

**Investigating the Problem of Underutilization of Clinic-based Prenatal Services in  
Rural Communities in the Eastern Cape Province, South Africa**

By

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## DECLARATION

This thesis is submitted in partial fulfilment of the requirements for the Degree of Master of Arts (Clinical Psychology), in the School of Applied Human Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I Vanessa Mirienkie Kondile, declare that:

This thesis is my original work.

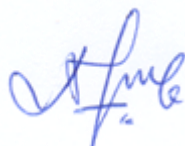
All references and citations have been acknowledged.

This thesis has never been submitted for any degree or at any other university.

Student Name \_\_\_\_\_

Date \_\_\_\_\_

I confirm that this research was carried out by the above named student under my supervision.



Professor Augustine Nwoye \_\_\_\_\_

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Date: 31. July 2017 \_\_\_\_\_

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## ABSTRACT

In its response to the high maternal reproductive morbidity and frequent pregnancy wastage, as well as the general problem of reproductive vulnerability among child-bearing women in South Africa, the government of the Eastern Cape Province has been able to increase the number of clinic-based prenatal services in various hospitals and health centres in urban and rural areas of the province. However, despite the noted increases in the provision of these services, most pregnant women in the rural areas of the province appear reluctant to utilize or still delay prenatal clinic consultations, thereby limiting their opportunity for prevention and treatment of preventable pregnancy complications. The purpose of this study was to explore the factors responsible for this anomaly.

The study was carried out in two selected rural communities in the Amathole district, Eastern Cape Province, South Africa. The target communities were Gcuwa and Komanishini. Purposive (inclusion criterion-related) sampling was used to recruit participants for the study. The participants were selected based on the criteria of being pregnant, having given birth or being of child-bearing age. Two instruments were used to collect data: the interview guide and a self-developed questionnaire. The interview guide comprised eleven questions for the focus group discussions. The guide was used to ensure that important themes relevant to answering the research questions were tabled for discussion. The questionnaire data from 84 participants were analysed by means of descriptive statistics. A thematic analysis was performed on the responses from the focus group discussions to identify themes that emerge on the factors responsible for the reported reluctance of pregnant women to make use of prenatal services.

The findings showed that the major factors responsible for the problem of underutilization of prenatal clinic-based services in the two villages include: “Lack of money to pay for services”; “Poor road network leading to where clinic is located”; “A lack of transport and the money to pay for it”; “Long distance to be covered”; and “Fear of being bullied or insulted by the nurses”. Implications of these findings were drawn and some recommendations for improved policy and practice and for further research were offered.

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## CHAPTER ONE

### INTRODUCTION

#### 1.1. Background of the Study

In its response to the high maternal reproductive morbidity and frequent pregnancy wastage, as well as the general problem of reproductive vulnerability among child-bearing women in South Africa, the government of the Eastern Cape Province has been able to increase the number of clinic-based prenatal services in various hospitals and health centres in urban and rural areas of the province (Brueton, Yogeswaran, Chandia, Mfenyana, Modell, & Nazareth, 2010; Ngomane & Mulaudzi, 2012). However, despite the noted increases in the provision of these services, most pregnant women in the rural areas of the province appear reluctant to utilize or still delay prenatal clinic consultations, thereby limiting their opportunity for prevention and treatment of preventable pregnancy complications (Finlayson & Downe, 2013). A study by Maimbolwa, Yamba, Diwan and, and Ransjo-Arvidson (2003) in Zambia confirmed this irony: people fail to use facilities provided for their own good. Thus, apart from South Africa, the reluctance of pregnant women to make use of clinic-based prenatal services exists in other African countries such as Mozambique and Zambia, as highlighted below.

#### 1.1.2. Preliminary Review of the Literature.

Many empirical studies, both foreign and local, have investigated the problem of reluctance on the part of some pregnant women in sub-Saharan Africa to make use of clinic-based prenatal services early and consistently (Brueton et al., 2010; Finlayson & Downe, 2013; Rowe, Magee, Quigley, Heron, Asklam, & Brocklhurst, 2008). Among such studies is the one by Chapman (2003) who reported on the theme of factors endangering safe motherhood among rural, poor women in Mozambique. Her findings pointed to the influence of some negative pregnancy beliefs and other related cultural values and practices in maintaining the women's reluctance. She also unearthed some of the important underlying socio-economic factors exacerbating the impact of these factors on the general attitude of the pregnant women towards the need for early use of clinic-based prenatal services. Another related study by Ngomane and Mulaudzi (2012) explored the indigenous beliefs and practices that influence the attendance of prenatal clinics by women in the Bohlabele district in Limpopo, South Africa. Their findings showed that both cultural and situational factors were responsible for the delay of these women in

acknowledging the need for early attendance of prenatal services. The authors specifically discovered that fear of bewitchment was among such factors and that women still resort to the use of herbs to preserve and protect their unborn from harm. They further noted the enduring reliance of these women on the knowledge and expertise of traditional birth attendants in their neighborhood with whom they feel more comfortable in times of need. These women prefer their care and expertise to the harsh treatment they receive from midwives in hospitals and clinics who look down on their indigenous beliefs and practices.

Ngomane and Mulaudzi (2012) recommended that indigenous beliefs and practices be incorporated into midwifery curriculum so that the modern health sector is able to meet the needs of all members of the community. Similarly, in their study of cultural birth practices in Zambia, Maimbolwa et al. (2003) explored the reasons why Zambian women still choose to give birth at home. They found that their fundamental reason is related to the fact that the traditional birth attendants are closer to their own homes and are ever ready and willing to attend to their childbirths. Unfortunately, Maimbolwa et al.(2003) failed to investigate more deeply the explanation of these women for their assumption that giving birth at home would be more beneficial to them than doing so at the clinics. This is part of the gap which the present study intended to close.

## **1. 2. Statement of the Problem**

Given the above-noted gap in the literature, it is clear that an in-depth exploration is needed to determine why some women in rural communities in the Eastern Cape Province tend to delay or underutilize clinic-based prenatal care services made available to them (Brueton et al., 2010). In this regard, the critical questions include the following: What factors are responsible for the delay by pregnant rural women in the Eastern Cape Province to take advantage of the free clinic-based prenatal services at their disposal? In general, is the issue of long distance to be covered part of the problem in this regard? The central motivation for this study was to explore answers to such questions as these.

## **1.3. Purpose of the Study**

The purpose of this study was to explore the factors responsible for pregnant women's tendency in the Eastern Cape to delay attendance or to feel reluctant to make use of the prenatal services made available to them.

#### **1.4. Objectives of the Study**

Among the key objectives of the study were to:

- Identify and analyse the factors responsible for the delay by the pregnant rural women in the Eastern Cape Province to take advantage of the clinic-based prenatal services made available to them.
- Determine the average distance, in kilometres, which pregnant women in the rural Eastern Cape Province reportedly cover when they wish to attend for prenatal care services
- Identify the main antenatal care services offered in mobile clinics in two rural communities in Eastern Cape.

#### **1.5. Research Questions**

1. What factors are perceived to be responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in the Eastern Cape Province?
2. What is the average distance, in kilometres, which pregnant women in the rural Eastern Cape Province reportedly cover when they wish to attend for prenatal care?
3. What are the main antenatal care services offered in mobile clinics in two rural communities in Eastern Cape?

#### **1.6. Significance of the Study**

The study is meant to benefit primary health-care practitioners in understanding why pregnant women delay to register for prenatal care. It will also help government to make prenatal health care accessible to all the areas as it lessens the challenges women face in trying to access these services. It will also highlight the cultural beliefs that prevent women from seeking prenatal care.

#### **1.7. Research Assumptions**

In implementing this study, the researcher went out with the following assumptions:

- The majority of pregnant women in the Eastern Cape do not utilize clinic-based prenatal services until the 26<sup>th</sup> and 27<sup>th</sup> week of their pregnancy.
- Women in the Eastern Cape have their reasons as to their reluctance to make use of clinic-based services, and they would be ready to share these reasons when requested to do so.

### **1.8. Scope and Delimitations of the Study**

The study was confined to two districts in the Eastern Cape and focused on women who were either pregnant at the time of data collection or those who had given birth before. It was expected that these women had been to the clinic or were planning to go to the clinic for prenatal care.

### **1.9. Operational Definition of Terms**

*Clinic-based prenatal services* – As used in the present study, these refer to services provided by clinics to pregnant women in order to improve pregnancy and birth outcomes by reducing the risk of low birth weight and preterm births. This is equivalent to what the Department of Health (2007) referred to as maternity care.

*Prenatal care services*– As used in this study, this refers to services provided by clinics to pregnant women either at home or at a clinic. This is equivalent to what the Department of Health (2007, p. 19) referred to as antenatal care.

*Health-care providers*– As understood in this study, this refers to clinics that provide preventive, curative, promotional or rehabilitative health-care services in a systematic way to people, families or communities. However, according to Department of Health (2007) Guidelines for Maternity Care in South Africa, there is need for such health care providers to include not only the clinic, but also community health care; Level 1 Hospital; Level 2 Hospital; and Level 3 Hospital (pp. 13-17).

*Traditional birth attendants*–Also known as traditional midwives, is a term, which is used in this study to refer to community midwives or lay midwives, who provide pregnancy and childbirth care services to women in rural areas in Eastern Cape understudy.

### **1.10. Summary and Overview of the Study**

This study explored the factors that influence pregnant women's decision to seek prenatal care. These factors contribute to how women chose to use clinic-based prenatal care or traditional birth attendants. The theoretical framework, international literature and local literature of the behaviours and attitudes of women towards prenatal care were explored in the next chapter. Chapter 3 details the methodology followed in the study, starting with the research design, selection of participants, data collection and analysis. Chapter 4 presents the results, while

chapter 5 provides the discussion and interpretation of the results, conclusions and recommendations for future research.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1. Introduction

This chapter reviews both local and foreign literature on the challenges faced by pregnant women in the utilization of clinic-based prenatal services with particular reference to experiences in countries in the southern and other regions of Africa. The chapter covers a review of the following areas: attitude towards use of antenatal services, timing of and reporting for service, factors that affect underutilization of services, and the extent of the services available at the clinics.

#### 2.2. Theoretical Review of the Literature (foreign and local)

A number of foreign and local studies have investigated the problem of reluctance on the part of some pregnant women in sub-Saharan Africa to attend clinic-based prenatal services early and consistently. As mentioned, Chapman (2003) reported on factors endangering safe motherhood among rural, poor women in Mozambique. Her findings raised concerns about the influence of some negative pregnancy beliefs and other related cultural values in maintaining this reluctance. She also discovered some of the important underlying socio-economic factors exacerbating the impact of these factors on the general attitude of the pregnant women towards the need for early use of clinic-based prenatal services (Brueton et al., 2010; Ndyomugenyi, Neema, & Magnussen, 1998; Simkhada, Teijlingen, Porter, & Simkhada, 2008).

Another related study on this issue of attitude and reluctance to the use of clinic-based antenatal services is that by Ngomane and Mulaudzi (2012) which explored the indigenous beliefs and practices that influence the attendance of antenatal clinics by women in the Bohlabele district in Limpopo, South Africa. Their findings showed that both cultural and situational factors were responsible for the delay of these women in acknowledging the need for early attendance of antenatal services.

According to Ngomane and Mulaudzi (2012), fear of bewitchment was among such factors. They also discovered that women still resort to the use of herbs to preserve and protect their unborn from harm. They further noted the enduring reliance of these women on the knowledge and expertise of traditional birth attendants in their neighbourhood with whom they say they

feel more comfortable in times of need. These women prefer their care and expertise to the harsh treatment they receive from midwives in hospitals and clinics who look down on their indigenous beliefs and practices. Based on this understanding, Ngomane and Mulaudzi (2012) recommended that indigenous beliefs and practices be incorporated into midwifery curriculum so that the health sector is able to meet the needs of all members of the community.

Similarly, in their study of cultural birth practices in Zambia, Maimbolwa et al.(2003) concentrated on exploring the reasons why Zambian women still choose to give birth at home. They found that their fundamental reason is related to the fact that the traditional birth attendants are closer to their own homes and are ever ready and willing to attend to their childbirths. As indicated in the previous chapter, Maimbolwa et al.(2003) did not further investigate the explanation of these women for their assumption that giving birth at home would be more beneficial to them than doing so at the clinics. This is part of the reason why this study was considered essential (Fekede & Mariam, 2007; Hoque, Hoque, & Kader, 2008; Larsen, Lupiwa, Kave, Gillieatt, & Alpers, 2004).

The Empangeni sub-district of Uthunguluin South Africa reported that some women go to the clinic to give birth only without having attended prenatal services (Hoque et al. 2008). According to Hoque et al. (2008), some women do not attend prenatal service in order to avoid visits insisted upon by health-care workers for the protection of the baby from mother-to-child HIV viral transmission and for provision of relevant medication and precaution. Similar studies by Phafoli, Van Aswegen and Alberts (2007) in Lesotho also reported that, in some cases, young school girls hide their pregnancy to avoid embarrassment. Although most of these girls were noted to be uneducated and uninformed as a result of staying in rural areas, they were still firmly set the indigenous way.

Ngomane and Mulaudzi's (2012) study investigated the problem of some indigenous practices and how they affect pregnant women's attendance of prenatal facilities. They noted that pregnancy is regarded as sacred and that the matter remains a secret until the ancestors are informed of the pregnancy. Adhering to this belief causes a delay in seeking prenatal care services from local health-care clinics. The authors also found that some rural women in their study believed that their coming into contact with other pregnant women at the clinic might result in miscarriage because of evil spirits sent by jealous people. Based on this negative belief,

the community regards attending prenatal clinics after three months of pregnancy more important than before three month of gestation.

Participants in the above study also mentioned that pregnancy needs to be preserved both physically and spiritually with herbal medicines. The study reported that pregnant women are advised by elders to drink a daily dose of *Mpendulo* ('herb cold answer'), which is a concoction for strengthening the pregnancy. They also use *Ritlangia* herb which is cooked and then tied around the waist for checking the growth of the pregnancy.

Another finding of the above study showed that seeking help from traditional birth attendants was still believed to be as effective as going to prenatal clinics because the former could also calculate gestational age and teach women how to deal with any complications that might occur. Traditional birth attendants were further believed to be equipped with the knowledge to deal effectively with any complication that might arise such as threatening factors causing miscarriage. For example, the roots of the *Nembenembe* tree are to be placed in a tin which needs to be buried upside down to prevent a miscarriage. *Mbheswana* is also administered to avoid foetal distress during labour (Abrahams, Jewkes, & Mvo, 2001; Hatherall, Morris, Jamal, Sweeney, Wiggins, Kaur, Renton, & Harden, 2016).

Ngomane and Mulaudzi's (2010) study further revealed conflict between medically trained midwives and traditional midwives. Medically trained midwives deem western medicine to be superior to traditional medicine because it has not been scientifically tested. Therefore, traditional midwives are seen as redundant and primitive by modern health standards.

However, modern health-care officials' lack of understanding of cultural and traditional systems proved to be another major reason why most women in rural areas fail to request prenatal services. Most of the Bohlabela women regarded the herbs administered to them by traditional birth attendants as being healthy and safe. For this reason, most of them saw little need in seeking alternative western services. On the other hand, their total dependence on use of traditional biomedical approach often results in harmful medicines being administered to some antenatal women in rural Africa. Another problem is the fact that knowledge of health benefits of traditional medicine is not being shared, which would ultimately help to better the prenatal health system (Ngomane and Mulaudzi, 2010).



### **2.3. Review of foreign Empirical Studies**

In support of the above, Phafoli et al. (2007) conducted a study on the predominant factors that led to a delay in seeking prenatal care among pregnant teenagers in Lesotho. The authors reported that, during 2006, the mortality rate in Lesotho was estimated at 762 per 100 000 live births while the infant mortality rate was estimated at 72 per 1 000 live births. The increase in mortality was attributed to an engagement of sexual activities by young people as they were not emotionally matured and prepared for the prenatal process. As one of the recommendations of the study, adolescent health clinics (also known as teenage corners) were established in response to the high maternal mortality rate among teenagers. These clinics were designed to assist young women during their prenatal period. Although the facilities were developed for all teenagers, out of 632 pregnant teenagers, 43% started using these services during their third trimester of gestation and only 14.9% attended during the first trimester of gestation. A number of reasons were found to contribute to the delay in registering for prenatal services, namely, a lack of knowledge regarding the value of early prenatal attendance and an attempt to hide the pregnancy because the father of the child denied the pregnancy. In addition, it was said to be regarded as a taboo for young women to be pregnant outside of wedlock. It was noted that this custom resulted in most women trying to hide their pregnancies; a behaviour that leads to a delay in registering for prenatal care services. Another reason was the policy according to which pregnant teenagers have to be expelled from school; a practice that also encouraged teenagers to hide their pregnancies. A number of structural variables such as poor services provided in the teenage corners were also reported to have led to teenagers' failure to use prenatal services (Chapman, 2003; Hatherall et al., 2016 ;). Mrisho, Obrist, Schellenberg, Haws, Mushi, Mshinda, Tanner, & Schellenberg, 2009; Pretorius & Greeff, 2004

Mathole, Lindmark, Majoko and Ahlberg (2004) conducted a study in rural parts of Zimbabwe. They reported that prenatal care is not regularly used and that there are many reasons for that behaviour, one of which is the age of the pregnant woman. Younger women seemed to prefer to attend prenatal care service in order to first find out what is going on within them and then to monitor the health of the baby as the baby grows older. Women above 35 years of age did not see the need to attend prenatal service due to their experience of giving birth and the perception that, since the previous pregnancy was fine, nothing would be wrong with the current one. These women also seemed to argue that, because they had managed previously to give birth at home without professional help, they would be able to do so at any time. The same

research reported that most women attended prenatal service at the 21<sup>st</sup> week when the pregnancy was fully showing. Participants indicated such factors as distance to the clinic, transport problems, financial problems, difficulties in crossing big rivers during the rainy season, embarrassment to visit the clinic with torn clothes or tight dresses, embarrassment because of too many pregnancies or being over 40 years and pregnant, as some of the critical reasons for their irregular use of prenatal services. They also mentioned the negative attitude of service providers and long hours of waiting for attention and, eventually, poor quality of care.

Besides the above-mentioned problems, local cultural beliefs regarding pregnancy seem to be held firmly, such as the belief that when gestation period is below three months, the pregnant woman and the pregnancy is vulnerable to witchcraft. For their protection, women would turn to other health-care options, including traditional healers, traditional birth attendants and faith healers (prophets). For example, it was reported by Mathole, et al. (2004) that women in the Apostolic Faith Church are prohibited to use biomedicine. Participants in the same Mathole, et al.'s (2004) study believed that traditional and faith healers possessed power that protects the pregnant woman and the pregnancy from people who could harm the woman. In the same study, the participants claimed that prophets can see what is happening to the mother and the baby and that they can provide prayer and holy water to protect the pregnancy. The study also found that the views of the pregnant women on the objective of prenatal services were contrary to those held by health-care providers. The former assumed that prenatal services are needed only in emergencies and not when the pregnancy and the pregnant woman are healthy and all seems to be in order.

Mrisho et al.'s (2009) study focused on the use of prenatal and postnatal care in southern Tanzania. They specifically explored the perspectives and experiences of women and health-care providers in rural southern Tanzania. According to their findings, 94% of women attended a prenatal visit once, but only 47% gave birth with a skilled attendant. They recommended that pregnant women start attending prenatal service before the 16<sup>th</sup> week of gestation. Yet, more than 80% of the pregnant women they studied indicated that they started attending antenatal service later than 17 weeks of gestation despite the service being free. In addition, although the majority of women studied attended prenatal service, more than half of the women gave birth at home. The participants indicated that they choose to give birth at home because they lack

money to attend the clinics. Another problem they mentioned was the issue of great distance to the health facility, the participants also stated that they had fears of meeting wild animals on the way to the clinic, as well as of lack of money and the fact that prenatal hospitals lack privacy. Among the reasons that were commonly mentioned for late registration for prenatal care services was that of avoiding to attend several visits to the clinic before they are due to give birth. Two perceptions also came to the fore. First, these women associated hospitals with complicated births and, secondly, they believed that if they were to have prolonged labour pains they would be offered a Caesarean section at the hospitals, a practice they dislike.

The same women stated that, when referred to hospital, they are not happy and usually do not attend because of the fear of having to undergo a C-section. Many avoid a C-section because it would require them to rest after birth. Participants claimed that they have many household duties, they cannot afford to take time to recover from birth after the C-section. For this reason, they argued, they only go to hospital when things go wrong at home.

Prenatal care coverage is regarded as high in Tanzania. However, there are worrying gaps with regard to diagnosing or treating complications as well as the quality and ability to prevent these when they occur. Also, little is known about the use of postnatal care in the country, although the study reported that some women were generally positive about both antenatal and postnatal care services (Ali, Osman, Abbaker, & Adam, 2010; Mrisho et al., 2009).

Although they perceived postnatal service to be beneficial, the women participants claimed that there was a lack of postnatal care for mothers. In addition, members of the community complained about shortages of equipment, supplies and staff. Based on these findings the researchers concluded that there is an urgent need to improve prenatal and postnatal care for these women and that focus should be placed on addressing geographical and economic access, while striving to make services more culturally sensitive. The researchers also suggested that prenatal and postnatal care be regarded as important opportunities to link the health system and the community by encouraging women to deliver their babies with the assistance of a skilled attendant.

According to Chapman (2003), 85.5% of the women in her study agreed that they did not initiate prenatal consultations during the first trimester. Additionally, Chapman (2003) found that most women tended to initiate prenatal care between the fifth and seventh month of pregnancy which is the most difficult time to hide the pregnancy. Chapman (2003) states that the average time for initiation of prenatal care happens within six months gestation. Her study also focused on identifying the reason for high infant mortality rates in Mozambique, which was established to be the delay in seeking prenatal services even though the services were widely available.

Chapman's (2003) study equally explored the matters that contributed to pregnant women's underutilization of clinic-based prenatal services. Many women reported that, if miscarriage occurs before the pregnancy becomes public, it would not matter since they would not be subject to the stigma attached to miscarriage. In this regard, many women reported feeling vulnerable to pregnancy loss, especially because repeated pregnancy loss comes with the stigma of being an inadequate wife. However, as the pregnancy progressed most women indicated to have stopped utilizing care services to start attending alternative prenatal treatment for personal threats on the mother and unborn baby. The women studied claimed that alternative prenatal treatment was more effective in protecting the mother and baby from harm because the bigger the pregnancy the more vulnerable the mother and unborn were considered to be. Women considered latter gestation period as a time to start taking traditional herbs in order to facilitate massaging of the birth canal and perineum. They also stated that their household tasks did not change or decrease during pregnancy and, as a result, it was hard for women who did not have pressing health matters to lose half a day waiting in the clinic for a prenatal check-up.

Reproductive threats posed by witchcraft or sorcery appeared to have the strongest influence in determining whether women sought prenatal care or not. In fear of witchcraft, the majority of women hid their pregnancies until they could no longer hide them and, consequently, women started utilizing prenatal care services in late pregnancy. Women who attended maternity clinics were considered as confident and being boastful of pregnancy, which is seen as an act that might attract unwanted interest from harmful individuals, including resentful infertile women, envious neighbours, female rivals who have had sexual relations with the male partner or jealous birth assistants. According to the study, the delay in utilizing prenatal care was a

purposeful or deliberate practice with the aim to protect the mother and the unborn baby from both people and spirits that could harm them (Hatherall et al., 2016; Myer & Harrison, 2003).

A study conducted by Anafi (2012) investigated maternal mortality in Ghana. The study showed that only 55% of pregnant women requested prenatal care treatment in the first trimester of gestation. The study concluded that the factors responsible for maternal mortality in the country can be described in the Three Delay Model comprising the failure to recognize maternal health care problems and request suitable services, a lack of efficient transport and poor roads. All these factors cause a delay in the attendance of prenatal care services. Consequently, many women had not received adequate treatment on time. Apart from the above-mentioned reasons for delay, there are also factors such as cultural, socio-economic constraints which prevent women from using prenatal services at their disposal.

Ghana is in support of the United Nation's Millennium Development Goal (MDG) of decreasing maternal mortality. To meet this objective, the Ghanaian Ministry of Health has developed programmes such as the safe motherhood programme. These programmes have ensured that prenatal services are available to all, regardless of geographical location, and that the services of midwives would be improved. But despite these efforts the maternal mortality has not yet been reduced in Ghana. Studies revealed that only 59% of maternal deliveries are conducted by physicians or midwives. The study showed that 41% of maternal deliveries are still carried out at home by traditional birth attendants. The study also found that low numbers of delivery services at public health facilities were associated with poor treatment received from health-care providers, which is aggravated by a combination of traditional beliefs.

Van Eijk, Bles, Odhiambo, Ayisi, Blokland, Rosen, Adazu, Slutsher, & Lindblade, (2006) conducted a study assessing the use of prenatal services and delivery care among women in rural western Kenya. They evaluated the progress of MDGs, specifically regarding maternal health. The study sample included women who had recently delivered. The researchers also wanted to determine whether women were receiving appropriate care. Their findings revealed that out of 635 participants, 90% had visited the prenatal clinic at least once during their last pregnancy. A total of 64% of women stated that their first visit had been in the third trimester. This late first prenatal clinic visit was associated with a lack of providing quality service in those clinics. Women who had not visited prenatal clinics were more likely to have less than

eight years of education and low socio-economic status (SES). However, only 14% of the participants had started attending prenatal care services in the first trimester of pregnancy. On the whole most of the women claimed that they had used these services in their late stage of pregnancy, with most of them failing to return for follow-up visits. A total of 87% of women who had recognized their need for prenatal services were over the age of 25 and had decided on their own to start using prenatal care services, unlike younger women who were more likely to start attending prenatal care after being advised by their mothers or mothers-in-law.

Pregnant women in a more stable relationships and married women were more likely to seek prenatal care timeously. A total of 18% of the women in the study had not visited the nearest clinic but preferred to attend a more distant clinic in order to get better treatment from nurses, and 7% of women had attended more than one prenatal care clinic searching for better patient treatment. A total of 10% of women had never bothered to attend any prenatal care during their pregnancies. Among the reasons given for not attending was that no need for attendance was perceived. The second reason was high transport costs and inadequate quality of patient care. However, 18% of women preferred to use alternative sources of prenatal care such as herbalists and traditional healers as they were believed to be more effective in optimizing the pregnant woman's health during her prenatal period.

With regard to services offered at health-care clinics abdominal palpitation, tetanus vaccination and weight measurement were 90% higher than other services, while provision of other services was low, such as malaria prevention (21%), iron (53%) and foliate (44%) supplementation, syphilis testing (19.4%) and health talks (14.4%). However, 80% of the women delivered outside a health facility. A total of 42% were assisted by traditional birth attendants and 36% were assisted by laypersons, while 22% received no help. Factors that were significantly associated with child delivery outside the health facility included being above 30 years of age, low SES, less than eight years of education and more than one-hour walking distance from the health facility.

The study concluded that the rural area usage of prenatal service was high, but the opportunity to deliver important health services was not fully utilized. The use of professional delivery services was low and almost one out of five women delivered unassisted. In the study, the majority of births took place without the aid of professional personnel such as doctors or

midwives, which was largely attributed to long distances and the apparent lack of quality of care in health facilities (Haddrill, Jones, Mitchell, & Anumba, 2014).

The above revelations suggest that many factors, apart from the impact of traditional beliefs and practices, were responsible for the women's inability to make use of the prenatal services. Most of the factors they mentioned were realistic in the context of their lives, for example, a lack of money for transport, and the poor quality of the services offered or the facilities available at the clinic-based health systems at their disposal.

Adamu and Salihu (2002) conducted a study on 107 pregnant women in a rural district of Kano State in northern Nigeria. They investigated the barriers affecting the use of prenatal care services and the opting for hospital delivery among women in the rural district studied. Their findings indicated that a combination of both economic and socio-cultural factors prevented women from using prenatal care services. They concluded that 88% of the participants did not attend any type of prenatal care during their pregnancy and that 96.3% of them had planned to deliver at their homes without the help of a skilled attendant. The findings further revealed three important reasons for the women's reluctance to utilize prenatal care in the district. These included a lack of financial means to seek prenatal care, husbands denying women the opportunity to attend prenatal care saying that the pregnancy was God's will and therefore predestined, it won't be necessary to attend prenatal services (African culture dictates that the man is the head of the family and that women should not question and disobey their husbands, Adamu & Salihu 2002). An optimistic bias was also one of the factors that discouraged women from care. Most participants simply believed that their pregnancy would be fine and that they would deliver their babies without problems.

Mekonnen and Mekonnen (2003) investigated the factors affecting the use of maternal health-care services in Ethiopia. They used secondary data from a study conducted on the 2000 Ethiopia Demographic and Health Survey. The maternal mortality rate in the year 2000 was 816 per 100000 live births in Ethiopia, which was among the highest in the world. However, the problem of failing to go for prenatal services was attributed to many factors, one of which was failing to predict pregnancy complications timeously.

The study concluded that a combination of demographic and socio-cultural factors was influencing the use of antenatal services. Independent factors such as the mother's level of

education, marital status, residential location and religion were also identified as significant factors predicting prenatal attendance in Ethiopia. In the same study, married women were five times more likely to seek prenatal care services compared to unmarried women, and women with at least a primary education were also more likely to seek prenatal care than those who had no education at all.

Religion was the most important predictor of attendance in the study. Traditional religion was used to explain disease as well as the well-being of the mother and unborn child. Traditional perspectives encouraged women to use formal traditional systems and to seek biomedicine only when the former failed. This resulted in the failure of many women to attend prenatal clinics.

Financial constraints were also a factor that contributed to women not being able to seek prenatal care. Also, the number of children that the pregnant woman has was also a predictor of whether a woman would seek prenatal care or not. Women with two or more children were more likely to seek prenatal care services and appreciate the value thereof as opposed to women who were having their first pregnancy.

#### **2.4. Review of Local Empirical Studies**

Hoque et al.(2008) study at Uthungulu in Empangeni involved women who were attending public health institutions for antenatal care services. The study participants were 244 women who were pregnant at the time and those who had delivered in Empangeni Hospital during July to December 2004. The study revealed that 99.6% of the women had attended prenatal care, but only 9% had registered for prenatal services in the first trimester. Only one quarter of the women had failed to enrol themselves in preventive mother-to-child programmes, which could be seen as failing to protect their children from mother-to-child HIV transmissions. The study also found a connection between low income and underdevelopment as the factors that resulted in a lack of utilization of prenatal services. The study concluded that, even though prenatal care services are freely available to women in rural settings, women are reluctant to seek prenatal services early.

In a study on health-seeking practices among pregnant women in a peri-urban location in Cape Town, Abrahams et al. (2001) reported that prenatal care attendance was influenced by a number of factors. One of these factors was pregnancy confirmation lag; in other words, women who suspected that they were pregnant after a missed period waited until they missed



three or four periods to confirm their pregnancy. Although a pregnancy test was free at the community clinics, people did not trust them due to the false results they often produce. Another factor was that the majority of the Xhosa-speaking participants were unclear about the aim of prenatal care. They saw it as a necessity only when a woman developed complications or needed help to 'deliver nicely.' The women who required prenatal care earlier in both groups had particular medical concerns which made them seek medical care early. The earliest booking in the Xhosa-speaking group was at 14 weeks, and the aim was in order to get tested for sexually transmitted infections. The earliest booking in the coloured group was at 12 weeks because the woman involved had a child with Down's syndrome and was concerned of the risk to the present pregnancy.

Women who had experienced complications in their previous or current pregnancy tended to demand prenatal care services more regularly compared with women who were not experiencing any problems at the time of pregnancy. Most of the older participants in the study reported that their requiring prenatal care in the second or third trimester was because they had not been aware of the fact that they were pregnant. Many women claimed that they were on contraceptive and that missing periods were therefore normal. Even though most women in the study were not sure of the value of attending prenatal services, all of them knew that they should consult with the health clinics if any complications occurred. However, the participants who did seek clinic health-care services reported being discouraged by the actions of the staff who were rude, unconcerned about their pregnancy health status and did not properly explain to the women why their complications were not serious. Many women participants also claimed that they were given either little or no information regarding delivery dates and the status of the baby after each palpation.

Age was another factor that came to the fore. Younger women seemed less likely to be ready to request prenatal care services. Also, long queues at the prenatal care facilities deterred most women from requiring prenatal services. In this regard, a Xhosa-speaking teenager stated that she lacked the courage to attend prenatal care services because she was too 'lazy to wake up.' She was referring to the fact that one has to wake up very early in the morning to see a nurse before closing time due to the large number of patients to the small number of nurses available. According to the women, attending prenatal service is important only to obtain a prenatal card in order to avoid being shouted at and neglected when arriving in labour without a booking.

Their assumption was that even if they attended once they would be able to get a prenatal card. Because of the above-mentioned factors, these women did not recognise the value of attending prenatal care services.

Myer and Harrison's (2003) study in the rural Hlabisa district in South Africa explored the reasons for the delay in prenatal attendance and the failure to return for follow-up care regardless of the extensive availability of free prenatal care services. The findings of the study attributed the delay to the fact that most women who participated in the study did not perceive pregnancy as a time of significant health threats. As a result they did not see the necessity of seeking prenatal services. What was more significant in this study was that women viewed labour and the delivery process as a period of momentous health risks which required biomedical attention. However, most women in the study had only sought prenatal care once, in order to acquire a prenatal attendance card which was needed to allow them to deliver in a medical facility. In the study, the contradiction regarding health care as a necessity during childbirth but not during pregnancy was regarded as the primary reason why women did not seek prenatal care during pregnancy.

## **2.5. Critical/ Concluding Summary**

The above review indirectly suggests that the ability to fully utilize clinic-based prenatal services in developing countries is affected by a number of factors. These factors include availability, accessibility, affordability and quality of health services including prenatal care services and women's socio-economic status, demographic factors, education, knowledge of the importance of antenatal care services, cultural beliefs, and previous obstetric history. Similarly, the above review revealed, with regard to the South African situation in particular, that the following factors, such as restrictive cultural beliefs, long distances to be covered, lack of money, bad roads, rudeness of nurses and lack of knowledge regarding prenatal services were responsible for pregnant women opting to delay attendance of prenatal services at their disposal. Taken together, these findings appear to suggest the direction in which some of the research questions explored in this study might be answered. But at this stage, it would not be easy to locate with precision which of the answers available in the above reviewed literature would be collaborated by the participants in the present study when faced with the question of why pregnant women in Eastern Cape tended to delay or to avoid attendance of prenatal services made available to them.

## **2.6. Research/ Operational Hypothesis**

Women who want to register for clinic-based prenatal services face a number of challenges.

*Research question* – What are the benefits of prenatal services for pregnant women?

Despite these benefits, why are rural South African women failing to visit prenatal clinics?

## **2.7. Theoretical Framework**

One of the key theoretical frameworks for this study is Skinner's theory of operant conditioning. According to Skinner (1953), behaviour that is reinforced tends to be repeated (strengthened), while behaviour that is not reinforced tends to die out or be extinguished (weakened). Skinner proposed an operant conditioning approach stating that, in order to understand behaviour, one needs to first consider looking at the causes of an action and its consequences. Human behaviour is majorly influenced by learning from the environment. The behaviour of rural women which, in most cases, results in high maternal and infant mortality rates in Africa can be explained according to the theory of Skinner. If women who deliver in the hospital often end up having a C-section – which rural women do not like others will not be encouraged to deliver their babies in prenatal clinics. They would prefer to deliver their babies at home instead.

Also, following the operant conditioning theory, if attending prenatal clinics would result in wasting their time by queuing at the clinic, rural women might be discouraged from attending such clinics in the future. Each aspect of operant conditioning will be discussed separately in relation to hypothesised rural women's behaviour.

### **2.7.1 Neutral Operant.**

This is another aspect of Skinner's theory of operant conditioning. It is a response from the environment which neither increases nor decreases the probability of behaviour being repeated. Women in rural areas who failed to relate maternal and infant mortality to an irregular or late attendance of prenatal care services would instead ascribe the above problem to witchcraft or sorcery. The above fact is contributing to the struggle of increasing the probable attendance to antenatal services in health clinics. Furthermore, women could be encouraged to see prenatal care services as a further option to take advantage of instead of resorting to the care of spiritual or traditional healer.

### **2.7.2. Reinforcement.**

This is a response from the environment that can encourage the probability of behaviour to be repeated or extinguished. Most women who seek prenatal services have had negative experiences in the past with regard to complicated pregnancy and births at home. The past experience influenced women's attending prenatal services early to prevent a repeat of the experience. Furthermore, women who opt for alternative prenatal services such as spiritual and traditional healer services argued that they had good treatment relations within the indigenous health system and that, since they were treated with respect and care by that system, they have no reason to abandon the traditional model in favour of modern prenatal health clinics. In this way, the caring behaviour from the traditional health-care system and the absence of complications during pregnancy serve as motivation or reinforcement to continue using the services of the indigenous health providers, which include the spiritual and traditional birth attendants.

### **2.7.3. Punishment.**

This is a response from the environment that decreases the likelihood of behaviour being repeated. Punishment weakens behaviour. In the current study, rural pregnant women who are scolded by nurses for coming to give birth without having a clinic card might learn from that experience and avoid coming to the clinic without a clinic card. In this way, they might decrease the behaviour of arriving for birth.

## **2.8. Social learning theory**

The social learning theory is another theoretical framework that is of relevance to this study. This theory was created by Bandura (1977) who stated that most human behaviour is learned by observation through modelling. Therefore, observing others within one's environment with regards to new behaviours, results in new coded behaviours which may serve as a guide to action. This theory is relevant for explaining some of the behaviours of rural women towards seeking prenatal care services.

Three core concepts at the heart of social learning theory are relevant to this study. The first is the idea that people can learn through observation. The second is the idea that internal mental states are an essential part of this process. Lastly is the idea of recognizing that just because something has been learned, it does not mean that it will result in a change in behaviour. In line

with these constructs, it could be speculated that, when pregnant rural women see their neighbours or friends go to the prenatal clinics and get good attention and care, they might learn from this and visit prenatal clinics themselves when they become pregnant (Ormrod & Davis, 2004).

### **2.8.1. Observational learning (or modelling).**

The theory of observational learning argues that people can learn new information and behaviours by watching other people engaged in the behaviour in question. When applied to this study, women in rural areas who see other women giving birth comfortably at home assisted by traditional midwives would, in the same conditions, be more likely to learn the behaviour of not attending health-care clinics and preferring to give birth at their homes.

Although this theory appears to offer a relevant explanation for some of the reasons why some pregnant rural women in Eastern Cape may become conditioned to prefer to resort to the use of traditional midwives over the use of clinic-based services in response to their antenatal care needs, it is not possible for the same theory to be relied on in search of a comprehensive reasons why the rural women in the province under study decide to delay or to feel reluctant to make use of antenatal services placed at their disposal.

### **2.8.2. Intrinsic reinforcement.**

Bandura noted that external, environmental reinforcement is not the only factor that influences learning and behaviour. He described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions helps connect learning theories to cognitive developmental theories. In this study, since some of the women were able to give birth at home, with no transport cost involved, they might feel that they have executed the task very well without being scolded and suffering financially. With this, they might feel internally motivated and satisfied to continue giving birth at home.

### **2.8.3. The modelling process.**

Bandura noted that not all observed behaviours are learned effectively because there are factors involved in both the modelling and learning that can play a role in whether social learning is

successful. There are, however, certain steps to be followed in the observational learning and modelling process:

### ***2.8.3.1. Attention.***

According to Bandura (1977), in order to learn, attention needs to be present. In that way, if there is anything that distracts the learner's attention. Distraction will have a negative effect to the learner's observation. Applied to the behaviour of pregnant women and their attitude towards using of antenatal services, it could be speculated that since most women in rural areas have many challenges such as transport money, distance, bad roads, severe rains, scolding by nurses. These women are more likely to pay attention to these issues than to the benefit to accrue from the prenatal help. Also it might be important for them to satisfy their husband by being obedient to their demand of not allowing women to seek prenatal care sine they claim is God's will. All these may constitute a distraction to the women in their consideration of the value of attending prenatal care services.

### ***2.8.3.2. Retention.***

This is the ability to store information but if is not properly stored it will be difficult to retrieve the information when needed to be used. In this regard, it seems that women in rural areas have ability to retain the experience they had about giving birth without the assistance of any type of midwives. Also the experience they had from previous birth seemed easily drawn upon when they need to act in their subsequent delivery tasks. Again, this theory, like the first one, while relevant for explaining some of the reasons why rural women in Eastern cape decide to delay the use of prenatal care services made available to them, it is not a comprehensive framework to serve as a viable theoretical model for guiding the present study. This is why, the next theory, the Health Belief Model was deemed necessary to be reviewed.

### **2.8.4. The Health Belief Model.**

Turner, Hunt, Dibrezzo, & Jones, (2004) used the Health Belief Model (HBM) to explain people's health behaviours. The Health Belief Model was developed in the 1950's by Hochbaum, Rosenstock and Kegels. The health belief model addresses the relationship between a person's beliefs and behaviours. HBM is employed for addressing problematic behaviours that evoke health concern. The focus is on issues of compliance and preventative health care. The model proposed that health-seeking behaviour in rural areas is influenced by

women's perception of the threat posed by pregnancy complications and the value associated with women's actions to seek prenatal service that is aimed at reducing the threat.

Other researchers who have used the Health Belief Model as principal theoretical framework for their research included: Odhiambo (2003), Volk & Koopman (2001), and Umeh & Rogan-Gibson (2001). The different aspects of the Health Belief Model of interest to the present study are reviewed below.

#### ***2.8.4.1. Perceived seriousness.***

Under this theme, the health belief model proposes that when women in rural areas believe that the complications in pregnancy are serious based on the knowledge and information they have regarding the pregnancy, the women would tend to seek help.

#### ***2.8.4.2. Perceived susceptibility.***

In this regard, when women in rural areas perceived themselves in danger because of pregnancy complications they are more likely to seek prenatal care service early in order to prevent the complications from increasing. However, if they perceived themselves as not having complications they are likely to not seek prenatal care service early.

#### ***2.8.4.3. Perceived benefits.***

Under this theme, the health belief model suggests that women in rural areas would likely request to receive prenatal care service when they believe attending the service will decrease the probability of miscarrying and, having complicated pregnancy and birth.

#### ***2.8.4.4. Perceived barriers.***

Here, the point of the HBM is that although prenatal care service may be perceived as beneficial to the rural women, yet the consequences of attending prenatal service if is perceived to be greater than the benefits, the chance of rural women attending it is less likely. The barriers in this regard may be includes finance, distance, and nurse's attitude.

#### ***2.8.4.5. Modifying variables.***

Similarly, when culture, educational level and past experiences about the prenatal services that might constitute a barrier to clinic utilization, are being positively modified, the perception of rural women will be positively influenced and many of these women would be motivated to attend prenatal services due to the positive modification of their perception.

#### ***2.8.4.6. Theoretical framework adopted for the Study.***

It is evident from the above indications that there are many psychological theories which can be drawn upon to explain pregnant women's responses to the research questions explored in the present study. However, of the three theories reviewed, it is the Health Belief Model that appears most relevant to serve as a theoretical framework for the study. Hence, the Health Belief Model has therefore been adopted as the theoretical framework for the present study.

### **2.9. Summary**

Research has shown that women face a number of challenges when trying to seek prenatal clinic services. These challenges are aggravated by the type of environment and cultural beliefs of the women. In rural South Africa some of the challenges include accessibility of the Health-care centres, specifically with regard to distance and transport. Most women have reported that they cannot afford to travel to clinics for prenatal services, therefore, they resort to traditional birth attendants. BF Skinner's operant conditioning theory, Bandura's social learning theory and the Health Belief Model were reviewed; and of these, the Health Belief Model was considered more relevant to serve as the theoretical framework for the present study.



## CHAPTER THREE

### METHODOLOGY

#### 3.1. Introduction

This chapter describes the research design, methodology, study location, population and sample, instrumentation, data collection, and the techniques used for analysing the data collected in this study.

#### 3.2. Research Paradigm, Approach and Design

The pragmatic research paradigm underpinned the mixed-method research approach adopted for implementing the present study.

The research approach is understood in this study to refer to how the study is to be conducted (Patton, 1990). In this study, the research approach is divided into two sections, that is, the research design and the research methods. The research design is understood to refer to all the preparations that were made to set up the framework of the study (Creswell, 2012). It determines the researcher's decisions on the sampling procedure, data collection, methods and analysis. In this study, the selection of the data-collection methods was determined by the research questions investigated. The research method therefore depended on the type of data needed to answer to the research questions formulated to guide the research (Creswell, Shope, Plano Clark, & Green, 2006).

A mixed-method (convergent/exploratory sequential) research design was followed in implementing the objectives of the study. The decision to follow a mixed-method approach was based on the *pragmatic* idea that the data to be collected through the use of the qualitative method and the quantitative method would complement each other; as through that process, data that could not be captured through the qualitative study strategy will be generated through the use of the quantitative approach. In that way, the overall result would provide a richer and more comprehensive picture of the factors responsible for the rural women's tendency to delay in utilization of clinic-based antenatal care placed at their disposal (Ritchie & Lewis, 2003).

Previous studies (have shown that the most useful way to study a social phenomenon (in this case, underutilization of prenatal services) would be to follow a combination of qualitative and

quantitative procedures – or mixed methods. The choice of a mixed-method approach to data collection in this study was informed by the type of research questions articulated for the study since it was clear that the research questions could best be answered using both types of data. The research questions were successfully answered using both qualitative and quantitative data (Creswell & Clark, 2007; De Vos, Delpont, Fouché, & Strydom, 2011).

While some researchers conduct research primarily using one approach, social researchers are increasingly drawing on either qualitative or quantitative approaches to data gathering or both in mixed-method approaches (De Vos, Delpont, Fouché, & Strydom, 2011). The present study illustrated that a study of any social phenomenon can be undertaken from different perspectives to obtain a holistic picture. The researcher had to gather a range of different types of data using different methods in response to the research questions and the study's definition of the core concepts.

The present study gathered quantitative data using a questionnaire and qualitative data by means of focus group discussions. Using two or more ways of gathering data helps the researcher to answer the research questions and to check the validity of the data. This process is called triangulation as it reflects the process of triangulation used in mapping – distinguishing one point by measuring the distance and angle from two other points. In social research, collecting and working with data from different sources on the same topic can help researchers cross-check their findings (Mertens, 2014).

When discrepancies or anomalies occur in data from different sources or from using different approaches, the researcher needs to consider why this is the case. Some cases might be explained by the fact that different operational definitions were used intentionally, or that different perspectives or understandings of the issues are being highlighted by means of different methods of collecting data. For example, people in a focus group might discuss some issues quite differently from the way people would deal with the issue when completing a questionnaire. This, in itself, could be an interesting finding, or the researcher could question whether the data-collection tools – in this case the questionnaire and focus group guides – have produced different responses because of wording differences, a different emphasis on questions or the use of different research assistants (De Vos, Delpont, Fouché, & Strydom, 2011).

### **3.3. Research Location and Population**

The study was carried out in two selected rural communities in the Amathole district, Eastern Cape Province, South Africa. The target communities for the study were Gcuwa and Komanishini. It was assumed that these two communities are varied sufficiently and reflect the socio-cultural conditions that are typical of other rural communities not included in the study. The major instruments for data collection consisted of a validated questionnaire and open-ended interview questions for the focus groups. The target sample of the study was all child-bearing women to be selected from the two communities earmarked for the study. The study took place between March and July 2015.

### **3.4. Sampling**

Purposive sampling was used in recruiting participants for the study. The participants were selected based on the criteria of being pregnant, having given birth or being of child-bearing age. The snowball sampling technique was used to recruit some of the pregnant women from the villages who then voluntarily participated in the study. On the whole, a total of 84 participants (42 from each community) were recruited into the study sample. The two sampling techniques are explained briefly below.

#### **3.4.1. Purposive sampling.**

This is a non-probability sampling design aimed at recruiting information-rich cases for answering the research questions investigated. This approach is generally associated with small, in-depth studies with research designs based on gathering qualitative data (Creswell, 2012; 2009) with the aim to explore and interpret experiences and perceptions of people on a given issue, like in the present study the problem of underutilization of clinic-based antenatal services. In this approach to sampling, the researcher does not attempt to create a sample that is statistically representative of a population. Instead, participants are chosen ‘with purpose’ to enable the researcher to explore the research questions under study. In this study, the cases were selected on the basis of characteristics or experiences related directly to the researcher’s area of interest and her research questions; in order to allow the researcher to investigate the research topic in-depth. The cases chosen were those that revealed and illuminated the most about the research area.

### **3.4.2. Snowball sampling.**

Some populations are hard to find because there are no lists of such people or cases, nor are there obvious places where the cases could be found. These ‘hidden’ populations are sometimes associated with behaviour that is seen as criminal or less socially acceptable. However, many other types of behaviours and characteristics can be hidden from the researcher.

A snowball sample for the present study started with a few people who fit the criteria. The researcher made contact with them at a shared meeting place, an internet site and through personal contacts. Each member of the initial group was asked to suggest others with the same characteristics, after which the researcher contacted them for inclusion into the study. Given that people who have certain characteristics or behaviours are often part of a network of similar people, this approach to sampling proved quite fruitful in the present study, particularly since it was combined with a quota sampling approach which sought out people with specific characteristics, for example, different ages and marital status.

### **3.5. Research Instruments**

Two instruments were used to collect data, namely the interview guide and the questionnaire. The interview guide comprised eleven questions for the focus group discussions. The guide was self-developed and its content was drawn from insight gained from the literature reviewed. It was used to ensure that the items it encompasses consisted of relevant questions to serve the interests of the study objectives. The interview guide also served as a triangulation tool in the data collection process, as it was indicated to complement the process of data generation along with the structured survey also self-developed for the study. Both interview guide questions and the questionnaire items were assessed for their trustworthiness through a pilot study. For the sake of credibility a copy of the interview guide and that of the questionnaire can be found attached at the end of the study (Appendix A, p 62).

Data were also collected as above mentioned using a self-developed structured questionnaire (Appendix B, p 64) with four sections. Section A focused on biographical data, section B on attitude towards using antenatal services, section C on time for reporting for service, and section D on factors responsible for the underutilization of the services. The questionnaire was piloted with members of the rural community in Eastern Cape with same characteristics as those to be used in the study. The aim of the pilot study was to detect any possible limitations of the questionnaire, such as concerns its vocabulary level so that it can be accessible for the

target study participants. Areas of difficulties detected from the pilot study were corrected in the process of further refining the questionnaire before its use in the field. The content validity of the questionnaire was cross-checked by the researcher's supervisor, who confirmed that the content was indeed targeted at measuring the issues it was intended to measure.

### **3.6. Validity, Reliability and Rigour**

In line with the trends in related studies reviewed (Adamu and Salihu, 2002; Chapman, 2003; Maimbola, Yamba, Diwan & Ransjo-Arvidson, 2003; Mathole, Lindmark, Majoko, & Ahlberg, 2004; Ngomane and Mulauduzi, 2012), the researcher took great care in ensuring that the instruments used in the study were valid and trustworthy; that is, that they measured what they intended to measure, namely the factors responsible for the underutilization of prenatal care among rural women in the Eastern Cape Province. To achieve instrument validity, the questionnaire and the focus group interview schedule were designed in such a way that all the questions focused on the basis for the underutilization of prenatal services among the target participants. The interview questions were formulated to address the key research questions guiding the study.

To ensure reliability of the reporting of the study, the technique of member checking was introduced. This involved the exercise of approaching some of the participants with the draft report of their views on the questions investigated. They were asked to cross-check and correct any possible misrepresentations of their position on the relevant issues investigated.

To further ensure validity of the study findings, a pilot study was conducted before the actual research commenced in order to identify any problems that might arise with regard to the research instruments (the questionnaire and the interview schedule). For this purpose, interviews were conducted with a small sample of pregnant women from a rural community in the Eastern Cape who did not participate in the main study. Also as part of the pilot study a focus group discussion was conducted with a small sample. The problems that were identified, such as the vocabulary level of the instruments or ambiguity of the items/interview questions, demanded adjustments to be made. The amended instruments were given to my supervisor for further scrutiny. His positive feedback on the same encouraged my belief that the instruments of the study have been vigorously scrutinized.

At the same time this study was exploratory in nature. It aimed not at generalizability, but at stimulating sustained interest in the area of understanding and gaining meaning as regards

pregnant women's reluctance to make use of the antenatal services made available to them. The goal was to achieve an illuminating insight into this phenomenon by exploring relevant women in the Eastern Cape who are familiar with this problem and getting to hear their views concerning it.

The researcher complied with measures recommended by qualitative researchers (Polit and Beck, 2008; Creswell and Clark, 2012) for ensuring the trustworthiness of data to be collected from this study, such as ensuring the *credibility*, *transferability*, *conformability*, and *dependability* of the data to arise from the qualitative arm of the present study. In this regard, to ensure credibility, participants recruited for the study were familiar with phenomenon of underutilization of clinic-based prenatal care studied. The researcher used purposive sampling to target information-rich cases (Patton, 1990) in this regard. To compensate for the lack of audiotaping of the focus group discussion, effort was made by the researcher to write down as much as possible the points made by the participants in response to the questions put to them. In some cases, participants' own words were captured through serious not field-taking and the tactics of calling back to relevant participants to repeat slowly the response they gave to pertinent questions put to them. In this way, it was easy to ensure correct representation of their voices after the interview. Similarly, to ensure *dependability* of the data collected the researcher made effort to return to the field notes of the day as soon as possible in order to flesh them out before the points saved in the memory regarding them could fade or evaporate. Dependability was further achieved by ensuring the reliability of data over time and the conditions under which it was obtained (Polit and Beck, 2008). Furthermore, data triangulation was used to enhance rigour and the trustworthiness of the findings, by combining different methods of data collection, namely structured focus group interview, with the questionnaire data. Member checking, as earlier indicated was undertaken for the clarification and confirmation of data with the participants (De Vos et al, 2002) after the draft of the report was prepared.

The phenomenon of *transferability*, which refers to the extent to which the findings can be applied to other settings (Polit and Beck, 2008) was promoted by giving of adequate information descriptions of the settings, and inclusion and exclusion criteria that were used for recruitment of study sample to allow others to visualize the type of people and the context and type of settings where the findings or the methods may be applicable.

Conformability of the findings were protected through the mechanism of ensuring that the data collected represent the information the participants offered in the course of the study (Polit and Beck, 2008). In this case, conformability was ensured during the focus group process by the checking of facts and by follow-up questions in order to determine the extent to which the researcher understood exactly what the target participant had said or what was meant.

The researcher followed a focus group guide to keep the sessions on track while exploring issues relevant to the research questions. The focus group guide was intended to provide a structure but not a strict order of questioning. The researcher continued with prompts, encouraged relevant participants to expand on their initial responses and followed up on ideas that the participants raised themselves. The sessions lasted for 40 minutes and ended when the participants' input appeared to have reached saturation.

In order to reinforce the most appropriate data-gathering and -analysis process, the researcher reread the field notes and reflected on the actions that took place during the focus groups.

### **3.7. Data Collection**

Data collection was effected by means of a questionnaire and focus group discussions. The questionnaire was self-administered to the sampled (42) respondents in each of the two communities studied. Focus groups sizes were determined by Babbie's (2004) recommendation which proposes the acceptable group sizes of between eight twelve participants. The decision was to use 9 participants drawn from each of the 42 participants for the questionnaire study in each of the villages. This point was further explained below.

The focus group discussions were conducted on average for 40 minutes. The researcher facilitated the discussions, which took place in arranged venues in the villages in each of the two communities targeted for the study. There were two focus groups, one group in each of the villages chosen for participation. For the quantitative component of the study, each village provided 42 participants. From the 42 participants from each village, 9 participants were selected for the qualitative component of the research, that being the focus groups. Participants granted the researcher permission to document her findings from the questionnaires and focus group discussions. The details about the processes of the focus from each of the villages are given below

#### *Focus Groups*

The Gcuwa focus group was conducted in one of the participants' house in the village. Whereas the Komanishini focus group was conducted in a quiet room at the nearest school. The researcher conducted both focus groups discussions on different days.

The researcher was accompanied by a member of the community to both villages. However the community member did not form part of the research and did not aide the researcher in any way in the focus groups process.

On arrival, the researcher presented herself and provided name tags for the participants. The participants selected were Xhosa speaking and the research was done in the participants' home language. Therefore, the researcher did not require translation services as she is Xhosa speaking. The researcher clarified what the study was about as well as the role of participants and the research ethics involved. The researcher explained that she was interested only in hearing what they had to say to the questions to be put to them, not whether they were right or wrong. Oral instructions were provided to the participants before commencing and they were asked whether they agreed to be audio-recorded.

Unfortunately, both groups were concerned about the audio-recording. After consultation with the researcher's supervisor regarding their resistance to being audio-recorded, and having secured the consent of the supervisor that the discussions could proceed without the audio-recording due to cultural influence and perceptions around audio-recordings, the researcher went on with the task of conducting the discussions with selected nine participants from each of the two villages. The researcher thus opted to proceed with the discussions without audio recordings. The data from the discussions was captured by means of written verbatim text from the participants. The researcher, therefore, resorted to detailed field notes instead of audio taping the discussions.

The researcher utilised a focus group guide to keep the sessions on track while exploring issues relevant to the research questions. The focus group guide was intended to provide a structure but not a strict order of questioning. The researcher continued with prompts, encouraging participants to expand on their initial responses; and followed up on ideas that the participants raised themselves. The sessions lasted for 40 minutes and ended when the participants' input was showing signs of repetition or saturation of points generated.



In order to reinforce the most appropriate data-gathering and -analysis process, the researcher reread the field notes and reflected on the actions that took place during the focus groups. The field notes were then transcribed in preparation for data analysis

### **3.8. Data Analysis**

The questionnaire data from 84 participants were analysed by means of descriptive statistics. Weightings to frequency of responses on each questionnaire item were calculated and their mean scores determined. The technique of thematic analysis was used in analysing responses of participants in the focus group discussions in order to identify themes, concepts and explanations for answering the research questions investigated. This means that a thematic analysis was performed on the responses from the focus group discussions regarding the factors responsible for the rural women's reported reluctance to make use of prenatal services (Creswell et al., 2006). Since the data set collected through the focus group discussions did not arise from audio-recordings, it was considered that the use of Braun & Clarke's thematic analysis procedure will not fit the collected data. This is because under Braun & Clarke's (2006) thematic analysis procedure there is a stage called data transcription which does not apply with the data collected for the present study. Consequently, the model of thematic analysis followed in analysing the data emanating from the present study is the procedure developed and described by Miles and Huberman (1994). According to Miles and Huberman's the following three stages should be followed in the thematic analysis process: Data display, data reduction, and drawing of conclusions in response to the research questions investigated. The thematic analysis procedure that was followed in analysing data from the focus group discussions in the present study was the one highlighted above credited to Miles and Huberman (1994), aimed at rich description of the data collected in order to help the reader to get a sense of "the predominant and important themes" arising from the FGD (Blacker, 2009, p. 83).

Consequently, the following three stages were traversed in analysing the data arising from the focus group discussions in the present study:

#### **3.8.1. Stage One: Data Display.**

This is described by Miles and Huberman (1994) as entailing the process of achieving "an organized, compressed, assembly of information that permits the stage of visualizing the data using a number of strategies including quotations, and narrative texts, and outlining of different sets of data arising from the different groups investigated. In the present study this stage

involved the researcher first of all bringing together the two field notes collected from the FGDs, sitting them side by side, so as to facilitate a close inspection of the two notes. This process makes possible the highlighting (through the use of different marking pens) all the key statements, observations, phrases, etc, that emanated from the fleshed out data of the focus group discussions among the two groups studied. Through this process of data display and close inspection of data from the two FGD groups studied, the researcher became familiar with the data collected from both FGD and the answers they offered in relation to the research questions investigated.

### **3.8.2. Stage Two: Data Reduction.**

According to Miles and Huberman (1994, p. 11) “data reduction is “a form of analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that “final” conclusion can be drawn and verified” through constant reading and rereading of the field notes and the salient data they contain, already highlighted in the previous stage. In the present study, this task entailed the process of reducing the data through selection, and through summary and paraphrase, to sift the relevant data from the narrative texts of the FGD discussants making up the researcher’s field notes. Consistent with Bogan and Biklen’s (2007), recommendation, this stage involved the task of reading and rereading the respective field notes from the two FGDs, going through each note, at least twice, so that the researcher could get an accurate and thorough overview of the points and ideas or themes they contain. This stage was very important for the present researcher because it was while engaging in it that the researcher was able to appreciate the full picture of the answers to questions provided by the discussants. In this way, it was easy to make connections between the participants’ thoughts, ideas and the data collected during the FGD encounters. A major phase of this stage as underscored by Miles and Huberman which was implemented in the present study involved picking out salient sentences already marked as illuminating ideas for answering the research questions investigated. This process gave rise to pertinent excerpts from the field notes arising from the participants’ submissions to questions put to them. Halldorson (2009) advised that in engaging at this second stage of thematic analysis of collected field notes, “researchers should at all times keep an eye on the study’s questions”, as this will assist the researcher to identify accurately ‘excerpts’ that relate to the research objectives. The present researcher took this suggestion into account in attending to this stage of her data analysis process.

### 3.8.3. Stage Three: Data Drawing and Conclusions.

Having gone through the data reduction process and sifted salient aspects of it that answer to the research questions investigated, the excerpts to be used in composing the report and arriving at conclusions of the study to the questions investigated came to the fore. In the present study, the effect of this process could be seen in the chapter that follows where the results of the study emerging from the two FGDs were highlighted and drawn together for easy verification and making of conclusions as regards the extent to which they have contributed in responding to the research questions investigated.

Needless to say, the above three stages are deeply complementary and interlinked as none could stand on its own in facilitating the reaching of conclusions from the FGD data in relation to the research questions guiding the study.

### 3.9. Ethical Considerations

The research was conducted based on the Health Professions Council of South Africa (HPCSA, 2008) guidelines for conducting research. It was also approved by the Biomedical Research Ethics Committee (BREC) of the University of KwaZulu-Natal. To ensure high ethical standards in the execution of the present study, effort was made to avoid any opportunity for exploitation of participants. To this effect, participants were served with informed consent form (See Appendix 2, p 82) to fill before data collection could commence (Neuman, 2007). In addition, information sheets for the survey questionnaire and the focus group discussion were adequately informative as to assist study participants to come to an informed decision whether or not to take part in the study. In particular, effort was made to preserve the autonomy of the participants in the course of the study. To this end, the following principles of research ethics as articulated by Emmanuel, Wendler, & Grady (2000, 2008) were strictly followed in conducting the study: the research ethical principle of *collaborative partnership* and principles of non-maleficence and beneficence. The principle of collaborative partnership was adhered to by assuring participants that participation was voluntary and that one was entitled to discontinue participation without penalty if, at any time, they discover that any aspect of the questionnaire/interview schedule was against their values or personal interests or both. The principle of *beneficence* was adhered to by letting potential participants know that the aim of the study was to determine and arrest any lingering obstacles to ensuring effective practice of antenatal services in their district. To this effect, they were assured that the study has high *social value*, as the overall goal was for the good of the society. To adhere to the principle of

*non-maleficence*, also emphasized by Emmanuel, et al.'s (2008), potential participants were assured that there was no danger to worry about for participating in the study.

To enhance the *scientific validity* of the study, effort was made to strictly follow the criteria for recruitment of participants. This meant that only those who fulfilled all the inclusion criteria earmarked for participation was recruited into the study sample. This sample selection procedure was consistent with Emmanuel, et al.'s (2000), proposition that respecting the principle of fair participation of respondents is another way of enhancing the ethical commitment of the study process. For instance, the researcher made sure that the participants included representatives of the married and unmarried female populations.

Finally, the participants were informed that should they have any concerns or questions regarding their rights as study participants, they could contact (through the relevant contact details provided) the appropriate authorities of the Human & Social Sciences Research Ethics Administration office of the University of KwaZulu-Natal, their contact details provided to them.

### **3.10. Dissemination of Results**

The study will be submitted to the University of KwaZulu-Natal in partial fulfilment of the requirements for the degree of Master of Social Sciences in Clinical Psychology and will be placed in the university library. It is expected that some sections of it will be published in a relevant psychology research journal.

### **3.11. Conclusion**

The researcher used a mixed-method as a convergent approach in trying to understand how pregnant women utilize prenatal services. This means that the research combined a quantitative survey design, using a questionnaire to collect data, and qualitative focus group discussions as a form of triangulation. The participants for the study were drawn from two districts in the Eastern Cape. The quantitative data were analysed by means of descriptive statistics while the qualitative data were analysed manually by extracting the dominant themes in line with the procedure developed by Miles and Huberman (1994). The results of the study are presented in the next chapter.

## **CHAPTER FOUR**

### **RESULTS OF THE STUDY**

#### **4.1. Introduction**

This chapter presents the results of the study. The presentation is organized according to the research questions investigated. The findings from the focus group discussions will also be outlined. The presentation is preceded by a descriptive/demographic analysis of the study participants.

#### **4.2. Demographic Data**

Participants for the quantitative part of the study were drawn from Gcuwa and Komanishini communities in the Eastern Cape. All 84 participants (42 from each community) were black, Xhosa females.

##### **4.2.1. Age characteristics of participants from Gcuwa and Komanishini Communities**

Figure 4. 1:

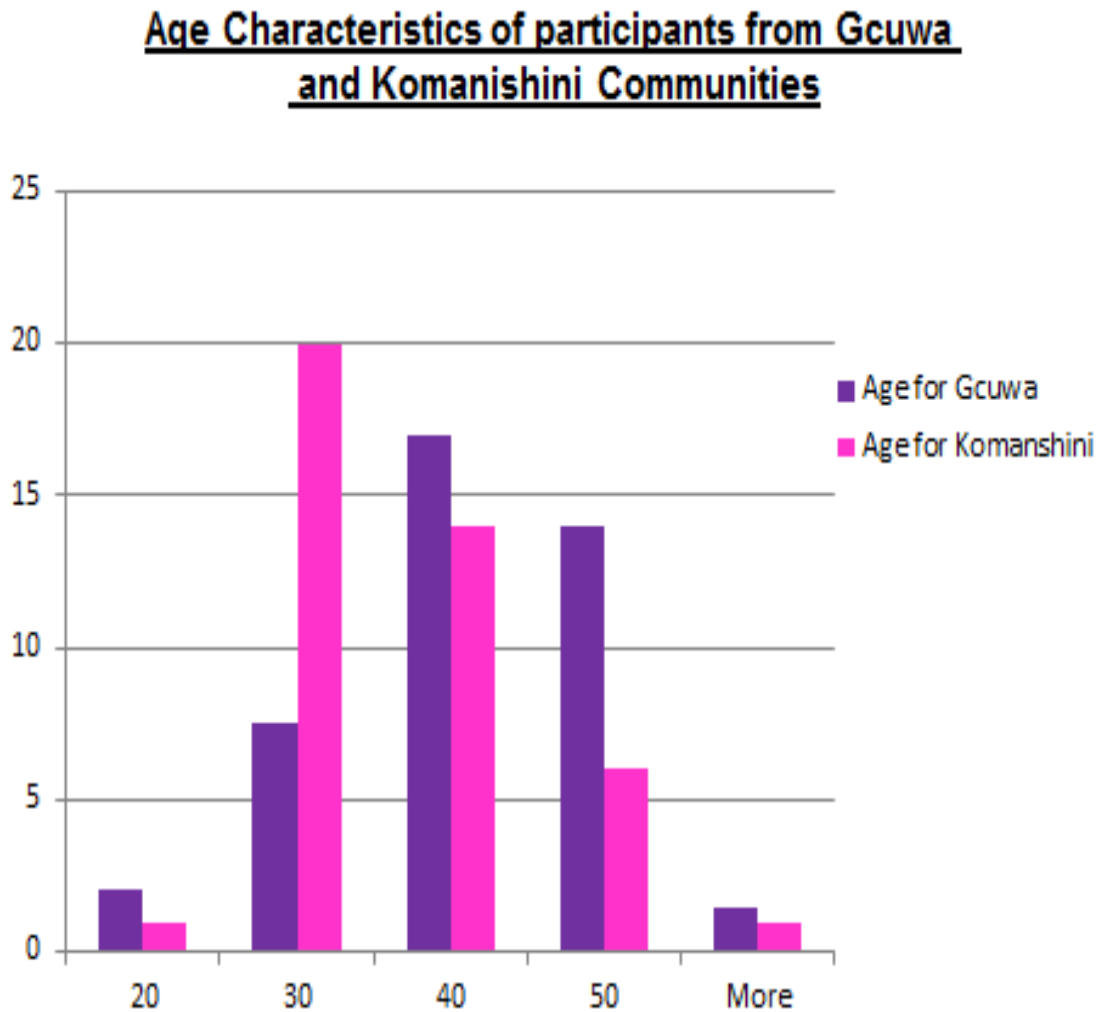
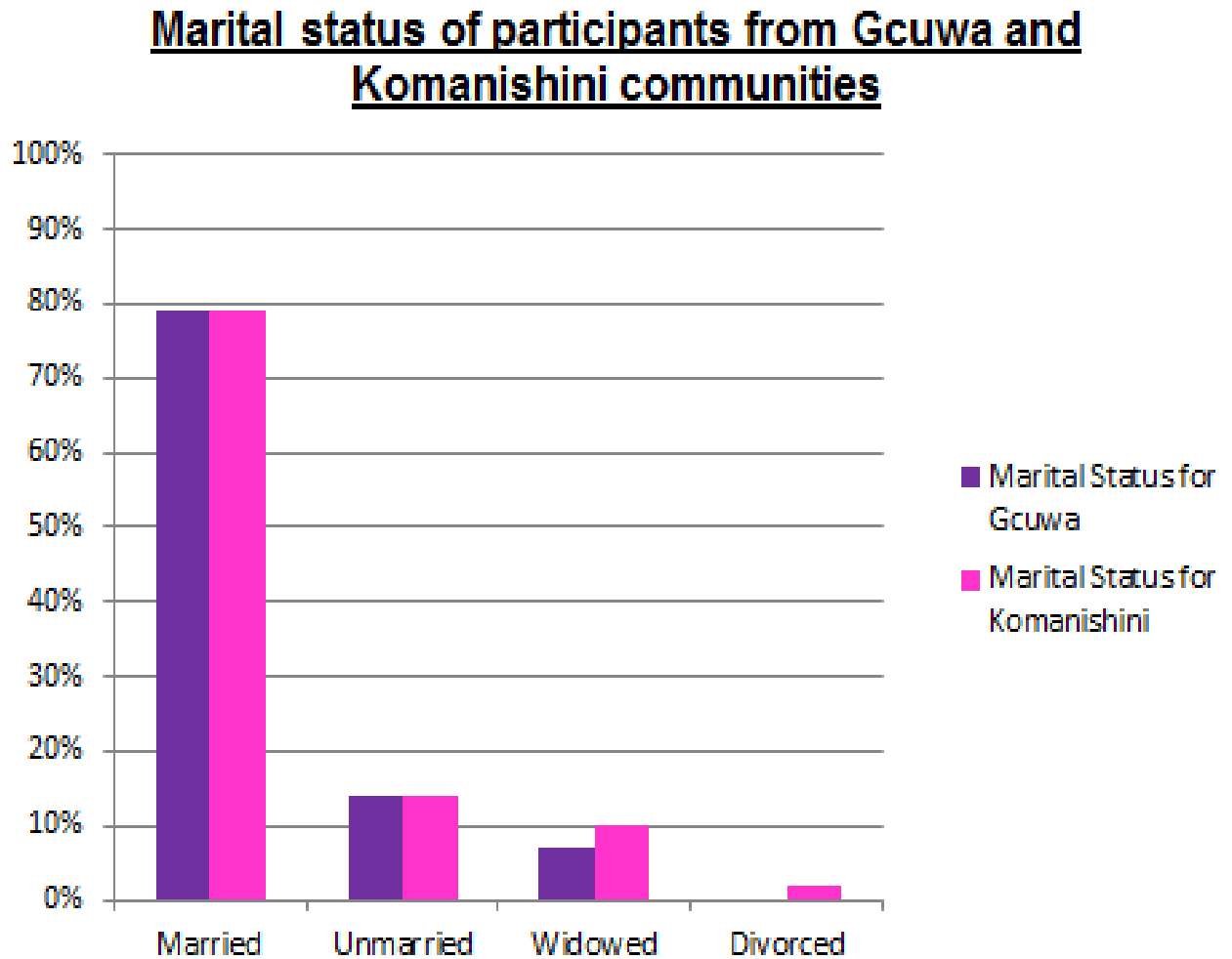


Figure 4.1 above shows that participants in the survey research from the two communities studied differ according to age, with most of the participants from Gcuwa between 40 and 50 years; while most of the participants from Komanishini being 30 and 40 years

#### 4.2.2. Marital Status of survey research participants from Gcuwa and Komanishini Communities

Figure 4.2



Information summarized in Figure 4.2 above illustrates that over 70% of survey participants from the two communities studied are married.

### 4.3. Results of the Study Research Question by Research Question

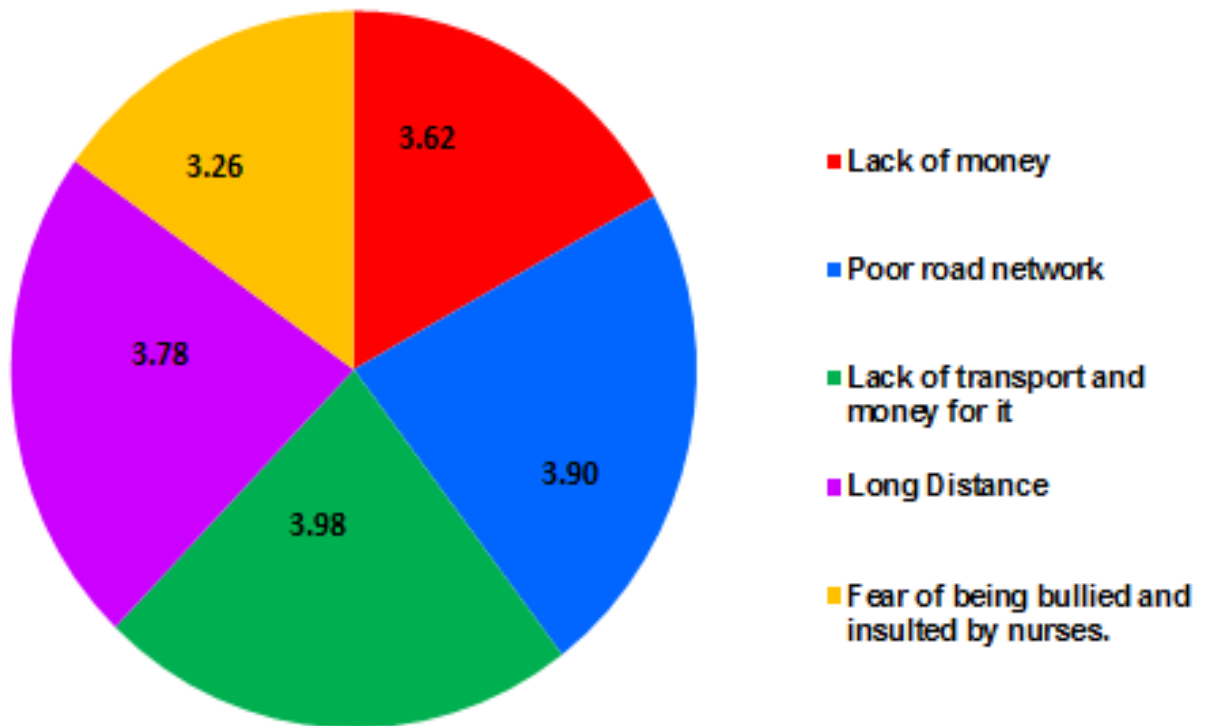
#### 4.3.1. Research Question One:

What factors are perceived to be responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in the Eastern Cape Province?

The results of this study in relation to the above question are summarized in Figures 4.3a and 4.3b, below.

**Figure 4.3a**

#### Factors responsible for underutilization of clinic-based prenatal services in the Eastern Cape province (Komanishini)

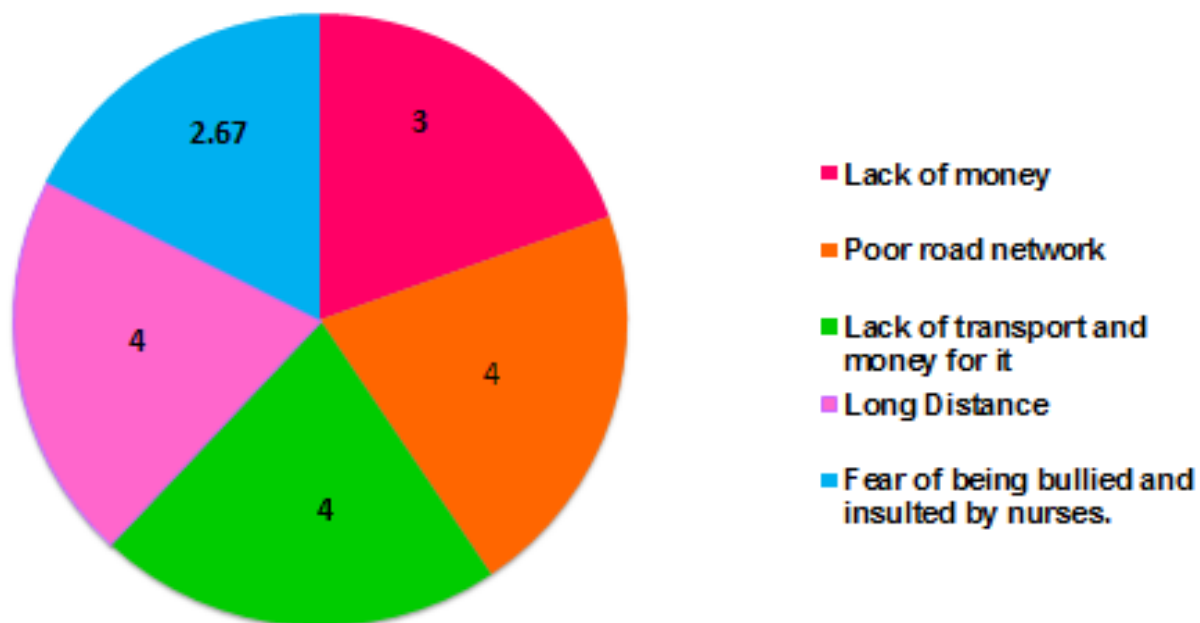


Information in Figure 4.3a above shows that the following are among the major factors responsible for the problem of underutilization of prenatal clinic-based services in the two villages studied: “Lack of money to pay for services”; “Poor road network leading to where clinic is located”; “A lack of transport and the money to pay for it”; “Long distance to be covered”; and “Fear of being bullied or insulted by the nurses”.



Figure 4.3b

**Factors responsible for underutilization of clinic-based prenatal services  
in the Eastern Cape province (Gcuwa)**

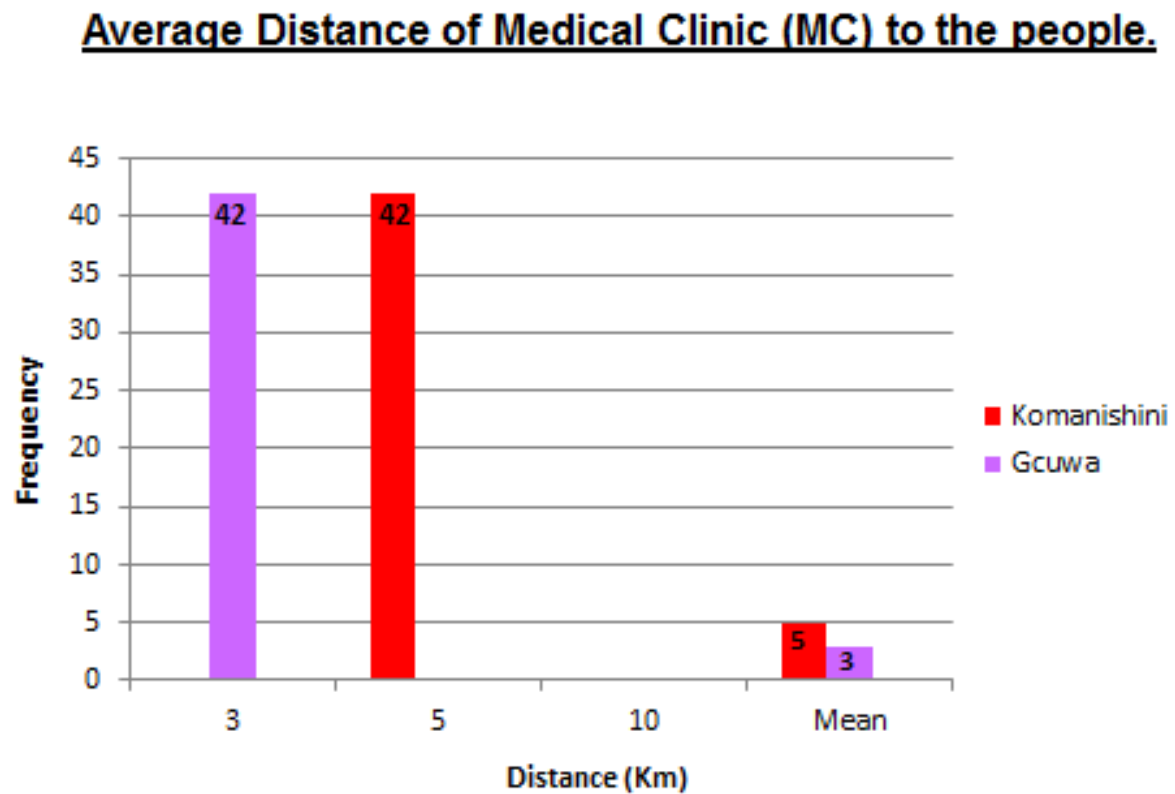


Information in Figure 4. 3b above shows that the following are among the major factors responsible for the problem of underutilization of prenatal clinic-based services in the two villages studied: “Lack of money to pay for services”; “Poor road network leading to where clinic is located”; “A lack of transport and the money to pay for it”; “Long distance to be covered”; and “Fear of being bullied or insulted by the nurses”.

#### **4.3.2 Research Question Two:**

What is the average distance, in kilometres, which pregnant women in the rural Eastern Cape Province reportedly cover when they wish to attend for a prenatal care service? The aim of this question was to explore the average distance to the people, of the nearest prenatal care facility. Data in relation to the question as gathered from respondents from the communities studied (Komanishini and Gcuwa) are highlighted in Figure 4.3c below

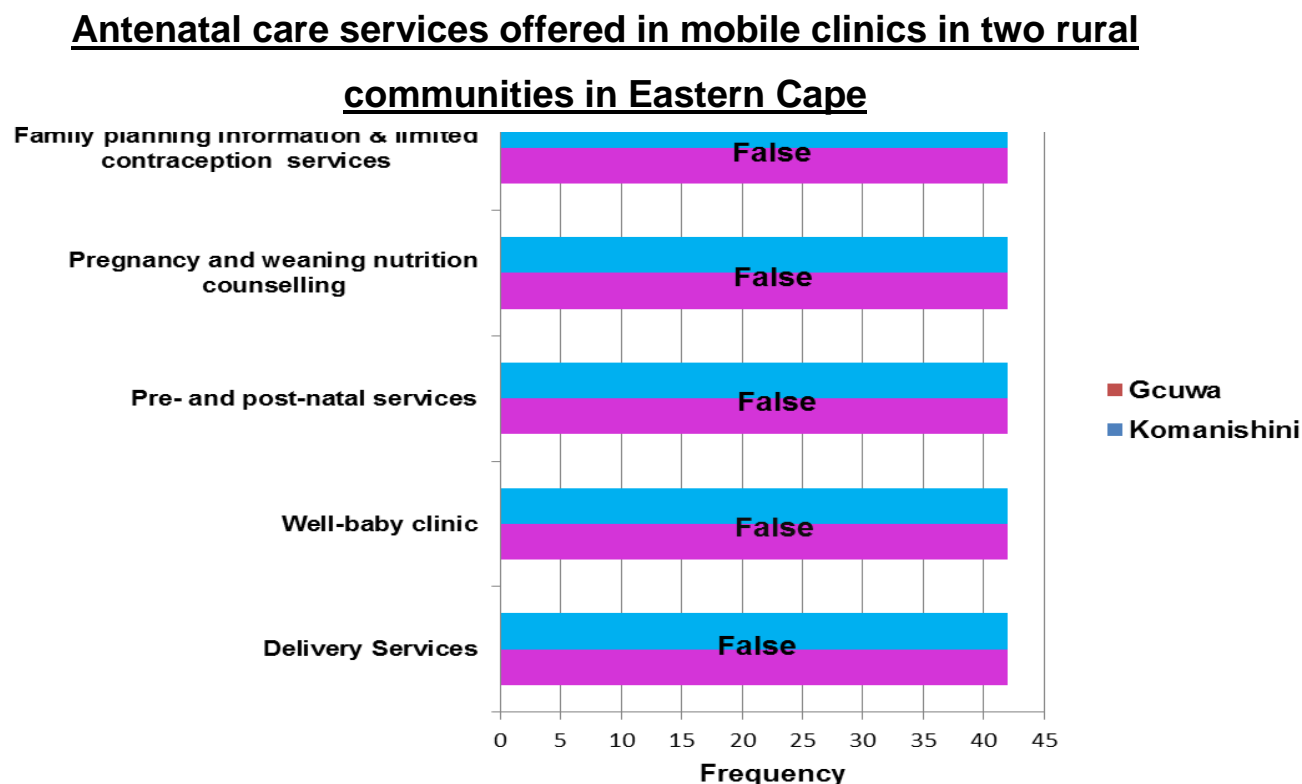
Figure 4.3c



#### 4.4. Research Question Three:

What are the main antenatal care services offered in mobile clinics in two rural communities in Eastern Cape? The results of this study in relation to the above question are provided in Figure 4.4 below.

Figure 4.4



Information summarized in Figure 4.4 above shows that participants from both villages denied that major antenatal services are made available to them since they do not have medical clinics in their villages. To have access to these services they have to travel a distance of up to 3 or 5 kilometres away from their own communities.

#### **4.5. Findings from the Focus Groups**

This section presents the qualitative study findings according to the themes that emerged.

##### **4.5.1. Theme one: Challenges associated with access to prenatal care services.**

According to data emerging around this theme FGD participants mentioned that they were scared to go alone to the clinic. They would try to find someone who is also going to the clinic, and when they do not succeed, they would wait till there is somebody going to the clinic. Participants also indicated that there is no regular transport to the clinic. Transport is available once a day, taking people to town, but there is no transport that goes straight to the village where the clinic is located. To visit the clinic, two taxis instead of one have to be taken, and using taxis is time consuming because, in town, one has to wait until the taxi is full, which could take up to three hours.

In relation to this particular challenge, participants from the Komanishini focus group agreed that:

- *'It is because clinics are afar.'*
- *'Transport is the issue and is irregular.'*

Similarly, participants from the Gcuwa focus group also agreed that:

- *'Clinic is far and we are afraid of going alone, [it] is not safe.'*

#### **4.5.2. Theme two: cultural belief of hiding the pregnancy**

All participants from the two FGDs admitted that they had attempted hiding the pregnancy until it was too difficult to do so. The general reason they gave was their belief that in the first trimester the pregnancy is vulnerable to witchcraft and that miscarriage often occurs in that period. In addition, to avoid being labelled as 'miscarrying women', it was better to suffer miscarriage when nobody would know about it. In this way, they would be protected against the stigma associated with miscarriage. When women miscarry they are told by other women that they have small graves in their tummies. Participants highlighted that this fear affects a great portion of their pregnant women. And they refuse to take the strain of travelling to the clinic for prenatal services that might result in such a mishap making it possible for others to get know of it.

Some of the FGD participants indicated that they did nothing once the pregnancy was showing, except praying and taking herbs. Some other participants denied that they perform rituals for the pregnancy while pregnant. The participants' culture does not require any performance ritual for officially reporting the pregnancy. But they did agree that they perform a birth ritual only when the child is born, that's when the ancestors are reported to be to about the new member of the family. They said they engage in such birth ritual due to their belief that anything can happen to a pregnancy if the ancestors had not been involved in protecting it.

Commenting in this regard, there was consensus among participants from the Komanishini focus group that:

- *'We do hide our pregnancy till it is showing because the first three months anything can happen.'*

- *'We are afraid being tightened for not delivering in time by witches.'*
- *'We also afraid of losing our pregnancies.'*

Participants from the Gcuwa focus group also shared a similar belief. They commented:

- *'We do hide our pregnancy till it is showing because the first three months anything can happen especially witchcraft.'*

#### **4.5.3. Theme three: Poor service at clinics.**

Participants indicated another aspect that influences their delay in using antenatal care service, namely that nurses take their time to attend to people even while knowing that there are few nurses and many patients. Also, at times, the medication is not available and patients are sent home and told to come back the following week.

Commenting in this regard, there was consensus among participants from the Komanishini focus group that nurses do the following:

- *'They ignore you in clinics when you are in labour pains, they will look at you later after a long time.'*
- *'You will scream and the response will be, "leave me alone and stay there".'*
- *'You deliver alone on the bed and you lose interest for nurses, they laugh at you and punish you at the chair or in bed.'*
- *'Especially when they are on lunch and tea they don't return on time.'*
- *'They tell you it is not the minister who is pregnant, don't rush us.'*
- *'Nurses return people because of demarcation.'*
- *'Demarcation is noticed and considered, you will be told go to Ngqamakhwe but you are close to Butterworth.'*

A similar trend of complaints on the theme of poor services at the clinic was received among participants from Gcuwa who noted that service is poor in clinics:

- *'The service is poor.'*
- *'There are many people with few nurses.'*
- *'Nurses take their time.'*
- *'They ignore people.'*
- *'They stay long to their tea and lunch leaving patients unattended.'*
- *'Some of them are rude to patients.'*

Furthermore, the majority of the participants in both focus groups reported that nurses have a habit of going to lunch all at the same time, taking more than an hour, especially when the sister in charge has gone to attend meetings at the district office. However, although some of the nurses are always on guard, they do not wait for the patient to ask a question; they answer before the patient can finish the sentence. This attitude makes it difficult for patients to ask questions about their concerns. In addition, some of the nurses, some of the FGD participants indicated, discuss patients' problems in front of other patients and they sometimes disclose patient status to others without regard to the concern of the patient.

#### **4.5.4. Theme four: The use of traditional antenatal care services.**

All the FGD participants denied that they opted for other services such as prophets, traditional healers and birth attendants to help them deliver or to obtain antenatal care services. They indicated that they are aware of the law and the risk involved in such services. They also affirmed that no other services were provided in their communities.

In relation to the above, participants from the Komanishini focus group reported:

- *'We do not have anything like that and such services. People are aware of law in Eastern Cape, no one wants to render services that can lead to arrest. They are aware that should you help somebody to give birth and something goes wrong you will be asked to produce paper that qualifies you to help delivering a baby. Even if someone is able to do that they refuse and tell people to go to the hospital. There were number of radio talks and teaching in clinics for women in Eastern Cape, no one want to be arrested especially the service provider.'*

Participants from the Gcuwa focus group noted a similar experience:

- *'We go to hospital only, to avoid any harm and arrest.'*

#### **4.6. Conclusion**

The findings of the study indicated a number of challenges faced by expectant mothers wanting to access prenatal care in the two communities studied. Both the quantitative qualitative findings indicated that the distance to the clinic was a major challenge. This was confirmed by means of triangulation with responses from focus group discussions. The cost of transport to the clinic goes hand in hand with the distance to the clinic and poses another set of challenges

to pregnant women, namely being forced to walk unsafe routes and risking their lives. The pregnant women did, however, acknowledge the importance of clinic-based prenatal care, because they believe it offers better safe delivery compared to other alternatives that might be available. However, cultural barriers impacted on the participants' use of these facilities due to the fact that they always want to hide their pregnancy for fear of being bewitched.

## CHAPTER FIVE

### DISCUSSION AND CONCLUSION

#### 5.1. Introduction

This chapter discusses the findings of the study presented in the previous chapter. The discussion is organized along the lines of the three major themes investigated. The discussion will also take into account the major themes emerging from the focus group process. In the course of the discussion, the findings will be interpreted and related to some relevant studies highlighted in chapter two of the present thesis. Furthermore, implications of the findings will be examined and some recommendations offered for improved policy and practice. Lastly, some of the limitations of the study and areas for further research will be outlined.

#### 5.2. Discussion of Results Research Theme by Research Theme

##### 5.2.1. Research Theme One:

Factors perceived to be responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in the Eastern Cape Province

Data related to this question were summarized in Figures 4.3a and b, in the previous chapter. According to information presented in that chapter among the major factors perceived by the participants to be responsible for underutilization of clinic-based antenatal services include: “Lack of money to pay for services”; “Poor road network leading to where clinic is located”; “A lack of transport and the money to pay for it”; “Long distance to be covered”; and “Fear of being bullied or insulted by the nurses”.

From the results of the focus group, the researcher discovered that participants from Gcuwa have to pass dangerous squatter camps where rapes and murders had occurred in the past, to reach the nearest clinic for their antenatal care services. Similarly, participants from Komanishini as revealed in the focus group process, have to pass a field and river where rapes and murder had occurred as well. For this reason, it was discovered, participants preferred not to attend antenatal care services if they do not have someone to accompany them, to ensure their safety.



The researcher also established through the focus group process that a lack of transport and money is equally responsible for irregular attendance of antenatal care services. Both the Gcuwa and Komanishini participants strongly agreed that they lacked money to pay for transport taking them directly to the clinic. Komanishini participants complained that they do not have transport that goes to Ngqamakhwe which is where demarcation places them for services—they only have transport that goes to Gcuwa where they have to take another transport going to Ngqamakhwe. Therefore, they have to pay double for transport if they must attend the clinic. Yet, availability of money for such expenses is not on their side.

Furthermore, focus group participants from Komanishini village narrated the effort they have often made to use Gcuwa facilities in the past, only to be told that they do not belong to that region for primary health-care purposes and have to go to Ngqamakhwe. Sometimes, according to the same focus group participants from Komanishini, they have sometimes hidden the fact that they come from Komanishini, and claim to be residing in Butterworth. Consequently, from information arising from the results of this study, ‘demarcation’ has disadvantaging effects for the Komanishini women especially.

Again, a special transport cost of about R500, was an amount which focus group participants from the two villages claimed they need to have for a successful clinic attendance; an amount of money they claimed they do not have most of the time. The same focus group participants also indicated that they at times “fear they might deliver on the way to the hospital seeing that the vehicles shake heavily on bumpy roads which could speed up the delivery process. “Some of the participants also complained that “owing to the condition of the roads, it is also difficult to rest while the vehicle is moving.” These same focus group participants from the two villages noted that “the Department of Health is aware of some of their challenges and has tried to assist them. However, the Department cannot assist with some of the challenges, such as road structure.” They admitted that they had been assisted by mobile clinics in the past, but, in their view, “the services were inconsistent.” According to them too, “at times, the mobile clinics would not come due to rains and flooded roads. The mobile clinic vehicles also require regular service due to the poor condition of the roads.”

Some of the members of the focus group discussion from Komanishini admitted that “Transport is available once a day, taking people to town, but there is no transport that goes straight to the

village where the clinic is. To visit the clinic, two taxis instead of one have to be taken, and using taxis is time consuming because, in town, one has to wait until the taxi is full, which could take up to three hours.”

These findings concur with those from the studies by Anafi (2012) who investigated the problem of maternal mortality in Ghana in which it was found, like in the present study, that part of the problem was that of socio-economic constraints against use of the services. The present study findings also corroborate those by Brueton et al (2010), Ndyomugenyi, Neema & Magnussen, 1998; and Simkhada, Teijlingen, Porter & Simkhada, 2008), all of which reported that socio-economic factors were among those that prevent pregnant rural women from effective use of clinic-based services.

Most of the data on factors responsible for women’s underutilization of clinic-based prenatal services emerging from the questionnaire survey of the present study, were also outlined by participants in the focus group from the two villages. Thus, as indicated in the previous chapter, participants from the Komanishini focus group reported that the most important reason why some of their pregnant women tended to be reluctant to attend to the clinic-based services include the following:

- *‘It is because clinics are afar.’*
- *‘Transport is the issue and is irregular.’*

Corroborating the above views, participants from the Gcuwa focus group also mentioned in their own words that:

- *‘Clinic is far and we are afraid of going alone, [it] is not safe.’*

Apart from the problem of transport or lack of money and the problem of far distance in location of these clinics as a deterrent to the women’s use of the services is the presence of some cultural beliefs that members of the focus group discussion admitted influence their attitude in this regard. Among such cultural beliefs is the idea that making the pregnancy public too early will be injurious to the life of the pregnancy. For this reason, some of the women as noted in the literature and as admitted by participants in the focus groups from the two study

communities engage in the preventive act of hiding the pregnancy from public view as much as possible. Through that practice, most of them became reluctant to present themselves for clinic-based antenatal services that would have the negative implication of exposing the pregnancy to the gaze of others. Commenting in this regard, data from focus group discussion from participants in the two villages revealed that on account of the women's cultural belief that something bad can happen to the pregnancy if it is made public so early, participants from the Komanishini focus group reported that:

- *'We do hide our pregnancy till it is showing because the first three months anything can happen.'*
- *'We are afraid being tightened for not delivering in time by witches.'*
- *'We also afraid of losing our pregnancies.'*

Participants from the Gcuwa focus group also shared a similar belief. In this regard, some of the participants from Gcuwa admitted

- *'We do hide our pregnancy till it is showing because the first three months anything can happen especially witchcraft.'*
- 

On the factor of fear of nurses bullying them as noted in Figure 4.3 highlighted in the previous chapter, participants from the Komanishini focus group noted that nurses do the following:

- *'They ignore you in clinics when you are in labour pains, they will look at you later after a long time.'*
- *'You will scream and the response will be, "leave me alone and stay there".'*
- *'You deliver alone on the bed and you lose interest for nurses, they laugh at you and punish you at the chair or in bed.'*
- *'Especially when they are on lunch and tea they don't return on time.'*
- *'They tell you it is not the minister who is pregnant, don't rush them.'*
- *'Nurses return people because of demarcation.'*
- *'Demarcation is noticed and considered, you will be told go to Ngqamakhwe but you are close to Butterworth.'*

Corroborating the above, participants from Gcuwa were of one voice in noting that service is poor in clinics:

- *'The service is poor.'*
- *'There are many people with few nurses.'*
- *'Nurses take their time.'*
- *'They ignore people.'*
- *'They stay long to their tea and lunch leaving patients unattended.'*
- *'Some of them are rude to patients.'*

Indeed, as indicated in the course of the focus group in the two communities, majority of the participants unanimously agreed that “nurses have a habit of going to lunch all at the same time, taking more than an hour, especially when the sister in charge has gone to attend meetings at the district office. “In addition, as could be read from the focus group discussion in the two communities, “although some of the nurses are always on guard, they do not wait for the patient to ask a question”; “they answer before the patient can finish the sentence.” This attitude, they emphasised, makes it difficult for patients to ask questions about their concerns.

Furthermore, many participants in the focus group in the two communities complained that “some of the nurses discuss patients’ problems in front of other patients and they sometimes disclose patient status to others without the concern of the patient.”

Based on these revelations it becomes easy to understand why some of the pregnant women decide not to make use of the prenatal services even when they (the pregnant women) could afford it, money-wise.

The above findings are in line with those by Van Eijk et al. (2006) who conducted a study in Western Kenya similar to the present one in which they found that among the reasons why pregnant women in that area were reluctant to make use of prenatal services made available to them was because of poor services from the nurses. The same is true of the findings of the study by Haddril, Jones, Mitchell & Anumba (2004) who, like in the present study, discovered that lack of money for transport and poor quality services were among the factors that deterred pregnant women from effective use of the prenatal services placed at their disposal. Also, a

similar study by Adamu & Salihu (2002) in Kano State of Nigeria, came out with findings that concurred with the present study findings, since in theirs like in the present one, a combination of economic, social-cultural and poor quality services were among the negatives factors that offered explanation as to why pregnant women are often unwilling to present themselves for clinic-based prenatal services.

### **5.2.2 Research Theme Two:**

Average distance, in kilometres, which pregnant women in the rural Eastern Cape Province reportedly cover when they wish to attend for a prenatal care service

Data relating to the above question can be found summarized in Table 4.3.2.1 in the previous chapter. According to information presented in that Table, the average distance in kilometres covered by pregnant women in their wish to attend for prenatal care service is 3 kilometres for those from Gcuwa and 5 kilometres for those from Komanishini. This is an unfortunate situation given that participants from focus groups in the two villages studied reported that they would like to deliver at health-care facilities where there are skilled professionals. This finding showed that participants did not believe that traditional birth attendants give better service than nurses, nor that home delivery is more convenient than in clinics. Furthermore, the participants seem to regard clinics as a necessity for pregnancy and not only for emergencies when complications arise. However, to access these services they have to travel over three kilometres to do so, at the minimum.

Indeed, information from the focus group discussion with participants from the two rural communities studied showed that the participants had knowledge regarding prenatal service and its necessity for pregnant women. They indicated that they received relevant information from radio talks and clinic workshops which were held successfully by local and national stations regarding pregnancy and antenatal services. This health education seems to have been effective because the participants were aware of laws stipulating that the provision of services without proper training is a serious offence. Nevertheless, getting this knowledge is one thing while trying to implement it is another where transport is not available; and if available, where the money to hire them for attendance of the clinics is not available. The above problems result in many of the pregnant women not using a resource that they have been informed of and which is of relevance to them.

The above findings concur with study by Mekonnen & Mekonnen (2003) who discovered that one of the constraining factors was financial which made it impossible for those patients who do not have transport, to have access to the clinics. Similarly, the present study findings are in line with those by Maimbola et al. (2006); Fekede & Mariam (2007); Hoque, Hoque & Kader (2008), and Larsen, Lupiwa, Gillieath and Alpers (2004), all of whom in their findings blamed the problem of logistics as responsible for rural pregnant women's inability to make use of clinic-based prenatal services in the communities they studied.

### 5.2.3. Research Theme Three:

Main antenatal care services offered in mobile clinics in two rural communities in Eastern Cape? Questionnaire data collected in relation to the above question have been summarized Figure 4.4 in the previous chapter. According to information summarized in that chapter, the participants from the two communities studied were unanimous in their view that the main services provided in prenatal clinics hospitals are not available in the medical clinics available in their communities. Corroborating this standpoint, data that emerged during the focus group discussion pointed to the fact of the ill-availability within the two villages, of main services found in the clinic-based antenatal facilities. Like was the case in the response to the questionnaire items on this theme, focus group participants noted that no major prenatal care services were provided in their communities.

Commenting specifically in this regard, participants from the Komanishini focus group reported:

- *'We do not have anything like that and such services. People are aware of law in Eastern Cape, no one wants to render services that can lead to arrest. They are aware that should you help somebody to give birth and something goes wrong you will be asked to produce paper that qualifies you to help delivering a baby. Even if someone is able to do that they refuse and tell people to go to the hospital. There were number of radio talks and teaching in clinics for women in Eastern Cape, no one want to be arrested especially the service provider.'*

In corroborating the above, participants from the Gcuwa focus group noted a similar experience *'We go to hospital only to avoid any harm and arrest.'*

The trend from the above observations suggest then that “delivery services”, “well-baby clinic”, “prenatal and postnatal care”, “pregnancy and weaning nutrition counselling”, and “family planning information and limited contraception services” are not facilities commonly found in the two communities covered studied. The above findings concur with those by Ngomene & Mulaudzi (2012) which showed that both cultural and situational factors were responsible for inability of pregnant women in rural communities in Africa to access clinic-based prenatal care.

### **5.3 Summary of the Study, Implications and Conclusions**

The purpose of this study has been to explore the factors responsible for pregnant women’s tendency in the Eastern Cape to delay attendance or to feel reluctant to make use of the prenatal services made available to them.

The study was carried out in two selected rural communities in the Amathole district, Eastern Cape Province, South Africa. The target communities were Gcuwa and Komanishini. Purposive sampling was used in recruiting participants for the study. The participants were selected based on the criteria of being pregnant, having given birth or being of child-bearing age. Two instruments were used to collect data: the interview guide and the questionnaire. The interview guide comprised eleven questions for the focus group discussions. The guide was used to enhance uniformity in the questions and it served as triangulation tool for the questions. The questionnaire data from 84 participants were analysed by means of descriptive statistics. A thematic analysis was performed on the responses from the focus group discussions regarding the factors responsible for the reported reluctance of pregnant women to make use of prenatal services.

The results showed that the factors, such as distance to the clinic and transport problems, financial constraints, fear of being bullied or insulted by the nurses, and difficulties in crossing big rivers during the rainy season hinder their attendance of antenatal services.

The trend from the findings encourage the conclusion that although the women do appreciate the importance of clinic-based care of pregnant women, those from rural communities in Eastern Cape have many constraints that deter them from making effective use of these services. In other words, although they would like to make use of these services they are usually unable to implement their desire in this regard on account of a number of factors beyond their control.

#### **5.4. Recommendations for Policy and Practice**

Based on the above findings and the implications arising from them, the following recommendations are made to improved policy and practice:

- All relevant role-players should be involved because the problem is multifaceted, for example, poor roads as well as health issues are at stake. Vehicles such as 4x4s should be used for mobile clinics because they are suitable for the poor roads in rural areas. Regular service maintenance of mobile clinics is also important and therefore recommended.
- Demarcation issues need to be addressed and resolved because law does not allow public services to be denied users at any cost. Furthermore, because of fake addresses, it is difficult to locate family members in case of death. To prevent people from having to fake their address, in order to get a treatment, the demarcation restriction that is at the root of it should be softened, if not totally withdrawn.
- There is need for consistency of maintenance of health education regarding prenatal care service. Health education has helped to decrease the number of women giving birth at home at Gcuwa and Komanishini. It also deterred people from rendering services they are not qualified for. To enhance the situation further, easy access of the people to the clinic-based services is a necessity.

#### **5.5. Limitations of the Study**

A possible limitation of this research project was the limited sample size and the fact that the sample comprised participants from only two rural communities in the whole of the Eastern Cape Province. This means that the results might only be a reflection of the women from the sampled communities and not women in the Eastern Cape as a whole. Another possible limitation is that, for the focus group interviews, purposive sampling was used as opposed to random sampling. This could, to an extent, jeopardize the generalizability of the results of the study to the population of child-bearing women in the Eastern Cape Province.

Furthermore, participants in the focus groups were not comfortable being audio taped and only field notes were used. The researcher had to be accompanied by an individual whom the community knows and trusts.



### **5.6. Recommendations for Further Research**

Given the above limitations of the present study. Firstly, more research is required regarding the use of prenatal service and the implementation of proposed plans of action. Secondly, further research in other rural areas is necessary to gain insight into this phenomenon in the many diverse cultures in South Africa. Such research would provide deeper understanding as to how women's needs could be met without disregarding their cultural beliefs.

### **5.7. Conclusion**

The study explored and identified some of the factors that cause pregnant women to not visit prenatal clinics immediately after realising that they are pregnant. Some of the factors are cultural in nature, for example, fear of being bewitched once other people become aware of the pregnancy. Some of the factors that deter their commitment to seek prenatal care are expensive transport costs, the bad condition of the roads, the distance to be covered and the behaviour of primary health-care workers. The study made several recommendations regarding policy and future research because a single study might not be exhaustive as far as women's attitude towards effective use of prenatal services is concerned.

## REFERENCES

- Abrahams, N., Jewkes, R., & Mvo, Z. (2001). Health care-seeking practices of pregnant women and the role of the midwife in Cape Town, South Africa. *Journal of Midwifery & Women's Health*, 46(4), 240-247.
- Adamu, Y., & Salihu, H. (2002). Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria. *Journal of Obstetrics & Gynaecology*, 22(6), 600-603.
- Ali, A. A., Osman, M. M., Abbaker, A. O., & Adam, I. (2010) Use of antenatal care services in Kassala, eastern Sudan. *BMC Pregnancy Childbirth*, 10, 67. doi:[10.1186-2393-10-67](https://doi.org/10.1186-2393-10-67).
- Anafi, P. (2012). *Understanding maternal health-care seeking behavior in low-income communities in Accra, Ghana*. Amherst, MA: University of Massachusetts.
- Babbie, E. R. (2004). *The practice of social research*. Cape Town: Oxford University Press.
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215.
- Blacker, R. (2009). A thematic analysis of psychodynamically-oriented supervision of observations in an acute inpatient ward. Published thesis. University of Leicester.
- Bogdan, R. & Biklen, S.K. (2007). *Qualitative research for education: An introduction to theory and methods*. Boston: Pearson/Allyn & Bacon
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Brueton, V., Yogeswaran, P., Chandia, J., Mfenyana, K., Modell, B., Modell, M., & Nazareth, I. (2010). Primary care morbidity in Eastern Cape Province. *South African Medical Journal*, 100, 309-312.
- Chapman, R. R. (2003). Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk. *Social Science and Medicine*, 57(2), 355-374.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Creswell, J. W. (2009). *Research design: qualitative, quantitative, & mixed method approaches*. London: Sage Publication.
- Creswell, J. W. (2012). *Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research*. 4<sup>th</sup> Ed. Boston: Pearson
- Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage

- Creswell, J. W., Shope, R., Plano Clark, V. L., & Green, D. O. (2006). How interpretive qualitative research extends mixed methods research. *Research in the Schools, 13*(1), 1-11.
- Department of Health (2007). *Guidelines for maternity care in South Africa*. Pretoria: Department of Health.
- De Vos, A. S., Delport, C. S. L., Fouché, C. B., & Strydom, H. (2011). *Research at grass roots: A primer for the social science and human professions*. Pretoria: Van Schaik.
- Emanuel, E.J., Wendler, D., & Grady, C. (2000). What makes clinical research ethical? *Journal of the American Medical Association, 283*, 2701-2711.
- Emanuel, E.J., Wendler, D., & Grady, C. (2008). An ethical framework for biomedical research. In E.J. Emanuel, C. Grady, R.A. Crouch, R. Lie, F.G. Miller, & D. Wendler (Eds.), *The Oxford textbook of clinical research ethics* (pp. 123-135). Oxford, UK: Oxford University Press.
- Fekede, B. G., & Mariam, A. (2007). Antenatal care services utilization and factors associated in Jimma Town (south west Ethiopia). *Ethiopian Medical Journal, 45*(2), 123-133.
- Finlayson, K., & Downe, S. (2013). Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies. *PLOS Medicine, 10*(1), 1-12 page numbers. doi:10.1371/journal.pmed.1001373.
- Hadrill, R., Jones, G. L., Mitchell, C. A., & Anumba, D. O. C. (2014). Understanding delayed access to antenatal care: a qualitative interview study. *BMC Pregnancy and Childbirth, 14*, 2-14.
- Halldorson, J. D. (2009). *An exploration of Tajfel's social identity theory and its application to understanding metis as a social identity*. Canada: University of Manitoba
- Hatherall, B., Morris, J., Jamal, F., Sweeney, L., Wiggins, M., Kaur, I., Renton, A., & Harden, A. (2016). Timing of the initiation of antenatal care: an exploratory qualitative study of women and service providers in East London. *Midwifery, 36*, 1-7. doi: [10.1016/j.midw.2016.02.017](https://doi.org/10.1016/j.midw.2016.02.017)
- Hoque, M., Hoque, E., & Kader, S. (2008). Audit of antenatal care at a rural district of KZN, South Africa. *South African Family Practice, 50*(3), 61-66.
- Larsen, G. L., Lupiwa, S., Kave, H. P., Gillieatt, S., & Alpers, M. P. (2004). Antenatal care in Goroka: issues and perceptions. *PNG Medical Journal, 47*(3-4), 202-214.

- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Maimbolwa, M. C., Yamba, B., Diwan, V., & Ransjo-Arvidson, A. B. (2003). Cultural childbirth practices and beliefs in Zambia. *Journal of Advanced Nursing*, 43(3), 263-274.
- Mathole, T., Lindmark, G., Majoko, F., & Ahlberg, B. M. (2004). A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. *Midwifery*, 20(2), 122-132.
- Mertens, D. M. (2014). *Research and evaluation in education and psychology: integrating diversity with quantitative, qualitative, and mixed methods*. USA: Sage.
- Mekonnen, Y., & Mekonnen, A. (2003). Factors influencing the use of maternal healthcare services in Ethiopia. *Journal of Health, Population and Nutrition*, 21, 374-382.
- Mrisho, M., Obrist, B., Schellenberg, J. A., Haws, R. A., Mushi, A. K., Mshinda, H., Tanner, M., & Schellenberg, D. (2009). The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania. *BMC Pregnancy and Childbirth*, 9(1), 10.
- Myer, L., & Harrison, A. (2003). Why do women seek antenatal care late? Perspectives from rural South Africa. *Journal of Midwifery & Women's Health*, 48(4), 268-272.
- Ndyomugenyi, R., Neema, S., & Magnussen, P. (1998). The use of formal and informal services for antenatal care and malaria treatment in rural Uganda. *Health Policy Plan*, 13(1), 94-102.
- Neuman, W.M. (2007). *Basics of social research: Qualitative and quantitative approaches*. (2nd ed.). United States of America: Pearson Education, Inc.
- Ngomane, S., & Mulaudzi, F. M. (2012). Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabele district in Limpopo, South Africa. *Midwifery*, 28(1), 30-38. doi: 10.1016/j.midw.2010.11.002
- Odhiambo, C. (2003). *HIV/AIDS in Kenya and the Health Belief Model*. Nairobi: UMI.
- Ormrod, J. E., & Davis, K. M. (2004). *Human learning*. Prentice Hall New Jersey: Merrill.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage
- Phafoli, S. H., Van Aswegen, E. J., & Alberts, U. U. (2007). Variables influencing delay in antenatal clinic attendance among teenagers in Lesotho. *South African Family Practice*, 49(9), 17-17.

- Polit, D.F., & Beck, C.T. (2008) *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. (8th ed.). Lippincott Williams & Wilkins, Philadelphia: Pa.
- Pretorius, C. F., & Greeff, M. (2004). Health-service utilization by pregnant women in the greater Mafikeng-Mmabatho district. *Curationis*, 27(1), 72-81. *Psychological Review*, 84(2), 191.
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: A guide for social science students and researchers*. London: Sage.
- Rowe, R. E., Magee, H., Quigley, M. A., Heron, P., Askham, J., & Brocklehurst, P. (2008). Social and ethnic differences in attendance for antenatal care in England. *Public Health*, 122(12), 1363-1372. doi: 10.1016/j.puhe.2008.05.011.
- Simkhada, B., Teijlingen, E. R., Porter, M., & Simkhada, P. (2008). Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. *Journal of Advanced Nursing*, 61(3), 244-260.
- Skinner, B. F. (1953). *Science and human behaviour*. New York, NY: The Free Press.
- Turner, L. W., Hunt, S. B., Dibrezzo, R. & Jones, C. (2004). Design and implementation of an osteoporosis prevention program using the Health Belief Model. *American Journal of Health Studies*, 19(2), 115-121.
- Umeh, K., & Rogan-Gibson, J. (2001). Perceptions of threat, benefits, and barriers in breast self-examination amongst young asymptomatic women. *British Journal of Health Psychology*, 6(4), 361-673.
- Van Eijk, A. M., Bles, H. M., Odhiambo, F., Ayisi, J. G., Blokland, I. E., Rosen, D. H., Adazu, K., Slutsher, L., Lindblade, K. A. (2006). Use of antenatal services and delivery care among women in rural western Kenya: a community based survey. *Reproductive Health*, 3(1), 2.
- Volk, J. E. and Koopman, C. (2001). Factors associated with condom use in Kenya. A test of the health belief model, *AIDS Education Preview*, 13(6), 495-508.

## APPENDICES

### APPENDIX A

#### Question Outline for Focus Group Discussion

1. Is it possible to enumerate the factors responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in Eastern Cape Province?
2. Which of these factors is the most important of all? For instance, is it true that here in Eastern Cape, people still fear sharing the news of their pregnancy within the first trimester to avoid losing their babies due to problem of witchcraft and sorcery from their neighbours?
3. Is true that in some communities in Eastern Cape Province, a woman's pregnancy cannot be made public until the ancestors have first been notified, a fact that may drag the time of seeking antenatal care for these women beyond the first trimester?
4. It has been noted that in some antenatal clinics in the Republic, pregnant women who report for antenatal care are not happy with the way they are treated or indeed, that they are bullied by the nurses and midwives. To what extent is this true with experiences in clinic-based antenatal care in Eastern Cape?
5. Where do pregnant women in the rural Eastern Cape Province go to seek prenatal care?
6. Is it true that many pregnant women still depend on the services of the traditional birth attendants or the traditional healers or even the mother-in-laws for their antenatal care?
7. What range of health care facilities and providers are utilized by the rural women in Eastern Cape during pregnancy and childbirth?
8. Apart from clinic-based antenatal services, which other institutions and personnel provide antenatal care to pregnant women in Eastern Cape Province? For instance, is it true that some prayer-healing churches undertake to offer this service for the members of their religious groups?
9. Is it true that many pregnant women prefer to deliver their babies at home than to do so in antenatal clinics; and only opt for hospital delivery in problem cases or when things are not going on well with the said pregnancy?
10. What are the factors that you think push rural women in Eastern Cape to engage in this behaviour? That is, their preference for home rather than hospital care and delivery?
11. What do pregnant women in rural Eastern Cape complain about the antenatal care services made available? E.g. its distant location, or the poor and hilly roads to leading to them, or problem of transport or lack of money to pay for services provided; lack of knowledge and good behaviour on the part of the nurses?

## APPENDIX A1

Imibuzo elungiselelwe abo bathatha inxaxheba kwiqumrhu

1. ungakwazi ukubala izinto ezingunobangela kukungasetyenziswa rhoqo kwekliniki zabakhulelweyo kumanenekazi akhulelweyo asezilalini kuphondo zasempumakoloni.
2. Ngwaphi kula manqaku ingawona abaluleke kakhulu. Umzekelo, ingaba yinyani ukuba empumalanga koloni, abantu basenoloyiko yokuncokola ngendaba zokukhulelwa kwabo kwinyanga zokuqala ezintathu bekhuselela ukuphulukana nentasana ngenxa yokuthakatha okusuka ekuhlaleni.
3. Ingaba yinyaniso ukuba kwezinye indawo empuma koloni, ukuba ukukhulelwa kowasetyhini akunokwaziswa bantwini kude kubikelwe abaphantsi, lonto ibangele ukulibaiseka kokufuna uncedo lokukhulelwa ekliniki kwabo base tyhini kude kudlule kwinyanga zokuqala ezintathu.
4. Kuye kwaqwalwaseleka apha esizweni kwezinye iikliniki zabakhulelweyo ukuba amanenekazi akhulelweyo awayeze kunyango lokukhulelwa awonwabanga yindlela abaphatheke ngayo inga yinyani. Kuba badlakathiswe ngabongikazi nababelekisi. Ingaba kukoluphi uqondo ngokwamava akho ezikliniki ezisekelwe amnenekazi akhulelweyo empumalanga koloni.
5. Ingaba ayaphi amanenekazi akhulelweyo asezilalini zasempuma koloni, ukufuna uncelo lokukhulelwa.
6. Ingabe yinyani ukuba amanenekazi amaninzi akhulelweyo asaxhomekeke kuncedo lamagqirha namaxhwele kunye nabo bangababelekisi bemvelo kunye nomamazala kuncedo ngokukhulelwa.
7. Liliphi izinga lecandelo ngezempilo kunye nabaququzeleli ezizetyenziswayo ngamanenekazi ase empuma koloni kwixesha lokukhulelwa nokubeleka.
8. Ngaphandle kwekliniki zabakhulelweyo ngawaphi amanye amacandelo akho kumanenekazi akhulelweyo akuphondo lasempuma koloni . umzekelo, ingaba yinyani ezinye inkonzo eziphilisa ngothandaza ziye zinikezele kumalungu azo ngoluncedo lwabakhulelweyo.
9. Ingaba yinyani ukuba amanenekazi amaninzi akhetha ukubelekela abantwana babo emakhaya kunasezikliniki zempilo zabakhulelweyo. Okanye bakhetha ukuya esibhedlele xa kukho ingxaki naxa izinto zingahambi kakuhle ekukhulelweni.
10. Ngawaphi amanqaku ocinga ukuba atyhalela amanenekazi asezilalini zasempuma koloni ukuba benze esisimbo, sokukhetha ukubalekela emakhaya kunasesibhedlele.
11. Yintoni amnenekazi asempuma koloni akhalaza ngayo kuncedo lwekliniki zabakhulelweyo ezikhoyo kubo. Umzekelo ingaba bubude bendlela, indlela ezimbi nezinamaqhina ezibheka khona, ingxaki yokukhwela okanye ukuswela imali yokubheka khona, okanye ukuswela kolwazi nokuziphatha kakuhle kwicala labongikazi.

## APPENDIX B

### Participants' Questionnaire

Dear Participant,

Please do not write your name anywhere on this questionnaire. The responses you give to the questions stated below will be treated with utmost confidentiality.

#### I. Section A: Background

1. Rural location: \_\_\_\_\_

2. Age: \_\_\_\_\_ Religion: \_\_\_\_\_

3. Gender: (Male) \_\_\_\_\_ (Female) \_\_\_\_\_

4. Race: (Black) \_\_\_\_\_ (White) \_\_\_\_\_ (Coloured/Indian) \_\_\_\_\_

5. Spoken Language: Xhosa \_\_\_\_\_ English: \_\_\_\_\_ Other \_\_\_\_\_

6. Marital Status: Married/ \_\_\_\_\_ / Divorced/ \_\_\_\_\_ / Single/ \_\_\_\_\_ / Widowed/ \_\_\_\_\_ /

#### II. Section B: Attitude to Use of Antenatal Services

Direction: Kindly read each of the following statements carefully and choose from options provided the one that agrees with your opinion on the matter:

1. When I notice that I am pregnant I share this news with my family members and then plan to register as soon as possible for clinic-based antenatal care. True, / / Don't Know / / False / /.

2. When I notice that I am pregnant I try to hide it until when it becomes difficult to do so. I do this to avoid losing the pregnancy the jealousy and witchcraft from people with evil eye on me. True / / Don't Know / / False / /.

3. When I notice that I am pregnant I do not make it public until after the ancestors have first been notified according to the custom of my people. True / / Don't Know / / False / /

4. True / / Don't Know / / False / /



### Section C: Timing for Reporting Services

At which month after becoming pregnant did you start to attend antenatal clinics?

1. 1 - 3 months: Yes / / No / /
2. 3- 5 months: Yes / / No / /
3. 5- 7 months: Yes / / No / /
4. 7- 9 months. Yes / / No / /
5. Only when there is complication. Yes/ / No / /

### Section: D. Factors responsible for underutilization of the services

To what extent do you agree that the any of the following is part of the reason why pregnant women in Eastern Cape tend to avoid attendance of clinic-based antenatal services made available to them? In each case, choose (circle) the option that applies to you on the matter: SA = Strongly Agree; A = Agree; D = Disagree; and SD = Strongly Disagree

Pregnant women in rural Eastern Cape do not often make use of the clinic-based antenatal services made available to them due to:

- |   |           |
|---|-----------|
| 1. Lack of money to pay for services provided   | SA A D SD |
| 2. Poor road network leading to where the clinic is located   | SA A D SD |
| 3. Lack of transport and the money to pay for it.   | SA A D SD |
| 4. Due to long distance to be covered to get to the clinic  | SA A D SD |
| 5. Fear of being bullied or insulted by the nurses  | SA A D SD |
| 6. Their belief that traditional birth attendants give<br>better services than the nurses at the clinics  | SA A D SD |
| 7. Their assumption that antenatal attendance is only<br>necessary in emergencies, not when the pregnancy<br>is proceeding normally and without problems. | SA A D SD |
| 8. Their belief that home delivery is cheaper and more<br>convenient than clinic-based delivery   | SA A D SD |

9. Their belief that clinic-based antenatal is time wasting. SA A D SD

10. The fact that traditional birth attendants are very close

them and can attend to their needs anytime, any day SA A D SD

11. The need to satisfy their mother-in-laws who discourage

them from attending the clinics SA A D SD

12. Their inadequate knowledge of tetanus immunization

services, essential for pregnant women SA A D SD

What is the average distance of MC to the people?

(a) 1 km True / / Don't Know / / False / /

(b) 2 km True / / Don't Know / / False / /

(c) 3 km True / / Don't Know / / False / /

(d) 5 km True / / Don't Know / / False / /

(e) 6 km and above True / / Don't Know / / False / /

#### Section E: Extent of Services Available at the Clinics

What are the main services offered in the clinic-based antenatal services many in rural communities in Eastern Cape?

(a) Delivery services True / / Don't Know / / False / /

(b) Well-baby clinic True / / Don't Know / / False / /

(c) Prenatal and postnatal care True / / Don't Know / / False / /

(d) Pregnancy and weaning nutrition counselling True / / Don't Know / / False / /

(e) Family planning information and limited  
Contraception services. True / / Don't Know / / False / /

**APPENDIX B1**

Imibuzo yabathathi nxaxheba

Bhota mthathi nxaxheba

Uze uncede ungabhali gama lakho naphi na kulemibuzo. Impendulo ozakuzinika kulemibuzo ekhankanyiweyo ngezantsi zakuphathwa ngobunono bokungaziwa ngumntu.

I. icandelo A: imvelaphio

1. Ilali okanye Idolophu: \_\_\_\_\_

2. Iminyaka: \_\_\_\_\_ Inkolo: \_\_\_\_\_

3. Ubuni: (Ndoda) \_\_\_\_\_ (Bhinqaa) \_\_\_\_\_

4. Ibala: (Mnyama) \_\_\_\_\_ (Mhlophe) \_\_\_\_\_ (Abebala/Indiya) \_\_\_\_\_

5. Ulwimi olothethwayo: Xhosa \_\_\_\_\_ Isingesi: \_\_\_\_\_ Ezinye \_\_\_\_\_

6. Isazi ngokomtshato: Utshatile/\_\_\_\_\_/Wahlukenenomtshato/\_\_\_\_\_/Awutshatanga/\_\_\_\_\_/  
Ingumhlolokazi/\_\_\_\_\_/

II. Icandelo B: izimbo ekusetyenzisweni kwekliniki zabakhulelweyo.

IMIGAQO: Ggobunono ; funda nganye kulamabinzana alandelayo uze ukhethe ngocoselelo enye yezi zimvo uzinikiweyo eyakuthi ukhethe ehambelane nezimvo zakho.

1. Xa ndizibona ukuba ndikhulelwe ndiye ndixelele omye wezizalwane, ndize ndizilungiselele ukuya kubhalisela uncedo lokukhulelwa ekliniki. NYANI, / / ANDAZI / / BUBUXOKI / /.

2. Xa ndizibona ukuba ndikhulelwe ndiye ndizame ukufihla kude kubenzima ukufihla. Oko ndikwenzela ukukhusela ukuphulukana nesisu nomona kunye nokuthakathwa ngabantu abanamehlo ancolileyo ngakum. NYANI, / / ANDAZI / / BUBUXOKI / /.

3. Xa ndizibona ndikhulelwe andazisi ngako esidlangalaleni de kubikelwe abaphantsi kuqala ngokwesiko labantu basekhaya. NYANI, / / ANDAZI / / BUBUXOKI / /.

ICANDELO C: uqikelelo lokuvela kwintsebenzo.

Ku kweyiphi inyanga emva kokukhulelwa oye waqala ngayo ukuya ekliniki elungiselelwe amanenekazi akhulelweyo.

1. 1 - 3 inyanga: Ewe/ / Hayi / /
2. 3- 5 inyanga: Ewe/ / Hayi / /
3. 5- 7 inyanga: Ewe/ / Hayi / /
4. 7- 9 inyanga. Ewe/ / Hayi / /
5. Kuphela xa kukho ubunzima. Ewe/ / Hayi / /

ICANDELO D. Amanqaku angunobangela wokungasetyenziswa rhoqo kwentsebenzo.

Kukuluphi uqondo ovumelana nalo ukuba amanye ala alandelayo ngamanye ezizathu zokuba amanenekazi esempuma koloni atyeshela ukuya ezikliniki ezilungiselelwe abo bakhulelweyo ezikho kubo. Kwindaba nganye yenza isangqa kwindawo enxulumene nawe : ND= Ndivuma ngamandla ; N= ndiyavuma; A= andivumi; AN= andivumi ngamandla.

Amanenekazi akhulelweyo ezilalini zasempumalanga koloni akasebenzisi rhoqo ikliniki zabakhulelweyo ezenzelwe bona.

- |  |           |
|--|-----------|
| 1. Ukuswela imali yokubhatala intsebenzo.  | NN N A AN |
| 2. Indlela ezingatshongo khona eziqhagamshelisana nendawo ikliniki ezikuzo.                            | NN N A AN |
| 3. Okuswela into yokukhwela kunye nemali yokubhatala Into ekhwelwayo.                                  | NN N A AN |
| 4. Kungenxa yomgama ekufuneka uhanjiwe ukuyokufika ekliniki.   | NN N A AN |
| 5. Uloyiko lokugxagxanyiswa ngabongikazi okanye ukuthukwa.   | NN N A AN |
| 6. Yinkolo yabo ukuba ababelekisi bemvelo banikezela ngentsebenzo izibhetele kunabongikazi ezikliniki. | NN N A AN |

7. Zingcinga zabo zokuba ukuya ezikliniki  
ezilungiselelwe amanenekazi akhulelweyo ibaluleke  
kuphela kwixesha lobunzima obuyingozi, hayi ukub  
a ukukhulelwa kuqhuba kakuhle kungekho zingxaki. NN N A AN
8. Zinkolo zabo ukuba ukubelekela ekhaya akubizi  
futhi kuhlelekile kunasezikliniki zokubelekela. NN N A AN
9. Inkolo yabo yokuba ukuya ekliniki kwintsebenzo  
zabakhulelweyo kukuchitha ixesha. NN N A AN
10. Ikukuba ababelekisi bemvelo basondele kakhulu  
kwindawo zabo bangabanceda nanini,  
nangaliphi na ixesha bebefuna. NN N A AN
11. Ukufuna ukukholisa umamazala  
okunyembayo ukuya ekliniki. NN N A AN
12. Ukungabinalwazi oluqondileyo kubo ngentsebenzo zogonyo,  
ezibalulekileyo kumanenekazi akhulelweyo. NN N A AN

Ngowuphi umgama ovamileyo ukubheka ezikliniki zempilo ebantwini.

- (a) 1 km NYANI, / / ANDAZI / / BUBUXOKI/ /.
- (b) 2 km NYANI, / / ANDAZI / / BUBUXOKI/ /.
- (c) 3 km NYANI, / / ANDAZI / / BUBUXOKI/ /.
- (d) 5 km NYANI, / / ANDAZI / / BUBUXOKI/ /.
- (e) 6 km NYANI, / / ANDAZI / / BUBUXOKI/ /.

Section E: uqondo lwentsebenzo olukhoyo ekliniki.

Zeziphi intsebenzo ezingundoqo ezikliniki zabakhulelweyo ezinikezelwayo kwilali ezininzi zasempuma koloni.

- (a) intsebenzo yokubelekisa NYANI, / / ANDAZI / /BUBUXOKI/ /.
- (b) ikliniki yempilo yabatwana NYANI, / / ANDAZI / /BUBUXOKI/ /.
- (c) intsebenzo yaphambi kobeleka  
nasemva kobeleka. NYANI, / / ANDAZI / /BUBUXOKI/ /.
- (d) ukululekwa ngokukhulelwa nolumla

ekuncanciseni umntwana.

NYANI, / / ANDAZI / ]/BUBUXOKI/ /.

(f) Ulwazi ngokucwangcisa

nokusetyenziswa kwezinye indlela

zokucwanzisa eziqingqiweyo.

NYANI, / / ANDAZI / / BUBUXOKI/ /.

## APPENDIX C



25 March 2014

To: THE HEAD MASTER OF KOMANISHINI VILLAGE

My name is Vanessa Mirienkie Kondile I am a postgraduate student from the Discipline of Psychology in The School of Applied Human Science under the University of kwa-Zulu Natal. I am conducting a study whereby Investigating the Problem of Underutilization of Prenatal Services Clinic based care by woman in Rural Communities at Eastern Cape Province, South Africa.

I would like to request permission to recruit woman that have knowledge regarding this matter to conduct the research at Komanishini village. If permission is granted, Participants will be recruited in the village. The visitation will be arranged in consultation with the authorities. The visitation should not be disruptive.

Participants will be given a description of the study and what participation will entail and their permission will be asked if they would like to participate in the study at that specific date.

If you would like to discuss any further details of my project or have any questions about this request please contact Vanessa Mirienkie Kondile on (0745059933) email address 214583807@stu.ukzn.ac.za or my supervisors, Professor A Nwoye on cell 0762572990 or email nwoye@ukzn.ac.za.

Yours sincerely,

Vanessa Mirienkie Kondile

UKZN Master's Student (Clinical Psychology)

Signed .....

Supervisor: Professor A Nwoye

Signed.....

**APPENDIX CI**



25 March 2014

To: THE HEAD MASTER OF GCUWA/ BOOI FARM VILLAGE

My name is Vanessa Mirienkie Kondile I am a postgraduate student from the Discipline of Psychology in The School of Applied Human Science under the University of kwa-Zulu Natal. I am conducting a study whereby Investigating the Problem of Underutilization of Prenatal Services Clinic based care by woman in Rural Communities at Eastern Cape Province, South Africa.

I would like to request permission to recruit woman that have knowledge regarding this matter to conduct the research at GCUWA /BOOI FARM village. If permission is granted, Participants will be recruited in the village. The visitation will be arranged in consultation with the authorities. The visitation should not be disruptive.

Participants will be given a description of the study and what participation will entail and their permission will be asked if they would like to participate in the study at that specific date.

If you would like to discuss any further details of my project or have any questions about this request please contact Vanessa Mirienkie Kondile on (0745059933) email address 214583807@stu.ukzn.ac.za or my supervisors, Professor A Nwoye on cell 0762572990 or email nwoye@ukzn.ac.za.

Yours sincerely,

Vanessa Mirienkie Kondile

UKZN Master's Student (Clinical Psychology)

Signed .....

Supervisor: Professor A Nwoye

Signed.....



## APPENDIX CII



25 March 2014

KU: MPHATHI WASE GCUWA/ BOOI FARM VILLAGE

Igama lam ngu vanessa Mirienkie Kondile. Ndingumfundi ophantsi kwe univesi yakwa Zulu Natali ndisebenzela ukufundela ukuba yi Clinical Psychology. Ndenza ufundo elugxininise Kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika. Injongo yam kukuba ndicazulule ndiphinde ndiseke amanqaku angunobangela kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika. Ndingathatha ukucela imvume yokukumema abasetshini base GCUWA /BOOI FARM abanolwazi kulomba ukhankanyiweyo uzakufundwa.

Ukuba imvume ifumanekile abathathi nxaxheba bayakuba ngabaselalini. Utyelelo lwakuququzelwa ngemvume yabasemagunyeni. Kuyakwenziwa inzame zokuba kungabina siphazamiso sanqubo ngolutyelelo. Abathathi nxaxheba bakunikwa incukacha ngolufundo nokuba lwakube luqulathe ntoni kuphinde kucelwe imvume kubo yokuthatha inxaxheba ngomhla ayabe ubekiwe.

Ukuba ungathanda ukuthetha ngencukacha ezithe vetshe ngolufundo kunye nokubuza ungaqhagamshelana no Vanessa Mirienkie Kondile kulomnxeba (0838768887) email address 214583807@stu.ukzn.ac.za okanye umphathi wofundo, Professor A Nwoye kulomnxeba 0762572990 or email nwoye@ukzn.ac.za.

Ozithobileyo.

Vanessa Mirienkie Kondile

UKZN Master's Student (Clinical Psychology)

Signed .....

Supervisor: Professor A Nwoye

Signed.....

## APPENDIX CIII



25 March 2014

KU: MPHATHI WASE NGQAMAKHWE/ KOMANISHINI VILLAGE

Igama lam ngu vanessa Mirienkie Kondile. Ndingumfundi ophantsi kwe univesi yakwa Zulu Natali ndisebenzela ukufundela ukuba yi Clinical Psychology. Ndenza ufundo elugxininise Kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika. Injongo yam kukuba ndicazulule ndiphinde ndiseke amanqaku angunobangela kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika. Ndingathatha ukucela imvume yokukumema abasetshini base NGQAMAKHWE/ KOMANISHINI abanolwazi kulomba ukhankanyiweyo uzakufundwa.

Ukuba imvume ifumanekile abathathi nxaxheba bayakuba ngabaselalini. Utyelelo lwakuququzelwa ngemvume yabasemagunyeni. Kuyakwenziwa inzame zokuba kungabina siphazamiso sanqubo ngolutyelelo. Abathathi nxaxheba bakunikwa incukacha ngolufundo nokuba lwakube luqulathe ntoni kuphinde kucelwe imvume kubo yokuthatha inxaxheba ngomhla ayabe ubekiwe.

Ukuba ungathanda ukuthetha ngencukacha ezithe vetshe ngolufundo kunye nokubuza ungaqhagamshelana no Vanessa Mirienkie Kondile kulomnxeba (0838768887) email address 214583807@stu.ukzn.ac.za okanye umphathi wofundo, Professor A Nwoye kulomnxeba 0762572990 or email nwoye@ukzn.ac.za.

Ozithobileyo.

Vanessa Mirienkie Kondile

UKZN Master's Student (Clinical Psychology)

Signed .....

Supervisor: Professor A Nwoye

Signed.....

**APPENDIX D**

Query 1: Please add BREC contact details to the patient information sheet	Answer: I have added the BRECC contact detail in the participant's information sheet.
Query 2: It is not clear how many mothers will be included in the study-how many will complete questionnaire and how many will be in focus group? How many focus groups will the PI have in each clinic?	Answer: The research will include 60 women who have given birth and those who are in reproductive stage. The site for the study will no longer be the clinics but rather the 2 communities targeted for the study. 30 participants will be drawn from each community. Only 10 people will be included in the focus group process; 5 from each community. Each community's focus group will be held in its location.
Query 3: it appears the questionnaire will be self-administered by the mother. Please confirm with other researchers and the clinic whether this will be effective. The PI may get better response if the questionnaire is self-administered	Answer: The research questionnaires will be self-administered by the researcher, not by the mothers on her behalf
Query 4: It appears 10 HCWs will be included- What is the break down per clinic-will only be involved in a focus group discussion.	Answer: The health workers will no longer be involved in the study.
Query 5: Provide the focus group guide that will be used for HCWs- a separate information sheet and consent form need to be available for HCWs. Limits of confidentiality in FGDs must be described	Answer: The health workers will no longer be involved in the study
Query 6: On the patient information sheet the PI needs to make mention on the fact that in	Answer: On the patient information sheet, I have mentioned that BRECC and the

<p>special circumstance BREC and Department of Health may access confidential information.</p>	<p>Department of Health on special circumstances will have access to the information.</p>
<p>Query 7: It is not clear in the consent whether participants will still be eligible for the study if they do not consent for the audio-recording. The PI need to inform them if they can still be part of the study if they do not agree with the audio- recording</p>	<p>Answer: I have clearly indicated that the participants for the focus groups can still be part of the focus group even if they don't agree for audio recording of their views. In which case, an alternative measure will be used to capture their point of view during the group discussion.</p>
<p>Query 8: Check the letter to district manager- 3<sup>rd</sup> para, second line typographical error should be “study “not “money”.</p>	<p>Answer: I no longer need the District Manager's permission since the site of the research is no longer the clinic as earlier proposed.</p>
<p>Query 9: A support letter from a community based organisation should be ideally also be obtained</p>	<p>Answer: This question is unrelated to my own research.</p>
<p>Query 10: Please could the applicant provide further detail about how pregnant woman outside clinic setting (if any) will be recruited.</p>	<p>Answer: I will request the Chief in the target Village for the study to call a meeting for me to meet with the women in each community; and requests for permission to be granted for using the door- to-door visitation for the contacting the participants.</p>
<p>Query 11: The letter of information (appendix 1) Need to be adjusted to the language that is understandable to the research participants. The letter currently uses a very academic</p>	<p>Answer: The letter of information has been adjusted to suit the language that the participants will understand.</p>

language that is hard for everyone but an academic/ student to access.	
Query 12	Answer: The wording in the information sheet has been revised to avoid its being judgemental over research participants
Query 13: Please could the supervisor and the student submit their CVs and proof of ethical training to BREC.	Answer: All the requested documents have been attached.
Query 14: The questions in FGD need to be posed at a language level suitable for the participants understanding	Answer: The questions have been revised and posed in the language that the participants will understand.
Query 15	Answer: I will use mixed method and the number of participants has been increased
Query 16	Answer: I no longer need the health care workers to take part in the study.
Query 17	Answer: The health care worker is no longer needed.
Query 18	Answer: The focus group will be held at one of the houses to be arranged in each village.

## APPENDIX 1



### Letter of Information

Dear Respondent,

My name is Vanessa Mirenkie Kondile. I am currently a registered student of the University of KwaZulu-Natal working for a Master's Degree in Clinical Psychology. I wish, by this letter, to invite you to consider taking part in my study focusing on "The Problem of Underutilization of Clinic-based Prenatal Services in Rural Communities in Eastern Cape Province, South Africa." The primary aim of the study is to explore and establish the factors responsible for the current problem of underutilization of clinic-based prenatal services in rural communities in Eastern Cape Province, South Africa

If you volunteer to participate in the study, you will be asked some questions on your views regarding why many pregnant rural women in Eastern Cape Province do not attend antenatal clinics at the early stages of their pregnancy. Participants are not expected to answer questions in front of other participants. But those who volunteer to take part in the group discussion (to consist of about five volunteers) may be required to discuss their views on the key study issues with other members in the group. The group discussion on this topic will take place on an arranged date, venue and time. It will take about 60minutes (1hour) on the whole to get done. Completing the study questionnaire is expected to take only about 30 minutes (1/2 an hour) at most.

It is important to mention that your participation in the study is at all times voluntary and that you are under no obligation to participate. However, if you agree to participate in the study, for which I will be grateful to you, you are still free to leave the study at any time without penalty.

Furthermore, I wish to assure you that your identity will be kept confidential at all times. Similarly, the information to be gathered in this study will be used for academic and research purposes only. Your identity (name and personal details) will only be on the consent form and will be kept separately from other information and will at all times be secure. Your information, if in the hands of any person other than the principal investigator (Vanessa Marinkie Kondile) and the principal responsible person (My Supervisor, Professor Augustine Nwoye, Tel. 0762572990) will be anonymous. The research process has been organized in such a way that the person handling the information arising from the study will not know who the information belongs to. And so your information at all times will remain confidential.

In special circumstances, the Biomedical Research Committee and the Department of Health may access the information, but such information will still remain anonymous.

If there is any query regarding the study, the Biomedical Research Committee contact number (031 269 4769) may be used.

If you do wish to know about the final outcome of this study, you may give your contact details to the principal investigator (Vanessa Marienkie Kondile) and the results will be shared with you.

Thank you for your interest.

Yours sincerely

Vanessa Marienkie Kondile  
(Investigator, 0838768887)

Professor Augustine Nwoye  
(Supervisor)

## APPENDIX 1 A



Letter of information

Incwadi equlathe incukacha

Molo mthathi nxaxheba

Igama lam ngu vanessa Mirienkie Kondile. Ndingumfundi ophantsi kwe univesi yakwa Zulu Natali ndisebenzela ukufundela ukuba Clinical Psychology. Ndingathanda ukukumema ukuba uthathe inxaxheba kolufundo lwam elugxininise Kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika. Injongo yam kukuba ndicazulule ndiphinde ndiseke amanqaku angunobangela kwingxaki yokungasetyenziswa rhoqo kwe kliniki yabakhulelweyo kwilali zase Mpuma Koloni e Mzantsi Afrika

Ukuba uvumile ekuthatheni inxaxhaba kolufundo lungahlawulelwayo, uzakubuzwa imibuzo ngengcinga zakho malunga namanenekazi akhulelweyo asezilalini zasempuma koloni kusetyenziso lwekliniki zabakhulelweyo inyanga zabo zokukhulelwa zisephantsi. Abo bangathathi inxaxheba kwiqumrhu abalindelekanga baphundule imibuzo phambi kwabanye abathathi nxaxheba. Kodwa abo bavumileyo ukuthatha inxaxhaba kwiqumrhu (labantu abahlanu) bazakunyanzeleka bachaze ngokuzeleyo ngezimvo zabo kulendaba ichaziweyo. . Iqumrhu labantu abahlanu bazakuthatha inxaxheba bazakudibana kwindawo abayilungiselelweyo kunye nexesha nelanga elihleliweyo, buyakuthatha iyure ibenye ( imizuzu engamashumi amthandathu. ukugqiba imibuzo ehleliweyo kwakuthatha nje imizuzu engamashumi amathathu kwabo bangekho kwiqumrhu.

Kubalulekile ukugxininisa uba ukuthatha inxaxheba kuphuma emntwini akunyanzelwa. Ukuba ugqibe ekuthatheni inxaxheba ndiyakukuvuyela oko. Uze uqonde ukuba awusafuni kuqhubeka unalo ilungelo lokuyeka akukho zizamva nasinyanzeliso uyakuzifumana. Ndingathanda ukwazisa ukuba isaziso ngawe siyimfihlo akukho mntu oyakwazi ukuba ungubani. Isaziso ngawe sakuba kwileta yesivumelano kuphela.. Incukacha ngolufundo



Iwakusetyenziswa kuphela kwizifundo zophando. Zonke ezo ncukacha zakuigcinwa kwindawo ekhuselekileyo. Ukuba inxaxheba yakho isezandleni zomnye umntu ngaphandle kwam omququzeli oyintloko (Vanessa Marienkie Kondile. 0838768887) okanye umphathi wam (Unjingalwazi Augustine Nwoye. 0762572990) kwakuba yimfihlo ngencukacha zesaziso ngawe kuyakuba ngamanani okanye onobumba kuphela. Akokwaziwa ukuba ngubani umnikazi wezincukacha. Icandelo lezempilo kunye ne Biomedica Research Komiti zingakwazi ukufumana inxaxheba yakho kwimiba ethile ngokukhuselekileyo. Inobolo ye Biomedical Research Komiti xa uthe wanemibuzo ethile ngolufunde (032260 4769)

Ukuba uthe wanomdla wokwazi ngeziphumo zophando unganikezela ngencukacha zakho zonxubelelwano kumnququzeli oyintloko ongu (Vanessa Marienkie Kondile) iziphumo uyakuzabelwa.

Enkosi ngokubonisa umdla kwakho kolufundo

Ozithobileyo

Vanessa Marienkie Kondile

(Investigator, 0839768887)

Professor Augustine Nwoye

(Supervisor)

## APPENDIX 2 CONSENT FORM



### Consent form for focus group

I hereby agree to participate in this study, focusing on “Investigating the Problem of Underutilization of Clinic-based Prenatal Services in Rural Communities in Eastern Cape Province, South Africa.” I confirm that I have been given an opportunity to read and understand the information sheet given to me, and that the purpose of the study was clearly explained to me. I clearly understand what I am expected to do during participation and the time commitment I will be spending.

I clearly understand that my participation is voluntary and that I may discontinue at any time I feel to do so without any consequences. I confirm that I have also been informed that the focus group discussion will be recorded.

I understand that the data to be collected will be stored safely for five years and used for future research before it is shredded. I understand that secure measures will be taken into account to ensure that my identity is protected and that my participation in this research will be confidential; and I clearly understand that no identifying information about me will be published.

I have the contact details of the researcher and supervisor should I have any questions about the research.

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Signature of Participant

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Date

### Consent for audio recording

I hereby give permission for audio recording during focus group discussions as a part of data collection for the research. I understand clearly that safe measures will be taken to protect my identity and that my participation in the discussion will be confidential. I was informed that I can still be part of the study even if I do not agree with audio recording.

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Signature of Participant

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Date

## APPENDIX 2A CONSENT FORM



Consent form for focus group/ isivumelwano sequmrhu

Ndiyavuma ukuthatha indima kolufundo lujongise kuphando ngengxaki yokungasetyenziswa rhoqo kwekliniki zabakhulelweyo kwilali zasempumalanga koloni eMzantsi Afrika. Ndiyangqina ukuba ndiliniwe ithuba lokufunda ndiqonde okubhaliweyo kwincwadi endiznikeziweyo, kunye nenjongo zolufundo bezicacisiwe ngokucacileyo kum. Ndiqonda ngokucacileyo ukuba yintoni elindelekileyo kum njengamthathi nxaxheba kunye nexesha endizakulichitha ndizimanyile.

Ndiyaqonda ngokucacileyo ukuba ukuthatha inxaxheba kwam kuyintando akuhlululwa noba ndinelungelo lokuyeka nangaliphi na ixesha ndifuna ukuyeka oko kwaye kungekho ngxaki. Ndicacelwe nokuba ukuthatha inxaxheba kwiqumrhu indaba ezizakuxoxwa ziza kucutshwa kwitayipu yokoshicilela. Ndiyaqonda ukuba incukacha ezizakuqokelelwa zakugcinwa kwindawo ekhuselekileyo

Ndiyaqonda ukuba ipenduulo eziqokelelweyo zakugcinwa zikhuselekile iminyaka emihlanu ukuze zisetyenziselwe ezinye izifundo phambi kokuba zikrazulwe. Ndiyaqonda ukuba indlela ezikhuselekileyo zakujongwa ngobunono ekuqinisekiseni ukwaziwa kwam kuyimfihlo. Ukuthatha inxaxheba kwam kolufundo kuyimfihlo ndiqonda nokuba akukho ncukacha zam ezindichazayo kwakubhalwa ngazo. Ndinazo incukacha zonxulumana nomququzeli wolufundo kunye nomphathi wakhe ukuba ndithe ndanombuzo ngofundo.

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Utyikityo lwesandla

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Umhla

Isivumelwano sokucupha ngeteyipu

Ndinikezela ngemvume ukuba kucutshwe ngeteyipu ngexesha lokuthatha inxaxheba kuqumrhu kusenzelwa ulwazi uluzakusetyenziswa kufundo. Ndiyaqonda ngokucacileyo ukuba indlela ekhuselekileyo iyakuthathelwa ingqalelo ekukhuseleni ulwazi ngam ukuba ndingubani

nokuthatha inxaxheba kwam kuyimfihlelo. Ndixelelwe ukuba noba andivumelani nokushicilelwa ukuba ndiyafuna ndinga qhubeka ukuthatha inxaxheba kolufundo.

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Utyikityo lwesandla

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Umhla

### APPENDIX 3

#### Ngqamakhwe/ Komanishini focus group translation

1. Is it possible to enumerate the factors responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in Eastern Cape Province?
  - It is because clinics afar
  - Roads to clinics are bad
  - Nurses have attitude
  - We are sent back to go to the nearest clinics
  - Transport is the issue and is irregular+
  
2. Which of these factors is the most important of all? For instance, is it true that here in Eastern Cape, people still fear sharing the news of their pregnancy within the first trimester to avoid losing their babies due to problem of witchcraft and sorcery from their neighbours?
  - We do hide pregnancy because we are afraid being tightened for not delivering in time and bewitched
  - We are afraid of losing our pregnancies
  
3. Is true that in some communities in Eastern Cape Province, a woman's pregnancy cannot be made public until the ancestors have first been notified, a fact that may drag the time of seeking antenatal care for these women beyond the first trimester?
  - There is nothing like that in our culture
  
4. It has been noted that in some antenatal clinics in the Republic, pregnant women who report for antenatal care are not happy with the way they are treated or indeed, that they are bullied by the nurses and midwives. To what extent is this true with experiences in clinic-based antenatal care in Eastern Cape?
  - They ignore you in clinics when you are in labour pains they will look at you later after a long time
  - You will scream and the response will be leave me alone and stay there.
  - You deliver alone on the bed
  - You lose interest for nurses, they laugh at you and punish you at the chair or in bed

- They tell you it is not the minister that is pregnant, don't rush us and you are not sick only in labour pains.
  - The beat you thighs harsh
  - Nurses return people because of demarcation
  - They will say go to ngqamakhwe
  - Demarcation is noticed and considered, you will be told go to ngqamakhwe but you are close to Butterworth.
5. Where do pregnant women in the rural Eastern Cape Province go to seek prenatal care?
- We depend in clinics only and those with money will go to the doctor.
6. Is it true that many pregnant women still depend on the services of the traditional birth attendants or the traditional healers or even the mother-in-laws for their antenatal care?
- No we do not have anything like that
7. What range of health care facilities and providers are utilized by the rural women in Eastern Cape during pregnancy and childbirth?
- Clinics
8. Apart from clinic-based antenatal services, which other institutions and personnel provide antenatal care to pregnant women in Eastern Cape Province? For instance, is it true that some prayer-healing churches undertake to offer this service for the members of their religious groups?
- Hospital is used, no we don't go to prophets or to traditional healers
9. Is it true that many pregnant women prefer to deliver their babies at home than to do so in antenatal clinics; and only opt for hospital delivery in problem cases or when things are not going on well with the said pregnancy?
- No we go to hospital because we only want it.

10. What are the factors that you think push rural women in Eastern Cape to engage in this behaviour? That is, their preference for home rather than hospital care and delivery?

- They are running away from being labelled or stigmatised for being known you have certain disease.
- Because the hospital is far
- Not having R600 for transport
- Even if you hire a transport you don't know if you will give birth on the way to hospital.
- We don't have mobile clinics and our road is bad it breaks cars only 4x4 that survives.

11. What do pregnant women in rural Eastern Cape complain about the antenatal care services made available? E.g. its distant location, or the poor and hilly roads to leading to them, or problem of transport or lack of money to pay for services provided; lack of knowledge and good behaviour on the part of the nurses?

- We do have complains about all the things we mentioned and the stigma.

#### Gcuwa/ Booi farm interview

1. Is it possible to enumerate the factors responsible for the problem of underutilization of clinic-based prenatal services among pregnant rural women in Eastern Cape Province?

- Clinic is far
- We are afraid of going alone

2. Which of these factors is the most important of all? For instance, is it true that here in Eastern Cape, people still fear sharing the news of their pregnancy within the first trimester to avoid losing their babies due to problem of witchcraft and sorcery from their neighbours?

- We do hide our pregnancy till is showing because the first three moth anything can happen especially witchcraft.

3. Is true that in some communities in Eastern Cape Province, a woman's pregnancy cannot be made public until the ancestors have first been notified, a fact that may drag the time of seeking antenatal care for these women beyond the first trimester?

- Xhosa's don't have such thing



4. It has been noted that in some antenatal clinics in the Republic, pregnant women who report for antenatal care are not happy with the way they are treated or indeed, that they are bullied by the nurses and midwives. To what extent is this true with experiences in clinic-based antenatal care in Eastern Cape?
  - The service is poor
  - There are many people with few nurses
  - Nurses take their time
  - They ignore people
  - They stay long to their tea and lunch leaving patient unattended
  - Some of them are rude to patients
5. Where do pregnant women in the rural Eastern Cape Province go to seek prenatal care?
  - We use clinic and private doctors if we afford.
6. Is it true that many pregnant women still depend on the services of the traditional birth attendants or the traditional healers or even the mother-in-laws for their antenatal care?
  - We don't have such services around
7. What range of health care facilities and providers are utilized by the rural women in Eastern Cape during pregnancy and childbirth?
  - clinics
8. Apart from clinic-based antenatal services, which other institutions and personnel provide antenatal care to pregnant women in Eastern Cape Province? For instance, is it true that some prayer-healing churches undertake to offer this service for the members of their religious groups?
  - We use hospital not other services and we do not have such thing our department of health is very strict about who offers the services like that it requires trained nurses not spiritual and traditional knowledge. Instead if you do that you will be arrested for helping people to give birth with no nursing training.
9. Is it true that many pregnant women prefer to deliver their babies at home than to do so in antenatal clinics; and only opt for hospital delivery in problem cases or when things are not going on well with the said pregnancy?
  - We go to hospital only to avoid any harm and arrest.

10. What are the factors that you think push rural women in Eastern Cape to engage in this behaviour? That is, their preference for home rather than hospital care and delivery?

- They are running away from being tested
- Not having R600 for transport
- Even if you hire a transport you don't know if you will give birth on the way to hospital.
- We don't have mobile clinics that is regular and our road is bad when is raining.

11. What do pregnant women in rural Eastern Cape complain about the antenatal care services made available? E.g. its distant location, or the poor and hilly roads to leading to them, or problem of transport or lack of money to pay for services provided; lack of knowledge and good behaviour on the part of the nurses?

- All of the things we mentioned and the silliness of the nurses.