assisted by a professional health care provider (WHO, 2003). For example, women reporting four or more antenatal visits are far more likely to have given birth with professional assistance than women reporting fewer visits.

According to WHO (2003), the antenatal period presents opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their infants. For example, if the antenatal period is used to inform women and families about danger signs and symptoms and about the risks of labour and delivery, it may provide the route for ensuring that pregnant women deliver with the assistance of a skilled health care provider. The antenatal period provides an opportunity to supply information on birth spacing, which is recognized as an important factor in improving infant survival. Better understanding of foetal growth and development and its relationship to the health of mother results in increased attention to antenatal care as an intervention to improve both maternal and newborn health. Tetanus immunization during pregnancy can be life-saving for both mother and infant. The prevention and treatment of malaria among pregnant women, management of anaemia during pregnancy and treatment of STIs can significantly improve foetal outcomes and improve maternal health. It is also important to note that the antenatal period acts as an entry point for HIV prevention and care particularly for the prevention of HIV transmission from mother to child.

According to the United Nations Population Fund (UNPA, 2004), there are many advantages of FP. FP allows women to achieve higher levels of education and better balance between family and work. Contraceptive use confers health benefits due to the fact that it protects women and infants from the medical risks of pregnancy, delivery and postpartum period with particular reference to those associated with unplanned pregnancies, closely spaced pregnancies or pregnancies among women who are very young. In addition, contraception can avert significant economic, social and psychological costs, especially those arising from a mistimed or unwanted pregnancy (UNFPA, 2004).

In addition to supplying contraceptives, health facilities have an important role to play in ensuring good sexual and reproductive health outcomes (UNFPA, 2004). Providers of contraceptive services may advise clients to use condoms, which reduce the transmission of STIs, including HIV/AIDS. This, in turn, can lead to improved pregnancy and delivery outcomes for women, and improved outcomes for their newborns. Finally, postpartum and post abortion services often offer contraceptive counseling and services, which can help couples space their births and avoid recourse to abortion (UNFPA, 2004).

Besides yielding medical benefits, contraceptive services also offer a range of non-medical advantages. FP interventions also contribute to a range of development goals such as improving women's social position, contributing to economic growth, reducing poverty and inequality and expanding community and political participation. Delaying motherhood through the use of contraceptive services is likely to be an important factor that contributes towards women's achievement of higher education. Women of all ages report that using contraception to time births and avoid unintended pregnancies improves their personal well-being and status in the household. Qualitative research in different countries shows that contraceptive use reduces stress about the risk of unplanned pregnancies and improves relationships between partners. For example, in Bolivia, women using contraceptives demonstrate greater self-esteem than nonusers, and in the Philippines, contraceptive users report greater overall satisfaction with their lives than nonusers (UNFPA, 2004). Moreover, the dynamics of smaller families may reduce

gender discrimination over the longer term (UNFPA, 2004). A study in Ghana found that children, particularly girls in larger families were less likely to attend school and experienced greater inequality within the household than those with fewer siblings (UNFPA, 2004). By contributing to smaller families, contraception may contribute to female education and equality. Maternal health care and contraceptive services also provide opportunities to screen women for gender based violence and also offer counseling. Additionally, by protecting and improving health, contraceptive services and maternal health services, like other health interventions, increase productivity in the home and labor force, resulting in personal, household and societal economic benefits (UNFPA, 2004).

Contraception reduces poverty and inequality because the prime beneficiaries of public sector sexual and reproductive health care are the poorest and most disadvantaged women and men, who would otherwise not be able to access care. Empirical studies from many countries demonstrate the benefits of small families in reducing poverty at the household level (UNFPA, 2004). For example, a study of women in Kenya found that the main reasons for late repayment of micro credit loans was directly related to expenses in the family, often involving the diversion of funds to cover costs for medicines, school fees or housing costs. It is argued therefore that contraceptive services and maternal health care would help these women continue their entrepreneurial activities (UNFPA, 2004).

It should be noted, however, that the benefits of investing in maternal and newborn health plus FP cannot be accrued without involving men in MCH and FP care seeking. Thus, practical ways to include men in reproductive health are being sought. Specifically, the International Conference on Population and Development in 1994 and the 1995 Fourth World Conference on Women recognised the importance of including men in sexual and reproductive health for several reasons: men themselves have sexual and reproductive health needs; women's health cannot be improved without men's involvement, particularly in the areas of HIV/AIDS and contraception; and without men's involvement, gender equality cannot be achieved (Cooper et al., 2004). Following from this, Cooper et al. (2004) argued that identifying practical ways to include men in reproductive health is

a great challenge, as is re-orienting reproductive health services to accommodate male involvement.

In order to explore women's experiences of MCH and FP services, it is important to understand the historical, political, social and economic changes that have shaped the delivery of key reproductive health services in the country. This will be done by looking at the nature of reproductive health policy and services under apartheid and changes that have occurred to key areas of sexual and reproductive health in the post apartheid era.

1.2. Reproductive health policy and services

Under apartheid, South African society was racially segregated and extremely discriminatory (Cooper et al., 2004; Kaufman, 1998). The majority of the population were denied political, social, economic and health rights. The public health system was fragmented and characterised by geographical and racial inequalities. By the mid 1980s, ten state health departments existed as a result of the notorious 'homeland' policy. Three separate 'own affairs' departments of Health Services and Welfare for whites, coloureds and Indians were established under the Tricameral parliament, which was formed in 1983. The greatest proportion of health resources were allocated to the delivery of health care for the white minority in urban areas, with emphasis placed on the provision of curative, high technology, hospital based services in urban centres (Cooper et al., 2004; Kaufman, 1998).

Prior to 1994, women's health services consisted mainly of MCH services, with an emphasis on contraceptive services aimed at limiting population growth. Contraceptive provision had racial undertones, as the South African government sought to control the growth of the black population. Long-acting injectable contraceptives were strongly promoted for black women, particularly in rural areas, while the oral contraceptive pill, a more reversible method, was promoted for white women. By 1994, there were over 65,000 contraceptive service points in the country; the extensive availability of contraceptive services was in stark contrast to all other primary level health services,

including other reproductive health services, which were poorly developed and inaccessible to the vast majority of the population, especially people living in rural areas. Maternal health services were characterised by overcrowding, understaffing and lack of privacy, and women frequently experienced access problems. Hence, in 1994, the new democratic government inherited a deeply divided, fragmented and inequitable health system (Cooper et al., 2004).

There have been a number of significant achievements since 1994, although a number of challenges still remain (Cooper et al., 2004). There have occurred specific legislative and policy advances in areas of reproductive health, namely contraception, abortion, maternal health, female cancers, violence and HIV/AIDS (Cooper et al., 2004). Among the positive changes that have taken place is the growing interest in the role of men in reproductive health since the early 1990s (Maharaj, 2000). The 1994 International Conference on Population and Development (ICPD) in Cairo, and the 1995 Fourth World Conference on Women in Beijing, reaffirmed the importance of male participation in promoting gender equality and better reproductive health for men and women (Maharaj, 2000). It is also important to note that the 1998 Population Policy of South Africa provided a multi-sectoral framework for addressing population issues. This policy represented an important shift from the previous focus on population control to the focus on the empowerment of women, active involvement of men in reproductive health, and the need for both women and men to make informed reproductive decisions (Cooper et al., 2004).

The National Contraception policy (2002) and Service Delivery Guidelines (2004), which were developed using both local and international evidence, have been instrumental in identifying problems in contraceptive services (such as limited method choice, provider coercion, overly restrictive approaches to contraceptive initiation, the exclusion of men and lack of services for youth) and have provided a comprehensive framework for contraceptive care.

Despite the achievements highlighted above and the availability of contraceptive services, South African women continue to experience high rates of teenage pregnancies and unintended pregnancy (Cooper et al., 2004). For example; Cooper et al. (2004) point out that 35% have been pregnant by age of 19, and up to 53 % of pregnancies are either unplanned (36%) or unwanted (17%). Thus, greater efforts to improve women's use of effective contraception are required (Cooper et al., 2004).

1.3. Aims of the study

The aim of this study is to explore women's experiences of MCH and FP services in Cato Manor: both positive and negative. Those women who had negative experiences were asked what needs to be done to improve their experiences of MCH and FP services. The study also explores the extent to which partners of women clients are involved in MCH and FP. This is done not through interviewing men directly, but instead their female partners since the focus of the study is on women.

1.4. Significance of the study

It is hoped that this study will contribute to strategies that aim at making sexual and reproductive health services particularly MCH and FP respond to the people they serve through bringing to the fore women's voices.

Although this study is based on only twenty interviews and limited in geographical scope, the findings of this study provide detailed descriptions of women's experiences and as a result have value in the future planning and management of MCH and FP services in South Africa as a whole and in KwaZulu-Natal province in particular.

For the purposes of this paper, the term FP is used to refer to methods of preventing conception while MCH is used to refer to a set of services related to maternity care and basic childhood health care. MCH includes antenatal care, immunization against killer

diseases, emergency care for women and newborns during pregnancy, labour and delivery, newborn care, postpartum and post abortion care (WHO, 2003).

1.5. Organisation of the Dissertation

This dissertation is divided into six chapters. The first chapter provides a brief background to the study while the second chapter reviews relevant literature on women's experiences of FP and MCH. The following chapters examine the conceptual framework and the methodology. Chapter five reports on the findings of the interviews with women visiting FP and MCH services. In the final chapter, conclusions and policy recommendations are drawn and presented.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This literature review explores the experiences of women attending MCH and FP services. It covers a number of issues including information on the range of FP methods, contraindications and side effects, extent of provider's knowledge about contraception and MCH, interpersonal relations between women and health providers, appropriateness and acceptability of reproductive health services with a particular focus on privacy, confidentiality, waiting time, and consultation with provider.

2.2. Education

A number of studies show that female education generally increases women's receptivity to 'new technologies' including awareness and use of contraception and reduces women's desire for more children due to incompatibility between formal sector employment and child care. In addition, Navaneetham and Dhamalingam (2002) argued that educated and working mothers are more likely than uneducated and unemployed mothers to take advantage of modern health care services. Educated women are considered to have greater awareness of the existence of maternal health care services and benefits of using such services. They are likely to enjoy more autonomy within and outside the household and the skills acquired from schooling enable women to communicate with health professionals.

Education generally enhances knowledge about effective ways to prevent, recognise, and treat childhood and mothers' illnesses (Caldwell, 1979; Caldwell, Reddy & Caldwell, 1983; Mosley & Chen, 1984; Cleland and Van Ginneken, 1988 cited in Navaneetham and Dhamalingam, 2002; Streatfield, Singarimbun and Diamond, 1990; Stephenson and Tsui, 2002; Raghupathy, 1996; Burgard, 2004). Mekonnen and Mekonnen (2003) found that in Ethiopia the use of antenatal care linearly increased with education. About 72% of the

women with at least secondary schooling received antenatal care, while it was 45% and 21% for women with primary schooling and no education respectively. In rural India, Bonu and Rani (2003) also found that more educated women were more likely to seek care than their less educated counterparts. The probability of not seeking formal treatment was higher by almost five percentage points among women with no education compared with women with six years of schooling.

In South Africa, Fonn and Xaba (2001) noted that women are treated differently by health workers according to their educational level. A higher level of education enables women to get sufficient explanations concerning the health services that they seek. On the other hand, a lack of education on the part of women service users often limits the extent to which they get sufficient explanations for proper use of medications obtained from health facilities. For example, health workers sometimes feel that providing explanations to less educated women is not a good use of time because "*they just can't understand*" (Fonn and Xaba, 2001).

Chimere-Dan (1996) found that in South Africa the proportion of women currently using a contraceptive method increased markedly with level of education. Current use ranges from 16% among women with no schooling to 67% among those with higher levels of schooling. In Turkey, Celik and Hotchkiss (2000) found that women with at least one year of schooling were substantially more likely to use prenatal care than women without any schooling. Chiwizie and Okolocha (2001) assert that it is generally believed that formal education can make women less dependent on the more dangerous aspects of their culture that guide care seeking behaviour.

Paul and Rumsey (2002) pointed out that the educated family, in general, has better access to resources than the less educated family. They were of the view that educated families are more knowledgeable of health practices that influence the use of safer and more comfortable child birthing procedures. The influence of education goes beyond the mother's education to father's education, according to Burgard (2004). He highlights that father's education should also be included, because better educated men are likely to have more prestigious jobs and higher incomes than others. He found that in South Africa, each additional year of father's

schooling increases the odds of having a doctor present at delivery. From what has been highlighted therefore, it seems right to argue that education, or lack of it, to a large extent influences women's experiences of health services.

2.3. Age

The effect of age on women's experiences of MCH and FP services is largely seen in terms of older women's accumulated experience with these services and young women's exposure to modern medicine. Some researchers argue that since the younger and the older women differ in their experiences and influence, health seeking behaviour is likely to vary between younger and older women. On one hand, younger women are more likely to accept modern health care as they are likely to have greater exposure to modern medicine and have greater amount of schooling than older women. On the other hand, older women would have accumulated knowledge on maternal health care and therefore are more likely to have greater confidence about pregnancy and child birth and thus may give less importance to obtaining institutional care (Elo, 1992; Raghupathy, 1996 cited in Navaneetham and Dhamalingam, 2002).

In two rural and two urban areas of South Africa, Smit et al. (2002) found that younger women are more likely to have knowledge of certain contraceptive methods than older women. Klitsch (2002) found that knowledge of emergency contraception was higher among 15 to 34 year olds than older women. However, findings from different settings generally reveal that the direction of the effect of age is not clear. For example, Paul and Rumsey (2002) argue that the likelihood of pregnant teenagers dying from obstetric problems is at least 20% higher than for women in their twenties (Walsh, Feifer, Measham and Gertler, 1993; Tinkler et al., 1994). This is because the adolescent female does not reach full physiological maturation until she is in her late teens or early twenties. Similarly, women in the later years of their reproductive life are said to be at higher risk of obstetric complications; they have higher parities and with each succeeding birth, the likelihood of having a prolapsed uterus increases (Mahlasela and Pattinson, 1999-2001).

Burgard (2004) also noted that older women are more likely to be referred to hospitals for delivery than women of average childbearing age, especially those giving birth for the first time. In addition, older women may have more influence in household decision-making, leading to greater utilisation of prenatal and delivery care. It is noted that irrespective of maternal age, the risks of pregnancy and delivery complications increase after the third and especially after the sixth birth (Blair, 1980; Winikoff, 1983; Dixon-Mueller and Wasserheit, 1991 cited in Paul and Rumsey, 2002).

2.4. Birth order and parity

Number of previous live births also influences women's experiences of MCH and FP services. Mekonnen and Mekonnen (2003) found that in rural Ethiopia women with more than one child were less likely to receive delivery care compared to single parity women. They suggested that the possible explanation for the low use rate of antenatal care among high parity women seems clear and is mostly explained by the fact that such women develop confidence and may tend to believe that modern health care is not as necessary due to the experience and knowledge accumulated from previous pregnancies and birth. Stephenson and Tsui (2002) found that in Uttar Pradesh, India, high parities are negatively associated with the likelihood of receiving antenatal care and giving birth in a medical institution due to the fact that women with large numbers of children have greater difficulty than others in attending health care facilities because they must arrange for child care.

Closely related to the use of health services is birth order. Several studies have found a negative relationship between birth order and the use of health services (Raghupathy, 1996; Burgard, 2004). This could be due to many reasons. It is possible that high parity women tend to draw on past experience and are possibly less dependent on formal health care, particularly if they have not experienced difficulties with previous pregnancies. Alternately, such birth order effects could also reflect the time and resource constraints faced by women with larger families (Raghupathy, 1996; Burgard, 2004). An additional factor relates to whether these births had been planned or not.

Utilisation behaviour may vary according to birth planning status. Women who had planned their births may be more motivated to use health care compared to those whose births were mistimed or unplanned. However, findings by different researchers have yielded contrasting findings. For example, McCray (2004) found that in rural South Africa women who have experienced multiple pregnancies seem to utilise prenatal care services more often and begin earlier than those experiencing their first pregnancy. However, Celik and Hotchkiss (2000) found that with respect to parity, women who were pregnant with their first child were also more likely to use prenatal care than women who have had two or more previous pregnancies. Although the majority of studies have discerned a negative relationship between birth order and the use MCH services, when it comes to FP, some studies found that as the number of living children increases, the desire to seek FP services will increase because a higher number of children are often associated with a lower socioeconomic status (Celik and Hotchkiss, 2000).

2.5. Pregnancy wantedness/unwantedness

Burgard (2004) pointed out that one of the factors that could influence a mother's use of pregnancy related care is the wantedness of the pregnancy at the time it occurred; unwanted pregnancies may be less likely to receive timely and adequate care (Oropesa, Landale, Inkley and Gorman, 2000 cited in Burgard, 2004). Weller, Eberstein and Bailey (1987) also pointed out that many women may attempt to conceal or deny an unintended pregnancy. Some may decide that initiating prenatal care or adopting major changes in life style, for example, giving up smoking is of low priority or an unrealistic expectation. Others may be relatively unconcerned about the health of the foetus. By contrast, it seems reasonable to assume that a woman who has planned a pregnancy will be more highly motivated to seek early prenatal care to ensure a highly successful outcome (Rosoff, 1985).

Women with unwanted pregnancies may initially attempt to deny their pregnancies because of the fear of the consequences. Thus these women may be less likely to obtain prenatal care, especially early in pregnancy. This is likely to influence the women's health care outcomes and shape their interactions with health care workers. Contraceptive use may

increase with previous experiences of unwanted pregnancies. For example, Lutalo et al. (2000) found that in Rakai district in Uganda contraceptive use was higher (17%) among women who stated that they had previously experienced an unwanted pregnancy, compared with women who did not report an unwanted birth. Five percent of the respondents reported that they had experienced an induced abortion, but contraceptive use was statistically significantly higher among women reporting having had an induced abortion, compared with women who did not report undergoing one (16% and 7%, respectively).

2.6. Previous experience of a child's death and abortion

Bhatia and Cleland (1995) argue that if a woman had a still birth or an abortion (either induced or spontaneous) in the past, the use of maternal care services is likely to be higher. The argument is based on the fact that women who experienced either a stillbirth or an abortion in the past, understand the heightened risk associated with the current pregnancy and therefore are more likely to take more precautions, and seek health care services (Bhatia and Cleland, 1995 cited in Navaneetham and Dhamalingam, 2002).

Stephenson and Tsui (2002) point out that among those who have lost a child, the results indicate increased caution concerning pregnancy and delivery care and also, perhaps, the desire to replace the lost child and hence, there is lower contraceptive use. According to Stephenson and Tsui (2002) therefore, the relationship between the death of a child and contraceptive use may, again, reflect a relationship between service use and poverty. Infant and child mortality is concentrated among the lower socioeconomic groups; therefore, those who have experienced the loss of a child are likely to live in poorer households with fewer resources to devote to the use of health care services. Alternatively, these results may also reflect attitudes towards health management. Child survival prospects are lower in households holding more traditional attitudes toward health care. Such households may also be the least likely to use contraceptive services.

In a study in Cape Town, Abrahams, Jewkes and Mvo (2001) found that, in general, women who had experienced problems in previous pregnancies had a clear idea of the

assistance they required from antenatal care. In Benin, Grossmann-Kendall et al. (2001) also found that if women experienced maternity complications in a previous pregnancy and had experienced a miscarriage, they would seek antenatal care much earlier than other women. If the pregnancy did not present any abnormalities, the women waited to have their first consultation until the end of the second or the beginning of the third trimester.

In Kenya, Njogu (1991) found that contraceptive use rates were less than half among mothers who had experienced at least one child death than among those who had not experienced such a loss. In contrast, in Rakai district of Uganda, Lutalo et al. (2000) found that contraceptive use was found to be significantly greater among women who reported prior unwanted pregnancies or induced abortions. The timing of MCH and FP care seeking due to previous abortion or child death often impacts on the relations between health providers and their clients which partly determines how the clients will experience these services.

2.7. Women's perceptions of quality

Perceptions of the quality of services may also influence use of services. Kyomuhendo (2003) cites studies in Botswana which found that 47% of women respondents attended antenatal clinics at health facilities, but 82% preferred to give birth at home and virtually none attended postnatal clinics. Those women who preferred to give birth at home said that they did so in order to be able to use traditional medicine and abdominal massage, and also because they were reluctant to entrust the disposal of their placenta and other products of conception to strangers like nurses. In addition, some women felt that home deliveries were both more convenient and safer.

2.8. Limited knowledge about reproduction and services

Information regarding the beneficial impact of preventive care for MCH and FP is an important aspect that influences decisions to seek care. Some women may not seek care because they do not realise that they are pregnant. Abrahams, Jewkes and Mvo (2001) found that in Cape Town some women often waited until two or three missed periods before concluding that they were pregnant. Myer and Harrison (2003) also found that some women in rural South Africa expressed uncertainty about pregnancy as is illustrated by the following quote: *'sometimes it's difficult to tell that you are pregnant. Some people have irregular periods, they miss periods for months only to find that they are not pregnant, so it's better to wait, to see if you are really pregnant'*.

Myer and Harrison (2003) noted a lack of perceived benefit of antenatal care among women in their study. They point out that most women appeared to see relatively little direct benefit from antenatal care. Some women said they were 'too lazy' to book early and so they just wait until later to book. Several women said that they saw no reason to book for antenatal care early because they had not experienced any problems, during either the current and/or previous pregnancies (Myer and Harrison, 2003; Joyce and Grossman, 1990 cited in Bugard, 2004). In their study, Abrahams, Jewkes and Mvo (2001) also found that most of the Xhosa speaking women in the study were vague about the purpose of antenatal care apart from its role in facilitating access to care during labour. In Malawi, Lule and Ssembatya (1995) pointed out that while it appears from the list of the health education topics given in the antenatal clinics that most of these mothers should have had sufficient knowledge about the onset of labour, and many of them were multiparas, apparently, many of them did not put that knowledge into practice. Indeed, 53% of those who delivered at home said that they did so because by the time they realised they were in labour they were no longer able to walk to the health centre.

Abrahams, Jewkes and Mvo (2001) argue that even women who have had many contacts with health workers sometime have inadequate knowledge or misunderstand instructions. This results in incorrect application of methods and sometimes unintended or even

dangerous consequences. Gready et al. (1997) point out that some women are not aware that the pills or injectables offered are actually contraceptives. The ambiguity continues even when it comes to sterilisations. In their study, Gready et al. (1997) found that one in three participants who had been sterilised were ill-informed about it. Women thought that sterilisations were irreversible. Klitsch (2002) also found that even women in South Africa who had heard of emergency contraception in general, were misinformed about its specific attributes. Although the majority of the women in the study had heard of the method, they were uncertain how soon after unprotected intercourse emergency contraception needs to be taken.

2.9. Infrastructure and Resources

Sometimes service users may lack confidence in the ability of service providers to respond adequately to their needs (Fonn et al., 1998). This is because of undependable drug supply, lack of transport and telephones, lack of equipment and inadequate facilities. In two of the three South African provinces covered by the study, clinics had poor electrification and inadequate or unreliable water supply which meant that sterilisation of the equipment could be problematic and emergencies such as night deliveries had to be conducted in sub-optimal lighting (Fonn et al., 1998). With regard to drug supply in the clinics, Tetanus Toxoid or contraceptives were available at the central supply depot, yet pregnant women would go unvaccinated or women would have to be given a different brand of oral contraceptive on a repeat visit because the required drug would not be available at the clinic. Availability of equipment was not satisfactory either. Only one third of the clinics had speculums, making the provision of additional reproductive health services, such as cervical cancer screening, highly unlikely (Fonn et al., 1998).

2.10. Organisational and Managerial Issues

Poor organisation and scheduling of services in reproductive health services leads to unnecessary long waiting times at clinics. Fonn et al. (1998) observed that women had to wait for about an hour and sometimes even up to three hours to receive less than ten

minutes of contact time with service providers. A multi-country study by Creel, Sass and Yinger (2002) revealed that long waiting times and inconvenient clinic hours prevent clients from obtaining the services they need. In Malawi and Senegal, clients identified long waiting times as a concern. Some clinics do not post their hours of service, or do not serve clients during certain hours when they are supposed to be open. A study in Kenya found that although clinics were officially open from 8 a.m. till 5 p.m., providers discouraged clients from coming in the afternoons and often did not provide services to women who were only able to attend in the afternoon (Creel, Sass and Yinger, 2002).

2.11. Interpersonal relations

Interpersonal relations between health providers and service users also affect attendance. In their study in South Africa, Fonn et al. (1998) found that clients were dissatisfied with the disrespectful ways in which they were treated by service providers. In their study in Cape Town, Abrahams, Jewkes and Mvo (2001) found that all but one of the Xhosa speaking women perceived that they were neglected by the midwives during pregnancy. In most cases, patients complained of staff ignoring them when they said they felt they were about to deliver. Although some women described having been examined several times by staff before delivery, several complained that after being sent to the waiting ward, none of the health providers checked on them. Some patients complained that staff made them feel like they were not their main concern. This included staff dismissing them while talking to each other, staff sleeping, and a midwife taking a private phone call in the middle of a delivery (Abrahams, Jewkes and Mvo, 2001).

In Uganda, Kyomuhendo (2003) found that many mothers felt that maternity care at government health facilities is characterised by insensitivity of health workers towards women. Other studies have also noted complaints about the rudeness of service providers (Okafor and Rizzuto, 1994; Grossmann-Kendall et al., 2001; Gready et al., 1997; Sychareun, 2004). Fonn et al. (1998) noted that health workers themselves believed that they delivered sub-optimal care to clients. In the 'Health Workers for Change' workshops,

health workers described themselves as rude, uncaring and insensitive and acknowledged that they treated clients selectively, showing more respect for men and discriminating against poor and illiterate women. They attributed these attitudes to their socialisation in a society stratified by class, race and gender and the nature of education they receive, which ignores interpersonal skills.

2.12. Marriage

Marriage in some countries throws some light on the experiences of women with health facilities. In Ethiopia, Mekonnen and Mekonnen (2003) pointed out that married women were more likely to use antenatal care than their unmarried counterparts. Although marriage is universal in Ethiopia, they found out that about 10% of births in their study occurred to women who were not married. The stigma associated with out-of-wedlock pregnancies could be severe in societies like Ethiopia. It is therefore not surprising that most of these pregnancies are unwanted or unintended. Moreover, women with unwanted pregnancies may initially attempt to deny their pregnancies to themselves and to conceal them from others. As a result, these become less motivated to seek antenatal care compared to their married counterparts. In rural Vietnam, Duong, Binns and Lee (2004) found that childbirth was commonly associated with marriage. Some women who are unmarried choose to deliver at home to avoid embarrassing situations. In addition, ever married women were much less likely to use contraceptives than never married women, suggesting that unmarried women were motivated to seek contraception to avoid pregnancy, even in a society where non-marital childbearing is not uncommon (Mazur, 1995). Women in unions may also be less willing to state that they used contraceptives, due to fears of censure from partners or other family members (Motsei, 1994). In South Africa, Chimere-Dan (1996) found that never married women were more likely than currently married women to be using a method.

2.13. Socio-cultural norms and religious beliefs

Socio-cultural norms and religious beliefs also influence reproductive health choices (Creel, Sass and Yinger, 2002). In a study in Pakistan, researchers found that 76% of husbands and 66% of wives feared that God would become angry if they practiced FP (Population Council, 1997). In some settings, the use of FP methods may challenge bio-cultural beliefs. For example, women in some societies believe that it is healthy to menstruate monthly and therefore refuse to use injectable contraceptives that often result in irregular bleeding, spotting, or amenorrhea. Providers often ignore such concerns because they do not consider them clinically significant. Sadana and Snow (1999) found that Cambodian women's perceptions of how modern methods prevent pregnancy and cause side effects are informed by local beliefs concerning fertility, conception and balance of bodily elements, rather than modern reproductive physiology.

A study in Ethiopia by Mekonnen and Mekonnen (2003) revealed that religion was an important predictor of use of antenatal care in rural Ethiopia. The negative influence of traditional religion in rural areas may be attributable to the traditional spiritual explanation of events, including diseases. Traditional perceptions of events may compel followers to use traditional medicines and only encourage the use of formal systems when the traditional options fail. Mekonnen and Mekonnen (2003) observed significant variation in the uptake of antenatal care by religious denomination. Those women who followed Orthodox, Muslim and Protestant religions exhibited comparable and higher use of antenatal care, than those women who followed traditional beliefs. Muslim women were 30% more likely to receive professional antenatal care services, while women with a traditional faith were 50% less likely to use the service than Orthodox or Catholic women.

Furthermore, Sychareum (2004) found that in Vientiane Municipality of Lao, a considerable minority in her study argued against the provision of contraceptive supplies to unmarried youth as a general principle, and unmarried young women in particular. They justified this on the grounds that it was wrong according to Lao culture and custom, which

disapproves of premarital sexual activity that is believed to encourage drinking, sex and spread of disease.

Some beliefs and practices may also harm the pregnant women. For example, in Uganda, Kyomuhendo (2003) noted that cultural perceptions of pregnancy and childbirth shape women's care seeking. Childbirth is perceived to be a battle which every woman is expected to undergo without signs of fear. The woman who delivers herself is highly respected while those who need to deliver by caesarean section and those who die in childbirth are seen as weak.

2.14. Costs

Although financial costs for services are not a barrier to care in South Africa due to the fact that health care is free for pregnant women and children under six years of age and contraceptives are also provided free of charge in public clinics, other costs to care still remain. MacCray (2004) pointed out that women are faced with time constraints because they often have to assume responsibilities for carrying out daily activities as well. When there is no one at home to care for young children, they must be taken with the mother on the journey. Carrying more than one child in an environment where travel is challenging could become a deterrent to making the decision to take the trip.

In other countries, financial costs are important factors that deter women from seeking care. In Kenya, clients said that low costs and proximity of services were the two most important factors that attracted them to services (Ndhlovu, 1995). A study in Bangladesh indicated that families spent money on health care only in a crisis situation. Contraceptive side effects and related problems are rarely seen as emergencies. Many women stopped using contraception or switched methods because they could not justify the expense of dealing with side effects (Creel, Sass and Yinger, 2002; Schuler et al., 2001). In a study in China, one woman explained, *'of course [when you are sick] you should seek a doctor. But if you have no money, how can you talk about going to see a doctor? Money is the important*

thing. If you have money, you will go to see the doctor, even if there is no way to go but to walk' (Wong et al., 1996).

Creel, Sass and Yinger (2002) highlight that even free or low cost reproductive and other health care involves costs, including the opportunity cost of time away from income generating activities (AbouZahr, 1996). Competing demands on a woman's time can also make it difficult for women to use services, particularly when facilities are far away. Child care, food preparation, household sanitation, maintaining fuel and water supplies, and income generating work outside the home can make seeking health care seem like a luxury. Duong, Binns and Lee (2004) noted that in rural Vietnam the cost of services was an important factor that affected the delivery option. In addition to the formal fee, indirect costs such as transportation, bribe money and time were incurred at a health setting. Similar findings were observed by Mamdani and Bangser (2004); Okafor and Rizzuto (1994); Kyomuhendo (2003) and Nanda (2002).

In Uganda, Nanda (2002) observed that women's ability to pay is not only affected by user fees but by other informal or hidden costs in addition to fees. She notes that there are several out-of-pocket costs for maternity care, such as gloves, syringes and drugs. If the expectant mother cannot cover those costs, she is likely to get poor attention even if she has paid the user fee. Therefore, poor women may not be able to seek care. Duong, Binns and Lee (2004) asserted that costs could contribute to a low utilisation of maternity services, especially among low income groups. Other findings from Zambia revealed that while the unavailability of drugs was the most common reason for not receiving sufficient medical treatment quickly, seven women in their study pointed out that sufficient medical treatment was too expensive (MacKeith et al., 2003).

2.15. Access to health facilities

The presence or absence of MCH and FP facilities in a woman's locality influences her decision to seek care. For example, a study in Tajikistan confirmed that women living in areas without a polyclinic or without accessible women's health services were significantly

less likely to have consulted a doctor during their last pregnancy than were women living in areas where such services were available (Falkingham, 2003).

A Cape Town study by Abrahams, Jewkes and Mvo (2001) found that transport to the health facility was problematic and affected by the time of the day and day of the week. When labour started in the afternoon or early evening, some women decided to go to the clinic early to avoid the inconvenience of looking for transport in the middle of the night, particularly over weekends. Similarly, when labour started late at night the women would usually wait out the night at home, instead of waking the driver, and so arrive in advanced labour. The travelling cost represented a major problem, particularly for the poorer Xhosa speaking women who were asked to deliver at a tertiary hospital. At night, women had to pay between R80 and R100 for a trip to the primary obstetric facility and up to R200 for a trip to a tertiary hospital. Women saved well in advance for this, but, it was a major problem for them if, when they arrived, they were told they were not in labour. In the small group of women in the study, this resulted in one high risk woman deciding instead to deliver on her own at home and another to just go to the local primary facility. One woman interviewed used a public ambulance, which took five hours to arrive (Abrahams, Jewkes and Mvo, 2001). It is for these reasons that the number of women attending postnatal care services is even lower than the number who deliver in a health facility (Fonn et al., 1998).

Glei, Goldman and Rodriguez (2003) found that in rural Guatemala lack of transportation, the cost of transport, and the difficulty of walking for hours to the nearest government health facility may also pose problems for pregnant women. Mamdan and Bangser (2004) found that distance was the second most frequently cited obstacle limiting people's capacity to treat illness, following the major obstacle of cost. These scholars assert that health services continue to fail the very poor. Deteriorating roads coupled with inadequate and unaffordable transport make it impossible for the poor to reach facilities. In rural Nigeria, Okafor and Rizzuto (1994) observed that poor women face particular obstacles as they have neither the time, money nor necessarily the incentive to access distant and low quality care. In coastal Kenya, Boerma and Baya (1990) found that distance to the health facility was an important determinant for use of modern health services.

2.16. Experiences specifically related to MCH services

2.16.1. Beliefs about Bleeding

Attitudes towards bleeding shape the perception of danger in the postpartum period which influences care seeking (Fikree et al., 2004; Thaddeus et al., 2004). The belief that bleeding after child birth is necessary, healthy, and cleansing is wide spread. Among the Bariba of Benin, for example, postpartum bleeding is considered normal and therapeutic. The Bariba believe that bleeding 'should not be inhibited', because it eliminates impurities in the woman that may cause swelling or pain. Some communities believe that, because the blood of childbirth is harmful, a woman needs to bleed a certain amount to cleanse herself (Fikree et al., 2004; Thaddeus et al., 2004).

The recognition of bleeding as a danger sign in the postpartum period may be confounded by beliefs that bleeding itself is a good thing (Fikree et al., 2004; Thaddeus et al., 2004). Even if a woman appears to be bleeding excessively, it may be viewed as a cleansing process. It is often difficult to distinguish a point at which normal bleeding becomes excessive. In Indonesia, for example, unusual bleeding is described as that which exceeds the amount lost in menstruation. In deciding how serious and how excessive the blood loss is, community members often refer to the number of pieces of cloth soaked, consistency of the blood (clots are specifically mentioned), and colour ('dark red blood'). More precise measurement of excessive blood is very difficult to obtain. Increasing recognition that bleeding is a danger sign in the postpartum period will therefore require responding to beliefs about bleeding that might work against a decision to seek care (Fikree et al., 2004; Thaddeus et al., 2004).

2.17. Experiences specifically related to FP services

2.17.1. Partners' approval/disapproval of contraceptive use

Klugman (1993) notes that many South African women are using contraception and that the use of contraception is increasing rapidly. Client attendance at FP clinics increased by 12.7% for the period 1989-1990 in comparison with the same period for 1988/89 and by

6% again for the period 1990/91. Klugman (1993) also asserts that the little research into women's perceptions of their husbands' attitudes to contraception in South Africa indicates that they still perceive that their husbands, boyfriends or parents disapprove of contraception, and that women are unhappy with contraceptive services and side effects. Many women express reluctance to use contraception or to tell their partners that they are using it because of their perception that men have a negative attitude to contraception and have the power to stop women from using it. Womanhood is defined in terms of women's childbearing capacity, and practices such as lobola /bohadi (bride wealth) give husbands rights over their wives' bodies and their children. This finding was supported by a study in KwaZulu-Natal, South Africa (Maharaj, 2001).

In addition, Klugman (1993) notes that conventional wisdom has developed which argues that contraception allows women to become promiscuous, and this also makes both men and parents of teenage girls antagonistic towards contraception. It is likely that partner's approval/disapproval will therefore determine contraceptive use. Casterline, Sathar and Haque (2001) point out that women's perception that their husbands oppose FP is a dominant factor discouraging contraceptive practice in a wide variety of settings, including Egypt (El-Zanaty et al., 1999), Guatemala (Asturias de Barrios et al., 1998); India (Viswanathan et al., 1998; Mishra et al., 1999), Philippines (Casterline et al., 1997) and Nepal (Stach, 1999).

A husband's disapproval may reflect his fertility preferences or other adverse feelings about contraception. In Uganda, Wolff, Blanc and Ssebuliba (2000) noted that for all methods combined (including abstinence), partner opposition appears to reduce contraceptive use by roughly one fourth for both men and women. Wolff, Blanc and Ssebuliba (2000) also noted that a partner's disagreement about future childbearing desires was found to affect women's unmet need in two ways: First, those who desire to stop childbearing in opposition to their partners' wishes are less likely to use any method of FP. Second, partners' disagreement can affect unmet need by forcing reliance on less efficient traditional forms of FP, such as periodic abstinence, that are at least potentially concealable.

In Pakistan, Stephenson and Hennik (2004) observed that the approval of a husband is crucial for a woman to use FP services. This was clearly shown by the finding that women whose husbands approved of FP were ten times more likely to have used an FP service. However, they point out that the influence on a woman's ability to seek FP services extends beyond the husband to other household members, in particular, the mother-in-law.

2.17.2. Provision of other reproductive and sexual health services at FP clinics

Women who visit FP and MCH facilities may also receive other sexual and reproductive health services. A study in South Africa found that white women who attended gynaecologists and general practitioners were being given pelvic examinations, regular Pap smears and were being taught to do breast self-examination (Gready et al., 1997). In contrast, most African and Coloured women did not appear to be getting Pap smears, breast checks or even pelvic examinations at the FP clinics they attended. This study highlighted the serious imbalances in the availability of resources for different sectors of the population. Some women in the study were getting not only contraceptive services but a fairly comprehensive reproductive health service when they went for contraception while the majority of the population who were using public sector services were virtually excluded from access to this level of care or resources. This is consistent with the findings of the study by Klugman (1993) which found that most clinics do not routinely take Pap smears and there is no programme for prevention of cervical cancer and STIs, even though these are endemic to South Africa. This results in women leaving the health facility without having had the general checkups that are a requirement for safe contraceptive use.

2.17.3. Information on contraindications and side effects

Hardon (1997) asserts that the most commonly reported contraceptive side effects are headaches, dizziness, and weight changes. In Matlab in Bangladesh, Hardon (1997) found that side effects such as dizziness, nausea, headache and general weakness were major reasons for discontinuing the pill. When a lower dose pill was introduced, it was less likely to be discontinued. In Sri Lanka women mentioned nausea, vomiting, headaches and

dizziness while in Thailand women mentioned reduced menstrual flow, heart palpitations, headache, dizziness, and weight loss as side effects (Hardon, 1997).

In their study, Gready et al. (1997) found that almost all participants in the study had not yet received sufficient information about side effects and contraindications of the methods they were using from the health workers. Many women were not told in advance about possible side effects associated with their method of contraception. Women using clinics and gynaecologists alike experienced problems with the way in which service providers gave information. One woman commented that side effects are not the same for all people and that clinic staff need to be given feedback to understand how contraception is affecting an individual. But when women gave this feedback, their concerns were not taken seriously. This happened to women visiting gynaecologists and clinics (Gready et al., 1997).

Insufficient information regarding side effects of contraceptives makes women fear that they will become infertile when they use contraceptives (Hardon, 1997). Hardon (1997) points out that in 1980 few women in Iran, Sri Lanka and Bangladesh were willing to use the pill to space their children until they had had enough children, as they feared the pill would cause infertility, which they related to the diminished flow of menstrual blood. In their study in Kenya, Rutenberg and Watkins (1997) noted that one participant stated that using oral contraceptives '*can cause blood to flow out of the nose and mouth, and can cause delivery of children with two heads or no skin*'. In Lao, Sychareun (2004) observed that in-depth interviews with providers revealed that although contraception may be discussed, the discussion tended to be superficial, and in general they were reluctant to discuss contraceptive options or explain the advantages, disadvantages and how to use the different types of methods. In South Africa, women reported that they wanted more information about how methods work, side effects, instructions on using a method, and information about follow up services (Gready et al., 1997).

2.17.4. Choice of contraceptive methods on offer

Gready et al. (1997) observed that in South Africa contraceptive methods that are generally on offer are limited. The vast majority of the women attending public sector FP clinics were consistently offered injectables as their first option. Several of the women who attended public FP clinics described health workers at these clinics as 'pushing Depo'. It was noted that women who were serviced by private sector were offered more contraceptive options than those serviced by the public sector. Access to available methods was often restricted by the health workers themselves regardless of whether it was private or public sector. Almost all the women in the study wanted to be offered a greater range of methods. Providing a wide range of methods can help clients find those that match their health circumstances, lifestyle, and preferences (Ross et al., 2002 cited in Creel, Sass and Yinger, 2002).

2.17.5. Medical Barriers to contraceptive use

While citing medical barriers to contraceptive use, Cottingham and Mehta (1993) note that women seeking contraceptive services in many countries may be subjected to unnecessary tests, asked to return for follow up more frequently than is appropriate, told it is not safe for them to use a method when it would be safe, or required to furnish their husband's consent before obtaining a method. These practices have been described as 'medical barriers to contraceptive use' and defined as 'practices derived at least partly from a medical rationale that result in a scientifically unjustifiable impediment to, or denial of, contraception' (Cottingham and Mehta, 1993).

According to Cottingham and Mehta (1993), a recent WHO survey of more than 50 of its collaborating centres around the world found that there was a wide variation among the centres in the routine examinations and tests performed. Many of the centres offered pills, injectables and IUDs without conducting any blood tests, but others performed tests both prior to prescribing these methods and subsequently during their use. The most common practice was that of requiring users to come back to the centre more frequently than

appeared to be necessary. Most of the centres prescribed pills for only 2-3 months at a time, and called IUD users back every 4-6 months. The main conclusion of the WHO survey is that there appear to be no norms or consensus as to the minimum but necessary elements of care at the time of initial uptake of a method or subsequently during the period of its use. Cottingham and Mehta (1993) argue that one of the major problems appears to be a lack of overall standardised information about contraceptives, their side effects, and who can and cannot use them safely. From one country to another, information may be contradictory, and even the guidelines of different international agencies are not always consistent.

2.17.6. Appropriateness and acceptability of services

Indicators of appropriateness and acceptability of contraceptive services are mainly seen in terms of privacy, confidentiality, waiting time and time with provider (Gready et al., 1997). While almost all women in the study appeared to have ample access to contraceptive services, Gready et al. (1997) found that waiting time was a common problem. Many women mentioned changing to other services and being willing to pay more or travel further to find services with less waiting time. Many clinics only operate on certain days of the week, and several women suggested making services more convenient. Problems were also raised regarding lack of privacy at contraceptive services by women in the informal settlement and stockvel club groups. This was specifically related to FP clinics which served black working class areas. In the mobile clinic serving the informal settlement there was a complete lack of regard for privacy. The women were forced to queue out in the street and were therefore exposed to the public. Some women felt it would be better if separate services or service days were set up for men and for younger women. It was suggested that men would be less embarrassed about using condoms if they did not have to wait with women in order to acquire them (Gready et al., 1997). According to Creel, Sass and Yinger (2002), lack of privacy can violate women's sense of modesty and make it more difficult for them to participate actively in selecting an FP method. In a few places, obtaining and using contraceptives can be a difficult and risky decision that can lead to abandonment, violence, ostracism, or divorce. In those situations, women need assurance of absolute confidentiality (Creel, Sass and Yinger, 2002).

2.18. Male involvement in MCH and FP Care Seeking

Cooper et al. (2004) argue that women's health cannot be improved without the involvement of men particularly in the areas of HIV/AIDS and contraception. Male involvement also helps in achieving gender equality. Similarly, Kunene et al. (2004) noted that it is increasingly becoming clear that every pregnancy in South Africa faces an element of risk, because men, as partners and decision makers, are not informed about reproductive health issues. Furthermore, Tsui et al. (1997) noted that with respect to obstetric care, it is often families, and not the woman alone, who makes the decision and in the majority of cases, it is men who control the cash reserves or their permission needs to be obtained for obstetric care seeking. This suggests that listening to women's voices in order to make the services more responsive to their needs would yield little if their views are not sought regarding how to incorporate their partners in the use of those services (Tsui et al., 1997 cited in Kunene et al., 2004; Sivard, 1995 cited in Maharaj, 2001).

Salway (1994) observed that some scholars have recently suggested that African FP programmes are severely hampered by their neglect of men. These programmes are also hindered by the relative scarcity of information about men's knowledge, attitudes and practices regarding FP. Most investigations in this area focus only on women, ignoring their partner's role and the interaction between the sexes in fertility behaviour. Salway (1994) argues that research has often assumed that women's reports on contraception represent their partners' views yet evidence shows that women's reports often fail to represent the couple. Family relations involve both congruence and conflict, and the benefits and costs of childbearing and childrearing are not distributed equally between men and women. Thus neither sex can be ignored in attempts to understand fertility behaviour, and communication between partners may be vital to the use of a method of contraception. In order for men to become a positive force in a broad FP effort, they must see a benefit for spacing or limiting children, such as economic improvement for their families (Karra, Stark and Wolf, 1997). It was further noted that male involvement in FP is not dependent upon a change in gender relations, but it leads to changes in these relations over time as a result of increasing female education in smaller families. The findings of this research suggest that

male decisions to decrease family size can stimulate a process that results in long-term benefits for women and that male acceptance of FP need to occur in a context of women's empowerment.

Wegner et al., (1998) argue that men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use. Support may be essential if women are to practice safe sex or avoid unwanted pregnancy. Moreover, if men are knowledgeable about reproductive health issues and can communicate about them with their partners, they are more likely to be supportive during pregnancy and may make better health care decisions. They are more likely to ensure that their partner receives emergency obstetric services when needed, rather than delaying use of such care (Wegner et al., 1998).

Men's roles in contraception are seen in Davies, Mitra and Schellstede's (1987) findings from Bangladesh. It was noted that men play surprisingly important roles in Bangladesh's contraceptive marketing program. They act as providers of oral contraceptives in that they often collect contraceptives from the distributors and, in many cases, instruct their wives in correct method use. For example, 46% of women who were supplied by an urban provider, and 40% of those supplied by a rural provider said their husband was the main source of instruction in correct pill use. The only other sources mentioned with any frequency were field workers. Men are required to play such a key role because in some Muslim societies women generally do not venture outside their homes.

In Indonesia, Joesoef, Baghman and Utono (1988) found that the attitude of husbands towards birth control is the most important determinant of contraceptive use among urban women. Kamal (2000) points out that the findings from Muslim countries about the predominance of men in contraceptive decision making are true for other societies where traditional female gender roles mean that women have little say in sexual matters and lack the status to influence their partner's behaviour (Fort, 1989; Dixon Mueller, 1993). The same study also found that, in many cases, those women who are non-users use husband's disapproval as an excuse for being a non-user in future. In Kenya, husband's approval was

found to be an important predictor of use of modern contraception (Lasee and Becker, 1997).

2.19. Summary

This literature review has identified a number of factors that influence women's use of FP and MCH services in different contexts. Some of these factors impact positively on use of services while others impact negatively. However, these are likely to vary from one context to the next. A number of studies seem to suggest that men have an important role to play in the health seeking behaviour of women. Male involvement has increasingly been identified as an important factor contributing to the sustained use of health services by women.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

3.1. Introduction

This chapter presents the conceptual framework that informs the study. The conceptual framework draws on the quality of care framework and the behavioural model of health services. The quality of care framework emphasises the quality of reproductive health services while the behavioural model of health services emphasises contextual as well as individual determinants of access to health care.

3.2. Quality of care Framework

The quality of care framework stresses the importance of quality of services from the client's perspective, a neglected dimension of FP services. As shown in Figure 1, the quality of care framework emphasises six elements: choice of methods, information given to clients, technical competence, interpersonal relations, follow up and continuity mechanisms, and the appropriate constellation of services. This framework was designed to improve quality of care with the hope that improved quality can improve clients' clinic experiences and increase their knowledge and further resulting in more clients meeting their reproductive goals (Bruce, 1990).

Choice of Methods.

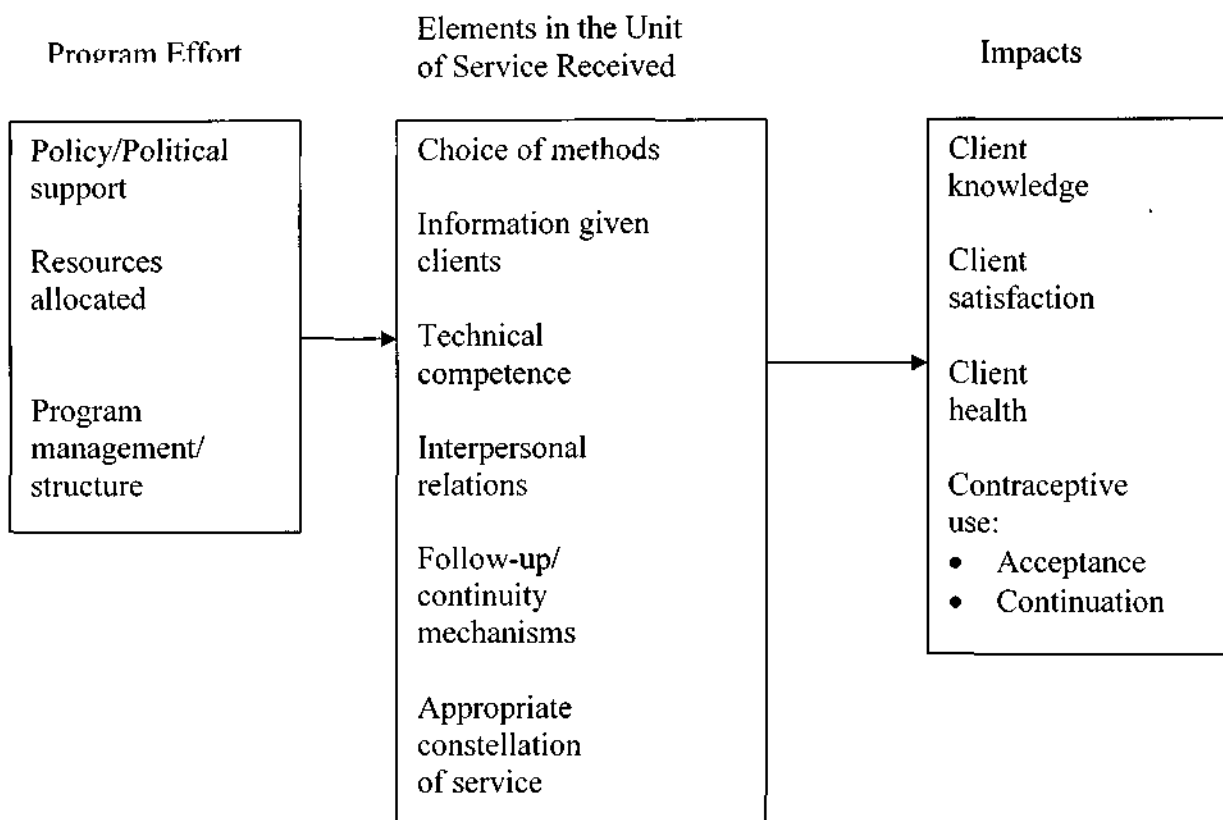
Choice of methods refers to the number of contraceptive methods offered on a reliable basis and their intrinsic variability. Methods should serve significant subgroups as defined by age, gender, contraceptive intention, lactation status, health profile, and also, income groups. In addition, there should be satisfactory choices for men and women who wish to delay or limit childbearing as well as those who cannot tolerate hormonal contraceptives. Providing choice does not necessarily mean that every program must

provide all methods, but the overall program effort on a geographic basis should enable prospective users to have equal access to a variety of methods.

Clients who are committed to practicing contraception may be discouraged from using a method if they are not given sufficient information or the desired method is not easily available. In addition, the information given to users must be practical and manageable. Although clients may not want and require a full scale lecture it is important to cover in sufficient detail information about the method they selected at the moment and emphasize the availability of other methods if their first choice becomes unacceptable after use.

Choice is the fundamental element of quality services. A range of methods, competently provided, will attract more acceptors and also, allow for switching of methods. Choice implies the provision of methods up to some standard of technical and interpersonal care. The provider's role should not be seen as the purveyor of technologies, but as a source of continuing support for individuals as their requirements change.

Figure 1: The quality of the service experience



Source: Bruce (1990).

Information given to clients

The second element in the framework is the information given to clients. Bruce (1990) defines information given to clients as the information imparted during service contact that enables clients to choose and employ contraception with satisfaction and technical competence. It includes information about a range of methods, their scientifically documented contraindications, advantages and disadvantages as well as screening out unsafe choices for the specific client and providing details on how to use the method selected, its possible impacts on sexual practice, and its potential side effects and finally, explicit information about what clients can expect from service providers regarding sustained advice, support, supply, and referral to related services, if needed.

If clients are not given usable and correct information, they cannot comply with the requirements of self-employed methods (condoms, spermicides, diaphragms, and oral contraceptives). If clinical methods, like IUDs and implants, are not explained sufficiently and their potential side effects appreciated, users are much more likely to discontinue use (Berelson, 1996 cited in Bruce, 1990). Unanticipated or unmanaged side effects lead to disappointed clients and result in discontinuation of contraceptive use, as Kreager (1977) persuasively documents. Lack of information is a reason for discontinuing use of a method and rumours may be a deterrent to use altogether. Contact between client and provider after the first encounter is irregular because too little attention has been given to establishing continuity or follow up mechanisms and because of the characteristics of the clients such as their geographic mobility and the desire for privacy which may tend to make them move among supply points.

Technical competence

Technical competence according to Bruce (1990) involves, principally, factors such as the competence of providers, the observance of protocols, and meticulous asepsis required to provide clinical methods such as IUDs, implants, and sterilization. Technical competence is the element in the framework least easily judged by clients. Clients mainly evaluate providers more on the amount of time they spend with them and their caring attitude than their technical skills (Lynn et al., 1985 cited in Bruce, 1990). According to this framework, interpersonal care and technical competence must come together and providers must understand the importance of observing safe clinical standards.

Interpersonal relations

The fourth element of the framework is interpersonal relations. Interpersonal relations as defined by Bruce (1990) refer to the personal dimensions of service. Relations between providers and clients are strongly influenced by a program's mission and ideology, management style, resource allocation, (for example, patient flow in clinical settings), the ratio of workers to clients, and supervisory structure. 'Interpersonal relations' is defined

as the effective content of the client/provider transaction. This dimension may strongly influence clients' confidence in their own choices and ability, satisfaction with the services, and the probability of a return visit. Bruce (1990) argues that what is desired is positive and productive exchange as perceived by the client. Furthermore, the client/provider contact should be characterized by two-way communication and question asking, and flexible guidance (as opposed to authoritarianism) on the part of the provider. The desired outcome from this transaction, from the point of view of the provider, may be that the client reports a belief in the competence of the provider, trust of a personal nature, and a willingness to make contact with the health facility again.

Mechanisms to encourage continuity

The fifth element of the framework is mechanisms to encourage continuity. Mechanisms to encourage continuity according to the quality of care framework can involve well informed users managing continuity on their own. They can rely upon community media, or on specific follow up mechanisms, such as arranging appointments or home visits by workers. According to Bruce (1990), poor initial contact, ignorance of side effects and the possibility of switching methods, and inadequate follow up are the primary reasons for terminating the use of specific methods or contraception all together. Although effective follow up and support of clients may demand some new resources, they also require a stronger marketing sense and innovative thinking.

Appropriate constellation of services

The final element in the framework is the appropriate constellation of services. Appropriate constellation of services as pointed out by Bruce (1990) refers to situating family planning services so that they are convenient and acceptable to clients by responding to pressing pre-existing health needs. Bruce notes that services can be appropriately delivered through a vertical infrastructure, or in the context of MCH initiatives, postpartum services, comprehensive reproductive health services, employee health programs, or others. At the very least, any family planning or reproductive health

service should include a sufficient standard. Reproductive health should seek to enable women to regulate their own fertility safely and effectively by conceiving when desired, by terminating unwanted pregnancies, and by carrying wanted pregnancies to term. In addition, women should remain free of disease, disability, or death associated with reproduction or sexuality (Germain, 1987 cited in Bruce, 1990). Although few programs can perform the above functions, such a concept provides a framework around which a broad service system could be organized (Bruce, 1990).

The quality of care framework has been criticized on grounds that its elements have been defined by 'experts' claiming to represent the clients' perspective, rather than by clients themselves (Veney et al., 1993 cited in Askew, Mensch and Adewuyi, 1994). Furthermore, Bruce (1990) argues that although the framework seeks to cover most aspects of care, it still may not be comprehensive enough for all purposes. One of the most obvious limitations of the model is that it does not directly deal with issues of access except that choice assumes access (Bruce, 1990). This calls for the behavioural model of health services, which attempts to address issues of access to care.

3.3. The Behavioural Model of Health Services

This is a model developed by Andersen in an attempt to understand basic trends as well as research and policy issues related to health care access. Access in this case is defined as actual use of personal health services and everything that facilitates or impedes their use (Andersen and Davidson, 2001). Similarly, access is the link between health services systems and the populations they serve. According to Andersen and Davidson (2001), conceptualizing and measuring access is the key to understanding and making health policies (see Figure 2).

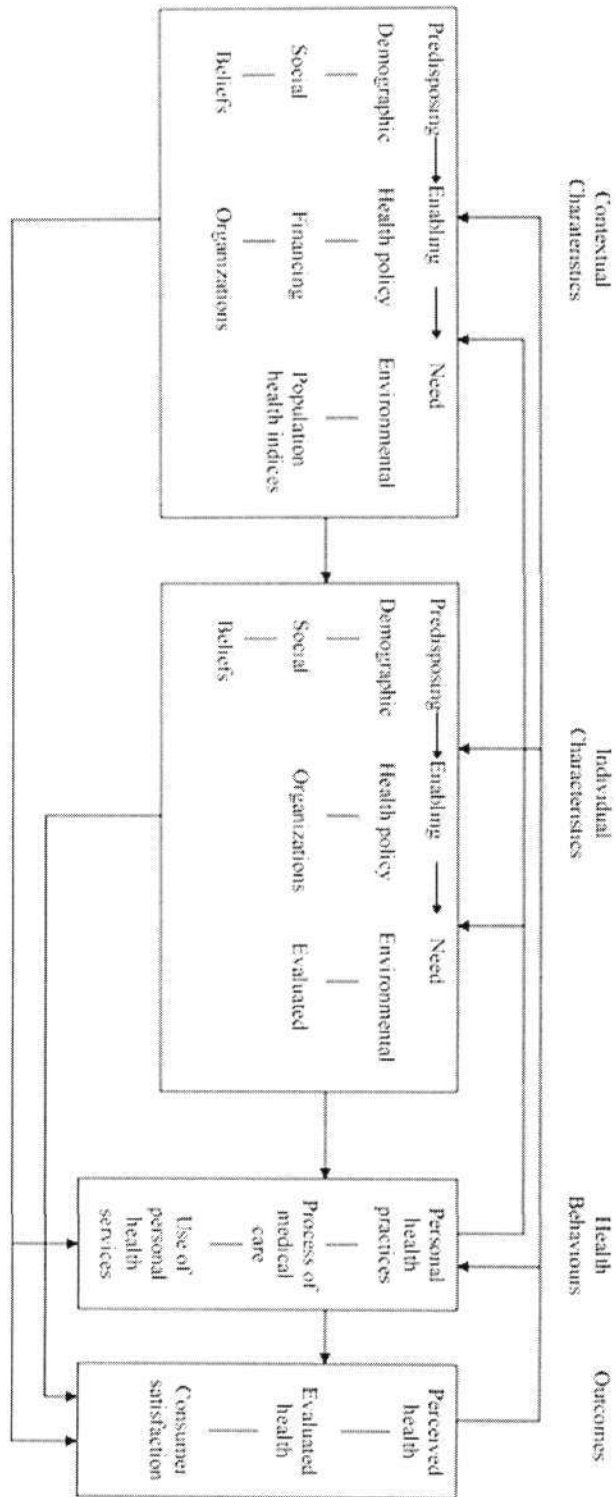
This model stresses that improving access to care is best accomplished by focusing on contextual as well as individual determinants. According to Andersen and Davidson (2001), context refers to the circumstances and environment of health care access. Contextual factors are measured at some aggregate level which ranges from units as

small as the family to those as large as a national health care system. In between are workgroups, provider organizations, health plans, local communities, and metropolitan statistical areas. Individuals are related to these aggregate units through either membership (family, workgroup, provider institutions, health plan) or residence (community, metropolitan area, national health system).

According to Andersen and Davidson (2001), the major components of contextual characteristics are (a) existing conditions that predispose people to use or not to use services even though these conditions are not directly responsible for use; (b) enabling conditions that facilitate or impede the use of services; and (c) conditions recognized by laypeople or health care providers as requiring medical treatment. The ultimate focus of the model rests on the health behaviours of individuals (especially their use of health services) and the resulting outcomes especially with regard to their health and satisfaction with services.

Figure 2: The behavioural model of health services

Source: Andersen and Davidson (2001).



Andersen and Davidson (2001) argue that the major components of the model are contextual predisposing characteristics that include demographic and social characteristics as well as beliefs. Social characteristics at the contextual level describe how supportive or detrimental the communities where people live and work might be to their health and access to health services. In addition, beliefs refer to underlying community or organizational values and cultural norms and prevailing political perspectives regarding how health services should be organized, financed, and made accessible to the population.

Contextual enabling characteristics involve health policies, financing characteristics and organization. Health policies are authoritative decisions made pertaining to health or influencing the pursuit of health while financing characteristics are described by an array of contextual measures that suggest resources potentially available to pay for health services. Organization at the contextual level includes the amount and distribution of health services facilities and personnel as well as how they are structured to offer services.

Contextual need characteristics involve environmental need and population health indices. Environmental need characteristics include health related measures of the physical environment, including quality of housing, water, and air. Population health indices are more general indicators of community health that may or may not be associated with the physical environment. These include rates of mortality, for example, infant mortality and mortality rates for HIV.

Andersen and Davidson (2001) argue that because contextual characteristics work through individual characteristics or influence health behaviours and outcomes directly, understanding the nature of contextual influences on access to care may permit important new insights into how to improve access to care.

In an attempt to improve access, the model also focuses on individual determinants which include individual predisposing characteristics. Demographic factors such as the age and

gender of the individual represent biological imperatives which determine the extent to which people need health services. Social factors determine the status of a person in the community and his or her ability to cope with presenting problems and command resources to deal with those problems. Health beliefs are attitudes, values, and knowledge that people have about health and health services which influence their need and use of health services.

Individual enabling characteristics involve the income available to the individual to pay for services. The organization of health services describes whether or not the individual has a regular source of care and the nature of that source including means of transportation and reported travel time to, and waiting time for care.

According to Andersen and Davidson (2001), individual need characteristics involve how people view their own general health, how they experience and emotionally respond to symptoms of illness, and worry about their health condition. Evaluated need represents professional judgment and objective measurement about a patient's physical status and need for medical care.

Health behaviours include behaviours by the individual that influence health status. The process of medical care is the behaviour of providers interacting with patients in the process of care delivery. Use of personal health services is the essential component of health behaviours in a comprehensive model of access to care. Andersen and Davidson (2001) note that one kind of result or outcome of health behaviour, contextual and individual characteristics is an individual's or patient's perceived health status. Evaluated health status is dependent on the judgment of the professional while consumer satisfaction is how individuals feel about the health care they receive.

Central to the model is feedback. This allows insights about how access may be improved. Feedback is depicted by the arrows from outcomes to health behaviours, individual characteristics, and contextual characteristics.

According to Bradley et al. (2002), there is a need to pay more attention to psychosocial factors in order to guide better, future investigations regarding long-term care use. It is important to note that although the model is not without limitations, it has been described as a leading model of access to care and has only been modified to apply to vulnerable populations and in the treatment of HIV-positive populations in the United States. It should also be noted that although the model has largely been employed in studies in the United States, it offers insights on issues of health care access even to developing country settings.

3.4. Summary

The conceptual framework for the study draws heavily on the Quality of Care Framework and the Behavioural Model of Health Services. For the purposes of this research, these theories are appropriate because they identify a range of factors that influence use of health services. These theories have been used in the design of the study, the collection and analysis of data.

CHAPTER FOUR

METHODOLOGY

4.1. Introduction

This chapter begins with examining the context of the study. It provides a brief description of the area in which the study was conducted. This study draws on qualitative in-depth interviews and key informant interviews. In-depth interviews were conducted with women attending a health facility in Cato Manor. Key informant interviews with Community Based Health Workers (CBHWs) complemented the information obtained from the in-depth interviews. The qualitative data provides detailed insights into the personal and private experiences of women attending the health facility.

4.2. Study area and study population

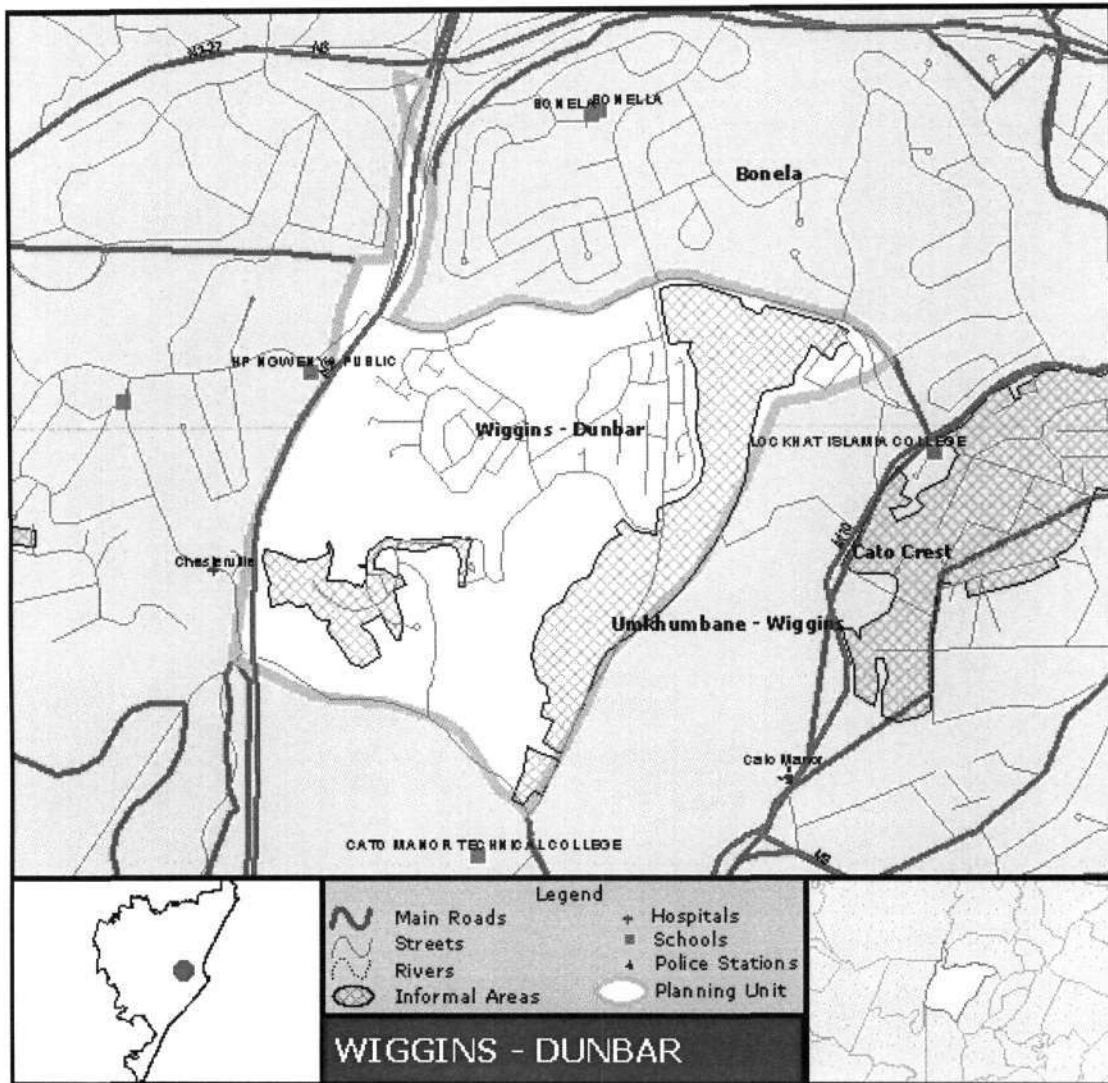
The study area (Umkhumbane) is located in Cato Manor in KwaZulu-Natal, one of South Africa's nine provinces, and the traditional home of the Zulu speaking people. The province is the third smallest, with a total population of 9 426 017 people living on 92 100 square kilometres of land (Statistics South Africa, 2004; Maharaj, 2004; McCray, 2004). In KwaZulu-Natal, the contraceptive prevalence rate is 57.1%. The province of KwaZulu-Natal is experiencing severe HIV/AIDS. The results of a survey conducted on blood samples from women attending antenatal clinics shows that the HIV prevalence in KwaZulu-Natal is 33% (South Africa Demographic and Health Survey, 1998; Department of Health, 1999 cited in Maharaj and Munthree, 2005).

Cato Manor is situated in the eThekweni metropolitan area and is 7 kilometres from Durban Central Business District. Durban lies on South Africa's eastern seaboard and is the largest metropole in KwaZulu-Natal (Cato Manor Development Project Progress report, 1999). The study area is bordered by the Pavilion Shopping Centre and the N3 freeway in the north, Samia road in the south, Manor Gardens and the University of KwaZulu-Natal in the

east and Westville Prison in the west, and is traversed by the national N2 freeway (Cato Manor Development Project Progress report, 1999).

Cato Manor encompasses an area of 2000 hectares and is a home to about 93000 people. The population is projected to increase to 170 000. This is an area that suffered greatly under Apartheid government's policy of forced removal of squatters. This therefore can partly explain the low socio-economic status of the majority of this study's interviewees. The post-apartheid development undertakings have had to redress these injustices and promote black empowerment through construction of low cost housing, schools, libraries, community halls, roads and clinics. The Umukhumbane Community Health Centre, whose clients were interviewed for this study is one of the clinics constructed in the area as part of the post-apartheid developments (Cato Manor Development Project Progress report, 1999). The study area was purposely selected because it was hoped to provide one of the most suitable environments that reflects how women's living conditions affect their access to health facilities.

Figure 3: A map showing the location of Umkhumbane



Source: eThekweni Municipality: http://www.urbstrat.org.za/urban_web/

4.3. Data collection, sample size and selection

This study was qualitative in nature. According to Rubin and Rubin, 1995 (cited in Ulin et al., 2002), qualitative data collection refers to a process of bringing what one wants to learn together with what one observes and with what participants know and have experienced (Ulin et al., 2002; Maykut and Morehouse, 1994). Mason (1996, cited in Ulin et al., 2002)

highlights that qualitative research is concerned with how the social world is interpreted, understood, experienced, or produced.

Qualitative research enables the exploration of a phenomenon in the light of related social, cultural, political, and physical environments of the people being studied (Ulin et al., 2002). It generates knowledge of social events and processes by understanding what they mean to people, exploring and documenting how people interact with each other and how they interpret and interact with the world around them. Valuing natural settings, one of the principles of qualitative research, helps researchers understand the lived experiences of people.

The qualitative research process is flexible, emergent, and iterative. The study design is never fixed; there is constant interplay between design and discovery and findings emerge continuously. The investigator is always in touch with the research process, observing how participants respond to the topic and examining data for fresh insights that might lead to altering a technique, modifying questions, or changing direction to pursue new leads. It therefore enables the researcher to be in partnership with the participant, working together to explore and find answers. Furthermore, as the researcher listens, interprets and responds to the participant, he/she becomes a key instrument, not only absorbing information but also influencing how it is elicited (Ulin et al., 2002). According to Ulin et al. (2002), three primary methods form the foundation of qualitative data collection: observation, in-depth interview, and group discussion. The qualitative methods that were employed for this study are the in-depth interviews with women aged 15 to 49 using FP and MCH services at Umukhumbane Community Health Centre plus interviews with five CBHWs as key informants.

4.4. The rationale for using qualitative methods

Qualitative methods, using in-depth interviewing approaches, produce contextual or holistic explanations for a smaller number of cases, with an emphasis on the meaning rather than the frequency of social phenomena (Van Maanen, 1983; Miles and Huberman, 1984;

Kirk and Miller, 1986; Patton, 1987; Merriam, 1988; Strauss, 1987 cited in Simmons and Elias, 1994).

Similarly, qualitative approaches such as direct observation in the field and in clinics have been employed to understand more fully the nature of the interaction between workers and their clients (Simmons et al., 1988 and 1990; Koblinsky et al., 1989). Additionally, these approaches provide an opportunity for people to reveal their feelings, the complexity or intensity of their feelings about FP and MCH services. According to Warwick (1982), such feelings are likely to differ from the more cursory appraisals possible in survey research (Warwick, 1982 cited in Simmons and Elias, 1994).

Simmons and Elias (1994) point out that qualitative methodologies yield contextual explanations that are essential for the full understanding of client-provider interactions and for designing user-oriented and effective programmes. In addition, Waitzkin (1991) argues that quantification alone does not address the complexities, context, or underlying themes of discourse and that it is only through 'an in-depth interpretive analysis' that these can be understood adequately. Gilligan (1982) noted that 'the way people talk about their lives is significant. The language they use and the connections they make reveal the world that they see and in which they act'. However, Simmons and Elias (1994) have noted that such research requires great skill as well as much closer association on the part of senior researchers with day-to-day research process in the field than is typically required in survey work.

4.4.1. In-depth interviews

The data for the study comes from in-depth interviews. In-depth interviews refer to an exchange between one interviewer and one respondent usually guided by a few broad topics. This method of data collection encourages study participants to take a more active role in determining the flow of the discussion. The interviewer and participant are collaborators, 'working together to achieve the shared goal of understanding' (Rubin and Rubin cited in Ulin et al., 2002). In a relaxed and comfortable setting, the interviews

generate empirical data by enabling participants to talk freely about their lives (Holstein and Gubrium, 1999 cited in Ulin et al., 2002; Simmons and Elias, 1994). Maykut and Morehouse (1994) observe that in-depth interviewing helps study participants to collaborate more actively with the researcher, generating rich, detailed data through expression of their own views and experiences. Furthermore, the depth of the conversation that characterises these interviews, which moves beyond surface talk to a rich discussion of thoughts and feelings allows prolonged engagement with the interviewee. This prolonged engagement allows the competent interviewer to establish rapport with the interviewee and to foster a climate of trust (Maykut and Morehouse, 1994).

However, Ulin et al. (2002) assert that in-depth interviews require creating natural involvement, encouraging conversational competence and showing understanding. While these may be good attributes, enough time and a highly competent interviewer are required for the fulfilment of the attributes. This may not be guaranteed especially for studies like the present one which was carried out by a research assistant due to language barriers and time constraints.

In addition, qualitative research in general requires flexible research methods, careful interviewer training, and recognising the limitations of results from small samples (Ulin et al. (2002). The fact that findings from small qualitative samples cannot be generalised, means that these studies require to be supplemented with quantitative research methodologies which may not be applicable to every context. Additionally, probing beneath the surface may be a difficult aspect of data collection for some interviewers and moderators and hence valuable information may be lost if data collectors miss opportunities to probe significant comments (Ulin et al., 2002). Finally, qualitative analysis is complex and hence undertaking a full scale qualitative study can be a very lengthy and tedious process (Hayes, 2000).

For purposes of this study, in-depth interviews explored women's experiences of health services during pregnancy, postpartum period, immunisation, contraceptive services and partner involvement in MCH and FP. An interview guide was used to ensure that all the

topics considered necessary for understanding the above experiences were covered. Ten FP clients and 10 MCH service users (five immunising their children and five seeking pregnancy related care) were interviewed.

In order to gain access to the health facility, permission to conduct the research was first obtained from the provincial department of health in KwaZulu-Natal. First, however, ethical approval to conduct the study was obtained from the Faculty of Humanities, Development and Social Sciences at the University of KwaZulu-Natal. Permission was also obtained from the health facility in which the study was conducted. In order not to disrupt the clinic activities, the chief nursing sister was informed of the visit before the interviews.

Clients were approached directly after they had completed their consultation with the health provider/s and asked if they would be willing to participate in the study. Upon agreement to participate in the study, clients signed consent forms and permission to tape-record the interviews was sought. The clients were assured that their responses would be kept strictly confidential to protect them from undue physical or psychological harm as a result of participating in the study. Recruitment of clients stopped when the required sample size had been achieved. The participation rate was high and only a few clients refused to participate in the study citing time constraints as the reason for not participating.

Participants were also assured that the study results would be sent to the organisations working in the area in order to contribute to local knowledge and discussion of the issues that would be raised in the interviews. The interviews were conducted at the Umkhumbane clinic and each interview lasted approximately for 20 minutes. All but one were conducted by a IsiZulu speaking researcher. A female researcher was preferred for the study because it was hoped that women service users would feel free to share their experiences with her. The interviews were conducted in the months of April and May 2005.

Five informal interviews were conducted with the CBHWs in the area. This was in order to explore differences between their views and those of women service users. The interviews

with the key informants took place at a time and place that was convenient to the CBHWs. These interviews were carried out in the month of June 2005.

4.5. Analysis

Interviews with clients were taped and later translated by the research assistant. A considerable amount of time was spent reading the transcripts and developing themes according to the study objectives and items covered in the interview guide. The transcripts were used extensively to illustrate particular findings.

Data obtained from the key informant interviews was mainly used to guide some of the study recommendations. Thematic analysis was used for the analysis of the study findings. Hayes (2000) asserts that thematic analysis involves identifying particular themes which occur in the material. These themes may emerge from the data as it is being analysed, taking the form of recurrent statements, attributions or assumptions which people make. Alternatively, the themes may have been determined before the analysis began, and the analysis may consist of identifying statements which relate to them. This type of thematic analysis is theory driven, and allows the researcher to use this kind of qualitative analysis to test specific hypotheses and ideas. It involves first sorting information into themes. Themes are recurrent ideas or topics which can be detected in the material which is being analysed, and which come up on more than one occasion in a particular set of data. This method is said to be original, and probably the most straightforward method of all the different qualitative techniques. However, Hayes (2000) points out that because the data are qualitative, often taking the form of interview, the information can vary a great deal. Thematic qualitative analysis involves the researcher searching diligently through the data in order to identify these themes. As a result, thematic qualitative analysis is almost always a long and tedious process (Hayes, 2000). This is because there is really no way of reducing the data and still retain the scientific rigour which is needed for research. Therefore, conducting a full qualitative analysis can be a lengthy process.

The process involved in thematic qualitative analysis according to Hayes (2000) begins with the preparation of the data. This is done in such a way that the researcher can return to

them over and over again. In the case of interviews this almost always means transcribing them so that the researcher can use a transcript of the results. Once the data has been prepared, one can begin to identify themes. In inductive thematic analysis, themes emerge from the data collected (Hayes, 2000).

In an inductive thematic analysis, the second stage of the research (after the data preparation stage) consists of reading carefully through all the data, and noting down any items of interest or other bits of information which seem to be relevant to the research topic. This is done separately for each transcript. At this point, the themes have not yet emerged. What the researcher is dealing with are specific items of information which seem to have some relevance to the topic which is being investigated. The third stage involves sorting out these various bits of data, and it is here that the themes begin to emerge. Items which appear to be dealing with similar topics are placed together literally, if the researcher is using paper records, or electronically in a computer system, the piles which develop as a result of this sorting process represent the themes which will form the basis of the analysis. At this stage, though, they are not the themes in their final form, each pile represents the beginning of a theme which will develop and change as the analysis proceeds. The researcher now has to take each pile separately and examine it to see exactly what each theme is. The theme will have to be given a provisional name. Once the above has taken place, the researcher then needs to take the themes, one at a time, and go through each of the transcripts again. Each one is carefully reread, to see if it contains anything which is relevant to the theme which the researcher is currently exploring. Once this second 'trawling' of the data has been completed, the researcher is in a position to take each theme and construct its final analytical form. This has three parts (a) a name, or label for the theme, (b) a definition of the theme, (c) the third part is the data which are relevant to the theme. In case of the interview data, this will consist of quotations (Hayes, 2000).

4.6. Limitations of the study

Interviews were conducted with women service users at the clinic premises through exit interviews and hence this study missed out on the perspectives of women who choose not

to seek services or those that were turned away. The study covered a limited geographical scope and thus, generalisation of results to the whole province of KwaZulu-Natal or to the entire country should be cautious. In an attempt to avoid bias, the interviewers took care not to show excessive interest in any of the details of what was being reported; they were also careful not to convey positive or negative judgements about what had been reported. Askew, Mensch and Adewuyi (1994) note that client reporting on interpersonal relationships is inevitably subject to courtesy bias and to a fear of criticizing those in authority (Askew, Mensch and Adewuyi, 1994). Moreover, people who experience a lengthy wait at the facility may be unwilling to spend more time answering questions. Due to the anticipated courtesy bias on the part of the clients, the client information was complemented by that obtained from the key informant interviews and this was obtained from a neutral setting with adequate privacy. However, it seems right to point out that more studies covering both client and provider experiences in the study area and in the country generally would provide more balanced views regarding experiences of delivery of health services.

CHAPTER FIVE

RESULTS AND DISCUSSION

5.1. Introduction

This chapter presents the findings of the study which are presented under a number of themes. The themes include knowledge and role of antenatal care, timing of immunisation, knowledge of family planning, provision of other reproductive health services alongside FP and MCH services and partner involvement in MCH and FP. It should be noted that while the reviewed literature on MCH included delivery, the results presented in this chapter do not include it because the clinic had not yet started performing deliveries at the time of the study.

5.2. Social demographic characteristics of the population

The study population was generally a young and fairly educated sample. The youngest respondent was 17 years while the oldest was 39 years. The mean age of the sample was 26 and only a quarter were older than 30 years. Level of education was relatively high. The majority of the respondents had secondary education. Only one had more than secondary education. Almost all the respondents were single and only one of them was married. The majority of the women were unemployed. Those women who were employed were either temporarily, informally or self-employed. Almost half of the respondents were FP clients while others had visited the clinic for pregnancy related care and for the purpose of immunizing their children.

5.3. Knowledge and role of antenatal care

The first component of MCH is antenatal care (WHO, 2003). Some of the essential components of antenatal care involve checking for eclampsia, anaemia, syphilis, responding to observed signs or volunteered problems, providing preventive measures, advising and counseling on nutrition and self care and developing a birth and an

emergency plan (WHO, 2003). The South African Saving Babies Report (2000) argues that provision of antenatal care and attendance at antenatal care is regarded as a cornerstone of perinatal care. It is pointed out that there are four aspects to antenatal care; prevention of problems, screening for problems, treatment of problems and transfer of information to the pregnant woman. For example, screening for problems enables detection and management of Syphilis, Anaemia, Rhesus iso-immunisation, Asymptomatic bacteriuria, Diabetes mellitus, Hypertension, HIV infection, Multiple pregnancy, previous pregnancy problems and fetuses with congenital abnormalities. Follow-up visits also allow detection, management and prevention of poor fetal growth, proteinuria, abnormal lie of the fetus, and postterm pregnancy. Overall, antenatal care thus helps ensure a successful outcome to the pregnancy (South African Saving Babies Report, 2000). Accordingly, the study attempted to explore knowledge of antenatal care among pregnant women that were interviewed for this study. The findings revealed that the majority of the women had inadequate knowledge about antenatal care and its role. Only a few of the women elaborated beyond ultrasound - what was commonly referred to as 'being shaken'. Some of the roles of ultrasound include checking the accurate date of the foetus as well for multiple pregnancies, placental location, unsuspected maternal abnormalities and fetal anomalies (American Family Physician, 2005).

For the majority of the women, antenatal care was almost synonymous to ultrasound. The majority of the respondents did not have a clear idea about the purpose of ultrasound. They referred to antenatal care day as the day for the ultrasound. The purpose of ultrasound according to the respondents is to find out whether the child is sitting and if it is still alive. The following quotation sums up what one of the women highlighted regarding her knowledge of antenatal care:

'what I know and understand is that my child is alive, he is sitting well. Those are the things that I need to be given here at the clinic' (Pregnant woman, # 2).

However, for the other respondents, who were able to elaborate on the importance of antenatal care beyond ultrasound, it included getting cards, testing blood, checking the

health of the mother, advising on breastfeeding and its importance, abstinence and safer sexual practices as well as what women should do in case they have tested positive for HIV. This is illustrated in the following comment:

'they teach you that if you are pregnant that you should go early to the clinic so that they may give blood tests, check if the child is fine and if the mother is in a healthy state to be able to give birth. And how a child is breastfed, and how important that is, and that we should abstain and practise safe sex' (Pregnant woman, # 4).

These findings are consistent with a study by Myer and Harrison (2003) which noted that beyond the procurement of antenatal attendance card, most women in their study appeared to see relatively little direct benefit from antenatal care. Similar findings were also noted in a study in Cape Town by Abrahams, Jewkes and Mvo (2001) which found that Xhosa speaking women were vague about the purpose of antenatal care apart from its role in facilitating access to care during labour. Additionally, the findings are also consistent with studies conducted in Tanzania and Benin by Aboud et al. (2002) and Grossmann-Kendal et al. (2001) respectively. These studies found that the majority of the women had very little or no information about the medical procedures used during pregnancy and birth, the causes of the complications they had or the purpose of the treatment they received. Given their limited knowledge of the role of antenatal care, it is highly unlikely that these women will demand all the antenatal care services they are entitled to, for better pregnancy outcomes and thereby not yielding the maximum benefit from the services that are in place to benefit them.

5.4. Timing of antenatal care

One of the other aspects explored was knowledge of the timing of antenatal care. WHO (2003) recommends that pregnant women have four routine antenatal care visits. The first visit should be before four months, the second visit should be at six months, the third visit at 8 months and the final visit at nine months. The findings revealed that almost all

women had no or inadequate knowledge about the required number of antenatal care visits. One of the women claimed that she had first visited the clinic on the sixth month of her pregnancy but had been turned away. She therefore only returned to the clinic in her eighth month of pregnancy, as is demonstrated in the following quote:

'I first came in the sixth month [of pregnancy], after two weeks they said they only see those who are eight months [pregnant]. I went and stayed at home and came back when I was in my eighth month of pregnancy' (Pregnant woman, # 1).

The women were generally uncertain about the required number of antenatal care visits. Even a fourth time antenatal care service user was unsure whether the number of visits was supposed to be three or five. She reported that she obtained most of her information from other clients. It therefore seems right to assert that insufficient number of antenatal care visits that result from inadequate knowledge about the timing of antenatal care may limit women from benefiting from other reproductive health services that are offered alongside antenatal services. Inadequate knowledge was not limited to the timing of antenatal care, but also extended to the timing of immunization.

5.5. Knowledge of different immunization packages

Immunization protects children from infectious diseases and forms an important part of child care. The timing and components of immunization and childcare particularly entail immunizing the newborn (for example giving BCG or Hepatitis B vaccine in the first week of life), advising on routine postnatal and follow up visits, and advising the mother to seek care if the baby has danger signs such as convulsions, fever, bleeding, difficulty in breathing or not feeding at all (WHO, 2005).

All the women interviewed for this study had basic knowledge about the importance of immunisation. They knew that immunisation is important for the health and wellbeing of the child and that it protects the child against diseases. None were able to highlight the specifics regarding the different immunisation packages administered to their children

apart from mentioning the parts of the body where their children had been injected such as thighs and arms. Furthermore, none of the women were clear about the exact timing and the required number of injections for a particular disease. What follows is what the women highlighted as the role for immunization:

'What I know is that a child receives this so that it does not get Polio and other diseases that could possibly be in a child' (Woman immunising her child, # 1).

'It is important to immunise the child because...what can I say; the child's lungs will harden if you do not immunise the child, I do not know how' (Woman immunising her child, # 2).

'Immunization protects the child from sicknesses. The child is protected from sicknesses like chicken pox and a lot of other diseases' (Woman immunizing her child, # 5).

'This is my first child. I did not know that I had to immunise my child. They told me that six weeks have to pass and then I should immunise the child, but unfortunately I came on the seventh week. I do not know, I last immunised at King Edward [Hospital], and they said that it is for Polio. At this clinic they gave him two injections on his thigh. I do not know if they wrote it on the card' (Woman immunising her child, # 3).

These comments reveal that some women do not understand what the health providers write on their children's cards and perhaps even on their own cards. It therefore seems unlikely that the women will be able to ask for clarification about issues that concern their health and the health of their children even when the health providers have time to address their concerns. It is also important to point out that inadequate knowledge about immunization may contribute to increased susceptibility to infections, particularly Tuberculosis (TB) which is already rampant in the area partly due to overcrowding and high HIV/AIDS infections. Inadequate knowledge regarding the importance and timing

of immunization therefore calls for reproductive health care training by CBHWs as well as the urgent need for visual health information such as charts.

5.6. Knowledge of FP

Clients should be given adequate information about a range of FP methods in order to make an informed, voluntary choice of a contraceptive method (WHO, 2005). In addition, information given to clients to help them make this choice should at least include explanations of the relative effectiveness of the method; correct use of the method; common side effects; health risks and benefits of the method; signs and symptoms that would necessitate a return to the clinic; information on the return to fertility after discontinuing method use and information on STI protection. The study found that the majority of the FP clients interviewed highlighted that all they know about FP is that it delays and stops pregnancy. Many of the women referred to FP as a method of prevention, as is illustrated in the following comments:

'Yes, I know that family planning protects you from being pregnant at any time'
(FP client, # 4).

'Prevention stops one from having a baby' (FP client, # 5).

'Ah, I know that it protects me from falling pregnant and things like that' (FP client, # 10).

5.7. FP methods used

Offering a variety of contraceptive methods to clients on a reliable basis offers satisfactory choices for men and women who wish to space, limit or who cannot tolerate hormonal contraceptives (Bruce, 1990). Askew, Mensch and Adewuyi (1994) point out that a client's ability to make an informed choice is determined by the number of methods discussed with her.

The majority of the clients had heard about both injectables and oral contraceptives. The most commonly used method was injectable contraceptives (Depo). However, a few were also using oral contraceptives (Nestalate). Some women were using injectables on the advice of their health providers. They stated that the health providers informed them that the methods are the 'right' ones for them. Some women also explained that they prefer to use injectable contraceptives because they only have to remember to take it once every three months. The oral contraceptive requires daily use and they were afraid that they may forget to take it and as a result, may fall pregnant. Only one of the clients reported that she had been asked to explain why she had decided to use the method by the health provider. One of the women pointed out that she had learnt about the method of contraception she was using from friends.

'I use Depo because it lasts long. I use it every three months. If I were to use the pill there is the danger that I will forget to use it. The nurse at the clinic suggested the injection for me and they thought that this was the right one for me' (FP client, # 9).

'I use Depo because most of the time they say that it is right. They say that when you are old it protects you. I decide to use it because I know it. I know that Nestrate is for younger people who are still fresh. That is what they say. But if Depo gives you problems then you can also use Nestarate (FP client, # 10).

'I heard that Depo protects if you are going to have sex. It protects you from pregnancy. This is what I have been told by others. I therefore decided to use it. I was told that if I had not used it then I would fall pregnant' (FP client, # 3).

Overall, the findings seem to suggest that the use of injectable contraceptives among black women under Apartheid has not changed much in the post-apartheid era. The findings of this study are consistent with another study in KwaZulu-Natal conducted by Maharaj and Cleland (2005). Their findings suggest that there has been little change in the available contraceptive method mix. Injectables continue to be the most widely used

method of contraception by women. Obviously there is a need for more information about other contraceptive methods, and it is imperative that the concerns of women regarding particular methods need to be taken seriously by providers (Cooper and Marks, 2001; Ndhlovu et al., 2003 cited in Maharaj and Cleland, 2005).

5.8. Knowledge of contraceptive side effects

Contraceptive side effects refer to the effects of contraceptives on the health of the user. A multi-country study found that side effects involved headaches, dizziness, weight changes, bleeding irregularities, decreased libido, depression and fatigue, nausea, vomiting and heart palpitations (Hardon, 1997). Most of these side effects were most common for women using pills. It should be noted that knowledge of contraceptive side effects is important if women are to continue using the FP methods they use. According to Gready et al. (1997), some side effects are annoying but others can be very serious. Hence, it is crucial that all potential users of a method are counseled on what to expect, and how to act regarding side effects they encounter.

In the study, women were asked whether they had experienced any problems with the method(s) they were using. The findings revealed that most women had no problems with the method(s) they were using. However, on further probing, it became clear that women did indeed experience side effects.

'Side effects? No, I have not experienced side effects. There have been no changes. However, my periods have changed. Sometimes I get them and sometimes I do not' (FP client, # 4).

'I do not see any problems. All I know is that I am gaining weight. That is all. With regard to changes in my period, I sometimes see drops of blood. I am not sure if this is normal' (FP client, # 5).

'No, family planning has done nothing to me. I get my period but not every month. The amount of blood is now less (FP client, # 7).

The findings reveal a general lack of knowledge of the side effects. Some women experience side effects of contraceptives but are not aware that these are side effects of the method. This seems to suggest that they may have received insufficient information about the methods of contraception. This is consistent with the results of a study conducted in Nigeria by Askew, Mensch and Adewuyi (1994). Their study found that less than two-thirds of new users in the study had been told how to use the method they accepted and about its possible side effects while only about one-third had been told how to manage any side effects that might have occurred.

5.9. Contraceptive counseling

The provision of complete and accurate counseling has been associated with higher levels of client satisfaction, as well as higher contraceptive prevalence and client retention (Townsend, 1991 cited in Creel, Sass and Yinger, 2002). Counseling is a key element in quality of care and is also an important component of both initiation and follow up visits (WHO, 2005). It is argued that counseling should respond to client needs not only for contraception but also related to sexuality and the prevention of STI, including infection with HIV. However, the findings of this study revealed that the majority of the FP clients had not received any contraceptive counseling. In most cases, they were only given the injection and informed of the dates on which to return. Only one had been counseled on the FP method she was using, but not about other methods. She had this to say:

'No, they did not explain to me [about other FP methods]. They just explained about the one that I am using. They told me that sometimes I will menstruate a lot, and then it will stop for a long time. They also said that sometimes I will notice drops of blood' (FP client, #9).

Upon further probing concerning counseling offered for other FP methods, the client explained that she had only been given information on the contraceptive method at a separate clinic while she was still pregnant. However, one woman explained that clients are sometimes told about condoms. The promotion of condoms in a setting with a high prevalence of HIV is important. Condoms provide dual protection against pregnancy and STIs (including HIV/AIDS).

'Yes, they sometimes tell you about the use of condoms, as you can see 'Love Life' is outside. They tell you about condoms, and sometimes when you go outside, they give you a packet of condoms' (FP client, #10).

According to WHO (2005), while the development of international norms for contraceptive provision is essential for quality of care in services, the social, cultural and behavioural context of each client must also be considered. In this regard, exposure to STIs (including HIV), deserve special consideration because of the high levels of HIV infections in South Africa. When the risk of STI/HIV transmission exists, it is important that health care providers strongly recommend dual protection to all persons at risk, either through the simultaneous use of condoms with other methods or through the consistent and correct use of condoms alone for both pregnancy prevention and disease prevention.

WHO (2005) argues that women and men seeking contraceptive advice must always be reminded of the importance of condom use for preventing the transmission of STI/HIV and such use should be encouraged where appropriate. Male latex condoms are proven to be highly effective against STI/HIV when used consistently and correctly. However, the study findings seemed to suggest that condoms are only promoted as a method of preventing STI/HIV and not as a method of contraception. This is based on the fact that most women did not regard condoms as a method of FP.

The results of the study indicate that women are rarely counseled about the benefits of a range of methods. Women are usually given information about a limited number of methods. In most cases, it is about one method, usually the injectable contraceptive. This

is consistent with the findings of other studies which found that contraceptive counseling is non-existent (Gready et al., 1997). Gready et al. (1997) observed that many women are not told in advance about possible side effects from their method of contraception yet it is crucial that all potential users of a method are counseled on what to expect, and how to act regarding side effects they encounter.

5.10. Provision of other reproductive health services

In South Africa, the definition of integration has taken the form of a 'one stop' supermarket approach, in which clients are offered a comprehensive range of reproductive health services (Lush et al., 1999; Department of Health 2000a cited in Maharaj and Cleland, 2005). Maharaj and Cleland (2005) point out that at the primary health care level the integrated reproductive health care package includes contraceptive services (except sterilization), early diagnosis of pregnancy and delivery of normal pregnancy, antenatal care, growth monitoring, child immunization, nutrition education, abortion services, screening for breast and cervical cancer, the prevention and syndromic management of STIs and to some extent, HIV education, counseling and testing (Department of Health, 2000a; Ndhlovu et al., 2003). Similarly, the integrated package of services is expected to be delivered at one location by the same staff. Maharaj and Cleland (2005) also argue that with quite high infant mortality rate, severe burden of curable STIs and with the highest level of HIV infection in South Africa, the case for high quality integrated sexual and reproductive health services is particularly strong in KwaZulu-Natal province.

In order to investigate whether women are offered a comprehensive range of services, women were asked whether they are offered any other information in addition to either pregnancy related care, immunization or FP services. Clients attending MCH services were more likely to report having received additional services than FP clients. All the women attending MCH services stated that they were offered additional services. The services offered at the clinic in addition to pregnancy related care included information

on child vaccination, advice on the types of food to eat, blood testing for HIV and explanations on child breastfeeding and its duration. This is illustrated in the following excerpt:

'We were told about AIDS so that we check so that we know the status of the child and so that we should receive help if we are HIV + positive' (Pregnant woman, #2).

Women who were immunizing their children were offered information about child spacing, nutrition, breastfeeding, testing blood for HIV and condom use. One woman pointed out that she had watched a film at the health facility that provided useful information on breastfeeding and its duration and also, included some information on child growth monitoring. Clients observed that providers give clients information on breastfeeding. One woman observed that providers often counsel clients on the importance of breastfeeding for babies younger than six months, as is illustrated in the following statement.

'The health providers encourage us to breastfeed up to six months and that we should not give the children other food because their stomachs are small. They tell us that when we have delivered we should not give the child the bottle because it upsets the child's stomach because the bottle is not as clean as the breast. They include many subjects. There is one provider who tells us something about breastfeeding, and then there is another provider who tells us something about diseases' (Woman immunising her child, #5).

However, it is important to note that some women felt that they also need information on how condoms work. Women observed that health providers mentioned the role of female condoms in protection against diseases but they would have liked more information about female condoms.

The majority of FP clients reported that they were told the date when they should return to the clinic. In most cases, the consultation only lasted a few minutes. Providers were able to answer all their questions but they were rarely offered additional information. Only few clients reported having been informed about the use of condoms, and the availability of other FP methods. Some clients would have liked to receive other services.

They usually give me all the information when I ask them but if I do not ask anything, they just give me an injection and tell me when I should come back, it does not even take five minutes (FP client, #10).

Almost none of the women interviewed for the study reported having been told about Pap smear or cancer screening in general, despite the fact that cancer is endemic to South Africa. The only woman who was aware of the Pap smear had heard about it in another clinic.

The inadequate information provided by providers especially as highlighted by FP clients is consistent with the finding of a study in KwaZulu-Natal by Maharaj and Cleland (2005). They noted that clients visiting health facilities are rarely offered a comprehensive range of services that will protect them against the twin risk of unwanted pregnancy and STI/HIV. Additionally, they assert that although some studies in KwaZulu-Natal found that the majority of clients were encouraged to use condoms, a critical prevention message in the high prevalence region, providers seldom mention the specifics of condoms, such as the sensitive issues of negotiation and gaining partner cooperation.

5.11. Time spent travelling from home to the clinic

In this study, the distance women covered from home to the clinic did not seem a major problem. While the study findings may be similar to what other studies have observed in urban and peri-urban areas, they are in sharp contrast with what other studies have observed in rural parts of the country where women often travel long distances to get to a

health facility (Mturi, Xaba and Sekokotla, 2005). For the majority of pregnant women, the distance from their homes to the clinic is very short because some of them reside in the informal settlement close to the clinic premises.

'It does not take long to travel from home to the clinic. It takes approximately 30 minutes because I stay in the squatter camp which is close to the clinic' (Pregnant woman, #1).

However, some of the pregnant women complained about the long distance. One of the pregnant women spent almost one and a half hours walking from her home to the clinic. Distance was not a barrier to health care for women who were bringing their children for immunization. The time spent walking to the clinic ranged from five to forty five minutes and most felt that this was reasonable. One woman had this to say:

'when I leave at seven you find that at 7:30 I am here. It is close but sometimes I arrive at 7:45 am' (Woman immunising her child, #3).

FP clients also did not spend a long time travelling to the clinic. Most stated that it took approximately half an hour to get to the clinic. The study findings are in contrast with the findings in other African countries (Mamdani and Bangser, 2004). In many African countries, distance is a major hindrance to care seeking. In Tanzania, Mamdani and Bangser (2004) found that poor women face particular obstacles as they have neither the time, money, nor necessarily the incentive to access distant and low quality care. Hence, issues regarding quality care need to be enhanced to compliment accessibility issues.

5.12. Waiting Period

The majority of the women complained about the long waiting time. They often spent two to four hours waiting for their consultation. This appeared to be a major cause of frustration among the women. Waiting time is considered an important factor affecting the acceptability of FP services (Askew, Mensch and Adewuyi, 1994). The clients felt

that the long waiting period was a result of the providers being slow and mixing up their cards. Some women wondered whether the health providers were 'taking tea'. These women felt that this would justify the long queues. The following quotes capture the attitudes of women towards the long waiting period.

'I came here in the morning, but those that were behind me have left. And I have not yet been attended to by the provider' (Pregnant woman, #3).

'Most of the time, what I come across is that things are slow, you find that we came here long ago, our cards are not yet read. Those who came after us received attention before us. They often mix the cards' (Woman immunising her child, #5).

Many women felt that it was important to arrive early in order to receive attention. They attributed the long waiting period to the time of arrival at the health facility. A large proportion of women arrived at the clinic one hour before the clinic opens. It is interesting that some of these women expect to wait for long periods of time before they receive any attention. One woman stated that she had arrived at 7.30 am and she was prepared to leave late. Fonn et al. (1998) attributes the unnecessarily long waiting times at clinics to poor organization and scheduling of services. It seems imperative to point out that while the long waits may not deter women from seeking long term contraceptive services such as injectables, they may deter them from attending the required antenatal visits especially if they have had no problems with the pregnancies. It was also pointed out that the long waiting period may also discourage the partners from attending the services.

Although the time spent in consultation did not seem a very serious concern to most of the clients as did the waiting time, the next theme elaborates what the study findings revealed about the duration of the consultation, because it is an essential element in assessing the quality of sexual and reproductive services particularly FP services.

5.13. Duration of consultation

Huntington and Schuler (1993) highlight that at least three out of Bruce's six elements for the assessment of an FP service's quality are manifested in an FP consultation: interpersonal relations, information given to users, and technical competence of the provider. An understanding of the dynamics in the consultation is essential for improving quality of care in FP programs. In line with this, the study findings revealed that the time spent in the consultation room particularly for the pregnant women was short. Most consultations lasted approximately five minutes. It was also pointed out that clients are rarely offered a comprehensive range of services. They are usually only given services for which they came to the health facility. However, some women pointed out that providers are willing to provide information if they request it. One of the women interviewed summed up what goes on in the consultation room:

'I have just come out there and it took me, I think, 20 to 30 minutes because others [nurses] ... are sure about what they are doing, others just rush things. She gives you time to express yourself if you have a particular problem, she is able to wait for you and allows you to explain, and then she carries on' (Pregnant woman, #3).

For the women who were immunising their children, nearly all felt that the consultation time was short. Only one of them reported she had spent a long time in the consultation. One of the four women who considered the time to be short had this to say:

'The time spent in the consultation is very short. You just do what you have to do and then leave. It is up to you if you ask questions, but most of the time, things are rushed' (Woman immunizing her child, #5).

Nearly all FP clients felt rushed because of the very short time spent in the consultation room. They felt that the providers would not welcome any questions. Some clients

pointed out that the consultation time often does not even take five minutes. One of the clients summed it up as follows:

'It doesn't take long because the nurse just asks you if you are coming for the injection and the date of your injection and then after you tell her the dates she injects you and writes it on the card' (FP client, #2).

This is consistent with a study of FP clinics in Zimbabwe by Janowitz et al. (2002). The study also found that providers spent little time with clients. Providers spent only 40% of their time in client consultations (Janowitz et al., 2002 cited in Maharaj and Cleland, 2005). In their study, Maharaj and Cleland (2005) also found that the main complaints from the clients were unreasonably long waiting periods and insufficient time to ask questions. It is possible that because of long waiting time and short consultations, women miss out on the information that would be offered during a normal consultation as well as opportunities for improving their relations with providers which impact on the quality of care.

5.14. Women's experiences at the clinic

Interpersonal relations according to Bruce (1990) refer to the personal dimensions of service. Interpersonal relations are defined as the effective content of the client/provider transaction. This dimension may strongly influence clients' confidence in their own choices and ability, satisfaction with the services, and the probability of a return visit. Huntington and Schuler (1993) noted that the development of a trusting relationship between the provider and the client is a significant indicator of the quality of the FP consultation.

Almost all pregnant women expressed a general satisfaction with the services they had received. They felt that they had been offered the services they had come to seek. One of the women was quick to point out that she had experienced bleeding during her pregnancy and had been given appropriate treatment by providers which stopped the

bleeding and also allowed her check the status of her pregnancy. Another one (a fifth time visitor to the clinic) pointed out that what had made her particularly happy was that when they checked her pregnancy they found her child's heart '*beating very well*'.

In general, clients described the providers as friendly and helpful but some felt that they would have liked more information. Interestingly, a substantial proportion of clients felt that there was not sufficient time to ask questions and some felt that providers did not give them the opportunity to ask questions about issues that they thought were important. In addition, some women wanted to ask questions but were uncomfortable raising the topic.

'It does happen sometimes when you find that some of them [nurses] are not friendly, but most of them are fine. There are those who have short tempers, and if you want to ask a question, you see by their facial expression that, Eish! You cannot ask even if you have a problem, now your problem is how do you ask?' (Pregnant woman, #4).

For women who had brought their children to the clinic for immunisation, almost all were pleased with the services they received and were generally grateful to the providers. One of them had this to say:

'At this clinic, I have never experienced anything bad. I have only compliments for the services. I have a child that is premature. I brought my child to the clinic and I had him immunised. I saw the difference in my child and I saw him grow quickly' (Woman immunising her child, #4).

The clients had strong words of praise for the services that they had received at the health facility, although the long waiting period is a cause of discontent. One of the women stated that providers were very willing to accommodate clients but felt that clients with young children should not have to wait from morning to late afternoon.

'Once we were sitting and waiting for our children to be immunised. We waited for such a long time until one nurse saw us. She went to the other nurses as they were getting ready to go for lunch and asked them to please help us. They attended to us before going for lunch. This shows that they are helpful and they care about clients. I will not say that the providers are bad because maybe it is how they do things here at this clinic. However, it would help if the women who are bringing their children for immunization were seen early in the morning' (Woman immunizing her child, #3).

Some FP clients felt that the providers were very slow. They felt that it did not matter if they came early or late because they were often seen at the same time by providers. FP clients were just as dissatisfied with the long waiting period as women bringing their children for immunization. One woman who brought her child for immunization expressed her concerns as follows:

'I am not happy with the slow nature in which they do things, because if you come early it is the same as somebody coming now' [past 10 am] (Woman immunizing her child, # 4).

In summary, while the good experiences need to be commended particularly regarding pregnancy related care and immunization services, efforts are required to improve FP services if women are to benefit from the wide range of reproductive health services provided by the clinic. The argument is based on the fact that women seek all the three services at one time in their reproductive life.

5.15. Partner involvement in MCH and FP care seeking

Studies have shown that women's health cannot be improved without the involvement of men (Salway, 1994). Hence, one of the objectives of this study is to explore whether male partners are involved in MCH and FP. As part of fulfilling this objective, women were asked whether they were accompanied by their partners. The findings revealed that the

majority of the women were not accompanied by their partners. The women explained that their partners were working and therefore were not able to accompany them to the clinic. The clinic was usually only open during working hours so it was not possible for the partners to accompany them. Some of the women also felt that there was no need for them to be accompanied by their partners. They preferred to visit the clinic on their own. Also, sometimes partners were not able to accompany their partners because they were caring for their children at home while the women visited the clinic.

'My partner works at night and comes back in the morning. He has no time to accompany me to the clinic' (Pregnant woman, #3).

'I usually go on my own because he is working. When I come back, I sometimes find him having washed the dishes, cooked, and done the washing. I have never asked him and he has never thought that he has to accompany me. It is just that I am not used to being accompanied. I do not like it when somebody follows me' (Pregnant woman, #5).

A few women were accompanied by their partners when they were not working. The women explained that men usually provided them with transportation to the health facility. One of the women stated that her partner accompanied her to the clinic, but he remained seated at the bench outside while she was in the consultation room. It is clear that even if the partners do not accompany women to the clinic, they continue to support them. Many of the women stated that their partners provided them with financial and emotional support.

'Sometimes my partner accompanies me if he is not working. He accompanies me and then sits outside on the bench and waits for me until we leave' (Pregnant woman, # 4).

'My partner helps me because he is the one who buys disposable nappies, and gives me money to come here to the clinic' (FP client, #5).

Women were asked if they would want their partners to accompany them during the next visit to the clinic. Some of the women indicated that they had started to think about the importance of including partners in care seeking. However, some women insisted that they do not feel it is necessary to come to the clinic with their partners. The study findings are consistent with the findings of a study by the Population Council (2005) which highlighted some challenges of involving men in maternal care in South Africa. The study by the Population Council noted that because most clinics in South Africa have no affiliation with male partners' workplaces, when men are invited, they often find it difficult to find time to attend antenatal and postpartum appointments. In addition, most women in the study were neither married nor living with their partners and as a result, it is difficult to contact their partners.

5.16. Suggested changes and additional information required

Understanding the needs of clients is an essential dimension of the quality of service delivery, according to Askew, Mensch and Adewuyi (1994). In line with this, women were asked what they would like to see change at the clinic and the information they would like to be offered during their next visit. The suggested changes involved increased speed in the provision of services, better treatment by health providers, more information on contraceptive side effects and immunisation, plus the need to throw more light on mother to child transmission of HIV and offering a place to rest for pregnant women.

The majority of the women felt that the providers were friendly and helpful but it was also clear that a few women felt that there was a need for some change in the attitudes of some providers. These women stated that they wanted to be treated with respect and dignity. One woman suggested that there should be translators at the health facility which would encourage good interpersonal relations between client and provider.

I wish we would be treated equally and nicely regardless of the languages we speak. I would also wish for a translator for the people who speak Afrikaans. I

would like to know what happens to the child in case one misses the immunization dates' (Woman immunising her child, #4).

Some women also expressed the need for more information. It would appear that many women are not able to broach particular topics with providers and as a result, they have many unanswered questions. Some women wanted more information about side effects of particular contraceptive methods while other women wanted more information about child immunization.

'If I am coming to prevent, I would like to have more information about the injection that I use. For example, how is it going to affect me physically? How long does it last and will it cause other sicknesses or problems later on in my life? If I am immunising the child, I would like to know the purpose of immunization. What does immunization protect against? (Woman immunising her child, #3).

'I would like to receive more information on injections on my next visit. I want to know how it works, because I hear that there are different types of injections' (FP client, #2).

'I would like to have more information about injections. I sometimes hear that when you use the injection you may experience problems. You become sick and blood comes out of your nose and ears. Now I do not know if that is the truth' (FP client, # 8).

Some women were very dissatisfied with the long waiting periods and they blamed the providers for the slow service. They felt that providers need to work faster so that they can attend to more clients in a day. Some women also argued that the long waiting period was resulting in the loss of FP clients. Women spend a long time waiting for FP services and usually the consultation only lasts for a few minutes. Some women blamed the long waiting time on the lack of efficiency. They wondered why women who came last often received services first.

'It is the long waiting time. I feel that things need to be quicker. I think that they need to hurry up. Otherwise I don't see a problem with the clinic. It is the people who work here. They are so slow because we spend all our time sitting here waiting to see them' (Woman immunising her child, #5).

'I would like them to call the numbers that we have been given in the correct order. They should not mix the cards. You find that you are number ten, and then you are called only among the 100s, and then you become puzzled' (FP client, #5).

'I would like them to speed up the services because most people are running away now. They say that this is my first and last time for coming to this clinic if the service is like this. You find that most people are going to Chasterville because the services here are not good' (FP client, #10).

Some pregnant women suggested that there should be a place at the health facility for pregnant women to rest. They found the long waiting period extremely exhausting and felt that it would be easier if there was a room where they could rest while they wait for their consultation. Some pregnant women also felt that they would like to receive more information about HIV/AIDS.

'I would like the clinic to have a place where I could rest. I would like to get information on AIDS. I would like to hear about AIDS properly, I have not heard about it properly' (Pregnant woman, #5).

It is important to note that while the women had a number of concerns about the services, this has not yet hindered them from seeking care at the health facility. However, these concerns may serve as a deterrent to women's future health care seeking behaviour if they are not addressed.

5.17. Sources of information

Information given to clients refers to the information imparted during service contact that enables clients to choose and employ contraception with satisfaction (Bruce, 1990). The study hence sought views from the women regarding the sources of information on FP and MCH. The majority of the pregnant women insisted that the clinic should be the sole source of information on pregnancy. Most of these women felt that they received all the information that they required from providers. However, a few women also felt that relatives (such as older sisters) have a role to play in the provision of information about MCH services because they often have personal experiences to share. In addition, a few women pointed out that the media has an important role to play in creating awareness of FP and MCH services. FP clients were more likely to suggest that the media has an important role to play in the provision of information. The FP clients were more likely to argue that the providers did not offer them all the information that they needed.

'If I could listen to the radio and also watch TV... I would like the TV because we come here [at the clinic] just to inject. We do not know anything that the injection does in particular. All we know is that it stops prevention' [controls birth] (FP client, #6).

'I receive all the information that I require from the providers. For this reason, I do not need to read newspapers or listen to the radio' (pregnant woman, #2).

'I think TV is the right source of information because they talk about something that you can see. Sometimes when you read the paper, and then do research on what is written, you find that what is written does not exist' (Pregnant woman, #4).

'I get my information from other people who have children. I have an older sister who provides me with information' (Woman immunising her child, #1).

5.18. Roles played by Community Based Health Workers

Friedman (2002) asserts that the umbrella term 'Community Based Health Worker (CBHW) embraces a variety of health auxiliaries who are selected, trained and work in the communities in which they live. The term is often used to include community/village health workers (CHWs/VHWs), *Onompilo*, community resource persons (CORPs) as well as a range of more specialised cadres such as community rehabilitation facilitators (CRFs), community based directly observed therapy short-course (DOTS) supporters, HIV/AIDS communicators (HACS), home based care (HBC) workers, first aid workers and lay health workers. All these types of CBHWs carry out one or more functions related to health care delivery and welfare, are trained in some way in the context of the intervention, but usually have no formal professional or para-professional certified or tertiary education. In general terms, the role of CBHWs is to act as agents for health promotion, care and health development. They also provide local outreach for health services that might otherwise be unavailable.

Friedman (2002) notes that in South Africa, CBHWs have played an active role in reducing child morbidity and mortality by promoting nutrition, growth monitoring, breastfeeding, immunisation, contraception and oral rehydration. Many groups have become involved in working with disabled children and on intersectoral social issues such as poverty relief, food security, water and sanitation, income generation, literacy education, obtaining child maintenance, care dependency grants and documents such as birth certificates. According to Friedman (2002), CBHWs would have played a more critical role in reducing child mortality, reducing fertility and improving life expectancy through out the country if it had not been for HIV/AIDS pandemic which is reversing the gains. But even given the challenge presented by HIV/AIDS, CBHWs continue to play a crucial role spanning health promotion, prevention, care, rehabilitation and palliation.

The study findings revealed that CBHWs in the area have been instrumental in promoting oral rehydration, hygiene, breastfeeding, condom use, reducing teenage pregnancies, fighting T.B and encouraging vegetable growing.

One of them pointed out that *'when it comes to running tummy, we do advise the women on how to make home made glucose and go to the clinic only when it has failed. We teach them about breastfeeding and also talk about T.B with the families. However, we often encounter problems because some of the houses in the area are very small yet some families have large numbers of people. People argue that they cannot get rid of T.B because of the large numbers of people sleeping in the same house. They often assert that we cook here, we sleep here, we do everything in one house. So, how can we run away from T.B?'* (CBHW, #1).

Another CBHW pointed out that they visit schools and remind teachers to talk about condoms. *'We do not only talk about HIV/AIDS in schools but also pregnancy because there are high pregnancies in schools. We also encourage people to have small vegetable gardens and share the harvest, cleanliness as well as teaching them about how to look after the dead'* (CBHW, #3).

However, it is important to note that specifics on FP, immunisation, male involvement in MCH and FP had never been tackled because the CBHWs highlighted that they had received no training on such issues. This calls for continuous, community-based and problems-oriented training to CBHWs to enable them to be true spanners of health care promotion and especially regarding reproductive health.

5.19. Summary

The results of the study are encouraging. The majority of the women expressed satisfaction with the services they had received at the clinic. However, women who were using MCH services were more to express greater satisfaction than women using FP services. The major source of discontent was the lack of contraceptive counseling and the long waiting times at the clinic. Partner involvement in MCH and FP was limited. Most women reported that they were not accompanied by their partners. It therefore seems right to argue that improving women's experiences of the three services covered by the

study lies in implementing the suggestions by women service users elaborated in this chapter.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study highlighted that overcoming women's death, disease and disability that are caused by poor health is dependent on women accessing reproductive health care services that prioritize their needs. Generally, the study findings noted that knowledge of antenatal care was inadequate. This is echoed by studies in other parts of the country and elsewhere in Africa (Myer and Harrison, 2003; Aboud et al., 2002). The studies found inadequate knowledge about the importance of antenatal care among rural women in South Africa and among women seeking antenatal care in Benin. Since some of the components of antenatal care involve checking for anaemia, syphilis, advising and counseling on nutrition and self care, inadequate knowledge of antenatal care therefore implies that some women miss out on opportunities of being informed about syphilis and anaemia despite the fact that they live in an area with high levels of poverty and HIV/AIDS. Both HIV/AIDS and poverty increase susceptibility to anaemia and STIs which may result in foetal and maternal anomalies. Inadequate knowledge about reproduction and antenatal care may also prevent women with pregnancy related problems from seeking assistance. This is largely because they cannot identify the causes of the complications during previous pregnancies.

Secondly, the study findings also revealed insufficient knowledge regarding the timing of antenatal care. This is likely to limit women from benefiting from other reproductive health services offered alongside antenatal care and may not help reduce complications related to pregnancy in order to contribute to improved labour outcomes.

While women in the study area had general knowledge regarding the importance of immunization, limited knowledge regarding the specifics about immunization may increase susceptibility to TB infections among both mothers and children since the area

has rampant HIV/AIDS rates coupled with a substantial number of its people living in poor houses.

The results show that the most commonly used method of contraception was injectables which is consistent with studies in other areas in South Africa. However, the dominance of injectable contraceptive limits clients from making informed choices about their method of FP. It should also be noted that lack of contraceptive counseling contributes to clients' uncertainty about health risks and benefits of different methods. This inevitably calls for information on other contraceptive methods to help clients have wider choices. It is also important that providers address women's concerns about particular methods. While the study dealt with women who access health services and found out that they had very limited knowledge about contraceptive side effects, it is important to point out that this knowledge is essential in order to ensure contraceptive continuation and to attract new users of FP.

The findings of this study revealed that contraceptive counseling seemed inadequate. Contraceptive counseling is associated with higher levels of client satisfaction, client retention and contraceptive prevalence. A similar phenomenon was also encountered in Sri Lanka, Iran and Bangladesh by Hardon (1997). Counseling is also a key element of quality of care. It is important that health services respond to the contraceptive needs of clients specifically with regard to sexuality and prevention of HIV and STIs. Inadequate counseling thus makes women encounter uncertainties regarding what to expect and how to act regarding side effects encountered.

It was noted that a range of reproductive health services is provided alongside immunization and antenatal care. However, regarding FP, limited additional information was offered. Additional information regarding specifics of other FP methods and condoms was only reported by few clients. The absence of knowledge on different types of cancer is also worrying since the prevalence of cancer is high among South African women.

In the study area, distance from home to the clinic was generally not a barrier to seeking health care. However, respondents expressed deep dissatisfaction with the long waiting time at the clinic. The long waiting time is a major deterrent to quality of services. The long waiting time at the clinic was found to be the greatest source of discontent among users of all the three services and was largely attributed to mixing of the numbered cards issued to women at the clinic. This calls for reorganization of service delivery in order to ensure that clients return to the health facility.

The consultation time which was reported to sometimes last for 'not even five minutes' is likely to impact on the quality of care. This makes women miss out on opportunities of improving relations with providers. This in the end impacts on quality of care since interpersonal relations influence confidence in choices, satisfaction with services and the probability of return visits. In addition, clients felt that they could not ask for information from the providers.

It is also important to note that male involvement in different aspects of reproductive health is essential if women's health is to improve. The ways in which men were involved in MCH and FP were through provision of transport to the clinic for their partners. Overall, men were not involved in MCH and FP care seeking. The main hindrance to partner involvement was the opening hours of the clinic. Most men were working during the opening hours of the clinic and therefore were not able to accompany their partners to the clinic. In addition, another major hindrance to partner involvement is insufficient knowledge by both men and their partners about the importance of male involvement in MCH and FP. Thus, suggestions for increasing male involvement included use of multimedia messages to inform men and their partners about the importance of male involvement in MCH and FP and formation of men's clubs in the communities to discuss the importance of male involvement in sexual and reproductive health.

The suggested changes to service delivery by women service users mainly involved putting more emphasis on provision of information on contraceptive side effects, better

and equal treatment of clients by providers and addressing concerns raised by individual women.

6.2. Recommendations

Based on the findings that knowledge of FP was limited to a few methods, and also the inadequate knowledge of contraceptive side effects, it seems appropriate to recommend that clients be provided with adequate knowledge about contraceptive methods and their possible side effects. Most of the clients had limited knowledge of the range of methods and therefore it is important to create awareness of alternative methods of contraception. This will enable method switching which will ensure sustained contraceptive use. To ensure continued use of contraceptives by service users without adding much workload to the health providers at the clinic, additional training in counseling and side effect management is important. These will also assist in passing on the knowledge acquired to service users.

The long waiting time at the clinic was the major source of discontent by both women service users and also CBHWs. Thus, ways of decreasing client waiting time need to be explored. This may involve serving regular FP users who are seeking answers to quick questions separately from those having their initial visits. The long waiting time should also be used as a medium for reinforcing oral and visual educational messages especially for new users of the clinic or to deliver specific follow up methods for FP clients who are still in the early method adoption process.

In general, women were satisfied with the services. However, there were instances when some nurses were said to be short tempered. For example, some women reported that they were sometimes scolded by the nurses. It is therefore imperative that clinic managers ensure that in addition to providing accurate information and observing technical protocols, they should ensure that providers relate sympathetically to clients and provide follow up information.

Huntington and Schuler (1993) suggest that in some instances service providers themselves can pose as clients at clinics where they are unknown. The direct experience of the client role could be a useful first step in strengthening empathy and communication skills among clinic staff. This element could be built into pre-and in-service training programs. This recommendation is also relevant to the study area.

Bruce (1990) suggests that clinic programs could use the six elements of her framework to begin the process of engaging staff in discussing the current level of care. In such an exercise, each of the six elements could be used as a discussion topic with managers and direct service - giving staff, using these providers' views initially to pinpoint difficulties. The information obtained from the providers could then be supplemented by feedback from clients. This would help improve women's experiences of health services.

The study findings revealed that counseling was insufficient, if not non-existent. This was mainly with regard to the side effects of particular contraceptive methods. Part of the solution lies in developing the counseling skills of service providers. This would help provide emotional support to clients.

The findings also revealed that the majority of the women do not come along with their partners to seek care. This calls for specific measures to increase partner support. For example, men may be asked to accompany women when they visit the clinic so that the management of side effects of contraception, antenatal and postpartum care can also be explained to them. Multi-media messages such as dramas reflecting partners' roles in health care could be developed for the masses. CBHWs could also assist in the formation of men's clubs in the communities for the discussion of various issues related to reproductive and sexual health. Kamal (2000) found that in southern India more than 25,000 barbers have been trained as community health workers because village men say they feel more comfortable talking to their barbers than to clinic workers.

Employment was highly cited as one of the reasons why men do not accompany their partners to the clinic to seek care for themselves and for their children. Thus, possibilities

of restructuring workplace programs in ways that employees are not penalized for accompanying their partners to the clinic (having to miss important meetings while at clinics with spouses) need to be explored. Plans of action may include information, education and communication strategies to reach out to policy makers and other influential groups about reproductive health programs for men.

Some of the CBHWs received their training many years ago. There should be more emphasis on updating their training. More emphasis should be on the training of women on contraceptive methods and their side effects. Training to CBHWs should include improvements in communication skills to enable them to become a valuable and a trusted source of information. It is also important to point out that the department of health which is in charge of CBHWs should device innovative strategies for providing more support to these programs. These should include refresher training and facilitation skills. This will hopefully improve the overall wellbeing of the communities these workers serve.

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