Exploring the Journey to Maternal Death: Gender and Human Rights perspectives on the major causes of maternal mortality in the Western Cape Province, South Africa

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A thesis submitted in fulfillment of the requirements for the degree of Doctor Philosophiae, in the Department of Women & Gender Studies, University of the Western Cape.

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November 2003

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KEY WORDS:

Maternal deaths

Safe motherhood

Gender

Human rights

Accessibility

Health Care

Model

Case studies

Midwife Obstetric Units

Thematic analysis

ABSTRACT

Exploring the Journey to Maternal Death: Gender and Human Rights perspectives on the major causes of maternal mortality in the Western Cape Province, South Africa

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In this thesis, I use gender and human rights approaches to examine and analyse the major causes of maternal mortality, which result from delay in seeking maternity care and failure to attend maternity care during pregnancy. A gender approach was used to identify and analyse inequalities that arise from belonging to one sex or from unequal power relations between sexes and how these impact on women accessing maternity care. The Human Rights approach was used to identify and analyse health system related factors that led women to delay seeking care and also failing to attend maternity care.

A qualitative multiple case study methodology was followed with data analysed thematically. Findings were interpreted in the context of the International Bill of Rights, the South African Bill of Rights and International Human Rights treatises. Maternity women are unable to access maternity care because of their unmet gender equity needs, and because of maternity services that are not respecting, protecting and fulfilling their human right to access health care. A Gender-Human rights model of accessibility to quality maternity care is developed to assist health care providers in promoting availability of maternity services to health consumers. The model propositions are based on the major concepts which are: Gender equity, Women empowerment, Human rights to quality health care, Evidence Based Health Care, and Support during labour.

November 2003

DECLARATION

I declare that **"Exploring the Journey to Maternal Death: Gender and Human Rights perspectives on the major causes of maternal mortality in the Western Cape Province, South Africa"** is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

NOMAFRENCH MBOMBO November 2003

Signature:.....

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to:

- The Lord, for giving me strength and courage to complete this study.
- Dr Debra Jackson and Ass. Prof Tamara Shefer for their enduring support, guidance, patience and encouragement throughout this study.
- The PET Project for their academic support.
- Cobi Gilbert, Sonja Walker and Ingrid Oliphant for their assistance, especially Cobi for being a spare wheel in case of emergencies.
- Community Health Services Organization (CHSO) for granting the permission to conduct the study.
- My colleagues at UWC, Department of Nursing, "A person is a person because of other persons".
- University of the Western Cape Research Capacity Development, for financial support.
- The National Research Foundation for the Scholarship, 2002 – 2003.
- My social network and friends for their emotional and practical support during tough times, "I am because we are…"

DEDICATION

I dedicate this thesis to my daughters, INAM and MILA, for their patience and understanding.

It is also dedicated to my best friend, my inspiration, Dennis Vukile Mbombo, who sacrificed his dreams so I can pursue mine, and also for being both a father and a mother to the girls during my absence.

Lastly, to Mkwelo and Mbombo families, for their continuous support and encouragement.

"If women are indeed to benefit from actions to improve their health, we in the health care community must first benefit from women's voices... we must make listening and talking with women a fundamental principle of women's health..."

Brems and Griffiths (1993, p. 255)

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INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 Background And Motivation

> Childbirth is a universally celebrated event and an occasion for dancing, fireworks, flowers or gifts. Yet for many thousands of women each day, childbirth is experienced not as the joyful event it should be but as a private hell that may end in death.
>
> (Royston and Armstrong, 1989, p.9)

Maternal deaths account for the majority of deaths of women in the reproductive age in developing countries (World Health Organization, 2001; Doyal, 1995; Thaddeus & Maine, 1994). A woman from Africa or Asia is 100 times more likely to die in a single pregnancy than a woman giving birth in developed countries. In 1997, the World Health Organization (WHO) declared that maternal death should be addressed as a human rights issue because every maternal death is an event that could have been avoided, and should never have been allowed to happen (WHO, 1997). The WHO argues that international treaties and national constitutions that address basic human rights must be applied to maternal health to guarantee a woman a right to life, and a right to access quality services before, during, and after pregnancy and childbirth.

The 1998 world statistics show that 1 in every 15 women in Africa will die of complications of pregnancy or delivery compared to 1 in 9850 in Northern Europe, 1 in 6000 women in North America, in India it is 1 in 55; Afghanistan 1 in 15; United States of America 1 in 3500 and in United Kingdom, the ratio is 1 in 4600 (Centre for Disease Control, 1998; WHO, 1998). Previous studies also show discrepancies of maternal mortality between the rich and the poor countries, and between the rich and the poor people within a country. They identify race and class as risk factors for maternal mortality with Black and poor women at greater risk than White and rich women (Doyal, 1995). In South Africa, out of all the maternal deaths reported since 1998 when maternal deaths became notifiable to the government, 92.6 % were African women with their maternal mortality ratio being 60 % greater than that of White women.

Cook and Dickens (2001) confirm that one woman out of 12 in South Africa is likely to die during pregnancy and childbirth compared to other women from worst poor countries in Africa, for example, in Uganda which is less developed than South Africa, the woman's risk of dying from maternal death as well as her risk of becoming pregnant is 1in 17; in Sierra Leone it is 1in 70; and Kenya 1 in 19. The figures indicate the risk of a woman getting pregnant and a risk of dying from pregnancy/ childbirth related factors is high in South Africa compared to other less developed countries in Africa where women are being attended by least skilled health professionals during pregnancy.

In South Africa 82 % of maternity care is attended by skilled health professionals, compared, for example, in Zambia where it is 51%, Zimbabwe being 69%. However, the maternal mortality ratio in the country is 340 per 100 000 live births compared to 870 in Zambia, and 610 per 100 000 live births in Zimbabwe (Cook, Dickens & Fathalla, 2003).

The 2001 South African report on maternal mortality confirms a total of 940 maternal deaths occurred in 2000. This is 150 more than the 1999 figure and 264 more than in 1998. The Western Cape Province, where this study was conducted, had the lowest maternal deaths during this period, but there was a 53% increase above the 1999 total in the year 2000. The Western Cape is regarded as having the best health infrastructure compared to all other provinces (Department of Health (DOH),1998). The1999 maternal deaths report shows that there were probably 200 maternal deaths that were not reported during that year. This problem of under reporting of maternal deaths has been found in other countries, for example, in Egypt it was found that the true maternal death rate is said to be twice the official figure because the majority of deaths occur in rural areas where it is impossible for women to access the health services so that deaths go unreported (Doyal, 1995).

Several studies show that in 75 % of deaths, the delay in seeking care from the onset of a complication and a failure or infrequent attendance of antenatal care (ANC) during pregnancy are major contributory factors to these deaths world wide (Thaddeus & Maine, 1994; Thompson, 1996; Fathalla, 1994; Acosta, Cabezas &

Chaparo, 2000; Ezechi, Fasubaa & Dare 2000). In the inner cities of United Sates where maternal mortality rate is high, about 30% of women do not attend antenatal care (ANC) (Doyal, 1995). In Lebanon, the maternal mortality rate for women with no antenatal care was 197/100 000 compared to 19/100 000 of those who attended antenatal care. In Vietnam, a statistical significance difference of 74% for women who died in the control group had no antenatal care compared to only 34% in the experimental group (Sundari, 1992). In India, Khosla, Dahiya and Sangwan (2000) found that maternal mortality and women categorised as 'high risk' prevailed to women who did not attend antenatal care. Correa cited by Sundari (1992) found that in Senegal, from the maternal deaths statistics, women with no ANC were 20% compared to 2% in the control group. In northern Nigeria it is reported that women who received antenatal care had a maternal mortality rate three times lower than those who did not receive ANC (Doyal, 1995).

In South Africa, the Saving Mothers report (DOH 1998), the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) reports (1999, 2000) and the Saving Babies report (2001) identified the delay in seeking care and a failure or infrequent attendance of antenatal care during pregnancy as major patient related avoidable factors to almost half of maternal deaths that occurred in the country since maternal deaths became notifiable in 1998. The South African position on ANC is that the woman should start attending ANC as soon as she finds that she is pregnant, and that can be when the woman misses her menstrual period, preferably in the first trimester (Perinatal Education Programme (PEP), 1991). In all South African conferences and or seminars I annually attend, (eg. Annual conference on Prioties in

Perinatal Care in Southern Africa; Annual Midwifery Congress in Southern Africa; Western Cape Provincial maternal and neonatal services seminars), maternal and neonatal health care providers from different educational backgrounds, all share one view that lack of antenatal care is a major contributory factor to maternal and perinatal mortality in the country. In the Western Cape, in spite of the province having the lowest prevalence of maternal deaths compared to other provinces, non-attendance of ANC and delay in seeking care was 44% of patient related avoidable factors according to the Saving Mothers report. During the provincial Maternal Deaths Report conference that occurred on 19th April 2001 at Mowbray Maternity Hospital, Cape Town, concern was raised regarding this delay and non-attendance of ANC which emerged as major contributors to all reported maternal deaths considered as avoidable. The NCCEMD 1999 report shows that these deaths occurred mostly to women with pre-pregnancy existing medical diseases.

The WHO (2001) highlights the importance and benefits of attending antenatal care. Antenatal care provides an opportunity for preventive and curative care in high risk pregnancies. Pregnancy and delivery, although usually normal physiological processes with good outcome, are still defined as potential risks and any pregnant woman can die from complications such as haemorrhage, hypertension, obstructed labour if these are not detected early during pregnancy or delivery. The WHO recommends that it is essential for women to attend maternity care for early detection and management of complications and to avoid fatal complications. A woman who develops haemorrhage post delivery may die within 2 hours after onset. For eclampsia, which is a complication resulting from hypertension, the estimated

interval from onset to death is 2 days (Pittrof & Johansen, 1999). In addition to these obstetric medical causes, research shows that pregnancy itself aggravates other diseases such as anaemia, jaundice, malaria, tuberculosis and heart diseases that can be identified and prevented during antenatal care especially in cases of malaria in areas where it is prevalent (Abouzar, 1998).

The WHO recommends that pregnant women should 'book' early at least from 20 weeks gestation (second trimester) and should have a minimum of four antenatal visits with at least 20 minutes duration each. The WHO suggests that ANC care should comprise health promotion, assessment, management and or referral through history taking, physical examination; tetanus toxoid immunization; iron and folate supplementation; malaria prophylaxis and sexual transmitted infections management (WHO, 1999). Sundari (1992) stresses the importance of ANC visits that are spread over gestation period so complications that arise at different stages may be identified. In Thailand, women who started ANC before the second trimesters had lower maternal mortality rates than those who had ANC until their 2nd or 3rd trimester. In Zaire, the maternal mortality rate of women with less than three ANC visits was 270/100 000 compared to 250/ 100 000 for those with four or more ANC visits.

In 1999, the WHO found that the ANC coverage in South Africa is 89% which is lower compared to that of its neighbouring countries, for example, Zambia and Tanzania, where it is 92%; Zimbabwe 94%; Rwanda 94%, and Lybia, 100 % (WHO, 1999). One would expect a higher maternity coverage for a country like South Africa, which is more developed than its counterparts in Africa. Furthermore, in the recent years, there has been economic development in the country as defined by its

Gross Domestic Product (GDP). This endorses the notion that in spite of economic prosperity, the Human Development Index (HDI) has remained the same in the country, with no improvement in the health status and accessibility to resources by other groups of people including women (UNDP cited by Loewenson, 2000).

Comparing accessibility and availability of maternal health care among women in Tunisia and Morocco, Obermeyer (1993) found that women in Tunisia have access to health care because the government distributes the income generated from Gross National Product (GNP) evenly among the population, with high expenditure on health. Tunisia has GNP twice as high as that of Morocco where women are unable to access maternity care and the maternal mortality is high. The WHO (1997) elucidates that maternal health interventions are among the most cost effective investments in health. The cost of maternal health services can be as little as US $2 per person. Cook, Dickens and Fathalla (2003) argue that it is worth for a country to invest on reproductive health, specifically on maternal health, because of the long term effects on the economy of the country as a whole, among other things. They criticise that there is no country that is so poor that it is unable to improve the health of its people. They write:

> *Although we may not know exactly how much money it will cost to provide reproductive health services for all, we have a better idea about what it will cost in women's lives and health if we do not make reproductive care available.* (Cook et al,2003, p.35).

There is overwhelming evidence that maternal health has not been given wide attention by the South African health system and by the government. Maternal deaths became notifiable only in 1998 whilst in other countries, for example, United

Kingdom; they were notifiable as early as 1900, and in Nigeria, the1980's (Department of Health (DOH), 1998). According to Dr Eddie Mhlanga, Chief Director for Maternal, Child and Women's Health, the reason for this late legislation on notification is that the: "*previous government refused to make maternal deaths notifiable because they were regarded as not for public concern*" (maternal mortality notification, 1997, p.1). Further evidence is reflected in a statement by Dr Tshabalala-Msimang, the minister of health, commenting on the release of the first report on maternal deaths as follows:

> *Almost half of reported maternal deaths could have been avoided if health authorities had paid attention to women's health...there was an opportunity to prevent the death, but that opportunity was missed...*
>
> (South African Press Association (SAPA), 15 October 1999, p.6)

Maternal mortality contributes to underdevelopment because of its severe impact on lives of the families, young children and society in general (Donnay, 2000). Pittrof and Johanson (1999) theorise that this lack of development which results from poor appreciation of women's biological function manifests itself in a poor allocation of resources to women's health specifically reproductive health and, according to Mann, Gruskin, Grodi and Annas (1998), this can be interpreted as the violation of human rights. Tomaševski (1995) argues that although some countries, through their national constitution, recognise a right to access health, there is no recognition of these rights in economic policies and also in issues affecting women's health. Research shows that by not developing the population, this produces negative effects on health (Tomaševski, 1995), and this includes maternity health.

It was the purpose of this study to use both human rights and gender frameworks to examine and analyze the major contributory causes of maternal mortality, which result from delay in seeking maternity care and failure to attend antenatal care. The human rights approach was suitable for this study to identify health system related factors that led women to delay seeking care and fail to attend antenatal care. The main aim of using a gender analysis was to identify and analyze inequalities that arise from belonging to one sex or the other or from the unequal power relations between the sexes and how these impact on women accessing maternal health care.

The right to accessible and appropriate health care is embedded in a wide range of international and regional codes and treaties as well as in the South African constitution. In these codes and treaties, it is acknowledged that women are a vulnerable group, and that during pregnancy and childbirth the society needs to take special attention through provision of services. The study used the following codes and treatises to operationalise its conceptual framework : International Bill of Rights, the South African Bill of Rights, Women's Convention (1979), United Nations International conferences documents on the Population and Development (Cairo Programme, 1994) and that on Women (Beijing Platform, 1995); and the African Charter on Human and People's Rights (African Charter, 1981).

The study was seeking to answer research questions as to why women delay and/or fail to attend maternity care. Maternity care in the study is defined as that care during antenatal, intranatal and postnatal care. Women who delayed any of this care and those who attended the whole maternity care were interviewed to establish reasons

why they did not attend or delayed. The inclusion criteria were the following categories of women:

- Women who did not attend antenatal care but presented for delivery or postnatal care. They are referred to as 'unbooked' women;
- Women who booked late, from 30 or more week gestation, but presented for intranatal and postnatal care. They are referred to as 'late booked' women;
- Women who delivered immediately within 10 minutes on arrival at the health facility or those who delivered in an ambulance, irrespective of their booking status. They are referred to as women with 'born before arrivals (BBA)';
- Women who delivered at home, later presented to the MOU for postnatal/ neonatal care irrespective of their booking status. They are referred to as 'home delivered' women;
- Women who booked on time, at least from 20 weeks of gestation and who attended both intranatal and postnatal care. They are referred to as 'booked' women.

The first five categories are commonly classified as high risk groups in obstetrics whilst the 'booked' women are classified as 'low risk' cases. The latter group was included in order to meet the requirement of the study design selected. Details are on chapter 3. Women who developed complications were not included in the study as these women would have been referred to hospitals and could not be included in the study.

1.2 Research Problem

South Africa has a maternal mortality ratio that is gradually increasing and was assumed to be 12 times more than that of developed countries, for example, United Kingdom, until recently where it was found that this was an underestimation of the problem. In spite of the many efforts that have been implemented to reduce the maternal mortality ratio, numbers are increasing every year with patient avoidable factors contributing to almost half of the maternal deaths reported. The major contributory factors are the delay in seeking maternal care and non-attendance of antenatal care by maternity women.

The South African constitution places emphasis on 'equality and rights', therefore it is appropriate to conduct a study on maternity women's accessibility to health care by using gender and human rights approaches. The SA confidential enquiries on maternal deaths, though an important tool for identifying causes of maternal deaths to develop measures to prevent further deaths, have limitations in addressing reasons why women fail to attend maternity care.

1.3 Aims Of The Research

The aim of this study was to use gender and human rights approaches to examine and analyze the major causes of maternal mortality, which result from delay in seeking maternity care and failure to attend antenatal care during pregnancy. The human rights perspectives in addressing women's health problems is appropriate

considering the South African culture on human rights which has prevailed since the South African Constitution and Bill of Rights were adopted in 1996. The constitution has also had an influence on creating consciousness around gender. Both these discourses have rarely been used as approaches in examining the causes of a health problem, and none on maternal health problems. This study will bridge a gap of knowledge regarding the root causes of maternal mortality in South Africa beyond the bio-medical approach, which is currently hegemony in health service delivery and in defining the causes of health problems.

1.4 Research Questions

The study addressed these questions:

1. Why do maternity women delay seeking care?
2. Why do maternity women fail to, or infrequently attend, maternity care?

1.5 Research Objectives

In regard to maternity women the study attempted to do the following:

1. Identify and describe the reasons for presenting late or failing to attend maternity care (antenatal, intranatal, postnatal) at a health facility;
2. Determine and analyse women's gender roles and relations that impact on accessibility to maternal health care;
3. Determine and analyse human rights issues that impact on accessibility to maternal health care;

4. Elicit opinions and observations on the delivery of maternal health services as perceived by its recipients;
5. Develop a model on accessibility to maternity care using a gender and human rights approach.

1.6 Study Assumptions

This study used a conceptual framework based on human rights and gender analysis in examining and analysing the major contributory causes of maternal mortality in the Western Cape. These, as mentioned earlier, were identified as delay in seeking maternity care and delay in seeking care (Department of Health, 1998, 2001), hence the study is based on this information and hopes to take understandings beyond the key biomedical factors examined in the NCCEMD. The study was not engaged in the debates about whether antenatal care attendance has any effect on the reduction of maternal mortality, but based on the evidence from literature, it is assumed that antenatal care does have a positive impact on maternal morbidity and mortality. It was not the purpose of the thesis to test or question this relationship or to test rival theories, but to review women's issues through a framework never before applied to the question.

1.7 Interpretations Of Key Terms

Maternal deaths: deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes

Maternal mortality ratio: number of maternal deaths per 100,000 live births. It indicates the risk of maternal death among pregnant and recently delivered women. It reflects a woman's basic health status, her access to health care, and the quality of maternal services that she receives

Maternal death notification: a process that requires that all deaths of women that occur in pregnancy or within 42 days of being pregnant be reported to the department of health.

Confidential Enquiry of Maternal Deaths: .a process by which deaths are reviewed by experts, causes and avoidable factors are determined so to introduce appropriate interventions

Safe Motherhood: universally defined as one of the central components of reproductive health to promote safer pregnancy and childbirth. It means creating the circumstances within which a woman is able to choose whether she will become pregnant. If she does, ensuring that she receives care for prevention and treatment of pregnancy complications has access to trained birth assistance has access to emergency obstetric care if she needs it, and care after birth so that she can avoid death or disability.

Antenatal care(ANC): care during pregnancy

Postnatal care(PNC): care immediately after delivery of the baby up to 6 weeks post delivery.

Intranatal care (INC): care during labour and delivery / child birth.

Maternity women: Women attending antenatal, intranatal or postnatal care.

Maternity care: Antenatal, intranatal and postnatal care.

Unbooked client/ patient: never attended antenatal care at any stage during present pregnancy.

High risk client /patient: woman presenting late (in the last trimester of her pregnancy, from 28 weeks gestation) or failed to attend antenatal care. Note: Although this term is commonly used in maternity care for all medical and social factors that increase the risk of poor pregnancy outcome, for this study, I shall use it in the context of a person delaying or failing to attend maternity care.

1.8 ABBREVATIONS

SA: South Africa

ANC: Antenatal Care

PNC: Postnatal care

DOH: Department of Health

WHO: World Health Organization

UDHR: Universal Declaration on Human Rights

IBR: International Bill of Rights

ICESCR: International Covenant on Economic, Social and Cultural Rights

ICCPR: International Covenant on Civil and Political Rights

ACHPR: African Charter on Human and People's Rights

ICPD: International Conference on Population and Development

FWCW: First World Conference on Women

1.9 Conclusion

In this chapter, the problem to be researched has been elaborated based on the background which acts as the prime motivation for pursuing this research. Maternal mortality, a worldwide problem, manifests as a result of women's poor appreciation by society through unequal distribution of resources for women's development. Women do not access health services including antenatal care in spite of the country's economic prosperity. Evidence shows a relationship between non-attendance of antenatal care and maternal mortality. The WHO endorses and highlights the benefit of attending maternity care, including antenatal care where complications can be identified and managed timeously. The tool used by NCCEMD in South Africa in addressing maternal mortality has its focus on the obstetric causes of maternal mortality, failing to take into account women's health in the broader context and to why women fail to attend maternity care.

This leads to the next chapter where the study's conceptual framework is discussed, including the literature review pertaining to the research problem .

Chapter 2

LITERATURE REVIEW

2.1 Introduction

In chapter 1, a background of this research was provided and how the research problem, research questions and objectives were formulated. Chapter 2 begins by giving a comprehensive discussion on why gender and human rights approaches were selected as the conceptual framework for the research problem, concepts definition within the framework and how these were applied in the study. Other approaches are critically reviewed to deepen the understanding of why women fail in seeking care. The chapter ends with presentation of literature reviewed which centers on findings of other researchers and also on the similarities and gaps that prompted me to conduct this study.

2.2 CONCEPTUAL FRAMEWORK

This study used both gender and human rights approaches in defining accessibility to maternal health care services. Norwood (2000) suggests that a conceptual framework has a practical value in that it helps the researcher organizes the study, and it also

provides specific direction for data collection and analysis techniques. She postulates that a conceptual framework has a "scientific value in that it enhances generalizability of findings" (Norwood, 2000, p.135).

Patton (1990) argues that although the researcher does not begin with a hypothesis in qualitative studies, it is necessary that (s)he must have a "general formulation" to guide direction of the study. Miles and Huberman (1994,p.99) warn:

> *any researcher, no matter how unstructured or inductive, comes to fieldwork with some orienting ideas, foci and tools...and it is impossible not have these.*

Below follows the discussion on how these approaches and their concepts were applied in the study.

2.2.1 Gender Perspectives

The HERA (Health, Action, Empowerment, Rights & Accountability) women's group (1999) defines gender as sets of relationships, attributes, roles, beliefs and attitudes that define what being a woman or a man is within society. The main aim of using a gender analysis is to identify and analyze inequalities that arise from belonging to one sex or the other or from the unequal power relations between the sexes and how these impact on women accessing maternal health care. Cook and Dickens (2001) support the argument that these inequalities can create risk factors that affect women's access to resources including health care.

Gender roles and relations are not determined by biological sex, they are socially and culturally constructed (Doyal, 1995). Doyal posits that gender relations and role

expectations for women are structures within dominant system of patriarchy that appears to be universal. She argues that unpaid gender roles in production (eg. household labour) and reproduction (e.g. child bearing and rearing) have a major influence on women's accessibility to health care.

Power imbalances and lack of control in the allocation of home resources such as money make women unable to have a greater voice and control in sexual, reproductive and health decisions. Thaddeuas and Maine (1994) maintain that a woman's status in society underlies and shapes her access to health care. The authors quote studies conducted in developing countries, for example, Nigeria and Ethiopia, which show cultural factors as contributory to the delay in seeking care by women who could not decide on their own to seek care. In Zaire, it was common for women to develop obstructed labour as a result of waiting for the husband to give permission. In many instances the husband was away and those present were unwilling to accept responsibility. In India, in most instances, the eldest women in the family make decisions regarding antenatal care and the place of delivery. While in this case power rests in the female role it still denies the young woman her right to self determination.

A gender justice approach, which entails gender equality and equity is an appropriate approach to use when discussing problems related to the specific needs of women (Moser, 1993). Gender concepts from the World Health Organization (WHO, 2001) and those from Moser's Gender Analysis framework (1993) guided this study in explaining how gender roles, relations and gender needs as described by maternity

women have impacted on accessing health care. These gender concepts and tools of analysis, as mentioned in the previous chapter, are reflected in the agreements reached at the United Nations international world conferences on Population and Development in Cairo (Cairo Programme, 1994), and the First Women's conference (Beijing 1995).

2.2.1.1 Gender roles identification and gender relations

Gender roles map the gender division of labour by asking 'who does what?', whilst gender relations entail questions about 'who is the decision maker' in regard to important issues that affect women. Moser (1993) outlines a set of triple gender roles for women that entail reproductive, productive and community work.

Reproductive work

This is defined as the maintenance of household work and its members, child bearing, child rearing, preparing food and taking care of other family members. Women carry these tasks, irrespective of their health status and pregnancy state, which is medically regarded as a state of vulnerability. That maternity women may need increased rest does not warrant exemption from performing these tasks in most societies. Some do not get any form of assistance from partners or from the members of the household (Moser, 1993).

The Cairo Programme of Action puts an emphasis on the role of men in reproductive work. Paragraph 4(27) states that:

Special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood...

Maternity women tend to ignore their own health because of these expected roles. In Zaire, for example, most maternal deaths occur during the first five months of planting and harvest seasons. This is the period when women work in the field and this impact on her attendance of maternity care (Sundari 1992). Women in this study were asked to describe their typical day, before and during pregnancy, and also whether the roles had an impact on their delay or failure to attend maternal health care service. The findings of what has emerged are discussed in chapters 4 and 5 in the thesis.

Productive work

This entails employment whether formal or self-employment. Moser (1993) explains that many women are breadwinners. Women usually work full time in addition to their reproduction role, making it difficult to find the time to attend to their own health (March, Smyth and Mukhopadhyay, 1999). Kwast (1991) found that in Ethiopia, poor antenatal care attendance was particularly common among women from the lowest economic status, as determined by their income and occupation. Smyke (1991) maintains that women account for the two-thirds of the world's working hours in addition to their unpaid reproductive roles they are expected to perform. In spite of the economic gains, in some societies, there has been no improvement in the development of some women including accessibility to health care.

Community work

This entails participation in groups and organizations, local politics and so on. According to Moser (1993), women primarily undertake community management activities as an extension of their reproductive roles. This is usually voluntary unpaid work and in addition to their other work. It undermines women ability to take care of their own health. Women in the study were asked about any community involvement or whether they were participating in any community work that would have made an impact on accessibility to maternity care.

2.2.1.2 Gender needs

Moser's concept of gender needs assessment is based on the idea that women as a group have particular needs, which differ from those of men and if they were met, these would enable women to transform existing imbalances of power between men and women. Education, one example, empowers women to be able to make sound judgments and decisions regarding issues that affect their health (Moser 1993). Most women are deprived of this opportunity through cultural expectations and or through imbalances in the allocation of resources. Graham (1991) found that, in India, illiterate women form a large proportion of those who failed to attend antenatal care and whose pregnancy ended in maternal death.

2.2.2 Human Rights Approaches

According to Cook (1998), maternal deaths are too important to be left to health personnel alone. Rather, parliamentarians and activists, for example, must play their part for maternal deaths link to broader questions about human rights and equality in a society. The human rights approach can be one of the tools in the fight to reduce maternal deaths (Katzive, 2003; Freedman, 2001; WHO, 2001; WHO, 1997).

The human rights approach as mentioned earlier, was suitable for this study to identify health system related factors that led women to delay seeking care and neglect antenatal care. According to Hendricks (1999, p.226), human rights "*protect individuals from abuses of state power and obligates states to provide the conditions necessary for prosperity and well being*". A human rights approach acknowledges that maternal deaths (and morbidity/disabilities) result not simply from women being disadvantaged but from a denial of their human rights. The right to accessible and appropriate health care is embedded in a wide range of international and regional codes and treaties as well as national laws as illustrated in BOXES I, II and III .

The treatises acknowledge and recognise motherhood as that requiring special protection during and after childbirth. The Cairo Programme (ICPD) 1994, principle 4 mentions that:

> *The human rights of women... are an inalienable, integral and indivisible part of universal human rights.*

It recognises that women's survival of pregnancy is an issue of women being equal

in dignity and rights. The UDHR article 25 (2) emphasizes that:

> *Motherhood and childhood are entitled to special care and assistance.*

The Economic Convention (ICESCR), article 10(2) states that:

> *Special protection should be accorded to mothers during reasonable period before and after childbirth...*

The Children's Convention recognises that the health of the mother during pregnancy impacts on the health of her unborn child. Article 24(2d) states that state parties should commit to ensure appropriate antenatal and postnatal care for mothers. The delay and or failure to attend maternity care were identified as the major contributory factors not only to mothers, but also to perinatal deaths in South Africa (DOH, 2001). The ICPD (1994) paragraph 7.2 recognises safe motherhood as being integral within the broad definition of reproductive health. It is stressed that:

> *... the right of access to appropriate health-care services that will enable women to go to safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*

The Beijing Platform of Action (FWCW, 1995) paragraph 106(e) takes this further by committing governments to:

> *Provide more accessible, available and affordable primary health care services of high quality (*including quality maternity services)...

The Women's Convention (CEDAW, 1981) article 12 identifies that discrimination against women should be eliminated because it is a barrier to accessibility of health services including maternity services:

> *States shall act to eliminate discrimination against women in health care to ensure equal access to health services.*

The African Charter (ACHPR) article (16) emphasises that states:

> *should take the necessary measures to protect the health of their people and to ensure that they receive medical attention...*

South Africa ratified all the international and regional human rights treaties through a formal agreement that legally binds the country to these instruments (Women, Law & Development International, and Women's Rights Watch, 1997; Cook et al, 2003). In addition, the national constitution is said to offer more concrete and enforceable remedies for someone who wants to use a human rights approach to hold the state accountable for gross violation of human rights including rights to access maternity care. The SA Bill of Rights article 27 (1) states that:

> *Everyone has the right to have access to health care services, including reproductive health care...*

All the treaties emphasise that during pregnancy and childbirth women should be provided with quality maternity services, and the state, through its systems is obliged to promote, protect and fulfil this right to access maternity care. Freedman (2001) argues that maternal mortality is not just a natural phenomenon that randomly strikes at pregnant women; it is a journey that has started from women being denied their rights to access resources, including health.

It is suggested that there are two approaches in applying a human rights framework in health. They can be used as a system of formal law based on the national, regional and international treaties and conventions (Cook et al, 2001, Freedman, 2001; Hendricks, 2001). This approach is regarded as punitive and it is mostly used to hunt and expose violators of human rights. The other approach, which was applied in this

study, is more philosophical in the sense that human rights have been used as a tool to describe and paint the 'big picture' with the aim of setting standards against which quality of maternal health care is evaluated.

BOX I. International Treatise

- Universal Declaration of Human Rights (UDHR) (1948).
- United Nations' International Covenant on Economic, Social and Cultural Rights (ICESCR) also known as the Economic covenant that was adopted in 1966 entered into force 1976.
- United Nations' Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) also known as Women's Convention that was adopted 1979, entered into force 1981.
- United Nations' International Convention on the Rights of the Child (the Children's Convention), adopted in 1989 into force 1990.
- United Nations International conference documents on the Population and Development held in Cairo (Cairo Programme, 1994).
- United Nations International conference documents on Fourth World conference on Women held in Beijing (Beijing Platform, 1995).

BOX II. Regional treatise

The African Charter on Human and People's Rights (African Charter) adopted in 1981entered into force 1986.

BOX III. National law

- The Constitution of the Republic of South Africa, Bill of Rights (1996)
- The South African Patient's Rights Charter (2000)

The WHO (2001) and Cook and Dickens (2001) give a framework on how one can combine these rights and make them suitable in addressing safe motherhood. This study used these concepts in establishing why women delay seeking care and fail to attend antenatal care from a human rights perspective. Below is an outline of those that were applied:

2.2.2.1 Rights to access quality maternal health care:

- Availability of maternity service: This entails a supply of a health service including functioning health care facility, and health facility opening and waiting times.
- Accessibility to maternity service: Participants were asked about the physical accessibility to the health facility in regard to distance, and any other factors impacting on their accessibility to health service such as economic affordability of the service.
- Quality: Participants described the service in regard to whether was good in relation to functioning equipment and healthy environment.

2.2.2.2 Rights to non-discrimination:

- Health services must be accessible to all and no client should be denied health care on the basis of age, race, language and ethnicity, culture. Participants were asked about this information and whether the above impacted on their maternity care attendance.

2.2.2.3 Rights relating to accessing information:

- This entails the woman's right to seek, receive and impart information and ideas related to health issues. Women should be provided with appropriate and specific information on what constitutes a complication, how to prevent and where to receive care for such complication. This should be in a language that the client can understand.

2.2.2.4 Rights relating to human dignity and respect:

- This entails positive disposition by health worker, and not to be treated in any dehumanising way. Confidentiality and privacy with procedures performed in privacy are very crucial.
- Health service to provide informed choices for women to make informed decisions regarding their health.
- The South African Patient's Right Charter emphasises that a person has the right to be treated by a named health care provider with clear identification of her/ his name.

A combination of gender and human rights approaches in defining why women delay seeking care and why they infrequently or fail to attend antenatal care helped to look at the reasons related to accessing health care from two dimensions. A gender approach guided the study in seeking information related to participants' identity roles and lived experience as women, whilst the human rights approach elicited information related to the broader health and political context.

For the rigour of the study, in the next paragraph I discuss other theoretical perspectives that add value to and understanding of the research problem, and that have been used in the area of maternal health care. According to Yin (1994), when conducting case studies, it is crucial for one to explore the broadest base of theoretical work that may have explanation for the phenomenon under study even if these are critically assessed. Theory triangulation, argues Norwood (2000), contributes to a deeper analysis of the phenomenon.

2.3 THEORETIC FRAMEWORKS FOR UNDERSTANDING THE USE OF MATERNITY CARE

There are many perspectives that have been applied to define maternal morbidity and mortality and why women are unable to access quality maternity care. Two of the dominant approaches in this context are the bio-medical model, which is regarded as hegemonic in health delivery; and feminist theory.

2.3.1 The Biomedical model

The biomedical model also seen as Western and/ or technocratic model is the dominant model in explaining causes of ill-health. Macdonald (1995) argues that this model was exported from developed countries to developing countries as one of the instruments of colonial exploitation. Although there are medical benefits to this approach to health care, the dominance of this framework has resulted in the health system adopting the values and beliefs of the colonizers (Macdonald, 1995). The main underlying principle of this approach to health care is the norm of separation.

The disease is separated from the person, and the ill health is understood as external to the person's context. The distorted emphasis on biological and medical causes in defining the causes of health problems, overlooking the promotive and preventive aspects, makes it difficult to analyze health problems prevalent in poor countries such as Africa. In Africa, the causation of ill health is rooted in psycho-social, economic and in political factors, among other things. Women cannot access health care, not because they might be feeling well and do not need the service as explained by this model, but because there might be other reasons that might be political, economic and social factors that may impact on their responses to health seeking (Davis-Floyd, 2001).

The biomedical model defines the causes of maternal mortality as disease related, for example, postpartum haemorrhage or hypertension. It has been widely documented and accepted that maternal mortality is complex and multifaceted, that the causes are not only medical, but are rooted in a wide range of factors such as socio-economic, cultural, political and other weaknesses of the health system (WHO, 2001). Kwast (1991), argues that, a woman, for example, does not die because she has a post-partum haemorrhage. Rather, she dies because she is having too many children, and she might have wished to prevent pregnancy but had had no access to family planning due to the fact that she lives far away from the clinic in a poor, rural area with no roads. Or it might be because the last time she asked for contraceptives from health service she was badly treated by health workers; or many other examples of the complex interplay of culture, socio-economic and political context.

The 'victim-blaming approach', is another underlying effect of the biomedical model, in defining the causes of a health problem (Macdonald, 1995). Women are inadvertently blamed for things that are frequently beyond their control. Rather, the dual approaches used in this study acknowledge the fact that women find themselves in situations beyond their control that make them unable to make decisions related to their health. The biomedical model closes down questions that take us further in understanding the complex context of women's relationship to their health and health- care practice.

Furthermore, argue Brems and Griffiths (1993), this model divides health from the setting that produces it. In the context of maternal health, most doctors are trained to see labouring mother as at risk patients, whose normality can only be proved after the event (Doyal, 1995). This, according to the model, implies that woman's pregnancy is more important than woman herself. It does not look at woman holistically, but centres woman's maternity care around the pregnancy itself. Pregnancy is seen as a mechanical event in the mother and that she differs from other non-pregnant women by 'virtue of the presence of this thing growing inside her' (Katz, 1990.p.8).

Matamala (1998) elucidates that the patriarchal nature of the biomedical model, which most public health services are based on, promotes hierarchal relations between health care recipients and health care providers. The model encourages dependency and submission, and thus impacting on the relationship between health recipients and health care providers. The overemphasis on prescriptive medicine

within the biomedical knowledge is another element of this model. Women are regarded as ignorant, lacking any form of knowledge related to maternity including their own childbirth and pregnancy (Davis-Floyd, 2001).

This model, argues Katz (1990), sees pregnancy and childbirth from men's eyes that the woman is pregnant with the man's child. Explicating that the woman is pregnant with the man's child, the model shifts responsibility away from woman's partner by implying that the father of the child cannot be a barrier to accessibility of maternity service, 'it's his own child'.

In conclusion, although there are empirical studies showing benefits on the use of this model in the context of physical ill-health, evidence does show that women delay to seek care and they fail to attend maternity care. The model implies that women are unable to attend maternity care, not because there might be other reasons impacting on that such as socio-political, cultural and economic factors, among other things, but it is the woman's fault.

2.3.2 Feminist approaches

> "The heart of woman's oppression is her childbearing and childrearing roles".
>
> Firestone (1970, p.81)

An approach to health care informed by feminist theory has also been applied to questions about why women delay seeking care. Whilst feminism is not a homogenous theory, all feminists share the unifying belief that women are oppressed

and that the unequal and unjust status of women exists (Maynard, 1994). Because feminism is multifaceted and no one feminist movement exists, a feminist approach incorporates distinct theoretical, philosophical, methodological and political tenets (Kirkley, 2000). This produces diverse groups of thinkers with different viewpoints on maternal health. Feminists share a common ground that patriarchy is the oppressor of women, and that frequently makes it difficult for women to make decisions pertaining to their health, including accessing health care.

South African feminism, which was mostly rooted in the democratic struggle against apartheid, argues that class and gender among other things influence women's oppression. Feminist accounts of the health system have addressed such issues as access to sanitation, housing, water and these have not been traditionally defined as being feminist issues (Eagle, Hayes and Sibanda, 1999). It has been argued that women cannot access health care because of inequities in the distribution of health care services (Lockett, 1996). In this study, South African feminist ideology on the health inequities and distribution of resources such as housing was acknowledged. Women were asked about walking distance between their living accommodation and the maternal health care service.

The thinking behind radical feminism is that women are often forced into motherhood because of patriarchal oppression that promotes compulsory heterosexuality (Firestone, 1970). In this thesis women were asked about the decision maker at home, regarding reproductive health issues.

Black feminism has its roots in African-American response to White dominated feminism in the United States, and has found resonance in South Africa where Womanist and Africanist feminism thinking have been strong. In Black feminism, motherhood as an institution is seen as dynamic and dialectical – it is a burden that exploits women's labour and makes them partners in their oppression whilst on other hand it is recognised as providing a base for self-actualisation, status in the Black community and a catalyst for social activism (Hill Collins, 2000). It remains a symbol of hope for many, especially the poorest Black women despite the economic costs related to childcare and costs to their health because of being deprived of economic resources. Most women view their maternal roles as the driving force behind public political action (Richardson, 1993). Because of these valued maternal instincts and community values that assign high prestige to motherhood, many Black women have children they may not personally want. They tend to neglect their health and even delay to seek care and these unwanted pregnancies could have tragic consequences such as back street abortions resulting in maternal death (Richardson,1993).

The feminist approach as outlined here will be used to interpret the findings from this study to deepen the analysis of the gendered human rights approach as feminism account of human rights discourse shows the weakness of this approach when dealing with women's issues. The feminist critique of the rights discourse surfaced in the early 1990's. The argument is that the rights based approach is vague and non-specific (Correa and Petchesky, 1994). They postulate that the International Bill of Rights (IBR), namely the UDHR, the ICCPR and ICESCR, lacks gender sensitivity

because they prescribe equality, individualism and universality without recognising gender roles that have put women in lower positions in the society, specifically in those societies where women are unable to access basic resources. Women can never be equal to men if the imbalances of the past are not redressed, firstly, through equal distribution of resources (Correa & Petchesky, 1994).

The IBR's endorsement of 'family' as the most important social group in the society implies that everybody should reproduce to maintain the 'family' status quo in the society. This subsequently promotes one choice of sexuality and sexual orientation, heterosexuality, which has put most women in the high risk of contracting HIV/AIDS and Sexual Transmitted Infections (STI) because of, among other things, lack of negotiation skills within heterosexual relationships. Correa and Petchesky (1994) hypothesize that human rights to reproductive health have little meaning for women without freedom to control their reproductive capacity. The human rights discourse does not count the context in which individuals pursue those rights. The male partner, same as the foetus advocates, can use the same human rights instrument to demand the right to reproduce. This does not recognise the circumstances to which the woman become pregnant in the first place. Furthermore, the UDHR endorses motherhood without looking at enabling factors that can make pregnant women to exercise this right safely eg. lack of accessibility to quality maternity care. In most instances, motherhood has put some women in subservient position (Firestone, 1970).

In the context of this study, the feminist perspective support the argument that

human rights approach alone cannot address accessibility to maternity care as this approach is gender blind. Correa and Petchesky (1994) advise that the rights discourse should not be abandoned, but should be constructed so that it specifies gender. The study used both gender and human rights approaches in establishing and analysing reasons why women delay or fail attending maternity care.

2.4 PREVIOUS STUDIES: Why do women delay seeking care and why they fail to attend maternity care?

Many women all over the world still do not attend antenatal care. They still delay seeking care despite the medical claims of the wonders of antenatal care in preventing illness during pregnancy and thus lowering of maternal and perinatal mortality (Cook &Dickens, 2001). Much research, time, money and efforts have been channelled in an attempt to determine the reasons for this non-compliance, and although a wealth of information has been generated, the problem prevails, particularly in certain areas of the world (Benn, 1994). Each country and even different areas within a country are likely to have their own problems related to antenatal care (Thompson, 1996). In South Africa, for example, 3 studies were conducted separately, two in Durban (Gcaba & Brookes, 1992; Jinabhai, Naidoo & de Pinho, 1994)) and one in Port Elizabeth (Benn, 1994) on the use of antenatal care. All came up with contrasting findings, making it difficult to use generated information to improve maternal health care utilization in other areas. This will be elaborated as the chapter unfolds.

Most international studies conducted on delay in seeking care focus on the interval between the onset of the obstetric complication up to when the woman decides to and reaches health care (Thaddeus & Maine,1994). The studies look at factors that facilitate a woman's delay in attending health care, once a complication surfaces. This focus stems from the biomedical model, which tends to take a victim-blaming approach in defining the causes of the health problem. This study attempted to bridge this gap by looking at factors that are beyond women's control.

There is no doubt that a large amount has been written on accessibility to maternal health care, but few studies have been found internationally, and none located nationally, that use a gendered human rights approach to define why women delay seeking health care. Both analytical and descriptive studies do not incorporate the broader context of women's lives in a holistic way. Most articles located on human rights, for example, were WHO publications that define how a human rights approach can be used as an analytic tool to address maternal mortality (WHO, 2001). Previously, rights based discourse was basically used as jurisprudence by 'academic lawyers', but not as a theoretical framework for other disciplines such as health, as a result no studies were located that used this approach in addressing health matters.

Some studies do not explicitly mention the use of human rights perspectives in defining the causes of maternal mortality, but use concepts derived from human rights in explaining the causes, for example, how women cannot access health service because of staff attitude or ill equipped health service. Sundari (1992), for example, in the review article *"The untold story: how the health care systems in*

developing countries contribute to maternal mortality" did a cross-national survey of studies conducted in developing countries. She gathered information dated from 1978 –1985 in seven different countries, namely, Zimbabwe, India, Tanzania, Malawi, Pakistan, Vietnam and Malaysia. Lack of equipment, poor patient management and absence of relevant antenatal care information from health facilities were found as main causes of maternal deaths in these countries. De Brouwere, Tonglet and van Lerberghe (1998) conducted a similar survey for developed countries, and found that, for example, in Sweden, 400 out of 651 maternal deaths could have been avoided if there was a commitment from the health system. In the USA, 63 % of all deaths that occurred in this century were health worker related and could have been avoided if "*the care of the woman had been proper in all respects*" (Ibid, p.74). Both these studies were conducted retrospectively comparing countries and were analyzed quantitatively.

Most studies on maternal health care do not use gender perspectives per se in analyzing women's accessibility to health care. It is extensively documented that although maternal deaths are directly caused by complications such as septic abortions, hypertensive conditions in pregnancy, AIDS complications, obstetric haemorrhage and obstructed labour; the underlying factors behind those immediate medical causes are the poor status of the woman (Christiani, 1996; Campbell & Graham, 1991; DOH, 1999; Walker & Wilging, 2000; Kolbinsky, Timyaro & Gey, 1993).

One international study conducted by Shen, John and Williamson (1999), used gender stratification as one of the study's tools in comparing causes of maternal mortality per country. They used lagged cross-sectional and path analysis with a sample of 79 less developed countries (South Africa included). The focus of the study was on the impact of predictors linked to three theoretical perspectives – modernization, economic dependency and gender stratification. The findings were that the women's status as measured by her level of education, age at her first marriage and reproductive autonomy is a strong predictor of maternal mortality. The shortfall of this study is that for the dependant variable, maternal mortality, and independent variable, the women's status, the authors used WHO 1990 data. Maternal mortality was not notifiable in South Africa until from1997, meaning the findings might not be a true reflection for South Africa. This may have been true for many of the other countries included in the study. The study was also a cross - national quantitative research with no involvement of the women and their perspectives.

Obermeyer (1993) compared maternal health care usage by pregnant women in Morocco and in Tunisia. Her/his findings show that the low status of women did not impact on their lower attendance of antenatal care. Obermeyer first used statistical analysis of the differences within these two countries in terms of the demographic, socio-economic, and educational characteristics. Secondly, s/he compared the social context, health-care systems and population policies of the two countries.

The barriers to antenatal care utilization that have been identified by numerous researchers in South Africa are those related to socio-economic factors, such as transport costs, as described by Gcaba and Brookes (1992). Their research was conducted at King Edward VIII hospital, Durban. They used ten case studies of women who did not attend antenatal care bookings in the current pregnancy. Their study used the health belief model as a theoretical framework, and participants were women from one health facility at a specialized tertiary level of health care. They found that maternal health is the motivator for attending maternity care. Women do not attend maternity care if they perceive that they do not have a life threatening condition. Benn (1994) found economic costs to be a barrier to utilization of ANC services among postnatal women delivered in four hospitals in Port Elizabeth. She used ex post facto research design analyzing 214 patient records.

Jinabhai, Naidoo and de Pinho (1994) conducted a study in KwaZulu-Natal to determine factors affecting the utilization of antenatal, delivery, postnatal and family planning services. It was a community based, cross-sectional, descriptive study conducted retrospectively for a two-year period. The sample of 445 women gathered from rural (47%) informal (21%) and urban (32%) areas had 23 women (n=23) who did not attend antenatal care, meaning, 95% of the sample had attended antenatal care. The reasons for non-attendance were transport costs and distance from the health service.

In the Western Cape, Jewkes and Mvo (1997) conducted a study on women's health seeking practices at MOU located in the southern region in Cape Town.

Ethnographic methods using semi-structured interviews were conducted with 17 women recruited on their first antenatal visit and re interviewed throughout their pregnancy until after delivery. Only two women were unbooked in the study, the rest began their antenatal care during the second trimester of their pregnancies. The main scope of enquiry for this study was to find out how these women had made decisions to attend antenatal care. Key findings of this study were that the reasons for being unbooked was 'laziness of getting up early in the morning' and having a long wait, and staff attitude at the health facilities. For those who were booked, they were satisfied with their antenatal care but also shared the sentiment of having to rise up early and having a long wait before having procedures performed on them with no explanation. This study was conducted in 1996 and early 1997 and since then more MOU were built to accommodate the increasing population. Currently some health services make use of a time appointment system to accommodate times suitable for women to attend antenatal care, but women still do not attend antenatal care and they still delay seeking care when the complications present (DOH 1998, 1999, 2000).

Clarke (2000) found that 90 –95% of women in South Africa do have access to antenatal care services, but the quality of what they receive is questionable. She argues that antenatal services in this country vary widely, from meeting first world standards (in many private and academic hospitals), to being almost non-existent (in both rural and urban public services).

In spite that women in South Africa are encouraged to attend antenatal care because of its benefit, recent debates, however, show that this evidence is insufficient to reach firm decision about the effectiveness of antenatal care in reducing maternal

mortality (McDonagh, 1996). The author argues that the evidence is sufficient enough to doubt the possible effect of ANC. Several authors support McDonagh's argument that ANC, which is often used as a risk approach to categorise women to low and high risk is a poor predictor of actual risk (Donnay, 2000; Rohde, 1995). McDonagh argues that health problems such as hypertension cannot be detected during ANC. She elucidates that many conditions are not recognised during ANC and that ANC attendance cannot reduce most complications that causes maternal deaths. She argues, evidence shows that hypertensive disorders, for example, cannot be detected in up to 30% of pregnant women attending antenatal care, and that hypertension can only be detected in the second trimester of pregnancy, hence the antenatal care visits should be problem oriented (Benn, 1994; Villar, Carroli, Khan-Neelofui, Piaggio & Gülmezolu, 2002).

Donnay (2000) supports the above argument that in the developing countries, more resources are put into ANC than into intranatal and immediate postnatal care, yet, s/he echoes, the majority of complications and deaths occur during this period, not during ANC. De Brouwere et al (1998) explicates that in developing countries where women are at risk of developing complications, the overemphasis on ANC which 'is reduced to an instrument for the prediction of risk' omits important roles such as giving health information and education to women during consultation.

Lumbiganon (1998) maintains that ANC care provided in the developing countries is different from that of developed countries, with that of developing countries focussing on the number of ANC visits rather than on the problems presenting during

that period. S/he argues that this has been proved to be no benefit to women and to reduction of maternal deaths. Women become reluctant to attend ANC, for an example, because they feel the visits are too many with no benefit attached. The traditional ANC includes a relatively large number of visits, and can be more than 10 when the woman book early in the first trimester.

In conclusion, empirical studies do show that women do not attend maternity care. These studies highlight several reasons on why women fail to attend maternity care, however, the findings are contrasting to be generalised to a broader context, and also that, the studies used traditional mainstream research methods that have limitations in researching womens' issues holistically. Furthermore, the literature above shows that evidence from case control studies questions the benefits of ANC in regard to identification of complications and to reduction of maternal mortality. These studies fail to acknowledge that ANC is not only about identification of obstetric complications, but is for all aspects related to women's health. As mentioned earlier in chapter 1, pregnancy itself aggravates other diseases such as heart diseases that can be identified, with complications prevented during antenatal care. From my experience as a maternal health provider, I have observed that some women in rural areas have their first exposure to health care only during ANC, and that is when the opportunity prevails to identify other issues affecting their health that might indirectly have an impact on their current pregnancy[1]. This approach of focusing on pregnancy only as ignoring other aspects affecting a woman, endorses a biomedical approach as already highlighted earlier on in this chapter.

Furthermore, epidemiological studies show a linkage between the woman's socio-demographic and obstetric factors, with under-utilization of maternity care, and subsequently, maternal mortality. Owing to the fact that this study is using a case study design which reinforces thick description of the phenomenon under study, I will present literature reviewed under these factors. The study design as defined in the next chapter, requires the researcher to define all boundaries, and to give a holistic picture about the phenomenon under study (Yin, 1994; Miles & Huberman, 1994; Stake,2000; Robson, 1997). Moreover, the study is *Exploring the journey to maternal death...,* meaning all factors pertaining to the contributory causes to maternal death are explored. However, because of the nature of this study, no attempt was made to test the causal links between these factors and maternity care accessibility. The factors are presented because, according to Patton (1990), if a study does give rise to ideas about causal linkages, there is no reason for the researcher to deny the readers the "data based speculations and conjecture" (Patton, 1990, p.158).

This approach of shifting the focus away from demographic factors is endorsed by the ICPD (International Conference on Population and Development) Programme of Action in their agenda to promote reproductive health rights through population policies (ICPD, 1994). South Africa is one of the many countries that ratified this programme of action (Cook et la, 2003). The ICPD changed the focus of their population policies, which until then had been directed at demographic factors and the regulation of women's fertility. The ICPD Programme of Action supports the perspectives that the well being of women and their quality of life should emphasize

their reproductive health issues.

2.5 SOCIO-DEMOGRAPHIC FACTORS AND ACCESSIBILITY TO MATERNITY CARE.

Previous studies associated under utilization of maternity services with demographic factors such as woman's age, marital status, her occupation, education and housing (Campbell & Graham, 1991; Christiani, 1996; Graham, 1991; Thaddeus & Maine, 1994). Campbell and Graham (1991) and, Pittrof and Johansen (1999) support the argument that these factors are not necessarily causal to maternal mortality but they underlie and shape women's accessibility to health services. They warn that, it is of importance that the researcher elaborates on the basis of making such association.

Women's age

Jinabhai et al (1994), Gcaba and Brookes (1992); and Young (1990) found that pregnant women below age 20 have poor utilization of maternity services than older women. On contrary, Obermeyer (1993) found age has no significance in the utilization of services. In Tunisia and Morocco, s/he found that both young and old pregnant women delay to seek maternity care.

Marital Status

Marital status, as a personal factor, impacts on women's utilization of maternity services (Jinabhai et al, 1994). They found that the woman's marital status; together with her age determine her self- esteem and decision- making capacity within her family. Benn (1994) found that marital status as a means of social support has a

significant effect on the utilization of antenatal care services in a study she conducted in Port Elizabeth, South Africa.

Occupation

Jinabhai et al (1994); and Ezechi, Fasuba and Dare (2000) found that unemployed women have the poorest utilization of maternal health services than the employed ones. Both these studies only focused on formal employment versus unemployment not taking into consideration that some women though they might not have formal salaried jobs, they are involved in domestic work including informal employment such as street vending (SA Demographic & Health Survey, 1998). These unnoticed roles put serious strains on women's health and impact on their ability to attend health services, particularly, maternal health services (Christiani, 1996).

Education

Smyke (1991) hypothesises that a woman with more schooling years usually will marry at a later stage, will have a smaller family, will seek family planning methods, and will seek antenatal care. Thaddeus and Maine's (1994) literature survey on studies on accessibility of maternity services, found that several studies conducted in hospitals do show that women with little or no education prevail in poor socio economic areas where there is problem of unemployment, and these women tend to delay or fail to attend maternity care.

In respect of maternal mortality and woman's education, in northern Nigeria, where adult female literacy rate is 31% compared with Sri Lanka, 83%, the maternal

mortality ratio was 800 and 50 per 100 000 deliveries respectively. This was interpreted as being five times greater than that of educated women in the Nigerian case (Pitrof & Johansen,1999). Briggs (1994) in her/his article titled *"Illiteracy and maternal health: educate or die"* also maintains that educated women are more likely to be conscious about their health thus reducing maternal morbidities and mortalities.

These previous studies, however, are unable to substantiate on the mechanisms through which education may play a role in women's accessibility to maternity services, that role is not made obvious. It might not only be the education that is the factor on accessibility of maternity although significant, but there are other factors.

Thaddeus and Maine (1994) quote other studies showing that higher levels of education do not guarantee utilization of maternity health services. In Tanzania, for example, with a high adult female literacy rate of 85%, the maternal mortality ratio is about 469/100 000 live births. These educated women, they speculate, use self-prescribed medication and self-care and end up delaying care until the self- cure methods fail to produce the cure. They also hypothesise that the other reasons these educated women are not attending maternity care is because they are healthier and therefore requiring less care than the less educated.

Education, although a powerful tool for the advancement of women, may not operate in vacuum and it cannot overcome cultural factors that discriminate against woman and render them submissive in matters related to their health. It does not keep an

educated woman from feeling the social pressures to conform to the traditional image of 'woman' in a particular society[2] (Smyke, 1991). Focussing on education as a major factor in the delay and non-attendance of maternity services shifts the responsibilities from the health system, among other things, and it hides the fact that there might be other factors that deter accessibility to these services.

Housing

Socio economic status as defined by housing among other things has been identified as the barrier to antenatal care utilization by several researchers (Gcaba & Brookes, 1991; Brieger, Luchok, Eng & Earp, 1994; Shen & Williamson, 1999; Khosla et al, 2000). Obermeyer (1993) found residence to be the strongest predictor of the use of maternal health care in Morocco with urban women more likely to use services.

Distance

The South African Saving Mothers report speculates that distance and transport is barrier to accessibility of maternity services (DOH, 2002). Similarly, Jinabhai, Naidoo and Pinho, (1994); Ndebele (2000); Gcaba and Brookes (1991); and, Myrdal and Potgieter (1992) found transport costs and distance as barriers to accessibility of maternity services in Durban, South Africa. However, Benn (1994) did find distance to be a barrier to utilization of antenatal care services in Port Elizabeth, South Africa. All these studies were conducted in urban metro areas, more or less in the same physical environment where this study will be conducted.

Kolbinsky, Timyan and Gay (1993) support the argument that barriers to maternity care are more than distance, other factors should also be considered. A study done in Kenya showed that in spite of the road improvements and decrease in physical proximity to maternal health services, there was no improvement in the admission rate at those hospitals (Airey cited by Thaddeus & Maine, 1994). Furthermore, the Western Cape where this study was conducted, has the best health infrastructure in the whole country (DOH, 1998), so physical distance cannot be seen as the primary problem, though it does appear to play some role in relation to other factors.

2.6 OBSTETRIC FACTORS AND ACCESSIBITY TO MATERNITY CARE

From the literature the phrase "too early, too late, too many, too close" summarises the impact of obstetric factors on maternal mortality (Graham, 1991; Thompson, 1999; Seneviratne & Rajapaska, 2000). Medical research regards pregnancy occurring above age 35 as dangerous and as a high risk both to the woman and the child (Nel, 1995; Beischer, Mackay & Colditz, 1997; DOH, 2002). However, these factors are biomedical risks that focus on biological causal links and biochemical markers of the causes of maternal mortality (Graham, 1991). This endorses the notion as mentioned in chapter 1, that maternal health is viewed not as a public issue, but as a medical problem that operates at an individual level (Campbell & Graham, 1991; maternal mortality notification, 1997). It has been conceptualised as a discreet state, characterised by physical manifestations rather than social or mental ones, and also by a narrow time perspective that focuses on pregnancy, delivery, and the 16 weeks postnatal (Graham, 1991; Kolbinsky, Timayan& Gay, 1993). The NCCEMD

is currently looking at obstetric causes of maternal mortality. Though this approach is important inorder to get a sense and magnitude of the problem, the maternal deaths confidential enquiries, which are quantitative in nature, have limitations in addressing the problem of maternal mortality in a broader context. As mentioned earlier in chapter 1, behind those obstetric causes there are underlying social problems.

2.7 Conclusion

Conventional literature is dominated by research that uses approaches and perspectives that inadvertently and sometimes put blame on women for not accessing health care. Mainstream traditional approaches to investigating women's health issues have failed to address the root problem of maternal mortality, women still fail to attend antenatal care in spite of the overwhelming information available. Yet maternal deaths are still escalating in South Africa (and in other developing countries). Deviation from the hegemony of conventional approaches such as the biomedical model, among others, is crucial when one needs to conduct studies on women's health, hence the use of human rights and gender perspectives for this study. Gender and human rights, the two approaches that were used on this study, focus on factors that are beyond women's control and may help to shed light on how society can better support women to improve their own health and prevent untimely death.

In this chapter I highlighted work done previously by other researchers in terms of the research problem. I identified similarities and gaps in these studies and how the findings from this thesis will attempt to bridge those gaps identified. More literature will be used as a control in the main body of the thesis when discussing emerging themes from the findings. Glaser and Strauss cited by Holloway and Wheeler (1996) support the argument that literature review in qualitative studies is an ongoing process and happens throughout the study. The researcher becomes engage with literature when comparing and contrasting her/his findings with those of other studies.

In the next chapter, I am discussing how the research objectives were met by choosing the appropriate research design and research methods. Details about the study sample, data collection and analysis procedures are also discussed.

Chapter 3

RESEARCH METHODOLOGY

Words are the way that most people come to understand their situations. We create our world with words. We explain ourselves with words. We defend and hide ourselves with words ... the qualitative researcher is to find patterns within those words.

(Maykut & Morehouse, 1994, p.18)

3.1 Introduction

This chapter is about research methodology, discussions on the research design, methods and sampling strategy applied to the study. In chapter 2, literature was reviewed and the study's conceptual framework was presented. A qualitative approach was selected for this study because the phenomenon can be understood in all its complexity and within a particular situation and environment (Silverman, 1997; Marshall & Rossman, 1993; Patton, 1990; Potter, 1996; Munhall & Boyd, 199). In this approach the relationship between the researcher and the participants and or the phenomenon under study is acknowledged and emphasised (Lincoln & Guba, 1985).

This is the fundamental principle in researching women's lives, that is *"valuing others, adopting a position of equality"* (Holloway & Wheeler, 1996, p. 136). It is in qualitative research that the researcher can understand the woman's experiences in context within the natural setting where the phenomenon prevails. Most qualitative scholars recommend case study design because the subject- object dichotomy is completely rejected, and that the design allows a situation where all participants are equally treated (Cohen, Manion and Morrison, 2000; Denzin & Lincoln, 1994; Lincoln & Guba, 1985; Miles & Huberman, 1994).

3.2 Research Design

A qualitative multiple case study design was used for this study. Yin (1994, p.12) describes a case study as:

> *intensive, systematic investigation of a single individual, group, community, or some other unit, typically conducted under naturalistic conditions, in which the investigator examines in-depth data related to background, current status, environmental characteristics and interactions.*

Yin (1994) argues that evidence from multiple cases is compelling, and the overall study is therefore regarded as being more robust. This design is 'holistic and lifelike' and paints realistic pictures of actual participants in their own language (Yin, 1994; Miles & Huberman). Case study design is suitable to answer the research question of this study because case studies produce 'thick description' of the phenomenon with all boundaries defined (Stake, 2000; Robson, 1997). Using case studies for establishing and analysing reasons for women delaying to seek care helped to portray "what it is like" to be in a particular situation as defined by participants themselves. I

was able to understand that the human system has a wholeness to it rather than being " a loose connection of traits" (Cohen et al, 2000).

3.3 Participants And Sampling

The Western Cape province is divided into four regions, namely, the Unicity (Metro), West Coast, Boland/Overberg and South Cape/ Karoo. The sampling was drawn from the Metro region where according to Census (2000) 80% of the population in the Western Cape lives. The Metro is divided into the northern and southern areas with 6 and 5 Midwife Obstetric Units (MOU) per area, respectively.

The sample was drawn from all 6 MOU situated in the northern area, excluding academic hospitals, Tygerberg and Groote Schuur, and from the secondary hospitals, Karl Bremer, Somerset and Mowbray maternity. The hospitals provide maternal health care for life threatening situations and specialized levels of care. For ethical reasons, it was not considered in the best interest of participants to conduct interviews when they are in a critical condition. The MOU were chosen because they serve a population that is culturally and racially diverse, and the primary languages of communication are Afrikaans or Xhosa, with English often being a second language. The 6 MOU in the northern area selected for the study were Kraaifontein (situated in the eastside of Tygerberg); Elsies River and Bishop Lavis (from the Westside); Vanguard (from the north); and Michael Maphongwana and Macassar (from the south).

Participants were drawn from each of the above 6 MOU and any woman who met the criteria were eligible for the study. The final sample included 16 case studies of maternity women from the 6 MOU. Yin (1994) recommends no more than 15 case studies for this kind of study. There is no justification for a larger sample because case studies do not rely on statistical generalization but on analytical generalization. Moreover, there is no justification for a very large sample as data from large samples might lack the depth and richness of a smaller sample (Patton, 1990). Yin (1994) cautions that in case studies 'sampling logic' is not used and that the typical criteria regarding sample size that normally applies to conventional research methodologies is not applicable.

The ability to conduct case studies within a multiple case design is analogous to the ability to conduct six or ten experiments on related topics. Multiple cases are not similar to multiple respondents in a survey or multiple subjects within an experiment. An individual case is considered 'akin to a single experiment'. He emphasises that every case should serve a specific purpose within the overall study and each should be carefully selected with its boundaries explicitly defined. Each case should be studied in its own right and in its context.

The aim of the study was to access information from women who delayed and/ or failed to attend antenatal care (ANC), intranatal care (INC) and/ or postnatal care (PNC). Below are the inclusion criteria that were used for selecting participants:

- Women who did not attend antenatal care but presented for delivery or postnatal care. They are referred to as 'unbooked' women;

- Women who booked late, from 30 or more week gestation, but presented for intranatal and postnatal care. They are referred to as 'late booked' women;
- Women who delivered immediately within 10 minutes on arrival at the health facility or those who delivered in an ambulance, irrespective of their booking status. They are referred to as women with 'born before arrivals (BBA)';
- Women who delivered at home, later presented to the MOU for postnatal/ neonatal care irrespective of their booking status. They are referred to as 'home delivered' women;
- Women who booked on time, at least from 20 weeks of gestation and who attended both intranatal and postnatal care. They are referred to as 'booked' women.

The first five categories are commonly classified as high risk groups in obstetrics whilst the 'booked' women are classified as 'low risk' cases. The last category, the 'booked' was included, although they attended maternity care. This was seen as one way of strengthening credibility of the study; that is, to include participants that might not support the study assumptions. Women with pregnancy complications though classified as high risks were not included in the study as this group would have been referred to the hospital as MOU have capacities to manage uncomplicated cases.

The final sample was made up of 16 participants. Patton (1990) argues that the underlying principle of gaining rich, in-depth information should guide the sampling

in qualitative research. A sampling strategy is adequate if it generates appropriate and relevant information and sufficient quality data. This was the case with these participants who are as follows:

- One unbooked woman
- Four late booked women
- One 'born before arrival' woman
- Four home deliveries
- Six 'booked' women.

It was not the aim of the study to compare the MOU, hence no reference is made about which MOU each category of participants is drawn from. The MOU were selected because they are different in regard to staffing and clients they serve. The majority of staff at all MOU except for Michael Maphongwana, are predominantly Coloureds[3] and so are the clients attending these MOU. Michael Maphongwana is situated in a (Black) African township, Khayelitsha with their staff being the same race. The physical location and layout were also taken into consideration.

Participants were selected purposively whilst they came for postnatal care, and others whilst they were waiting for their relatives to fetch them, after they had delivered at the MOU. Although there is one woman categorised as 'unbooked', there were four, the other three have been categorised under 'home delivery' as well to avoid overlap.

3.4 Research Methods: Interviews

One of the most important sources of data for a case study is the interview (Yin, 1994). Data were collected by using an interview guide (Appendix A) with semi-structured and open-ended questions. The interview guide was developed from concepts emerging out of the conceptual framework of this study, namely, gender and human rights issues. Language experts translated it into Afrikaans and Xhosa versions. All three interview versions, namely, English, Afrikaans and Xhosa were piloted and the shortfalls were corrected.

3.5 The Pilot Study

A pilot study was conducted to examine our abilities as researchers (research assistant and I) to conduct a case study interview and also to observe some factors that might have a direct bearing on the phenomenon under study. Miles and Huberman (1994) suggest that, unlike in quantitative research approaches where the pilot study is for the purpose of testing reliability of the instrument, a pilot study in qualitative research strengthens the researcher's ability to collect and record information accurately. A pilot study was conducted with three women who met the criteria for inclusion in the study. Two women were interviewed whilst attending postnatal care 3 days post delivery whilst one was interviewed within 2 hours post delivery. Women are discharged from the MOU 6 hours post delivery if there are no complications, and are requested to return 3 days later, then after 6 weeks. The research assistant assisted in conducting two of the pilot studies and this was part of

her research training. Her role was to accompany the primary researcher, myself, to assist in interviewing Afrikaans speaking participants. Women who did not form part of the final sampling were selected from three separate MOU. All three translated versions of interview guides which were in each language were used.

3.5.1 Pilot Study Results

The interview guides were modified and one of the questions "In your opinion do you think the health facility has violated your human rights?" was excluded. The participants appeared to lack understanding of the concept "human rights" within a health context. It also emerged that it was better to interview clients during immediate postnatal. During this period, women were able to generate more information and they seem to be relaxed. At this stage they are normally in the waiting room waiting or postnatal ward already dressed waiting for relatives to fetch them. The woman who was interviewed after her intranatal care was reluctant to speak because she feared to 'badmouth the sisters (nurses)' as they might treat her badly when she comes for postnatal care in three days to come. From observation, I realised that it was too soon for her as she just delivered, and was still tired. It was at her best interest to interview at that stage.

3.6 Data Collection Procedures

Written permission was sought from the Community Health Services Organization (CHSO), which manages the MOU in the northern area of Cape Town. Additional

permission was obtained from the management of each MOU to access clients' clinic records and participants. The researcher first checked on the clinic records that were kept at the nurses' station whether the available clients met those categories required by the study. If there was a client meeting the sampling criteria, the researcher would ask permission to talk to her privately in one of the private consultation rooms where I would explain the study then ask her permission to participate in the study. All participants were required to sign a consent agreement (see APPENDIX B). Women were allowed to keep their newborns with them during the interview to avoid 'separation anxiety' that may affect the interview process.

Most interviews took about one hour. The whole data collection process and analysis took place over a period of four months. The research assistant and I exchanged visits to each MOU at least once a week during this period to check whether we could access these categories of women. I also made arrangements with the midwives at the MOU to phone me when women that met the criteria presented at the MOU. A research assistant who was trained to conduct the interviews and was orientated to the study assisted in the translation when I interviewed Afrikaans speaking participants. Because my knowledge of Afrikaans language is limited, the research assistant assisted in clarifying misunderstandings between the participant and myself. Field notes and self-reflection notes were all written down during and after each interview, as elaborated in the data analysis chapter.

3.7 Gaining Access And Entry

Purposive sampling was chosen for the study as it allows one to select participants that provide the required information. Most participants were approached at the postnatal area whilst waiting for relatives and friends to fetch them. Others were approached whilst coming for neonatal care which normally occurs on the second day after the mother-baby diad is discharged from MOU. For one participant who delivered at home, the interview occurred at her home because she "had lot of things to do". One of the participant's husband was against the interview fearing that "she will get into trouble". She was adamant that she wanted to be heard, and that 'something needs to be done about this clinic'. Some participants were not happy to use their real names on the consent agreement form for fear of victimization by the health facility staff even though they indicated that they would never visit to that particular clinic again. At Michael Maphongwana, clients were reluctant to be interviewed. Some were concerned that the interview was going to take most of their time, which according to them, was wasted already because of the long waiting. Three participants who were approached from this MOU refused to be interviewed because they assumed that the interview was the ploy because I wanted to recruit them for HIV/AIDS counselling and testing[4]. Also, it seemed as if women were reluctant to be interviewed because it seemed that the MOU itself was inundated with researchers who were keen to interview them.

3.8 Data Analysis Procedures

The taped recorded data were transcribed verbatim and then the Xhosa and Afrikaans versions were translated to English afterwards. According to Yin (1994), data analysis should occur simultaneously with data collection in order to determine whether evidence from various sources intersects on a particular set of facts. Potter (1996) identifies 20 different approaches to qualitative analysis, whilst Talbott (1995) identified 26 approaches. In this study, an eclectic approach to qualitative analysis was used. This involves blending deductive and inductive analytic approaches (Potter, 1990; Norwood, 2000) as elaborated below.

3.8.1 Deductive reasoning

The aim of using a deductive analysis was to convert the data into manageable units. After the verbatim transcription of tapes, the data was coded and sorted according to categories related to the study questions, namely, why women delay seeking care and why they do not attend antenatal care. After that the data was sorted and categorised into broader themes related to the conceptual framework. The themes as discussed in chapter 2, are: (1) gender roles and relations, and (2) human rights issues. The latter entails availability of maternal health facility, accessibility of maternal health facility, quality of care, human dignity and respect, information received from health facility and discrimination against by health facility. Detailed discussions of these areas are in chapter 4.

3.8.2 Bracketing

This strategy was utilised after deductive reasoning was applied. Any researcher's preconceived ideas and opinions regarding the phenomenon that potentially cloud and distort the findings were set aside (Talbot,1995). However, because of the nature of this study, such preconceived ideas, knowledge and opinions regarding the phenomenon were not completely rejected. Rather, for the rigour of the study, a reflexive journal was kept to record my personal attributions. A further discussion on self-reflexivity is on section 3.10 in this chapter.

3.8.3 Inductive phase

Themes were identified, and defined from each category as mentioned above. They were labelled and named according to concepts derived from the conceptual framework (known as sensitising concepts) and also from those used by participants themselves (known as indigenous concepts) (Talbot, 1995). The main aim of the inductive phase was to provide answers to the study research objectives. The themes were developed first within each case and then across cases. The discussion on themes across cases is in chapter 5.

3.8.4 Integrative phase

Patterns and relationships between themes both within and across research objectives were developed. The following questions as suggested by Talbot (1995,p. 386) were in my mind during this phase of analysis:

- "In what subgroup of cases does this theme appear?
- In what context does this theme occur?

- Under what conditions does this theme occur?
- What are the perceived causes of this theme?
- What are the consequences of this theme?
- How does this theme co-vary with other themes? ".

Once relationships between themes were identified, the themes were woven together into an integrated whole. The aim of this phase was to develop a framework on accessibility to maternal health care. Yin (1994) proposes the use of evidence from 'negative case' analysis for development of theory. Negative case analysis was performed with information elicited by booked women. Further discussion on this is in chapter 6.

3.9 Reliability & Validity

Lincoln and Guba (1985) argue that qualitative studies have different criteria to quantitative studies in establishing reliability and validity. One of the criteria to be used in ensuring internal validity is trustworthiness that is measured by the following: credibility, transferability, dependability, and conformability. These were applied in the study and they are presented in the form of table as follows:

TABLE 3.9 : Strategies For Credibility

CRITERIA	APPLICATION TO THE STUDY
1. CREDIBILITY	
1.1 Prolonged engagement	▪ Data was collected over 4 months ▪ Researcher spent 5 years in the setting and is familiar with the setting. She does student clinical supervision every week. And this indicates thorough knowledge of the field.
1.2 Reflexivity	My personal attributions and investment in the research was reflected. A journal was kept to reflect on experiences that might impact on the findings.
1.3 Triangulation	**Multiple Sources triangulation**: Comparing perspectives of several participants was done by doing cross case analysis with 16 case studies from 6 different settings **Theory triangulation:** By using both gender and human rights approaches as conceptual framework.
1.4 Authority of Researcher	▪ The researcher is experienced in multiple case study design; she used same design for her master's thesis. ▪ The researcher supervises research and teaches research at postgraduate level
1.5 Negative Case analysis	By involving low risk maternity women, booked women, as part of sample. This is essential for theory development.
1.6 Peer debriefing	This was done by presenting the study to two disinterested colleagues who probed the researcher's biases and this provided the researcher with opportunity to work on emerging hypothesis

2. TRANSFERABILITY	Retrievable case study database, namely, field notes, audio tapes, case logs is kept for other interested researchers and participants to examine the evidence to formulate generalization of findings
3. DEPENDEBIILITY	▪ An independent reviewer from the Medical Research Council audited the process from data collection to report writing. The reviewer has experience in qualitative research. ▪ The research supervisor reviewed all the steps of the research process ▪
4.CONFORMABILITY	An audit trail was developed to keep an account of the whole process from data collection and analysis.

Yin (1994) maintains that the quality of case study depends on three principles, namely: the use of multiple sources of evidence; the establishment of a case study database; and the maintenance of a chain of evidence. These were applied in the study as already stipulated on the above table.

3.10 Self- Reflexivity

In qualitative research, unlike in conventional studies, the role of the researcher is important and it should not be divorced from the phenomenon under study (Holloway & Wheeler, 1996). They posit that the researcher's values and that of participants are a essential part of the research, and also, his/her social identity impacts on the way in which s/he creates meaning. Silverman (1997) maintains that there is no research that is value free. My social identity as a young Black African woman who grew up during apartheid and post apartheid South Africa where socio-political shifts have occurred on issues related to gender and human rights among

other things, and also for being socialised in African culture, might have impacted on how I constructed my experiences as both a maternal health recipient and provider, and also as a maternal health educator. These experiences subsequently, might have impacted on how I constructed knowledge regarding the phenomenon under study.

This might have influenced my selection of the study's conceptual framework, methodology, and the model generated from this study. Furthermore, these personal attributions might have influenced the study's research findings, and that is accepted in qualitative research as long as the researcher reflects on these and reveal her /his investment in the study. The researcher should keep a reflexive journal to enhance the rigour of the study by recording those experiences, and this was done. Maykut and Morehouse (1994) support the above argument. They write:

> *...if knowledge is constructed, then the knower cannot be totally separated from what is known...and that the way we understand the nature of reality directly affects the way we see ourselves in relation to knowledge .*
>
> (p.11)

Because the researcher is an instrument in data collection, and that s/he brings her/his experiences to the study, s/he becomes an authority in the phenomenon under study. This is enhances trustworthiness and authenticity of the study (Maykut & Morehouse, 1994).

My investment in this research is related to my involvement as a Maternal and Women's health lecturer and I hope to make use of the findings for my students who are maternal/ women's health providers. Meleis (1985) emphasises that the researcher's philosophical and ideological views regarding the phenomenon should

also be mentioned as these may influence the selection and development of the model (objective 5 in chapter 7). I subscribe to the Midwifery philosophy which reinforces that the woman 'knows best'. I also subscribe to feminist principles as they put women's issues at the forefront.

3.11 Ethical Statement

The rights of the participants with respect to her safety from harm, informed consent, voluntary participation, confidentiality, anonymity, dignity and self-respect were applied. These are set within the principles of respect for autonomy, non-malfeasance, beneficence and justice as outlined by the Medical Research Council guide on ethics in conducting medical research (2001). Participants signed a consent form based on those rights (APPENDIX B). The consent form was also available in the three languages used in the interviews, Xhosa, English and Afrikaans.

Permission was sought from participants to conduct the interviews and to use a tape recorder. It is stated in the consent form that they were to remain anonymous and that pseudonyms were going to be used. They were informed that they were not going to be remunerated for participating in the study and that they could withdraw at anytime in the study. The consent also stipulated that the interviews were not part of the health service that they came for and that their participation would not impact on the care they were going to receive. The researchers introduced themselves as researchers from the university of the Western Cape. Permission was also requested from CHSO authorities to conduct research at the MOU (APPENDICES D and E).

Additional permission was also sought from MOU to access the participants. It was stipulated that no service was going to be disrupted whilst the study was conducted.

3.12 CONCLUSION

Qualitative approach with case study design was appropriate to answer the study's research questions: why do women delay seeking care, and why they fail to attend maternity care. Various methods on how the rigour of the study was reinforced have been highlighted, as this is crucial for this type of methodology. The data collection and analysis procedures have been discussed. In the next chapter individual case description is done where deductive reasoning is applied.

Chapter 4

PRESENTATION OF FINDINGS: INDIVIDUAL CASES

Introduction

The previous chapter dealt with research design and methods. This chapter reports on the research findings through a presentation of case. Cross case analysis with discussion is presented in chapter 5. Qualitative scholars on case study design caution that each case in a case study report stands alone, allowing the reader to understand the case holistically (Patton, 1990; Yin, 1994; Stake, 2000; Robson, 1997; Maykut & Morehouse, 1994; Miles & Huberman, 1994). It is crucial that each case be written such that it does not differ from the actual interview, and should be supplemented with the excerpts from participants. Cohen et al (2000) describe and equate the case study report as to the television documentary. They maintain, *"it is important for events and situations to be allowed to speak for themselves rather than to be largely interpreted, evaluated or judged by the researcher* (p.182). Lincoln and Guba (1985) agree this case study report can become so voluminous that the information may sound repetitive and monotonous to the reader when same information is generated from across cases.

Yin (1994) proposes that the participants not the researcher, should tell their story, and that a case study report should not differ from actual raw data, it should present the " *most compelling data so the reader can independently come to a conclusion...* " (p.32). The researcher should "*provide cases rich in information, rich in the sense that a great deal can be learned from a few exemplars of the phenomenon in question* (Patton1990, p.55).

Furthermore, when writing a case study report, Munhall and Boyd (1993 p.311) emphasize, "*...there are no rules or standardized procedures...the researcher must become immersed in a process of composing and, often, artistry*". They suggest the following, which were applied in this study:

- An explication of the problem or issue;
- A detailed description of the context/setting within which phenomena occurred;
- A complete delineation of the processes and transactions in the setting/context that is relevant to the focus of the inquiry" (Ibid p.333).

However, they caution that 'relevancy' should not mean exclusion of data that do not support the researcher's conclusions, but relevancy in relation to the most critical evidence or the fair treatment of all cases. This was taken into consideration in the study by providing information regarding my assumptions and biases regarding the phenomenon under study that emerge whilst collecting the data. Patton (1990) also argues that because the researcher is the instrument in qualitative inquiry, the report should include information about the researcher. This has already been discussed in chapter 3.

That the findings should be presented as true to participants' stories in a truthful, objective manner as possible, and should include supporting and challenging information was noted when presenting this data. The case studies have been described comprehensively and holistically so as to paint "lifelike and realistic pictures" of actual participants in their own language (Munhall & Boyd 1993; Yin, 1994; Lincoln & Guba, 1985; Patton 1990). Each case is presented with all it's boundaries defined and with excerpts from participants. However, the cases are presented in the context of broad categories from the conceptual framework and this might give an impression of restricting the information gathered. This approach, according to Miles and Huberman (1994) is the best option, as data gathered from case studies tend to be large and overwhelming, and thus needs to be organised. More details about the themes gathered from within these broad categories are presented in the next chapter. Cases are presented according to the inclusion criteria that were required for the study as mentioned in the previous chapter.

Patton (1990) suggests that the descriptions of cases should be comprehensive, and should *"include myriad dimensions, factors, variables, and categories woven together into an ideographic framework"* (p.148). Furthermore, he emphasizes that, each case must stand alone, presented and understood as an "*idiosyncratic and unique phenomenon"* (p.150). For "thick description" purposes, participants' socio-demographic factors and their obstetric history are presented (see APPENDIX A, an interview guide). The socio-demographic data include the following information about participants: Age, Race, Ethnicity, Home Language, Marital Status, Occupation, Highest standard passed, Type of Housing, Number of people in the household, Length of Stay in the current housing, and Distance to health facility.

The Obstetric history entails: Gravida, Parity, Age at first pregnancy, Current pregnancy spacing, ANC in previous pregnancy, and Medical History. These are described and discussed extensively in the next chapter on cross case analysis.

The findings of each individual case are also presented and defined within the key concepts from the study's conceptual framework. This is also to meet the requirements of deductive reasoning analysis that were discussed in chapter 3. Below are the broad themes drawn from the conceptual framework as mentioned in chapter 2, and from the study's research objectives. They are used to organise the presentation of the findings:

- Gender Roles and Relations
- Reason(s) and /or Perceptions why women delay seeking care or fail to attend antenatal care
- Availability and Accessibility of a maternal health facility
- Quality of maternal health care
- Discrimination by the maternal health facility
- Information received from the health facility
- Human Dignity & Respect
- Observations and Opinions on the delivery of maternal health service

Below is the description of case studies according to inclusion criteria as discussed in the previous chapter. The final sampling of the study was drawn from these categories of women as shown, with cases being presented according to these categories:

- **Category one**: The Unbooked. There was one woman who did not attend maternity care.
- **Category Two:** The Late booked. There were four women who presented late for maternity care.
- **Category Three:** The "Born before arrival". There was one woman who gave birth at the MOU less than 10 minutes of arrival.
- **Category Four**: The Home deliveries. There were four women who delivered at home.
- **Category Five**: The Booked women. There were six women representing this category.

4.1 CATEGORY ONE: UNBOOKED

There was one woman interviewed who presented in this category. There were also some women who did not book that I categorised under the category 'home delivery' to avoid overlap of the information. Those participants generated more information about why they delivered at home than about why they did not attend antenatal care. The woman interviewed did attend antenatal care in her previous pregnancy. As mentioned earlier, pseudonyms are used for the participants; she is named Ms A to ensure anonymity.

4.1.1 CASE STUDY A.

Demographic data and Obstetric History

Ms A is 22 years old, cohabitating with a partner, both staying with her parents in a council house in a household of eight other people. She has lived in the area for four and half years, and has passed standard seven. She works mostly in the evenings as a bar lady. She delivered her first child who is now two years old at the hospital because she was diagnosed with high blood pressure. She describes an event where one nursing sister kept calling her a " *16 year old*" which she felt was humiliating as she was about 20 years by then, "*...this one sister, I don't think she liked me much, she said to me 'this about you sixteen year old"* . She delivered the second child at the MOU where she did not book. The MOU is within one and half hours walk which, according to her is quite a distance.

Table 4.1.1 (i) Demographic Data

Age	Race	Ethn	Home Lang	Marital Status	Occup ation	Highest Std pas	Type Hous	No of Hous ehold	Lengt h of stay	Distanc e to Facility
22	C	N/A	Afrik	Cohabita Ting	Bar Lady	7	House	8	4,5yrs	More 1hr walk

Table 4.1.1 (ii) Obstetric History

Gravida	Parity	Age at 1st pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancies	Medical History
2	2	19	2	Nurse Sister kept on Referring to her as a 16yr old although was 20yrs, and this was annoying her.	Blood Pressure Problems in previous pregnancy

Reason(s) for not attending antenatal care

She indicated that she was not given time off from work to go and book and when she had the time, " *something else cropped up".* She also felt that the clinic was opening too early, " *they want women to book and then they only open from six o'clock or from certain time...they must give everybody a chance who may come late...for me it was far to come. I would not be able to get up at that time".*

Gender Roles and Relations

She indicated that she is receiving support from her boyfriend, and " *if I say one night I do not want to cook food, then he will do it ..., and with this pregnancy, it will be more because it is a boy".* She felt her job impacted on her pregnancy by making her exhausted, "*...since my pregnancy with my son it was hectic, for me, because I always felt tired, I always felt lethargic...and the baby caused me lots of backache, I always felt like lying down...I worked until the last, till a month".* She indicated that in spite of the hard work combined with pregnancy, her boyfriend was of help, assisting with house chores.

Human Rights Issues

Availability of maternal health service

As already indicated above, the clinic's times of service were a problem to her. Furthermore, she was turned away when she came late and this was not acceptable to her. When probed whether she had to go back home and come the next day, "*Yes, 'it's too late, come tomorrow morning six o'clock".*

Accessibility of a health service

The physical distance of the health facility was a problem, as she has to walk more than an hour, *"...for me it was far to come".*

Observations and Opinions on the delivery of maternal health service

She felt that sisters have a negative attitude towards women who are unbooked, the stern question of *"why didn't you book?'- as if I did not care, or was not interested"* made her uncomfortable. She highlighted how she was concerned about midwives "*chasing people away"* and that " *sisters must understand that it is not easy to bear children, one can make a mistake by not pushing*" (this relates to her current pregnancy experience, she did not want to elaborate because she did not want "*to badmouth the clinic").*

4.2 CATEGORY TWO: LATE BOOKED

There were four women interviewed who met this category. All women interviewed were booked for antenatal care from 30 weeks of gestation which is the last trimester of pregnancy. They delayed attending antenatal care, but attended intranatal care. They are named Ms B, C,D, and E to maintain anonymity.

4.2.1 CASE STUDY B.

Demographic data and Obstetric History

Ms B is 46 years old, married and was at the clinic to give birth to her fourth child. Although unemployed, she is responsible for cooking for her husband and his employees. Her highest education passed is standard six. The family (husband and herself with other three children) have lived in a council flat for more than 22 years. Her eldest child is 23 and the youngest is 10 years, with the baby now, she had her first child when she was 22. In this current pregnancy, she booked late at 34 weeks gestation although she attended maternity care in the previous pregnancies. According to her, she was diagnosed with high blood pressure in the previous pregnancy. The nearest health facility where she delivered with this pregnancy is less than one-hour walk.

Table: 4.2.1 (i) Demographic data

Age	Race	Ethni-City	Home Lang	Marital Status	Occup	Highest Standard passed	Type Housing	Number Hhold	Length of stay At flat	Distance to Facility
46	C	N/A	Afrik	Married	Unemplo-yed	6	Flat	5	22yrs	Less 1 hr Walk

Table: 4.2.1 (ii) Obstetric History

Gravida	Parity	Age at 1st pregnancy	Current Pregnancy Spacing	ANC in previous Pregnancies	Medical History
4	4	22	10 yrs	Satisfactory	Blood Pressure

Reason(s) for delaying attending antenatal care

She highlighted lot of reasons, which included the following, her "old age", she felt embarrassed to be pregnant at age 46. She also felt that there was no need to go for booking as she can make her own tablets for blood pressure by mixing herbs and medicine bought from chemist. Another reason given is that she has to be at home to cook for her husband, "*...my husband is a builder, he comes home at anytime during the day. He is rude when he wants food and then have to give food to his friends as well, that gives me stress*".

Gender Roles and Relations

As mentioned above, she cooks for her husband and his crew. During weekdays, she wakes early in the morning to prepare for the two school going children and for the eldest child who is working and this tires her. *"Yes as I said, I must get up in the morning to put bread in for the children, for the children, for the one who is working and the other one who attends school, then my husband arrives home at anytime, makes me run up and down, so that there can be bread and this and that"*. Also, she mentioned that, "*...children I can't take it, they give me headaches, the children tires one. You are tired, you have to cook, do the washing and have to do everything what a mother is supposed to do*".

When asked if her husband supports her, *" yes, not emotionally, but at least he is working and I get my pay on Friday, he gives me my money so that I can buy food".* Her husband was concerned about her attending of antenatal care clinic, *"he did ask me once or twice, whether I attended clinic yet, then I told him no, I don't feel like it and he didn't worry to ask me again".*

Human Rights Issues

Availability of a maternal health facility

For the two times she attended antenatal care, *"the sisters are nice and that they are not rude, because you see, we differ from one another...there is a difference between sisters, but the sister who attended to me was definitely not rude, they treated me good... I won't say staff that is not true, it was ok for the times I attended the clinic".*

Observations and Opinions on the delivery of maternal health service

Based on previous pregnancies and current pregnancy, she felt that lot of women are not eager to go to clinics because of long waiting hours and one has to get up early in the morning and " *when you get to the clinic they only work up until a certain total".* Also, *"...sometimes you have to wait for a long time, you sit and get impatient and you are hungry...the people get impatient, talks loudly and that all".*

For ways on how to improve the facility, she suggested " *point number one, friendliness, when one arrives at labour ward...where I delivered, some of the sisters are unfriendly, but some are nice. The people whom I spoke to said they don't want to go there, because the staff is rude and ugly toward patient".*

4.2.2 CASE STUDY C.

Demographic Data and Obstetric History

Ms C is 26 years old married and staying with her husband in a two- roomed informal house. They have been living there for two years. She works as a part time cleaner, and her highest standard passed is matric. She takes a taxi to antenatal clinic which is a satellite clinic offered by staff from another MOU because it is more than half an hours walk, she also states that she can't walk there because it is dangerous. The antenatal clinic and delivery place are not at the same place; all clients attending the satellite ANC deliver at MOU that is about 30 kilometres away from the ANC. She has two other children, the youngest is 2 years old, with one miscarriage because of blood pressure problems with the previous pregnancy. She had her first child at age 19. She did attend antenatal care with previous pregnancies and she was not satisfied with the treatment she received at that time. With this pregnancy, she attended clinic from 34 weeks and attended three visits.

Table:4.2.2 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marit Status	Occup	Highest Std Pass	Type Housing	No. Hhold	Lgth of stay	Distanc Facility
26	C	N/A	Afrik	M	Cleaner	Matric	Informal	4	2yrs	Taxi

Table: 4.2.2 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
4	3 and 1miscarriage	19	2	Bad, delivered baby alone	B P in the previous pregnancy

Reason(s) for delaying antenatal care

Long waiting hours at the clinic was a major problem, "*one has to go to stand very easily in the morning at clinic 'X'. From 5 o'clock, one has to go and stand there, you have to stand outside, because they only open the gates at 7 o'clock for the patients... the sisters only come at 9 o'clock to help the patients, and they only help a certain amount of people...*". The long waiting time was also described as having an impact on baby sitting, "while I was still pregnant, I have to go early so that I can come back to the one who is looking after her because the eldest son goes to school. You see, Mrs, the people want to be paid and all that". She had a bad experience with the previous pregnancy by delivering the baby alone, "I went there in the evening, then I had her alone, there were no sisters present, they sat down and drank tea and were knitting. When they came, she was born already... say now what would they have told me if the child was dead, or so, because that sister told me 'like this, like this, you want to murder your child' after I told her the child was born".

Gender Roles and Relations

Ms C was released early from work to go and book, but taking care of her children had an impact. She indicated that it would not have been a problem to go to the clinic if she didn't have to wait the whole day. She has to come back early to prepare for the school going child when he comes from school, and "*...to come back to the one who is looking after her (*babysitter for her two year old*)...people want to be paid and all that... ".* Her husband who is the decision maker at home did enquire about when she is going to book, but when she asked him to take care of the children, he was at work.

Human Rights

Availability of maternal health service

Antenatal clinic opening times was a problem, "*one has to go to stand very easily in the morning at X clinic. From 5 o'clock, one has to go and stand there, you have to stand outside, because they only open the gates at 7 o'clock for the patients... the sisters only come at 9 o'clock to help the patients, and they only help a certain amount of people, then you don't have to go to the clinic for a lot of times*".

The clinic is a satellite that opens once a week. They have to wait for the relief staff from other MOU in order to be serviced, "*during the winter then the pregnant people must stand outside and it is raining and is cold...then they only come at seven o'clock to open the gates. From seven o'clock they have to sit until nine o'clock and from there they help the people and they only help a certain amount of people. The other people who is standing there since five o'clock must go home again, they don't even get helped*"

When probed about the statement about other people having to go home again, she answered "*say there's now 60 pregnant mothers in the morning, they will perhaps help only 40 pregnant mothers. The other 20 must go home again and get another date to come back, but they got up early in the morning just to stand infront of that locked gates*".

Accessibility of maternal health service

In spite of her observation that midwives come late, she felt that "*...the service is good because it is X clinic's people who are now helping. They are ok...If your health wasn't good, then they let you wait for the doctor, they recommend it, I saw the doctor regularly*". The major problem she highlighted was the delivery place that is separate from the ANC (Ms C was interviewed after delivering at MOU 'Z' whilst she attended ANC at clinic 'X'), "*people have to go to trouble to get somebody to take them to MOU'Z', it is very far...they could build a labour unit closer to the people of this area, you see Mrs*".

Quality of care

She felt that midwives at MOU do not have patience with people, "*there is sometimes inexperienced mothers and youngsters and it is their first time and don't know what is waiting for them, then they must be patient with them*". What she experienced with the last pregnancy still haunted her, ""*with this one who is now two, I went there in the evening, then I had her alone, there were no sisters present, they sat down and drank tea and were knitting. When they came, she was born already... say now what would they have told me if the child was dead, or so, because that sister told me 'like this, like this, you want to murder your child' after I told her the child was born*".

Information received

She is satisfied with the information received, "*...they informed the pregnant mothers of alcohol abuse, smoking, HIV and AIDS and there was a lot of counsellors. They were very good...with the AIDS testing and everything, it was*

treated confidential".

Human Dignity and Respect

In this current pregnancy she indicated that she was happy with the treatment, *"everyone was seen separately, and examined and the test taken. When you got the results, then you are entirely alone with the Sister...".*

Observations and Opinions on the delivery of maternal health service

She was elaborating on the issue she raised that midwives have no patience, " *...can see a reason why other pregnant women do not want to go to clinics, it is for their own benefit and own health and it is dangerous".* She highlighted that she has heard of lot of people saying, *"they are not treated properly at MOU Z"*. Clinic staff coming late, *"I was there only three times"*, and according to her, this was happening to others as well. She indicated that people do not like standing and waiting, " *I don't know why they don't build carport at clinic 'X' so that the people can have shelter and it is dark".*

4.2.3 CASE STUDY D.

Demographic Data and Obstetric History

Ms D is 38 years old, married living with husband and other child in a three-roomed township house. They have been living there for 13 years, and she teaches in a local school. In addition to this full time job, she volunteers at hospice and at a local library. She had her first child at the age of 29 and she booked early. She had high blood pressure problem in both pregnancies, *"it was only at the end of my pregnancy,*

and not serious enough to be hospitalized...I only had to rest and be patient, not really a problem".

Table:4.2.3 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Status	Occup	Highest Std pass	Type Hous	No. HH	Lgth of stay	Distan facilit
38	C	N/A	Afrik	Married	Teacher	Post Matric	T.ship House	4	13 yrs	Transp

Table: 4.2.3 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
2	2	29	9 yrs	Booked Early, and 'was bad'	Had BP problem in both pregnancies

Reason(s) for delaying antenatal care

She mentioned that she hated that she has to sit and wait at the clinic for many hours without being attended to, "*with my previous pregnancy I did everything early, but I do not like the place itself, the community health center, to sit there for hours and wait to be helped- especially as a result of the people's attitude, the staff, so I didn't think it worthwhile to sit there all the time, since I was fairly healthy during my first pregnancy...did not think it was necessary*". . According to her, she experienced the same in the previous pregnancy. If it was not for her raised Blood Pressure, she argued, she would not have come again for antenatal care.

Gender Roles and Relations

Her eldest child is 9 years old and her husband gives her a lot of support in child rearing. He also accompanied her to ANC and during labour in both pregnancies. Her work did not have impact on her late booking as *"I can ask time off from work"*.

Human Rights

Availability of maternal health facility

She felt that sitting and waiting for a long time,"*put me* (her*) off"*.

Accessibility of maternal health service

She highlighted staff attitudes and the way they address people, *"after my first baby, when you take your baby to the clinic, in general, the staff is unfriendly and impatient, not really something that encourages you to – to motivate you to go to the clinic...with the people that sit there and wait, like I said, not very nice"*.

Quality of Care

She understands that staff work under pressure, and that they have a lot of work to do, but according to her, what she experienced was that *"they (*staff) *treat people like sheep or an animal, it's just another thing that have to happen, that they have to do...sometimes they (staff) forget that each woman who has a baby - that baby for her is special, and for you it's a special time go through, maybe, because they work with thousand of babies, it doesn't matter anymore, it's just another baby and another mother, but for you as a mother, even for the father- it's a special time – your child is special for you..."*.

She was concerned about the unhealthy physical environment of the health center, "*since everybody that's ill sit in one area also the TB sufferers and the coughing, you sit there in a place which should be clean and hygienic, sitting there with your baby fearing that she is exposed to the germs* " (the latter refers to her previous experience when she took the eldest child to baby clinic). When she was probed to elaborate on the statement, " *from the point of an expecting mother, or a woman who had a baby already, I would like to see a separate area for pregnant women instead of them having to sit in between all other people, and that there are enough toilets... when you can change nappies or clean your child at the moment they don't have anything like that...* "

Discrimination

She felt that staff 'became nice' after they found out that she is a teacher, "*if they know you, then you are treated nicely... they talk to you and make you feel good, but I think it's got a lot to do with whether you know the staff there, then it's much nicer...So once or twice when I was there, there were some of the staff that I knew, and that was nice*".

Information

She felt that the information given at the health center is not relevant, "*I think it should be a more comprehensive type of care that what it is given now, should be taught about- like what to expect when labour starts, general things like how to care for yourself, personal hygiene and nutrition...especially with the first baby, when the baby is born*". At the same she felt that what she was given was not really health education, "*they only look at whether you are ok, how far your pregnancy is...they*

never, for instance, show videos about the birth of a baby...so one can see and know what lies ahead".

Observation and Opinions on maternal health service delivery

She noticed that when staff know the patient is a professional person, "then *they treat you much better than the rest, somebody off the street, and not looking so nice, if they find out you are a teacher or a nurse then they treat you much better then the others".*

She mentioned that she knows of people who have been treated badly at this MOU, for example a friend who was badly treated whilst in labour. According to her, they said bad things to her friend like *"you knew how to lie down, and now you can't push', and that type of thing, there is definitely a lot of that even if it didn't happen to me personally".*

The physical environment of the MOU was viewed as inadequate for not having enough toilets, no area to change baby nappies for pregnant mothers with small children, and no areas "*where they (staff) can educate mothers with videos shown and maybe magazines that you can read while you, - in any case have to sit and wait to be attended to".*

4.2.4 CASE STUDY E.

Demographic Data and Obstetric History

Ms E is 34 years old, married with other two children. She is from the rural Eastern Cape and came to Cape Town during this pregnancy for the purpose of receiving quality maternity care. She left her family there and in Cape Town she lives with her sister-in law and her family. Her youngest child whom she left at Eastern Cape is 3 years old. She reassured me that, this is a very common scenario that pregnant women come from the Eastern Cape to seek maternity care in the Western Cape province, and go back to their families after delivery. She had her first pregnancy when she was 28 years old and she attended antenatal care in both other previous pregnancies, and she highlighted it was very bad, and that was prompted her to come to Cape Town for this current pregnancy. Although she was categorized as late booked, she was already booked at Umtata although no blood investigations were done.

Table: 4.2.4 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marit Status	Occup	Highest Std passed	Type Hous	No. HH	Lgth of stay	Distan facility
34	Afric	Xhosa	Xhosa	M	Unemp	10	Townsh ip house	9	3 months	Less 1hr walk

Table: 4.2.4 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
3	3	28	3	Bad Treatment	Nil

Reason(s) for delaying antenatal care

She was already booked at home, in rural Umtata, but the in-laws encouraged her to come over to Cape Town where she would get better care.

Gender Roles and Relations

There were no gender roles and relations impacting on accessibility to maternity care, other than she left her family, husband and children at home which is about more than 1000km away from where she is now. Her husband supported this decesion, because of the previous experience she had at that clinic, "*things are not the same, at Umtata, they can't see everything, these clinics do not give same care. At Umtata we were coming for ANC visits once a month, but here we come twice a month*".

Human Rights

Availability of maternal health facility

She indicated that she was happy with the opening time of the clinic which is 07:00, but, "*they will start working late, I assume that the reason that they always start late is that they have their own problems, but once they are started they move quick*".

Accessibility of maternal health facility

She is very happy and satisfied with everything. When probed about staff attitudes, "*all the time we (patients) are blaming nurses, nurses hit you or shout at you when you (patient) do not have nice approach to them...we need to ask ourselves (patients) why does the nurse behave this way, some people do not want to open their mouths*

and talk when a nurse ask something – how do you expect the nurse to know what do you want?". Other participants from this facility raised concern about birth companions being allowed in the labour ward, and when probed about this, " *at the clinic, nurses do tell us that that only husbands can come to give support because the other person becomes rude to staff, becoming know all person- with attitude, so no other person is allowed"*.

Quality of Care

She is satisfied with the care she received, "*here they identified that I have infection (sexual transmitted infection) which was not identified at Umtata,- at Umtata they can't see everything"*. She applauded the staff for giving them twice a month visits. In every ANC visit, she highlighted that "*nurses tell us what to do, like you must rest your legs up even during the day not at night only, at Umtata, they did not tell us*". She feels that there are lots of things she used to take for granted as a pregnant woman, now she understands those things after being exposed to this health facility.

Observations and Opinions on maternal service delivery

She felt that "*sisters are very helpful, they become rude only when provoked by patients, and when we come here, we (patients) just stand there and expect that because one is a nurseshe must understand what is wrong with you, you are unable to tell the nurse when did your labour pain starts...you expect the nurse to know it"*. She blamed patients for being impatient, "*we are expecting that when you come at 07:00 you will be served at 07:00"*.

4.3 CATEGORY THREE: BORN BEFORE ARRIVAL

There was one woman interviewed presenting this category, the others were categorized under 'home delivery' because they delivered at home and or reached MOU after 10 minutes post delivery. She attended antenatal care but delayed intranatal care. She will be named Ms F.

4.3.1 CASE STUDY F.

Demographic Data and Obstetric History

Ms F 28 years old , and is a Nursing Aid at an old age home. She is cohabitating and both have two other children. They have been living in a two- roomed informal house for 18 months. The current pregnancy spacing is 6 years and she had her first child when she was 19 years. She attended ANC in all her pregnancies. She delivered in the car on her way to hospital.

Table: 4.3.1 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Stat	Occup	Highest Std pas	Type Hous	No. HH	Legth of stay	Dist facility
28	C	N/A	Afrik	Cohab	Nursing Aid	8	Informal	4	18 months	Less 1hr walk

Table: 4.3.1 (ii) Obstetric History

Grav	Parity	Age at 1st pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medic History
3	3	19	6	Although there were long queues, this was not a problem because there were old midwives who were nice to patients.	Nil

Reasons for delaying intranatal care

She indicated that she was sent back home when the staff found she was not in true labour then she struggled getting transport when the pains got stronger, "w*hen going into labour, and go to the MOU, and you are still far, then they send you home, you are not in labour, you must go back, I mean now you do not have transport, and you live far from the MOU".* When I highlighted that the MOU is not so far, and that she did mention that she does not have transport problems, she blurted out with anger, *"I didn't even feel like going there to deliver...the things I heard of how they leave the mothers alone in the labour ward, and someone told of how her baby almost got born in the toilet".*

Gender Roles and Relations

Her boyfriend is supportive and usually drops her clinic card at the clinic on his way to work in the morning when it's her clinic day.

Human Rights

Availability of health facility

She indicated that the clinic routine starts as late as at 08:00 o'clock although clients are expected to arrive early. What bothered her mostly was when "*people that comes after you are called first...and when you complain the sister becomes rude and abusive".*

Accessibility of health facility

She indicated that there are some staff members that are "*nice, treat you well but*

others are rude and do not greet...they just want to show who is in charge there, I mean we are human beings...". Sharing a waiting room with other sick patients when one is pregnant was repulsive, "*I feel why do pregnant women have to sit among all other sick people, they should have separate place to sit*". She felt the environment is not conducive to pregnant women, " *the place is so cold, loveless, when you get there chairs uncomfortable, pregnant women in their last month or so, their backs cannot take anymore".*

Quality of care

She did not like the idea of being examined by students, " *I feel it's not right, rather a sister who knows".* Being examined in groups with other patients was a problem, "*...you wait and sit until sister comes about 08:00 o'clock...wait until eventually they come and call you in threes or fives...".*

Discrimination

She mentioned that the nurses treated her 'nice' when she was wearing her nurse's uniform although in other occasions it was the opposite, "*..when she saw me in my uniform...then she was ever so nice, I mean, why are they rude until they see you in uniform, now they are nice to you, but the rest, they still treat you very badly. That's not right, they should treat everybody the same, it's not right to have favourites".*

Information

She was not happy with information given, "*they only give us HIV information before testing, no other health education or so".*

Observations and Opinions on maternal health service delivery

She believes that patients are rude to sisters if sisters are rude to them, and that patients do not want "*five star treatment, but, I mean to be treated like a person, like a human being*". She has observed patients being sent away by MOU and that that's why they, "*think it's best to go to where people can support, assist you not to be sent away, then you have to come back here, 2 or 3 o'clock in the night...when they come late, then they get shouted at, why do they come so late or book, so they rather stay away*".

4.4 CATEGORY FOUR: HOME DELIVERY

There were four women interviewed for this category. All but one attended antenatal care in their previous pregnancies, the other was pregnant for the first time. Among the four, three did attend ANC in the current pregnancy, one did not book because she indicated that "she was turned away". The women are named Ms G, H, I and Ms J.

4.4.1 CASE STUDY G.

Demographic Data and Obstetric History

She is 17 years old, single pregnant for the first time. She lives with parents and siblings in a formal township house. The distance to health facility is half an hour walk. She has lived in the area for 12 years. She attended antenatal care in this current pregnancy.

Table: 4.4.1 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Status	Occup	High Std passed	Type Hous	No. HH	Length of stay	Distance facility
17	C	N/A	Afrik	Single	Student	9	Formal house	5	12 yrs	Less 1hr walk

Table:4.4.1 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical history
1	1	17	N/A	N/A	Nil

Reason(s) for delaying intranatal care

According to her, she was sent away back home because she was not in labour. "*...I went to the labour ward twice and both times they sent me home, I felt it was the right time the second time I was there... but then they send me home again, the next morning I delivered on my way to the labour ward*".

Gender Roles and Relations

There were none that impacted on accessibility to maternity care.Her parents are decision makers at home and she intends to go back to school, maybe her mother will look after the baby although she works.

Human Rights

Accessibility to health facility

The staff at ANC clinic, "*treats you nicely and quickly, there was no problem... they don't keep information to themselves, they are very helpful*". She highlighted that

she was not happy with the way labour ward staff treated her, *"I was there twice, and they send me home, even though the pain was stronger and stronger...they shout at the patients that come in,... they should treat patients better when they are in labour ward".*

Observations and Opinions on maternal health service delivery

She was very emotional with fear written on her face when she said, " *Pregnant women need a lot of support during labour, "...(*whispering voice) *a lot of women are afraid when pain starts, when they are really afraid,* (pause), *when they are really afraid (*voice rising), (long pause) *when they think about when the baby must come, and then they are really afraid (*whisper)*".*

(Probing further on this statement did not work, at that moment my instinct told me that she needed counselling, which was done.)

4.4.2 CASE STUDY H.

Demographic data and Obstetric History

Ms H is 27 years old, unemployed staying with boyfriend and their 6 year old child in a one –bedroom informal house. They have been living in the house which is within 15 minutes of walking distance, for two months. Highest standard passed is standard 8. She attended maternity care in the previous pregnancy and she highlighted that she was not happy with the treatment she received. It is the same MOU where she delivered the last baby.

Table: 4.4.2 (i) Demographic Data

Age	Race	Ethn	Home Lang	Marital Status	Occup	High Std pass	Type Hous	No. HH	Length of stay	Distance facility
27	C	N/A	Afrik	Cohab	Unempl	8	Informal housing	4	2 months	Less 1 hr walk

Table: 4.4.2 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
2	2	21	6	Bad Intranatal care	Nil

Reason(s) for not attending intranatal care

Ms Hs previous delivery experience as she highlighted was bad as result with this pregnancy she indicated that she did not feel like delivering there again, *"I was scared that something can happen to my child...I thought I will rather finish at home, because I am not going there with the second one!! (*almost shouting)*"*. Realizing her outburst, "*I had transport but my father was still at work (*one with transport), *my father gets home past five, then auntie Nettiie let me get up so that, then I pushed..."*

Gender Roles and Relations

Her parents are not staying far from her 'shack' which she shares with boyfriend and older child. They support them financially and everything, boyfriend not working.

Human Rights

Availability of health facility

Opening times and long wait was a problem regarding antenatal clinic, "*getting up early and that you have to stand there, but they take long, take long to open the clinic*". And that , "*...a person has to sit an hour or 2 hours before they help you*".

Quality of Care

When she came to MOU after she delivered at home, she reported that she was ignored and was kept sitting with the child and afterbirth until her boyfriend went to call them again. She felt that they should have at least came and looked at the child. In the previous pregnancy, she mentioned that the treatment was very bad, " w*here we deliver, you lie down alone, they are busy with their work, when you have to shout then they will come...I still had my clothes on...and then I felt I'm not going to make it...then I struggled to take off my pantie because I felt the head and then I shouted, then they came and said, 'couldn't I told them along time ago', then I said, 'but you said that I will deliver after 2 hours...to the second one, then I din't want to, I was scared that something can happen to my child*".

Human Dignity and Respect

She indicated that being seen in groups was not a problem,"*we got in two at a time, and we go again to another sister...* ".

Observations and Opinions on maternal health service delivery

Pregnant women have to walk alone early in the morning, *"sometimes in the rain"*, and that they only open the gates late. Staff must understand that, *"we got stuff to do at home"*.

4.4.3 CASE STUDY I.

Demographic Data and Obstetric History

Ms 'I' is 29 years old, single, unemployed, living with her parents in a 9-roomed house in a suburb. She has been staying there for 12 years. She walks more than an hour to the health facility as there is no direct taxi that goes there. She has a 10 year old child and attended maternity care in the previous pregnancy. She indicated that she had blood pressure problems in this last pregnancy but these did not warrant hospitalization.

Table: 4.4.3 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Status	Occup	High Std pass	Type Hous	No. HH	Length of stay	Dist facility
29	C	N/A	Afrik	Single	Unem	10	Suburb	8	12 yrs	More 1hrwalk

Table: 4.4.3 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
2	2	19	10	Good	B Pressure in previous pregnancy.

Reasons for not attending intranatal care

She reported that there was no transport available to take her to hospital, *"it is no use to ask people who have transport because they always have something to do".*

Gender Roles and Relations

Her mother is a decision maker at home and is very supportive. She did not want to discuss anything about baby's father.

Human Rights

Availability of health facility

That one arrives at 5 o'clock and leaves midday was a problem, *"Ok, I understand there is*[sic] *a lot of people and that there's always not enough staff, but otherwise, everything went well".*

Accessibility to health facility

Her response was, *"Everything's got positive and negative, some staff are friendly, they don't shout you around, they explain and help you, some have attitude "wait until I can help you...they were cross because I delivered at home".*

Quality of Care

She reported that she had a problem of not being seen by a doctor, *"they always said he couldn't come, why not, like on the 22nd I had to see him so they told me he wasn't there".* She has heard stories about labour ward, *"they don't have patience, I heard a*

*lot about sisters at MOU 'P', I am glad I delivered at home because when I got there (*after delivered at home), *I could see they are bit rough".*

Information

She highlighted that she was not happy with the information she received during ANC, "*they didn't give us any education, they only told us not to smoke or use alcohol when you are pregnant, and that we know".*

Human Dignity and Respect

She indicated that she was not satisfied with level of privacy whilst attending ANC, "no *privacy, everybody is in and out, patient or sister will come in"*

Observations and Opinions on maternal health service delivery

She felt that staff were taking a lot of ANC patients that they cannot manage, and that's what cause people to wait long. She also believes that for the people who do not attend antenatal care, "*they are lazy to wake up, 5 o'clock you get up...and you will leave there late".*

4.4.4 CASE STUDY J.

Demographic Data and Obstetric History

Ms 'J' is 24 years old living with boyfriend and other three children in a one-roomed informal house. They have been staying there for 8 months, and she walks less than an hour to the health facility. She had her first child at age 18, and she had

miscarriage with her last pregnancy which was 11 months ago. She indicated that she was not happy with the treatment she received with the last pregnancy and when she went for antenatal care as result she did not book. She delivered three days ago and neighbours went to MOU to ask nurses what they should do as mother and baby needed to be seen. They indicated that the mother was reluctant and afraid to come to the clinic for 'check up'. They indicated that they were there when the baby was born, but were not involved.

Table: 4.4. 4 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Status	Occup	Highest Std pas	Type Hous	No. HH	Length of stay	Distance Facility
24	C	N/A	Afrik	Cohab	Unempl	5	Inform house	5	8 months	Less1hr Walk

Table: 4.4.4 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
4	3 (1 passed away)	18	11months	Bad Treatment	Nil

Reason(s) for not attending intranatal and antenatal care

She mentioned that she was sent away twice during ANC because it was full and was shouted for coming late. She also indicated that, *"They didn't treat me right...my husband told me 'now you stay away from that clinic, you don't need that those sisters shout at you for nothing".*

Gender Roles and Relations

She is unemployed, selling odd things to public. Boyfriend ('husband'), looks after her, although *"children not his"*. He helped her in delivering this baby. She mentioned that, *"my husband is my family, (*when asked about whether he helps with

child rearing and domestic chores) "*...he has nothing to do with the children, I look after the children myself, he doesn't do anything for the children, he also doesn't help me with anything*".

Human Rights Issues

Availability of health facility

She mentioned that the clinic policy of taking only limited numbers for ANC was problematic.

Accessibility to health facility

She highlighted that staff attitude was a problem, "*...if they don't keep on sending you home everytime, and that you, like a human being, maybe I would have gone, but my husband said I musn't go there anymore, so I didn't*".

Human Dignity and Respect

She felt that health workers are disrespectful, "*the people who have to help you (health workers) have no respect, they have no regard for you, they have no respect for a person...they said to me "you hotnot, stand in the line', so I said to him, 'who is your hotnot'...they don't know how to speak to people...*".

Observations and Opinions on maternal health service delivery

She reported that she had a concern that staff send patients away without helping them, "*they treat people like dogs, then you rather stay away from there, and that's why people don't go, they don't really want to help you, they want to sit all day and*

drink tea, they don't want to help you...they abuse you...no, that's why people don't go, one doesn't have all day to sit there...we also have feelings...".

CATEGORY FIVE: THE BOOKED

There were six women interviewed who met the criteria for 'booked' women. All six women attended antenatal care in their first trimester and delivered (but one) at the MOU. The average ANC visits was eight. All the women attended maternal care in their previous pregnancies. The women will be named Ms K,L,M,N,O and P respectively.

4.5.1 CASE STUDY K.

Demographic Data and Obstetric History

She is 32 years old married with two other children, the youngest being 5 years old. Together with the husband they have lived in their township three- roomed house for 6 months. Her highest standard passed is seven. The health facility is within walking distance but the husband takes her and fetches her from clinic. Although unemployed, she helps full time in husband's business which is a garage. She attended maternity care in both other previous pregnancies. She had her first pregnancy when she was twenty, and the current pregnancy spacing is 5 years.

Table: 4.5.1 (i) Demographic Data

Age	Race	Ethnic	Home Lang	Marital Status	Occup	Highest Std passed	Type Housing	No. HH	Length of stay	Dist to Facility
32	C	N/A	Afrik	Married	Unempl	7	T/ship house	5	6 months	Private Transport

Table 4.5.1 (i) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
3	3	20	5	Long waiting hrs were a problem	Nil

Gender Roles and Relations

Ms K helps her husband with administration in his business. The whole family spend the whole day there, "*we return around 9 o'clock...it's seldom that we get home early, we get something to eat there, when we get home we all go to bed, it's night then so there's not really time for...(*tailing off, nothing to say). Husband does help with domestic work, "*...he is supportive, but I feel he can do more, like this morning...*".

Human Rights Issues

Availability of health facility

She felt that she had to wake up early, and wait for the whole day then nothing satisfying after that long wait, "*sitting there from early morning all day and long waiting when they eventually call you then it's not even such a long story...the other day the doctor came about eleven,...*". And also, "*Nurses and doctors starting*

routine after tea time, already past 10 o'clock".

Accessibility to health facility

She mentioned that midwives are not approachable, "*and when she (midwife) says 'she is going to be nice today', you do not want to spoil that by asking her questions". (*she made a lengthy story about one incidence – see APPENDIX about specimen of interviews). Staff attitude, "*...there are some (*staff*), a few that treat you well, but the majority, they only do it because they have to, not really because they want to...one needs to feel that you want to go to the clinic, look forward to going, but you don't really feel like going".*

Quality of care

Procedures performed were questionable, not satisfying according to her, "w*hen I went in, the doctor felt my chest over my jersey (*mimicking auscultation) *...and just like that, I was, - I don't think I was in there five minutes, before I was done, yes without lifting my jersey, and then I said to myself, we sat here all day just for this (*raising voice)*, five minutes, and we were done, I mean, (*tailing off) *... everybody complained about the doctor who comes eleven o'clock and you are barely in, then you come out again...".* She argues that the treatment is bad because of free maternal services, "*yes it's for free, that's why they treat you like that...if you had medical aid then you get the best care".*

Unhealthy physical environment, "*I don't think thy wash the floors, the toilets also...it makes it uncomfortable for you to sit there for long periods and we know that when you are pregnant you need to go to the toilet often...".*

Information

About health education, she felt midwives did not do it enough, "*...there is nothing, HIV or something like that, I think they should, people sit there all day, it shortens the day"*. When probed further, she mentioned that midwives do health education when there are students, "*because they had to get a mark*".

Human Dignity and Respect

Being seen as a group, "*when the doctor came, they called three women at a time...* ". Also, *"in the treatment room, whatever, there's three at a time, at the same time, one has BP taken, the others urine is tested...so it's is a, - because I wanted to know how they go about sterilization,... it was such a crowd"*.

Observations and Opinions on maternal health service delivery

Ms K felt strongly that some women, *"don't get treated well, that's why they rather stay away*". Whilst she thinks some deliver at home because, *"you can lie down when you want...sometimes at MOU, they say no, you can't go to the toilet, in the labour ward, no you can't go, you must lie still..."*. Long waiting hours, "*one has to come early for the clinic but will leave very late*". According to her, she experienced this in both her previous and current pregnancy.

4.5.2 CASE STUDY L.

Demographic Data and Obstetric History

Ms L is a 16 year old standard 9 student living with her parents in township house.

Gender roles and Relations

None of the above were identified. She lives with her parents and two siblings. She is still at school, and would like to go back in the following year.

Human Rights

Availability of health facility

She indicated that she was not happy with the opening times, "*they say they open at 07:00 but start routine at 08:00 or past ten then they will go for tea and will be back past 12:00 as a result you will go home very late*".

Accessibility to health facility

Staff ignoring the patients, working slow although they have started late, "*they keep on talking and laughing to each other... They will leave you and they all go to lunch*".

Discrimination

She highlighted that the labour ward staff shouted at her when she screamed of pains , " *... you were not supposed to get pregnant at your age (*16)". She was not happy that her mother was not allowed to come with her to labour ward because, "*only husbands allowed to support their wives in labour ward, nobody else is allowed*".

Information

She was satisfied with the information received and was helpful, " *they told us signs of labour, what must you do when water breaks, and baby kicks or something...*"

4.5.3 CASE STUDY M.

Demographic Data and Obstetric History

She is 25 years old widowed and remarried. The husband moved to Johannesburg three months ago to look for work as his "*work contract was expired in Cape Town*". She lives in a three-roomed township house which she shares with other 6 adults in addition to her other three children. Highest standard passed is standard 9, and she sells sweets to public (street vendor). She was pregnant for the fourth time, with the first child 9 years old and the youngest, 18 months old. The father of her first two children was murdered. She attended antenatal care in all her pregnancies and has been "*feeling stressed since the last pregnancy*". On the day of the interview, she was from the hospital to continue with antenatal care at the MOU. She was interviewed whilst she was attending ANC at her 39 week gestation.

Table 4.5.3 (i) Demographic Data

Age	Race	Ethn	Home Lang	M. Stat	Occup	High Std	Type Housing	No. HH	Length of stay	Distance facility
25	Malay	-	A	widow	Vendor, House wife	9	T/ship House	11	10yrs	Less 1hr Walk

Table 4.5.3 (ii) Obstetric History

Gravida	Parity	Age at 1st pregnancy	Current Pregnancy Spacing	ANC in previous Pregnancies	Medical History
4	3	16	18 months	Attended	Stress

Observations and Opinions on maternal health service delivery

She attended antenatal care in the previous and current pregnancy because she wanted to talk to somebody, "*like at the moment, I feel very depressed, I need someone to talk too...*". She feels other women do not attend maternity care because she feels they cannot cope, *"you get lot of cases where women can't go, sometimes I also struggle to get out to do the things that need to be done, for I have three children and nobody to help...so you can't get to the clinic, and if you get there the next day, they have long sermon to tell you, that you don't care, and don't care about yourself, so why should they care"*.

She also felt that there were enough sisters to carry the routine and finish quick, only that , *"they walk up and down too much"*.

Gender Roles and Relations

Her husband left to look for a job, but still has not found one. Her husband was murdered and left her with two children. She is not happy living with these children with the current in-laws if she is going to clinic, "*there are other children here too, in the yard...and because they are step children, there is always trouble here at home*". And also, "*...and when you leave, the children are still asleep, but you don't*

know, when they wake up, if they ask piece of bread, whether somebody will give them some". She does have her family not far with whom the children can stay whilst she is at the clinic if the family was willing to, but, "*my family is totally against me, you see, I was Muslim, but the man (*current husband*) I have is Christian,- they are staunch Muslims, they say I knew what I was getting myself into, so I don't get any support, and the man (husband) sits in Johannesburg".* About arrangements she made on this day regarding children (it was little boy who was with her), "*...like this morning, when I had to ask my brother in law to look after the daughters, the boy who is handful to rather take him with me...things are always not too nice at home, and things happen at home...the girls are quiet, very reserved, like they get along with all".*

Human Rights Issues

Availability of health facility

Long waiting a problem, "*you sit there all morning, my back was aching, I was hungry, tired and sleepy, and I thought about the children at home, whether they had something to eat already, and they call number one, then two numbers, so it goes..."* When asked about this particular day, "*I waited quite long, I was number 74, like I said there were many before me..."*

When asked to elaborate about availability of food, "*there are machines installed where you can buy chips and cool drinks, but then people don't always have money to buy...people get hungry, they faint or become nauseous, or just feel sick".*

Accessibility to health facility

She indicated that some staff are 'nice' and some ,"*abusive and rude, like this morning...*(she relate a story about not bringing urine from home for testing because she did not have a pee when she left home at 5 o'clock)*...but that was my own fault...but she made me feel quite bad, she was rude in front of all these people sitting there...* ". She mentioned that there is always lot of gun shooting happening on the way to health center and this mostly happens at the early hours of the morning when one is supposed to rush for clinic appointments, "*...you don't know what dangers are on the road, sometimes I can't get away early, I don't know who is at the corner, they shoot around here day and night...* ".

Quality of Care

She indicated that she was happy with the treatment she received in labour ward with her previous pregnancy, "*...they clean the baby, and you clean yourself, there's showers..* ". In this pregnancy she felt that sisters do not have time to talk to people although there are lots of them, "*like today, I feel depressed, I need someone to talk to...if there maybe could be a sister in the unit that would take time, maybe ask one of the mummies that have time, maybe, to talk to me about anything, a person gets very emotional when pregnant...you feel you can't cope, feel depressed...(*becoming tearful)".

Information

She mentioned that she was not satisfied with the information she received, "*...only thing they teach now is AIDS, but I feel it's no use they preach and preach about same thing, nothing like nutritional talks ...* ".

4.5.4 CASE STUDY N.

Demographic Data and Obstetric History

She is 22 years old, single, staying with parents in 4-roomed township house where she was born herself. She passed standard nine, and works part time in a building contract. The health facility is within half an hour walk from her home. She is pregnant for the first time, and has no medical illnesses in this pregnancy.

Table: 4.5.4 (i) Demographic Data

Age	Race	Ethn	Home Lang	Marital Status	Occup	High Std pas	Type Hous	No. hhold	Length of stay	Distan facility
22	C	N/A	Afrik	Single	Contract worker	9	Towns hip house	4	22	Half hr walk

Table: 4.5.4 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
1	1	N/A	N/A	N/A	Nil

Observations and Opinions on maternal health service delivery

She felt that women will not come to clinic when they were treated badly," t*hey think is better to be at home then they get all the support that they do not get from sisters".*

She observed that there is staff shortage, and she would like, "*if they could start earlier so you do not have to sit and wait...and for the sisters that do not treat you nice...".* She attended antenatal care because "*I was afraid there might be something wrong with the baby or that I maybe had contrasted a disease".*

Gender Roles and Relations

She stays with parents and is responsible for preparing food and tiding up, *"just normal girl's work"* . Now that she is pregnant she has stopped working, but not is not on maternity leave.

Human Rights Issues

Availability of health facility

She was not happy with the health facility routine that commences late, and long waiting hours a problem were s problem to her.

Accessibility to health facility

She mentioned that the health facility staff shouted at her for forgetting to bring her urine from home for testing. She indicated that some midwives *"have good attitude and their support is good, some have bad attitude like ignoring you when you greet her, or when asking her something, she will ignore you and not answer".*

Discrimination

She indicated that she was concerned that staff do not give pain killers and do not give support when one has pains, *"I do not know if it's their job to help but if they cannot do it, to allow your family to support you in the labour ward".* When probed further, *"I asked (*whether she can bring companion) *but they said only if you are married".*

Information

She indicated that she was happy with information given, "*at the antenatal clinic the sisters look if the baby is progressing...I think it was actually good, then you know if you got a disease and how to deal with it*". She was happy with information they gave her about family planning and that she can choose any method she wants.

Human Dignity and Respect

She indicated that she was happy that everything was kept confidential when they were explaining things to her, but was not happy with examination, "*no privacy, anybody enters the examination room...there is only one room that they divide and there is constantly people entering the room at antenatal clinic*". And in the labour ward, "*I gave birth with other people in the room*".

4.5.5 CASE STUDY O.

Demographic Data and Obstetric History

Ms O is 29 years old, single staying in a two-roomed house with her mother, her sister and her child, boyfriend (Ms O's) and her other two children. She has been living in the area for more than 10 years and she walks more than one hour to health facility (no taxis to other area). She had her first pregnancy when she was 18, and has attended maternity care in all her pregnancies. She booked early because, "*...sometimes you do not know in which condition the child is or your own health during your pregnancy*".

Table: 4.5.5 (i) Demographic Data

Age	Race	Ethn	Home Lang	Marital Status	Occup	High Std pass	Type Housing	No. HH	Length of stay	Distance facility
29	C	N/A	Afrik	Single	Unemply	6	Township house	7	19	More 1hr walk

Table: 4.5.5 (ii) Obstetric History

Gravida	Parity	Age at 1st Pregnancy	Current Pregnancy Spacing	ANC in Previous Pregnancy	Medical History
3	3	18	9	Attended, all good	Nil

Observations and Opinions on Maternal Health Service Delivery

She highlighted a lack of support in the labour ward for pregnant women, "*at the maternity ward, there must be someone to support you, just to support you, like an older person*". She felt that although, " *sisters take their time, and I am in hurry, younger generation (*young patients) are *not mature enough to take advise (*from sisters/ midwives*), they are childish and think like children*". She was relating to a question raised about her observations regarding health care delivery, "*They are only stepping into the adult world, now they do not find it interesting to talk to adults*".

Gender Roles and Relations

She mentioned that she has support including financially, by her boyfriend, her mother and her sister. She has a huge responsibility for tidying up ,"*her mother's house and doing laundry*", and there is no exemption from this task irrespective of her pregnancy.

Human Rights

Availability of health facility

She indicated that midwives work very slowly and they commence routine very late.

Accessibility to the health facility

They make jokes and laugh and , " *no words that can describe how wonderful they are*". The only thing is, "*no person to support you when you have pains*".

4.5.6 CASE STUDY P.

Demographic Data and Obstetric History

Ms P is 40 years old living in a one-roomed (divided) house with her boyfriend and her other 5 children. She is not employed, and she has been living in the house for 4 years. She takes a taxi to MOU, but walks to ANC clinic as these are not in the same premises. Her eldest child is 22 years old, the youngest 2 and half years old. She attended ANC in the previous pregnancy, and she says it was bad. At the time of the interview, she was waiting for an ambulance to take her to hospital for sterilization; she just had a baby 6 hours ago at the MOU. She was pacing up and down outside MOU, and when asked, she needed to smoke desperately which she did eventually (during the interview).

Table 4.5.6 (i) Demographic Data

Age	Race	Ethn	Home Lang	M. Stat	Occ	High Std pas	Type Housing	No. HH	Length of stay	Distance facility
40	C	-	A	Cohab	nil	2	T/ship 1 bdrm	11	4	> 1hr transport

Table 4.5.6 (ii) Obstetric History

Gravida	Parity	Age at 1st pregnancy	Current Pregnancy Spacing	ANC in Prev. pregnancy	Medical history
6	5	18	2,5 yrs	Bad	Nil

Observations and Opinions on maternal health service delivery

She booked for antenatal care because she thinks, *" it's for your own health, and the baby inside you".* She highlighted that she can't tolerate the clinic (ANC) because it's so full and only managed by two midwives, "*the place is so chaotic...a terrible day hospital, everything on top of another...baby clinic right there next to clinic (ANC)...".* She is also concerned that they do not give iron tablets anymore, "*when you book at other clinic you get these tablets, but now since I book here, I didn't get, they say I must go and buy at the chemist...is that what they are supposed to do?".*

Gender Roles and Relations

Ms P is a housewife who takes care of the house chores and childrearing for her five children. She depends on her live-in partner for financial support. She also does laundry, clean their houses and look after children of her four neighbours to supplement family income but , "*not much...it's only the children's father that gives me something, I have two children that are his, he supports, also sometimes with their upbringing....there's this one, boy* (not his), *that's very unruly, very wayward...".*

She has a mother who wants her to get married to her live in boyfriend, "*my mother, who says we must decide...".* She takes the small children to her mother a day before

she goes to the clinic, she cannot take them with, "*they take very long, we get out there quite late, past four...they forget that we have other things to do, children...*".

Human Rights Issues

Availability of the health facility

She indicated that she was not happy with the waiting that start from 6 o'clock, and that staff starting the routine from 8 o'clock, "*you sit and wait there, things happen a little faster from eleven o'clock or so...then they start calling out names two at a time...only two sisters working there and there are loads of people, they easily take hundred per day...and when they take tea then they take very long...they should start earlier or move faster or have more sisters... , the doctor comes at eleven, Tuesday or Thursday, I don't know...*".

Accessibility to the health facility

She highlighted she was satisfied, "*the sisters, and the doctor, they are not too bad, they make you feel good, when you get out there...it's just that there are too many people*". She indicated she is always not looking forward to go to the clinic because it is full, "*...every time I go there, there's a fight...like the people come, ...and the sisters take no note, like you have no idea, a terrible day hospital...* ".About being hungry, "*we bring food or we have to buy, sometimes you don't have money, there are shops*". She was not happy about the physical layout that contributes to the congested, "*you come in on one side, then the baby clinic is right there, if they move the baby clinic...*".

Quality of care

She mentioned that she was not happy that she has to buy iron tablets when she used to be given in the previous pregnancies and in other clinics. She thinks that it is the reason that she gets tired, the tablets were going to make feel better "*only the tablets that I had to use, also for my blood pressure, for the tiredness...I don't have money everyday to buy tablets...*".

4.6 CONCLUSION

In this chapter, each case was presented using subcategories gathered from study questions, objectives and from the conceptual framework. In the next chapter, cross case analysis will be done, each subcategory will be analysed using literature control. In the next chapter, a summary of demographic and socio-economic factors will be presented as these are analysed.

Chapter 5

CROSS-CASE ANALYSIS AND DISCUSSION OF FINDINGS

5.1 Introduction

In the previous chapter findings from individual cases were presented using sensitising concepts derived from the conceptual framework and the literature, and indigenous concepts derived from participants. This chapter presents a cross case analysis using themes generated across the participants as a basis for discussion. Interpretation of these findings is discussed in the next chapter. I chose to use the conventional approach of reporting by separating the analysis and interpretation into different chapters and the rationale for this will emerge as the chapter unfolds.

Sandelowski (1998) argues that there is no one style for reporting the findings from qualitative research. Qualitative researchers, she suggests, must choose the most appropriate for their study, but should avoid retelling participants' stories. Rather, they should transform these stories through analysis and interpretation. The researcher must establish a balance between data description, analysis and interpretation. In this respect, description refers to the facts of the cases observed; analysis being breakdown and recombination of data to allow the researcher to see them in new ways; and interpretation is used to refer to the new meanings and

significance the researcher creates from this data (Sandewloski 1998; Patton 1990). The previous chapter dealt with description, this chapter addresses the middle process of analysis.

The purpose of this study was to establish reasons why women delay or fail to seek maternity care. The task in this chapter is for me to ensure that the reader hears these women speaking for themselves through paraphrasing "*with minimal voice- overs*" from the researcher. In this way, the locus of the thesis rests on the evidence from women. It is for this reason that the analysis chapter has been separated from the interpretation chapter, to 'showcase' the women's words. My task is to present my 'take' on those perspectives and voices because "*the generation of ideas can never be dependent on the data alone, data are there to think with and not to think about"*(Sandelowski, 1998, p. 376). In the previous chapter, each case study was comprehensively described on its own and in this chapter the focus is on comparing and contrasting data generated from all cases in order to form a more general explanation.

Most qualitative research scholars fully agree on the difficulties in analysing qualitative case study data (Lincoln & Guba, 1985; Patton, 1990; Potter, 1996; Silverman, 1997; Miles & Huberman, 1994; Yin, 1994; Munhall & Boyd, 1993; Norwood, 2000). They agree on the lack of clarity and guidelines as reasons for these difficulties. Yin (1994) notes that case study analysis is one of the least developed and most difficult aspects of doing case studies, and

> *...unlike statistical analysis, there are few fixed formulas...and the strategies and techniques have not been well defined...instead, much depends on an investigator's own style or rigorous thinking, along with sufficient*

presentation of evidence and careful consideration of alternative interpretations. (p.102).

Patton (1990) also, supports the argument there is no right way to go about organising, analysing, and interpreting qualitative data, "*...it is a process demanding intellectual rigor and a great deal of hard, thoughtful work"(p.146).* Miles and Huberman (1994) agree that this lack of guidance highlights the creative latitude this approach provides to researchers; hence they regard qualitative analysis as some form of 'art'. However, they emphasize, the analysis should be systematic and not inflexible. There are principles or 'cardinal rules' that the researcher should apply in order to produce a high quality analysis. Yin (1994) suggests the following for case study analysis and these were applied in the study:

- Analysis should rely on all the relevant evidence. In the preceding chapter, data from each case was presented with supporting excerpts from participants to give a holistic picture and thick description of each participant.
- Analysis should include other perspectives and or major rival interpretations. Patton (1990, p.159) labels this as 'intellectual integrity'. Competing themes that do not support the phenomenon under study were searched and identified and these were interpreted within other theories such as the bio-medical model. A detailed discussion on this is in the next chapter.
- Analysis should address the most significant aspect of the case study and should focus on the biggest target. The question Yin imposes is why would the researcher go to the effort of doing case study unless he/she addresses the largest issue? It has emerged from the findings that gender

roles and quality of maternal health services are the largest issues that need to be addressed.

- Prior and expert knowledge is another aspect that is important when analysing case studies. Lincoln and Guba (1985) give a comprehensive description on who should write case studies, and one definition that summarises all is that the researcher should be somebody who is a 'paragon'. There were several criteria applied to the study to meet this principle. One important criterion that was applied was for me to become 'intimately' familiar with the 'case' by being the data collection instrument and also being involved in data analysis. I am also familiar with the case study design which I used for my master's thesis. I consider myself an authority in this design, and in qualitative research.

Below follows the cross case analysis and discussion of socio-demographic factors, the obstetric history, and emerging themes from the findings.

5.2 THE PARTICIPANTS: DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS, AND OBSTETRIC HISTORY

The aim of naturalistic inquiry is not to test causal propositions in a study or to generate statistical analysis (Patton, 1990; Maykut & Morehouse, 1994). On the other hand, Pattton suggests that if the study does give rise to ideas about causal linkages, there is no reason for the researcher to deny the readers these 'data based speculations and conjecture' (Patton, 1990, p.158). Patton further warns that when the researcher decides to consider using these causal links, consequences, and interdependent relationships in the study, he/she should avoid falling on the linear assumptions of quantitative analysis by specifying isolated variables that are

mechanically linked together out of context.

Robson (1997), and Miles and Huberman (1994) suggest that the 'data based speculations and conjecture' should not be based on the conceptual framework but on the data collected and these should be context specific. In this session demographic, socio-economic factors and obstetric history, as 'data based speculations' are presented in the aim of giving a holistic and thick description of the participants, one principle of the case study methodology (Yin, 1994).

5.2.1 DEMOGRAPHIC AND SOCIO-ECONOMIC FACTORS

These factors are summarised in TABLE 5.3.1 (i) according to the variables as discussed below. The factors were already presented within individual cases in chapter 4. In this chapter they are summarised across cases.

Age

There were ten women who delayed and or failed to attend maternity care and their age varied from 46 who delayed attending antenatal care to age 17, who delivered at home. The six women who were 'booked' had their ages ranging from 16 and 40. For both the older and the youngest, their reasons were linked to chronological age. The 46 year old woman was embarrassed to attend maternity care because of her age, whilst the 16 year old felt discriminated against by the health facility to the extent that she "*will never encourage any pregnant woman of her age*" to attend the health facility. In the study there were three women with ages of more than 35 years old. In the context of this study, age was a barrier to accessibility of maternity services in

relation to the women being discriminated against by the health facility. These women, as mentioned earlier, did attend maternity care in their previous pregnancies, when some of them then were 20 years or younger.

Marital Status

Most participants had partners with whom they were either married to or cohabitating. Those who were cohabitating had other children with these partners whilst others had already had children with someone else before cohabitating. In the study, as indicated in the earlier chapter, some women indicated that their partners did encourage them to attend maternity care, but were not available to look after the children to relieve the women to attend the maternity care. One woman who delivered at home mentioned that her partner supported her decision for not attending maternity care because of the poor treatment she received when she came for her first antenatal care visit. There were four women who were single.

Occupation

The occupation of participants varied from formal and informal employment, and to unemployment. Those unemployed were occupied with, for example, husband's business. The kinds of occupations of those who were employed included domestic work and nursing aid. There was also one teacher in the group who was forced to use the public health facility because of problem with her medical aid. Both the employed and unemployed women had difficulties in accessing maternity care with reasons being 'no time off' for those who were employed, and for other reasons pertaining to child rearing for those who were unemployed. Both the teacher and the

nursing aid felt that the health facility treated them 'nicely' when the midwives found that they were 'professionals'. This variable links up with other variables, namely, education and type of housing as they define the economic status of the woman.

Education

One participant, a practising teacher had a post matric qualification in teaching and the rest had highest education falling between standard 5 and 9, this was both among women who attended and those who did not attend maternity care. In the study, both women who were 'highly educated' were, according to them, treated with respect by staff when they found that they were a nurse and teacher, respectively. The interpretation of this is that education becomes a factor to accessibility of quality maternity care when health professionals use it as a way of deciding which clients to receive or not to receive quality care.

Type of housing

There was one woman who had accommodation in a suburb, with the rest mostly staying in the township council houses and others in the informal housing. Those who were married staying in formal houses did indicate that they had co ownership of the house with their husbands. Those who were cohabitating in the informal houses were also sharing ownership of the 'shack' with the partner. In the study some women who delayed maternity care came from both informal settlements and formal settlements including council/ government houses which are equivalent to ghettos of the inner city of United States.

Number of people in the household

The number of people sharing the house varied in each household but in most it was in the range of 5 to10. Mostly other siblings occupied the household. For those who had their 'shacks' in somebody else's yard, they indicated that there were lots of other people with their own shacks who were also sharing the yard. Few of the participants were staying with extended families; as a result some women with other smaller children indicated that they were struggling to get somebody to look after other children when going for maternity care. As mentioned, women in this study had to hire baby sitters to look after their children whilst they were seeking maternity care, and one indicated that she has to pay extra money for baby-sitting.

Length of Stay in the area

The length of stay in the current dwelling varied from one month to 22 years, the majority having stayed more than 10 years in the area next to the maternity health facility. This was applicable to both who presented late and did not attend maternity care, and also for those who attended maternity care.

Distance to Maternity health facility

The majority of participants had to walk more than an hour to the facility and were alternating the 'walk' with the use of public transport such as taxis. The others were living not far from the health facility. There was one whose husband was transporting her. Only one participant expressed the feeling that transport as a main obstacle to access the health facility. From the interviews, women alluded to transport after they had indicated many other problems related to the health facility. One woman who walked less than one hour alluded to crime and gun fighting that

prevails in the area in the early hours of the morning.

One woman indicated that one problem related to the distance was the separation of delivery place from the antenatal care clinic. Although the ANC clinic was within walking distance, she has to deliver at another facility because the existing facility does not provide intranatal and postnatal care facilities.

The demographic and socio-economic factors are summarised below in the form of TABLE 5.3. Although a quantity has been allocated to indicate how many participants from whom a particular variable or theme has been generated, Cohen et al (2000) warn that case studies do not seek frequencies of occurrences, "*significance rather than frequency is a hallmark of case studies*" (p.185).

Table 5.2.1 SOCIO – ECONOMIC DEMOGRAPHIC FACTORS N = 16

VARIABLE	UNBOOKED *n=1*	LATE BOOKED *n=4*	BORN BEFORE ARRIVAL *n=1*	HOME DELIVERY n =4	BOOKED *n = 6*
Age (years)					
> 45	0	1	0	0	0
36 –45	0	1	0	0	1
19 – 35	1	2	1	3	4
< 19	0	0	0	1	1
Race					
Coloured	1	3	1	4	5
African	0	1	0	0	1
White	0	0	0	0	0
Indian	0	0	0	0	0
Marital Status					
Married	0	4	0	0	1
Cohabitat	1	0	1	2	3
Single	0	0	0	2	2
Occupation					
Employed	1	1	1	0	1
Unemployed	0	3	0	4	5
Highest Std					
Post Std 10	0	1	0	0	0
Std 10	0	2	0	1	0
Std 5 –9	1	1	1	3	5
< Std 5	0	0	0	0	1
Housing					
Suburb	0	0	0	1	0
Township	1	3	0	1	6
Informal	0	1	1	2	0
No. Household					
>10	0	0	0	0	1
5 –10	1	2	0	4	3
< 5	0	2	1	0	2
Length of stay					
> 10 yrs	0	2	0	2	3
6 – 10	0	0	0	0	2
1 – 5	1	1	1	0	0
< 1 yr	0	1	0	2	1
Distance to facility (hrs)					
Walk >1 hr	1	0	0	1	1
<1 hr	0	2	0	3	2
Transport	0	2	1	1	3

5.2.2 OBESTETRIC HISTORY

Gravida and Parity

In the study most women were pregnant for the second and third time. Women who were pregnant for the first time were more in the booked category than in the non-attendance of maternity care category. It was evident that women in their first pregnancies have more of a tendency to attend maternity care than when repeating the pregnancies.

Age at first pregnancy

Most women had their first pregnancy around the age category of between 19 to 35 years. As mentioned in the study, most women did attend maternity care in their first pregnancy. There were a few women who had their first pregnancy at the age below 19. The youngest participant had her first pregnancy at age 16.

Current Pregnancy Spacing

In most participants, spacing between the current and previous pregnancy for those who had been pregnant before ranged between 1 to 5 years. There were a few women who had a spacing of 10 years with the rest having been pregnant for the first time. The smaller gap in current pregnancy spacing is highlighted to the fact that most women had other smaller children that they had to look after in addition to their current pregnancies. One woman who miscarried in the last pregnancy had a spacing of 11 months.

Antenatal Care (ANC) attendance in the Previous Pregnancy

As mentioned earlier, most women did attend ANC in their previous pregnancies and they were not satisfied with the care they received. They judged the midwives and the health facility based on these bad experiences and hence some chose not to attend maternity care in the current pregnancy as (themes are discussed in the next section). There were a few who did not have a bad previous experience of antenatal care but could not attend on time in the current pregnancy because of other factors, including family responsibilities amongst others.

Medical History

The medical history relates to any medical condition that one has in the previous and or current pregnancy. Half of the women from those who delayed or did not attend maternity care indicated that they had Blood Pressure problems in their previous and for some, in their current pregnancy. A 46 year old woman who was pregnant for the fourth time and was diagnosed with blood pressure (BP) problems in her previous pregnancy booked late for the current pregnancy because among other things she has to cook for her husband and his crew and therefore she had no time to go to the clinic. When probed further about the impact of not attending maternity care with that medical history, she indicated that she makes her own BP medicine by mixing herbs. The variables related to obstetric history are summarised on TABLE 5.4

TABLE 5.2.2 OBSTETRIC HISTORY *N = 16*

VARIABLES	UNBOOKED *n=1*	LATE BOOKED *n=4*	BORN BEFORE ARRIVAL *n=1*	HOME DELIVERY n =4	BOOKED *n = 6*
Gravida					
> 5	0	0	0	0	1
4- 5	0	2	0	1	1
2- 3	1	2	1	2	2
1	0	0	0	1	2
Parity					
> 5	0	0	0	0	1
4- 5	0	1	0	0	0
2- 3	1	3	1	3	3
1	0	0	0	1	2
Age 1st pregnancy					
> 40 yrs	0	0	0	0	0
36 – 40 yrs	0	0	0	0	0
19 – 35yrs	1	4	1	2	2
< 19 yrs	0	0	0	2	4
Pregnancy Spacing					
>10 yrs	0	0	0	0	0
6 – 10 yrs	0	2	1	3	1
1 – 5 yrs	1	2	0	0	2
< 1 yr	0	0	0	1	1
N/A	1	0	0	1	2
ANC previous pregnancy					
Good	0	1	1	1	2
Bad	1	3	0	2	2
N/A	0	0	0	1	2
Medical History	1 (BP)	3 (BP)	0	1 (BP)	0

5.3 DISCUSSION OF EMERGING THEMES

The reasons for delaying care and non-attendance of maternal care have been described by the participants in this study through a number of major themes that are intertwined. There was no single reason that contributed to women not attending maternity care rather they were multifaceted. Below are the themes identified:

5.3.1 (Lack of) Humane treatment

5.3.2 Safety concerns for the unborn/newborn child

5.3.3 Disorganised health service

5.3.4 Quality of Care

5.3.5 Juggling with family responsibilities

5.3.1 (Lack of) Humane treatment

Most participants felt that midwives at the maternal health services have no culture of caring and they frequently highlighted the dehumanisation that takes place. They felt that this kind of treatment contributed to women's resistance to attending maternity care. One woman commented:

> *They treat people like sheep or an animal, it's just another thing that have to happen, that they have to do...sometimes they* (staff) *forget that each woman who has a baby, that baby for her is special, and for you it's a special time you go through, maybe, because they work with thousand of babies, it doesn't matter anymore, it's just another baby and another mother ,but you for you as a mother, even for the father- it's just a special time- your child is special for you.*[5]

Another partcipant alluded to the fact that patients do not have high expectations but only basic humane care:

five star treatment, but, I mean to be treated like a person, like a human being.

Another participant criticised the top-down approach that she described in the care she received:

...they just want to show who is in charge, I mean we are human beings.

Another participant who opted to deliver at home reported:

They treat people like dogs, then you rather stay away from there, and that's why people don't go, they don't really want to help you...they abuse you...that's why people don't go...we have feelings.

Another participant felt that she made a good choice to deliver at home because midwives have no patience:

...they don't have patience...I am glad I delivered at home because when I got there [for checking the baby] *I could see they are bit rough.*

The same woman described how she had to wait in the passage with a placenta still attached to the baby after delivering at home.

One woman was warned by her husband not ever to go back to the MOU after the treatment she received in the last pregnancy:

They didn't treat me right...my husband told me 'now you stay away from that clinic, you don't need those sisters shout at you.

The same woman was addressed by one health worker with a name she regarded as derogatory:

The people who have to help you have no respect...they said to me' you hotnot[6], stand in the line...they don't know how to speak to people.

Women felt that the majority of staff have no passion to what they are doing, for them it is just part of their routine, it's a job :

> *... they only do it because they have to, not really because they want to...one needs to feel that you want to go to the clinic, look forward to going, but you don't really feel like going.*

Being shouted at the health facility instilled fears for some women and the discomfort of those experiences still lingers with them:

> *...they shout at the patients that come in, they should treat patients better when they are in labour ward. ..A lot of women are afraid when pain starts, when they are afraid* [pause], *when they are really afraid* [long pause], *when they think about when the baby must come, and then they are really afraid*[7].

Some women believed that the free maternal health services might have contributed to this harsh treatment they receive from staff and they believed that it is this treatment that drives most patients away from health services:

> *...it's for free, that's why they treat you like that...if you had medical aid then you get the best care.*

Participants also indicated that midwives were blaming them so they could feel guilty for delaying or failing to attend maternal services. Participants voiced out that the midwives were implying that they (women) were careless about their health and that of their unborn children by not presenting for maternity care on time.

One participant who did not book for ANC felt uncomfortable by the stern question from midwives of:

> *Why didn't you book as if I did not care, or was not interested.*

She concluded by saying,

> *Sisters must understand that it is not easy to bear children, one can make a mistake by not pushing.*

Another participant who attended maternity care and booked early for antenatal care both in the current and previous pregnancy:

You get lot of cases where women can't go, sometimes I also struggle to get out to do things that need to be done...so you can't get to the clinic, and if you get there the next day, they have long sermon to tell you, that you don't care, and don't care about yourself, so why should they care".

For some participants who attended maternity care, when asked about why they attended in spite of the bad treatment they received form the facility in their previous pregnancy, they mentioned benefits from attending ANC.

One participant who booked early gave her reason for attending antenatal care:

I was afraid there might be something wrong with the baby or that I had contracted a disease.

Another participant booked early because:

...Sometimes you do not know in which condition the child is or your own health during your pregnancy.

Not all participants were mishandled by the health facility in the current or previous pregnancy. These participants voiced out that they knew of a friend or acquaintance that was mishandled by the midwives at the facility and this had an impact on them being reluctant to attend maternity care in this current pregnancy. One participant made an example of her friend who was told by the labour ward staff:

You knew how to lie down, and now you can't push...there is definitely a lot of that even if it didn't happen to me personally.

Some participants noted midwives biases and favouritisms toward women of higher statuses. They felt that when the midwives know that a woman is a professional or is known to them, that woman would get special attention and will be the first to be attended by midwives:

If they know you, then you are treated nicely...they talk to you and make you feel good, but I think it's got a lot to do with whether you know the staff, then it's much nicer...

Another participant, a nursing aid felt that her uniform made an impact on her second visit:

When she saw me in my uniform...then she was ever so nice, I mean, why are they rude until they see you in uniform, now they are nice to you, but the rest, they still treat you very badly...it's not right to have favourites.

In spite of the frustrations the participants highlighted that they received from the health facility, others showed sympathy towards midwives. They understood the conditions that midwives worked under. Some felt that midwives had reasons for having this kind of behaviour towards patients because they work under pressure with large numbers of clients they had to see everyday. These are participants who attended maternity care on time in spite of their previous bad experiences with the health facility:

*Sisters are very helpful, they become rude only when provoked by patients, and when we come here, we [*patients*] just stand there and expect that because one is a nurse she must understand what is wrong with you....*

Another one:

the sisters are nice and that they are not rude...there is a difference between sisters...they treated me good.

The same participant when asked about suggestions to improve the health service,

...friendliness...where I delivered, some sisters are unfriendly...the people whom I spoke to said they don't want to go there, because the staff is rude and ugly toward patient.

Another one commended the midwives for their stunning work:

"no words that can describe how wonderful they are....

In conclusion, participants from this study, across their different backgrounds, having attended different health facilities at different stages of their pregnancy, expressed concerns about what they described as the inhumane treatment they receive from health workers, specifically from midwives. Both participants who presented and attended maternity care and those who did not attend maternity care share the same sentiments. Also it should be noted that there were participants who did acknowledge the midwives and commended them of their work but were not happy with some other aspects of health care, for example, lack of privacy.

Several researchers, nationally and internationally, have identified staff attitude as a barrier to accessibility and utilization of maternity services, (Jewkes & Mvo, 1997; Jinabhai, Naidoo & Pinho, 1994; Gcaba and Brookes, 1991; Larsen & van Middelkop 1982 cited by Jewkes, 1997; Myrdal & Potgieter, 1992; Doyal, 1995; Sundari, 1992). There has been several press articles and television news in South Africa about pregnant women verbalising their frustrations about staff attitude and some ended up giving birth on the side of the roads. One article published by newspaper Sunday Sun (13 July 2003) has the title "*Baby's horror: Now mom wants answers from hospital for her sickly child*" where a mother claimed was failed by hospital. Another article published in Cape Argus reads "*Giving Birth is a pain at Gugulethu clinic's obstetric unit*". In spite of the evidence suggesting the regular occurrence of inhumane treatment by health workers, little has been done in either research wise and/ or programmatically to address this serious issue. I hope that the study will bring solutions through proposing a framework on accessibility of

maternal health services.

5.3.2 Safety concerns for the unborn/ newborn child

Some participants felt reluctant to attend maternity care in the current pregnancy because of the bad experiences they had in their previous pregnancies. Mostly these experiences were related to the safety of their newborns. They felt that their unborn children's lives were at risk because of the midwives behaviours, and that they would rather stay home where it was safe:

> *I went there in the evening, then I had her alone, there were no sisters present, they sat down and drank tea and were knitting. When they came, she was born already...say now what would they have told me if the child was dead, or so, because that sister told me 'like this, like this, you want to murder your child' after I told her the child was born.*

One participant believed that the health facility is a danger to women:

> *...can see a reason why other women do not want to go to the clinic, it for their own benefit and own health and it is dangerous.*

One participant who delivered at home alluded to this:

> *I didn't even feel like going there to deliver...the things I heard of how they leave the mothers alone in the labour ward, and someone told of how her baby almost got born in the toilet.*

Another one:

> *I was scared that something can happen to my child...I thought I will rather finish at home, because I am not going there with the second one!*

Participants believed that they were safer to deliver at their homes than to deliver at the health facility. They could not entrust the health workers with their unborn children.

Similarly, Jaffre and Plural (1994) found that in most instances health professionals are often the cause of problems and are obstacles preventing women's seeking care. Dyhouse cited by Baumslag, Jelliffe and William (1994) also, found that women have long been accused by health workers of neglect and have been blamed for infant mortality. Previous studies, however, show that women were unable to access maternity care because of their concerns on their safety with minimal reference to the safety of the unborn child as a barrier to accessibility and or utilization of maternity services. The World Health Organization's (1986) article "*Maternal mortality: helping women off the road to death*" alludes to that. Jewkes et al (1997) used the terms "anxiety" and "fear"' to describe the feelings women had in regard to the treatment they received from health workers during childbirth. These women, who were scolded and beaten by health workers, indicated that they were not returning to the MOU because of this treatment. However, in that study, no reference was made to the safety of the unborn child as a barrier to accessing maternity care.

5.3.3 Disorganized Health Services

Some women observed that health workers and midwives were not properly organised in providing the service, and this was impacting on the waiting times. They felt that although they were expected to arrive as early as 5 o'clock, the health workers were starting the routine as late as from 9 o'clock. Most women agreed that

this was understandable because of the large clientele, but they were not happy that staff start routine very late and waste a lot of time by, for example, *'walking up and down, laughing'* and also by spending too much on tea and lunch breaks that they take at the same time leaving nobody to attend to them in the meantime. In the words of one woman, the tea and lunch breaks become *"a long story"*.

Some participants indicated that they had to walk long distances in the early hours of the morning in gang infested gun shooting areas to access the service, yet, they will be chased away at the health facility if the required total has been reached no matter how early one can be.

> *...you don't know what dangers are on the road, sometimes I can't get away early, I don't know who is at the corner, they shoot around here day and night....*

All participants were not happy with health services that were opening as early as 5 o'clock. One participant who did not attend ANC said:

> *they want women to book early and then they only open from six o'clock or from certain time...for me it was far to come....*

Another participant who presented late for ANC:

> *...From 5 o'clock , one has to go and stand there, you have to stand outside, because they only open the gates at 7 o'clock for the patients...the sisters only come at 9 o'clock...and they only help a certain amount of people...*

For the participant who attended maternity care and booked early for ANC:

> *You sit and wait there, things happen a little faster from eleven o'clock or so...then they start calling out names two at a time...only two sisters working there and there are loads of people, they easily take hundred per day...and when they take a tea then they take very long...they should start earlier or move faster or have more sisters...the doctor comes at eleven....*

One participant summarised the whole picture:

> *You sit there all morning, my back was aching, I was hungry, tired and sleepy, and I thought about the children at home, whether they had something to eat...and they call number one, two numbers, so it goes...I waited quite long, I was number 74...there were many before me....*

Another participant was concerned that the health facility becomes so full that it creates chaos and even the physical layout of the health service was causing more confusion to women:

> *The place is so chaotic...a terrible day hospital ,everything on top of another...baby clinic right there next to clinic [*ANC clinic].

She indicated she always felt reluctant to visit the health facility. Midwives make the situation worse by not monitoring the situation:

> *...every time I go there, there's a fight...and the sisters take no note, like you have no idea, a terrible day hospital....*

Participants were partly blaming the midwives for promoting favouritism and ignoring those who came first:

> *People that comes (*sic) *after you are called first...and when you complain the sister becomes rude and abusive.*

The impact of this long waiting time as highlighted by the participants, was being made worse by the quality of service one will receive after such long wait: They felt that the quality of care they were receiving after such long wait was not worth waiting for:

> *Sitting there form early morning all day and long waiting when they eventually call you then it's not even such a long story...the other day the doctor came about eleven...nurses and doctors start routine after tea time, already past 10 o'clock.*

There were participants who praised the staff about the care they received in spite of the long wait and awkward opening times:

> *The sisters and doctor, they are not too bad, they make you feel good when you get out there...it's just that there are too many people.*

Opening times and long waiting hours as barriers to utilization of maternity services were identified by researchers (Jewkes et al, 1997; Scupholme, Robertson & Kamons, 1991), however few studies linked these to poor clinic organization (Sundari, 1992). In Sundari's (1992) study, the author mentions of inappropriate procedures such as paperwork that caused unnecessary delays in institutional care. A study conducted in Australia by the department of health found that women were not happy with a 3 minute consultation with the doctor. They felt that the 3 minutes was not worth it after a 3 hour wait (Doyal, 1995).

Women in this local study understood the conditions the health workers were working under, but felt that health workers were so disorganised in handling the large clientele by, for example, taking long tea/ lunch breaks at the same time. Lasker cited by Thaddeus and Maine (1994) also, found that corruption by health workers was preventing women from attending maternity care. Women in this study were not happy that health workers were promoting favouritism when they know a client or when the client is a professional.

5.3.4 Quality of Care

This theme is divided into four sub-themes, namely:

5.3.4.1 Unhealthy physical environment

5.3.4.2 Questionable procedures and lack of privacy

5.3.4.3 Health information

5.3.4.4 Support during labour.

5.3.4.1 Unhealthy Physical environment

Women were not happy with the physical surroundings of the health facilities. They highlighted a lot of problems that include: uncomfortable chairs; sharing waiting rooms with other sick patients; lack of child facilities for pregnant women with other smaller children; dirty floors and lack of proper toilet facilities. These conditions, they implied, were appalling and wouldn't make anyone to look forward to visit the facility. Below are examples of excerpts from women.

...Everybody that's ill sit in one area also the TB sufferers and the coughing, you sit there in a place which should be clean and hygienic, sitting there with your baby fearing that she is exposed to the germs.

...And that there are no enough toilets...when you change nappies or clean your child, at the moment, they don't have anything like that....

...the place is so cold, loveless, when you get there chairs uncomfortable, pregnant women in their last month, or so, their backs cannot take anymore.

...I don't think they wash the floors, the toilets also...it makes it uncomfortable for you to sit therefore long periods and we know that when you are pregnant you need to go to the toilet...

You come in on one side, then the baby clinic is right there, if they move the baby clinic....

All women were not happy with these conditions, and these became an add on to other problems they already had regarding the health facility.

No studies located identify unhealthy physical environment as a barrier to accessibility of health services. Some similar studies identify problems related to the physical location of the health facility in relation to transport accessibility, but not in relation to physical comfort (Gcaba and Brooks, 1992; Ndebele, 2000).

5.3.4.2 Questionable procedures and lack of privacy

Most participants who were turned away by the facilities questioned this kind of decision made by those midwives. Most of them, for example, indicated that the health facility turned them away in spite of them being in true labour. Participants questioned the midwive's clinical judgement skills when assessing a woman in labour, for example:

> *I went to the labour ward twice, and both times they sent me home, I felt it was the right time the second time I was there...but they send me home again, the next morning I delivered on my way to the labour ward.*

Questionable clinical judgement skills, were also expressed, during delivery:

> *...I still had my clothes on...and then I felt I'm not going to make it...then I struggled...I felt the head and then I shouted, then they came and said 'couldn't I told them long time ago' then I said 'but you said that I will deliver after 2 hours...to the second one, then I didn't go, I was scared that something can happen to my child.*

According to participants, the problem did not only lie with the midwives, but with doctors at the facility:

When I went in, the doctor felt my chest over my jersey...and just like that, I was, - I don't think I was in there for five minutes, before I was done, yes without lifting my jersey, and then I said to myself, we sat here all day just for this, five minutes, and we were done....

Being examined by student nurses who had no knowledge and experience was found to be unacceptable:

I feel it's not right, rather a sister who knows.

Most participants were not happy with the lack of privacy experienced whist others did not mind this lack of privacy because "(they) we *are all women, there is nothing to be afraid of*". One of those who were not happy with this lack of privacy both during antenatal and intranatal examination had this to say:

*...no privacy, anybody enters the examination room...there is only one room that they divide and there is constantly people entering the room at antenatal clinic...(*in labour ward) *I gave birth with other people in the room.*

Another participant with three children, who was desperate to find about how can she be sterilized, missed the opportunity to ask because of this lack of privacy:

When the doctor came, they called three women at a time...in the treatment room, whatever, there's three at a time, at the same time, one has BP taken, the others urine is tested...so it's a, - because I wanted know how they go about sterilization.

In contrast with the above, women were satisfied with the privacy provided for undergoing HIV counselling and testing as compared when other procedures were being done:

Everyone was seen separately, and examined and the test taken. When you got the results, then you are entirely alone with the sister.

Women identified how health workers were putting more emphasis on HIV/AIDS and less on childbirth related issues, and for them, this was disturbing. The theme on health information is discussed below.

5.3.4.3 Health information

All women in the study except those who did not attend antenatal care were given health information at the health facility. But some of them felt it was not enough, they were expecting more information on childbirth, not only HIV/AIDS . As mentioned earlier on, they felt that health workers were placing too much emphasis on HIV/AIDS, which, they felt is already being taken care of by the media. One woman who presented late for antenatal care:

> *I think it should be a more comprehensive type of care that what it is given now, should be taught about-like what to expect when labour starts, general things like how to care for yourself, personal hygiene and nutrition...especially with the first baby, when the baby is born.*

Another participant who suspected that they were being given HIV/AIDS information only because they wanted people to go for HIV testing:

> *They only give us HIV information before testing, no other health education or so.*

Another participant who felt midwives only do health education when there are student nurses that they are supposed to teach:

> *There is nothing, HIV or something like that, I think they should, people sit there all day, it shortens the day.*

Another participant:

...only they teach now is AIDS, but I feel it's no use they preach about same thing, nothing like nutritional talks.

There were participants, though, who were satisfied with the HIV/AIDS related information and with other information. This varied from health facility:

*they informed the pregnant mothers of alcohol abuse, smoking, HIV/AIDS and there was [*sic*] a lot counsellors. They were very good...with the AIDS testing and everything, it was confidential.*

A 16 year old participant who was at the receiving end of inhuman treatment was very pleased with the information she received:

They told us signs of labour, what must you do when water breaks, and baby kicks or something.

It was mostly participants who attended antenatal care where this theme was generated because health information, as it shows, is only carried out during antenatal care. These findings show that most women were not satisfied with the content of the information they received. Most of them felt that information on childbirth and delivery was more important than HIV/AIDS information for them. Women were eager to know about what was going to happen in the course of their pregnancy, including complications. These findings are supported by other researchers although they didn't identify this as a key barrier to accessing maternity care (Fleissig, 1993; Thompson, 1996).

5.3.4.4 Support during labour

All participants were concerned that there was no support from the health facility for women during labour and they recognised support as the most important necessity for a woman during childbirth. Some felt that the health facility's policy of refusing a support person for the pregnant women or the facility offering the support during labour was not acceptable to them. At some MOU, only married women were allowed to bring spouses and those who were not married felt that they were discriminated against:

> *only husbands allowed to support their wives in labour ward, nobody else is allowed.*

One participant who attended maternity care observed that some women did not attend maternity care because:

> *they think it's best to go to where people can support and assist you....*

A 17 year old participant who described being terrified whilst giving birth because she had no support, observed that:

> *Pregnant women needs (*sic) *a lot of support during labour...a lot of women are afraid when pain starts....*

Another participant who, based on the previous pregnancy, chose to deliver at home with the current pregnancy:

> *Where we deliver, you lie down alone, they are busy with their work....*

Participants felt that if staff are unable to offer the support they should allow families to provide the support:

> *I do not know if it's their job to help but if they cannot do it, to allow your family to support you in the labour ward.*

A participant who felt extremely distressed because of family responsibilities felt a need to talk to somebody because of problems she had:

> *...like today, I feel depressed, I need someone to talk to...if there maybe, could be a sister in the unit that would take time, maybe ask one of the mummies that have time, maybe, to talk to me about anything, a person gets very emotional when pregnant...you feel you can't cope, feel depressed...(*becoming tearful).

Similarly, El-Mouelhy et al (1994) found that in Egypt, pregnant women complained of depression that was caused by, among other things, feeling overwhelmed by the children. The effect of stress on pregnancy has been to some extent associated with many complications that include preterm labour, low birth weight babies and various complications during labour and delivery (Tambyajia & Mongelli, 2000).

Social support during labour is one of the factors identified as beneficial within the Better Birth Initiative (BBI)[8](WHO, 2002) and that studies have shown that many women find it important to have social support during labour (Klaus, Kennel, Berkowitz, 1992; Hallorsdottir & Karlsdottir, 1996). Hodnett (2002), as part of this initiative, identified 14 research studies conducted in Belgium, Botswana, Canada, Finland, France, Greece, Guatemala, Mexico, South Africa and United States. These studies highlighted the importance of having social support during labour and the benefit of this in reducing in the likelihood of medication for pain relief, operative vaginal delivery, caesarean section, and length of labour.

Marital status as a barrier linked to lack of support during labour was found by Obermeyer (1993) in the study where s/he compared maternal health in the context of culture in Tunisia and Morocco. In this study, unmarried women felt that it was unfair that they were not allowed to bring support during childbirth, and yet, most of these women were pregnant for their first time and needed a lot of support.

5.3.4.5 Review of Quality Care Issues

A lack of quality care has been identified as a barrier to access maternity care by other researchers (Jinabhai et al, 1994; Ndebele, 2000; Tinker, 2000). Participants in the study verbalise this theme through sub themes, namely: unhealthy physical environment, questionable procedures and lack of privacy, health information, and lack of support during labour. Some studies define quality of care within a number of frameworks, namely, provider-woman information exchange, provider competence, interpersonal relations, and mechanisms to encourage continuity of medical care (Bruce, 1990). Donabedian (1992) defines quality of care as that kind of care that is expected to maximise an inclusive measure of patient welfare, after one has taken account of the balance of gains and losses that attend the process of care in all its parts.

Eduardo, Dodd and Bernstein (2000) and Thompson (1996) maintain that quality of care should not only focus on technical dimensions, but ethical and professional dimensions as well. Most of the previous studies focussed more on the technical standards, for example, availability of medical supplies, working equipment, and

cultural barriers to some extent. Nevertheless, Thaddeus and Maine (1994) suggest two mechanisms through which quality of care can affect the decision to care, and these are client's satisfaction or dissatisfaction with care. Women in this study were concerned that they had to share a waiting room with other sick patients, and that the toilets were dirty. The new trends related to the integration of services as part of achieving equity in the district health system, might have contributed to these changes in the physical layout in some MOU. Tinker (2000) supports the findings of the current study, namely, that quality of care includes and can be improved by reducing overcrowding and ensuring privacy. None of the studies identified physical environment, as the barrier to quality maternity care (Jinabhai et al,1994; Fonn, Xaba, Tint, Conco & Varkey, 1998; Bruce, 1990; Koblinsky et al, 1993).

As mentioned earlier, women questioned the procedures and were questioning the health worker's clinical judgement skills. Some reported being turned away when they felt that they were in their later stages of labour ready to give birth, and consequently delivered at home. Ezechi et al (2000) found that in Nigeria, one of the reasons clients presented late for maternity care was because they were dissatisfied for being used for teaching and learning. In this study, women expressed similar discomfort with students performing procedures on them. Overall, four women opted to deliver at their homes because of the quality of maternity care and also for their fears for the safety of their unborn children as these were reported by them.

5.3.5 Juggling with family responsibilities

In the study, intersections of human rights violations, and gender roles and relations have been identified as reasons for women delaying maternity care. The other themes as already discussed above indicate that women are unable to utilise maternity services because of heath system related factors. In this theme, in addition to the health system related factors, it is evident there are other factors that impact on women's attendance of maternity care, which are related to family responsibilities. Pregnant women with other small children, for example, felt that the maternity health facility's opening hours and long waiting times were impacting on their child rearing.

Some participants identified child rearing and taking care of their husband's business as key reasons for presenting late for maternity care. One participant could not attend ANC on time because she had to cook for her husband:

> *My husband is a builder, he comes home at anytime during the day. He is rude when he wants food and then I have to give food to his friends as well, that gives me stress.*

This was complicated by child rearing:

> *...I must get up in the morning to put bread for the children...then my husband arrives home at anytime, makes me run up and down...you are tired, you have to cook, the washing and have to do everything what a mother is supposed to do.*

Another participant with four children:

> *You get lot of cases where women can't go, sometimes I also struggle to get out to do the things that need to be done, for I have three children and nobody to help...so you can't get to the clinic, and if you get there the next day, they have long sermon to tell you, that you don't care, and don't care about yourself, so why should they care.*

The same participant, a widow, has to leave her small children all by themselves, as she has to rush for clinic opening times:

> *...and when you leave, the children are still asleep, but you don't know, when they wake up, if they ask piece of bread, whether somebody will give them some.*

With long waiting time and awkward opening times, for some this has a financial impact related to paying the baby sitter:

> *...I have to go early (*to the MOU) *so that I can come back to the one who is looking after her...the people want to be paid and all that.*

Because of early morning opening times, some participants had to walk alone in an area with gang violence:

> *...you don't know what dangers are on the road, sometimes I can't get away early, I don't know who is at the corner, they shoot around here day and night....*

Some participants indicated that although their partners did encourage them to attend maternity care, they were not giving any technical support in assisting with, for example, child rearing:

> *...he has nothing to do with the children, I look after the children myself, he doesn't do anything for the children, he also doesn't help me with anything.*

Another participant indicated that in spite of her husband assisting with domestic chores, she felt that he could do more by assisting with child rearing:

...he is supportive, but I feel he can do more, like this morning....

Some participants, because of the opening hours and long waiting times had to make arrangements to leave their children with relatives, which sometimes, is not an appropriate decision:

There are other children in the yard...and because they are step children, there is always trouble here at home...like this morning, when I had to ask my brother-in law to look after the daughters ,the boy who is handful to rather take him with me (sic)*...things are not always too nice at home, and things happen at home...the girls are quiet, very reserved, like they get along with all.*

Participants expressed concern that health workers did not recognise and acknowledge their responsibilities at home. For them as pregnant women, sitting and waiting for a very long time was impinging on these responsibilities:

They take very long, we get out there quite late, past four...they forget that we have other things to do, children....

Bradley (1994) supports the findings of this study that many women help in their men's business where they are seen as assistants and "helpmates" to men. Patriarchy does not "*preclude an appreciation of the male and female economic activities*" (Bradley, 1994, p.150). These women have to sacrifice their health by not attending maternity care in order to assist in their husband's business. Delphy and Leonard (1994, p. 159) also, agree that women, including unmarried ones, "have to keep the homes fires burning" and that women do twice the amount of domestic work, including reproductive roles, each day. On contrary, when men spend time on domestic work, it does not involve the same kind of strain.

Similarly, Sundari (1992) found that in Zaire, women were unable to access maternity care during the harvest time, and this was when most maternal deaths occurred. On the contrary, other studies have found that women delay or fail to attend maternity care because of the direct influence from their families, specifically, spouses (Pittrof & Johansen, 1999; Thaddeus & Maine, 1994)). In this study, the spouse did no apparently have a direct influence on women's attendance of maternity care. Rather, they were reportedly concerned about when their "wives" will attend maternity care, although they did not make themselves available to assist with the household responsibilities such as taking care of the couples' other small children to enhance their wives attendance.

5.4 Conclusion

This chapter focussed on a cross case analysis and discussion of the findings using themes generated from the interview scripts to establish reasons why women delay or fail to attend maternity care. Women expressed their concerns regarding the quality of maternity care which some of them find repelling. Although there were women who were satisfied with some aspects of the service, they indicated that they have acquaintances who were not happy with the service and ended up not attending maternity care.

The chapter ended with a description of themes across cases and also using demographic and social factors, and obstetric history so to expand on the thick description of the phenomenon under study. The next chapter focuses on an interpretation of findings.

Chapter 6

INTERPRETATION OF FINDINGS

6.1 Introduction

In the previous chapter a cross case analysis and discussion of the findings were done with themes generated from these cases presented. This chapter is about interpretation of these findings using literature control to substantiate the argument. Schlechty and Nolbit cited by Talbot (1995, p.485) describe the purpose of interpretation as to *"making the obvious obvious, making the obvious dubious, and making the hidden obvious*". The former will be through the use of the literature and the conceptual framework to interpret the findings. Making the obvious dubious will be carried out by interpreting the findings in the context of rival theories and other explanations, and lastly, a position will be generated through development of a model on accessibility of maternity care, so as to make the 'hidden obvious'.

The findings of the study have emerged as five themes: namely: lack of humane treatment, safety concerns for the unborn/newborn child, disorganised health service, quality of care , and juggling with family responsibilities. The first four themes relate to health system related factors, and the last theme, juggling with family responsibilities, relates to factors associated with women and their living conditions.

As already mentioned in the previous chapter, these themes are intertwined, and hence, the reasons why women delay or fail to attend maternity care are multifaceted. The findings show that all the categories of women, both those who did and those who did not attend maternity care, shared the same sentiments. Some women in the 'booked' category attended maternity care in this current pregnancy in spite that they were not happy with the treatment they received from health care providers in their previous pregnancies. The reasons were their understanding of the benefit of maternity care towards themselves and their unborn children. Below is the interpretation of each theme using the study's conceptual framework as the guide.

6.2 INTERPRETATION OF THE FINDINGS FROM HUMAN RIGHTS PERSPECTIVES

> "One cannot, one must not, approach public health today without looking for its human rights component..."
>
> Wiesel (1994), Nobel Peace Prize Laureate.

6.2.1 Human rights to health and access to maternal health care

Women in the study were reluctant to use health services because they perceived health workers to be rude, insensitive, and that they are not skilled enough to be trusted with their unborn children. Maternity services were not accessible in terms of opening times and long waiting hours and this was being made worse by the disorganization of health workers themselves. It is understandable that no service can satisfy all its consumers because of the historical diversities of the consumers, but when the women are being denied access to quality maternity care and this becomes

cumulative and repeated over and over, then it becomes a human rights issue.

The South African government, through its health workers who are their employees, has obligations under the national constitution and regional and international human rights treaties it ratified, to respect, protect, and to fulfil the human rights of its citizen, including health service recipients. The obligation to respect rights requires the health care system to refrain from interfering with the enjoyment of rights. The obligation to protect rights requires the health care system actively to prevent violations of human rights by third parties; and the obligation to fulfil rights requires it to take appropriate measures toward the full realization of rights (WHO, 2002). From this study findings, the health care system failed to protect and fulfil women's rights to access quality maternity care. How this argument has been constructed will surface as the session on interpretation of the findings from human rights perspectives, unfolds. The International Federation of Red Cross et al (1998) states that it is important to use appropriate terminology when defining human rights restrictions by the government. Terms such as violation, derogation, interference, limitation, encroachment, and infringement can be used depending on the severity of the restriction. This will be explored further under the conclusion session.

It becomes violation of human rights to access health care if these are not fulfilled. In the next session, I will discuss and interpret themes identified in the study within the HR context in order to meet the research objective "determine and analyse human rights issues that impact on accessibility to maternal health care".

6.2.2 (Lack of) Humane Treatment

Provision of humane treatment by health services is a fundamental right that is defined by South African Patient's Rights Charter, and by Bill of Rights of the SA Constitution. The Patient's Rights Charter formulated by the national department of health as a mechanism to provide health services that are accessible to community, states that:

> E*veryone has the right to access health care services that include a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance.*

The SA Bill of Rights article 10 consolidates this:

> *Everyone has inherent dignity and the right to have their dignity respected and protected.*

Women in the study were humiliated and they felt that the health workers were disrespectful. They equated this treatment with that of being treated like animals. Women felt that health workers showed no empathy, tolerance nor patience. Women felt that it was not worth it to attend these services because of this lack of humane treatment. This inhumane treatment is interpreted as violation of human rights in the SA Bill of Rights 12 (1)(e). It is stated that everyone has the right:

> *"... not to be treated...in a cruel, inhuman or degrading way".*

The ICCPR, article 7, explains this further that:

> *No one shall be subjected to ...inhuman or degrading treatment or punishment...*

Human rights encompass the fundamental principles of humanity which underpins Midwifery (and Nursing) as a caring profession (International Federation of Red

Cross, 1998). Humanity is embedded within the African philosophy of caring which is based on the principles of '*ubuntu*'. *Ubuntu* or humanism requires treating the woman in a connected, relational way as any human being would want to be treated, and that includes consideration, kindness, and respect (David-Floyd, 2001). Women in the study equate the treatment they received at the health facility as that of treating animals.

The South African government has made some effort to instil the caring culture among its public 'servants' by developing a strategy on public service delivery, called, *Batho Pele* (People First). This strategy was generated from White Paper on the Transformation of the Public Service (1995) to transform the public services to be client friendly so they be treated with respect and dignity. The principles that underpin *Batho Pele* are: Consultation, Service Standards, Courtesy, Information, Openness and transparency, Responsiveness and Value for money. The government conducted several workshops throughout the country educating public 'servants', including health workers, about humane service delivery. However, research shows that knowledge alone does not always change behaviour. A common practice in the services of putting the Batho Pele principles on the walls and conducting 'talk shops' can hardly change the health workers attitude and behaviour towards their clients. More efforts should be put up such as using human rights approach which is embedded in the South African constitution which is the strategy that is the most superior strategy in the country. The Bill of Rights is a "*cornerstone...it enshrines the rights of all people...it affirms the democratic values of human dignity, equality and freedom*" (The Constitution of the Republic of South Africa, Act 108 of 1996).

The South African Nursing Council (SANC), a nursing professional body, which is responsible for setting and maintaining the standards of the nursing and midwifery practice in SA has recently (2003) developed guidelines for patients on how to lodge a complaint against the individual profession. This approach, I believe, is punitive, and targets those who want to identify violators of human rights. Also, though each individual health care provider is accountable for his/ her acts and omissions, they collectively represent the health care system which is obliged to protect and fulfil human rights of its citizens. This can be through providing policies/ laws that will regulate the standards of practice of its health care workers. Furthermore, the SANC guidelines may not serve any purpose for those women who are illiterate; as the complaint should be lodged in writing and that the complainant should be "specific and should give much information as possible". This also puts more responsibilities on the client in getting every detail into writing, including witnesses involved. It is one objective of the study to develop a framework on accessibility to maternity care that is based on human rights approach that is embedded in the SA Bill of Rights.

6.2.3 Safety concerns for the newborn/ unborn child

Women in the study were reluctant to attend maternity care because they had bad experiences with the maternity service and they feared for the lives of their newborn/ unborn children. Some had perceptions about how other women's children were born in the toilet. These women were not only deprived of the access to maternity care but also their children's access to health care. The Children's Convention defines a child as a human being below the age of 18 years and this includes a newborn. The realization of children's rights according to the Convention is vital for the reduction

of maternal mortality and morbidity as well as for children's survival (Cook and Dickens, 2001). Article 24 (1) of the Convention recognises that children should not be deprived access to health:

> *...state parties shall strive to ensure that no child is deprived of his or her right of access to health care services.*

Article 24 (2) (d) of the Convention puts obligation to the states:

"to ensure appropriate prenatal and postnatal care for mothers".

The right of the child to access health care services is also stated in the SA Bill of Rights article 28 (1)(c). The Bill emphasises the importance of protecting the safety of the child under all circumstances and agrees with the women that their children needed to be protected by the health workers. Article 28 (2) emphasises that:

> *A child's best interests are of paramount importance in every matter concerning the child.*

When the woman gives childbirth all by herself in a health facility because of neglect from health workers, the health service does not only neglect the mother, but her newborn as well. Women felt health workers neglected them and they were afraid that their children might die because they were left giving birth all by themselves whilst health workers were "knitting and drinking tea".

Although no newborn died during the period when this study was conducted, the chances of these newborns being traumatised are very high because some women gave birth without any skilled support. Donnay (2000) argues that traumatised infants may survive but they may become physically or mentally disabled for the rest of their lives. Children's Convention cautions that states should take appropriate measures to:

diminish infant and child mortality, and to ensure the provision of ...health care to all children....

The SA Bill of Rights article 28(1)(d) supports that every child has the right to "*be protected from maltreatment, neglect...*". A health service that does not promote the safety of the child violates that child's right to access health care. These women, among other reasons, as evident from the study, opted not access these services to protect their children.

6.2.4 Disorganised Health Services

Women in the study mentioned that the clinic opening times and long waiting hours were not conducive for women to attend maternity health services. Although some women were empathetic about the conditions the health workers were working under in relation to large numbers of clients they had to attend, their concern was that the health workers were aggravating the situation by not organising themselves appropriately. This unhealthy environment that is detrimental to the health of these women is mentioned in the National Patients' Rights Charter that every patient has the right to:

a *healthy and safe environment that will ensure their physical and mental health or well being....*

Bryant, Khan, and Thaver (1990) identify several factors impacting on the disorganization of Maternal and Child health care services at primary health care level. They regard these factors as 'syndrome of severe administration' and that these are recurring, accumulating over time. Some of these, namely, understaffed and under-managed health service were identified by women in the study as part of the

problem. The factors of 'syndrome of severe administration' as explained by Bryant et al. (1990, p.56) manifest when the health service is:

> *under-planned, under-staffed, under-financed, and under-managed by personnel who, themselves, are under-trained, under-supported, underpaid and often demoralised*

In the study, two antenatal care clinics were managed by two midwives who were seeing more than 50 women per day. Women were not happy with this arrangement as they felt it was jeopardising the quality of the care. The research conducted at greater Cape Town on equity in the distribution of maternity health services found that Midwife Obstetric Units are understaffed by 24 professional midwives (UWC, School of Public Health, 2002). The WHO's (1994) guidelines recommends that each antenatal care visit should last at least 20 minutes, and for postnatal, the average time to spend by health workers should last at least 15 minutes, with delivery time taking about 6 hours of the midwife's time.

The WHO recommends that 10 minutes of paperwork and administration work should be added to all these times. All women should receive a postnatal visit within first week of delivery in order to ensure early detection and management of hypertension, haemorrhage and sepsis. This also provides opportunity to provide support to breastfeeding and family planning information and services. It is recommended that for every 500 000 people, there should be four facilities offering Basic Essential Obstetric Care (BEOC) and one facility offering Comprehensive Essential Obstetric Care (CEOC).

The Western Cape province, specifically, in the greater Cape Town where this study was conducted, these are already in place, 'the health infrastructure and services are well established' compared to other provinces in the country (DOH, 1998).

6.2.5 Quality of Care

Unhealthy physical environment; questionable procedures and lack of privacy; inappropriate health information; and lack of support during labour were identified as reasons for not attending maternity care. Sharing a waiting room with other sick patients was found to be uncomfortable when one is pregnant. Women highlighted that they could not understand that this arrangement is reinforced by health system when it is common knowledge that pregnant women and those with small children should avoid sick people, specifically those with contagious infections such tuberculosis. Medical research supports the fact that pregnant women should at all costs avoid close contact with any infectious or contagious conditions (Sellers, 2000).

The human rights principle states that although "*all human beings are... equal in rights and dignity*" discrimination is allowed if it is fair. This is supported by article 9in the South African Bill of Rights. The international Federation of Red Cross and Crescent Societies (1998) agree that treating people equally does not necessarily mean that people should be treated the same. Both the sick people and maternity women should be treated equally by the health facility whilst at the same time the facility should acknowledge that pregnant women have specific needs that warrant special attention. They are vulnerable groups whose well-being can be of

higher priority than other categories of people. Pittman and Hartigan (1995) maintain that equal care is not necessarily an appropriate care nor that different care is necessary a worse care. When pregnant women and mothers with small children are being provided with separate waiting rooms from those of other sick people, that does not necessarily mean those other sick people are discriminated against by the health facility. Separate waiting rooms can also create an environment where maternity women are being given information and videos about childbirth.

The ICESR General Comment 43 (a) explicate that pregnant women are vulnerable groups that need special protection. States should :

> *Ensure the right of access to health facilities and services on a non-discriminatory basis, especially for vulnerable and marginalized groups....*

In article 24 (a) of the SA Bill of Rights, it is stated that

> *Everyone has the right to an environment that is not harmful to their health or well-being, and to have the environment protected ....*

Some women in the study were not happy with the scanty or total **lack of health information** they receive from the health facility. The Women's Convention (CEDAW) article 10 (h) emphasises that women should have access to:

> *specific educational information to help ensure the health and well being of families, including information and advice on family planning.*

The right to access information is also explained in the SA Bill of Rights article 32 (1) (b) *"everyone has the right of access to any information that is held by another person..."*. Women in the study were relying on the health workers to give them appropriate information related to childbirth and pregnancy. Coliver cited by Cook (2001) explicates that the right to information can be used in the context of

governments providing information that is necessary for the protection and promotion of reproductive health. Traditionally the right to information was understood to guarantee freedom to seek, receive and impart information and ideas free from government interference.

El-Mouelhy, El-Helw, Younis, Khattab and Zurayk (1994) support these findings that women need health education and information about risk factors and symptoms of pregnancy related conditions so they can seek medical care instead of attempting to alleviate these symptoms through self medication. One woman, 46 years old, who was diagnosed of hypertension in her previous pregnancy opted to make her own medication by mixing herbs instead of attending maternity care promptly to minimise complication related to the condition.

Participants questioned the health workers' **clinical judgement skills** when they had to be turned away although they felt they were in true labour. Some eventually delivered at home. Article 12 of the ICESCR general comment emphasises that health is a fundamental human right indispensable for the exercise of other human rights. The highest attainable health can be obtained by provision of good quality care among other things. Health workers should be skilled and should use procedures that are scientifically approved. Article 12.2 (a) of the Covenant emphasises on the provision of measures to improve maternal health including access to quality antenatal and postnatal services. Article 12.2 (d) endorses the provision of

"*...timely access to basic preventive, curative...health services and regular health education...appropriate treatment...*".

The midwife has responsibility to make use of evidence-based care so to inform her practice (Bennet and Brown, 2000). This involves the knowledge about practices that are beneficial or harmful to the mother and her baby under her/ his care.

Some women felt that their **privacy** was not taken care by the health facility. One woman gave birth with other women in the same room, whilst another one who wanted to have sterilization was unable to discuss this because it was "such a crowd". Some women felt humiliated and degraded with this lack of privacy. This is interpreted as violation of human rights when interpreted in the context of the Political Covenant article 7 which states that:

"No one shall be subjected to ...inhuman treatment... ".

The SA Bill of Rights 12 (e) augments the above by emphasising that everyone has the right *"not to be treated or punished in a...inhuman or degrading way".*

Furthermore Article 14 emphasises that *"everyone has the right to privacy ... ".*

Lack of support from health workers during labour and refusal by health workers for the unmarried women to bring their partners was totally unacceptable to participants. Cook and Dickens (2001) supports that stigmatisation experienced by unmarried pregnant women may impair their access to care, and subsequently aggravate their vulnerability to unsafe motherhood. The ICCPR articles 2 and 26 agree that discrimination on grounds of marital status is a breach of a human rights obligation. The SA Bill of Rights article 9(3) explains that:

> *the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds including ...marital status*

Interpreting the findings from human rights highlights that in spite that the health care system has obligations to respect, to protect and to fulfil the right of women to access quality maternity care, women in the study were unable to access these services. The health care providers who are supposed to protect and fulfil these rights are the cause of the problem through their acts of commission and omission (Thomson, 1996). This is interpreted as violation of human rights to access the highest attainable reproductive health as interpreted within the International and National Bill of Rights.

6.3 INTERPRETATION OF THE FINDINGS FROM GENDER PERSPECTIVES

> "We have only one place to stand: with women, beside women and behind women..." (Fathalla, 1994, p.105)

It is evident from the findings that the health system was unable to acknowledge and recognise women's gender roles. They were unable to provide mechanisms or support to accommodate women's gender equity needs so to make services more accessible to pregnant women with small children. Women found the early opening and long waiting times impacting on their child rearing. In addition to that, some women had to 'take care' of their husbands who were not available to assist in the childrearing when women had to visit the maternity clinic.

They were concerned that health care providers, in spite that they being women themselves, could not recognise these family responsibilities. Women felt that the

health providers wouldn't be reinforcing long waiting times and early opening times if they were emphatic and sensitive to these. One woman, a widow, had to leave her small children at home all by themselves in the early hours of the morning in order to attend maternity care.

Similarly, Pitrof and Johansen (1999) established that women have multiple roles that entail looking after small children, the sick and the old family members in addition to their roles of producing food for the family. For, example, women in Africa produce 80% of the food consumed domestically and about 50% of export crops. Sivard cited by Kolbinsky et al (1993) estimates that women's unpaid household work, which is barely recognised by society, is about 4 trillion US$ /year which is equivalent to one third of the world economic production. Some women in the study were expected to carry responsibilities of child rearing and production roles in addition to their responsibilities of having to seek maternity care for their pregnancies. Being pregnant did not warrant exemption from these responsibilities.

Some women who delayed/ failed to attend maternity care mentioned that their partners were concerned about this non-attendance of maternity care but were unable to assist with these responsibilities to give them opportunity to attend to their health. This is against what ICPD paragraph 4(27) explains regarding men's role and responsibility in reproductive health rights:

> *Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood...and productive behaviour, including...prenatal, maternal and child health... shared control and contribution to family....*

Paragraph 4.1 of the covenant emphasises that pregnant women do not have to sacrifice at the expense of their health; instead partners should give them a lot of support during this period:

> *...The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household...women are facing threats to their lives, health and well being as a result of being overburdened with work and of their of their lack of power and influence.*

The Beijing Platform paragraph 96 stresses that:

> *...Equality relationships between women and men in matters of...reproductive health...require ...shared responsibility...and its consequences.*

Women did not attend maternity care in spite of being 'diagnosed' with blood pressure. In Egypt it was found that pregnant women with medical conditions were reluctant to seek care unless the condition would have direct effect on their childbearing (El-Mouelhy et al., 1994). This shows that women put more emphasis on health conditions that will impact on their expected role of childbirth which is valued by society, than on conditions that have no direct impact on these roles irrespective of the severity of the health problem. Like woman in this study, they would rather buy their own medication from the local store to make self-remedy that will cure the symptoms rather than to seek care.

The findings are also interpreted in the context of Moser's gender analysis framework (1993) which has been discussed extensively in Chapter 2. Moser identifies how women have triple roles that consist of reproductive, productive and community management activities. She supports the findings that although both men

and women are involved in productive work, women's productive work is often less visible and less valued than men's. Furthermore, reproductive work, which is always the responsibility of women is labour intensive and time consuming. In spite that women in the study were not happy with the hard domestic work that they were engaged in, they still felt responsible as mothers to take care of everything happening in the household.

Medical research shows women who are engaged in high levels of household duties during pregnancy tend to have low birth weight babies. These babies most of the time become a burden to the health system, as they need high care that becomes costly to the state (WHO, 1998). Women in the study had to take care of their small children in addition to their (in)formal occupation. Moser explains that although reproductive work is crucial to human survival, and to the maintenance of reproduction of labour force in the country, it is seldom considered as real work. Women in the study did not receive assistance from their spouses in order to attend maternity care (timeously) even though some of them were helping these spouses to generate family income. There were no facilities at the MOU such as enough toilets to change nappies for those pregnant women with small children.

Moser elucidates that women in general have particular needs, which differ from those of men as a group because of motherhood, among other things. Without challenging the status quo, these needs can be met firstly by assisting women in their current status of pregnancy through provision of quality maternity care. The HERA (2001) interprets this as gender equity which requires the full recognition of the

specific needs that women have because these arise from historical patterns of biological differences.

Secondly, these needs can be met by providing assistance towards those gender needs that exist because of women's subordinate social status. A study conducted in Bangladesh support these findings that the gender division of labour that entails productive and reproductive work impact more on women than on men. The survey conducted in an urban area in Bangladesh shows that women put an average of 31 hours per week in unpaid work such as domestic chores, child rearing; in addition to the 53hours they spend in paid employment. In contrast, men spend a total of 67 hours per week with 14 hours being spent on unpaid activities such as house repair, and 53 hours on paid employment (WHO, 2001). In Kenya women work an average of 56 hours per week compared to men who work 42 hours per week.

Women in the study were not given appropriate health information; they felt humiliated with the inhuman treatment they received from health care providers. The WHO (2001) postulates that the health sector mirrors and represents society in which it is located. The society's views and expectations of women are shown by the way the health care system treats women. Women are not supposed to question the health care provider's orders and decisions irrespective of what the woman believes in. In the study, only spouses of married women were allowed in the MOU whilst in some MOU no men were allowed. This can be interpreted as that the health care providers assume that all pregnant women are homogenous group. They are supposed to be married, and anyone who does not conform to this is stigmatised. Health workers' assumption that men should not be involved in childbirth synthesizes with the fact

that male spouses were not available to assist with childcare.

The study did not find any association related to community activities that women are involved in as a reason for delaying or failing to attend maternity care. However, one woman in the study was involved in charity work, and this was happening over weekends and this did not impact on the accessibility and availability of maternity care. There is no routine maternity care over weekends that can impact on women accessing maternity care. Most women did indicate that they were occasionally attending social gatherings such funerals, but were not engaged in any community activity that can hinder them attending maternity care.

6.4 INTERPRETATION OF THE FINDINGS - OTHER PERSPECTIVES

In chapter 5, I quote Yin emphasizing the importance of ensuring quality in the analysis of case studies and one way that was applied in this section is that case study analysis should include other rival interpretations and or alternative interpretations of the findings. Yin labels it as a'cardinal rule', whilst Patton (1990) calls it 'intellectual integrity'. According to Yin (1994) the researcher should use other existing alternative interpretations to explain the findings. He warns that a case study that fails to account for different perspectives warrants critical reader's suspicions. He suggests that examining the findings using different perspectives increases the rigour of one's study. He explains why the researcher should use these alternative interpretations when interpreting case study findings. The researcher should be able to present her/his argument on the findings without being defensive

about her/his choice of the original interpretation of the findings especially in situations where the researcher describes the case study to the critical listener who may offer an alternative interpretation of the evidence.

For this study, the other alternatives that are used are: feminist theory, the biomedical model, and the recent debate about the benefit of attending antenatal care. These 'alternative interpretations' that were gathered from the literature challenge the approaches used to interpret the findings of the study whilst at the same time they give alternative interpretation of the findings.

6.4.1 Feminist theory

Radical feminists support these findings that patriarchy which is characterized by male privilege, power, dominance and hierarchy, oppresses women (Tuang & Tong, 1995). The spouses were not available to take care of the couple's small children to relieve these women to attend maternity care. Historically, some radical feminists rejected motherhood completely arguing that motherhood annihilates women and is dangerous to women's health. Firestone (1970), for example, argues that women take a big slice of division of labour in the household because of these reproductive roles. On the virtue of them being able to reproduce, they are 'forced' to undertake all other roles pertaining to that reproduction, and other roles that are based on gender.

Women in the study had to carry reproductive and productive roles that they found oppressive to them and subsequently impacted on their ability to access to maternity care. This is interpreted in the context of **Socialist feminism.** Socialist feminism supports that women's oppression rests on the sexual divisions in reproductive as

well as productive labour that are not recognised by the society (Kirkley, 2000; Walker and Wilging, 2000). Women were unable to attend maternity care because of gender roles and relations. Socialist feminism links these reproductive roles to the women's low socio-economic status. Social feminists theorise that women 'labour to produce', and that in addition to their daily domestic chores they are expected to perform reproductive roles and child rearing. They postulate that women are kept in low paid and low status jobs, and in these circumstances, pregnancy and childrearing become the only fulfilling solution.

Imbalances of power relations between women and their spouses, and power relations between them and health care providers, were found to be contributory to inaccessibility of maternity care. Spouses and health care providers were not treating these women as their equals. Women received no respect from the health facility, rather a top-down approach to the interaction surfaced. This maybe interpreted in the context of **liberal feminism** which emphasises the power balance between men and women, and women with other groupings in the society in terms of personal relations (Tuana and Tong, 1995). Women were unable to stood up to their husbands and health care providers, they accepted their situation without question. Liberal feminism argues that women's oppression is rooted in a set of customary and cultural constraints. In most cultures, women are socialised to accept their men's behaviour unquestionable irrespective of whether it impacts on their wellbeing. Although women in the study did not indicate that their pregnancies were unwanted, liberal theory does emphasize that women have rights to decide whether to have and when to have children.

South African feminism links equality of women to economic development and distribution of resources in the society and subsequently influences the women's decision even to matters important to their own health. If there are still inequities in the distribution of resources and health care services, women will not be able to access those services (Lockett, 1996, de la Rey, 1997). Most women in the study were from informal settlements, unemployed, and were depending on the families and spouses to support them. For example, one woman who was unemployed delayed attending maternity care because she has to cook for her husband's employees. Because she was dependent on her husband for financial support, she was unable to approach and ask her husband for 'time off' so to attend maternity care. The woman's lack of financial resources contributed indirectly to accessibility to maternity care. In spite of progressive economic policies and improvement on the distribution of resources in South Africa, these have not been filtered appropriately at a micro-level, specifically to women at grass roots (Cape Argus, 2003). This perpetuates construction of social structures that channel women into motherhood and childbearing. In supporting this, Cook and Dickens (1998) write:

> *Motherhood can take a woman to the heights of ecstasy and the depths of despair; it can offer her production and reverence. But it can also deny a woman consideration as anything more than a vehicle for human reproduction (*p.253).

In Black African communities, for example, motherhood, and specifically women with large families are assigned a high prestige and this is the population that have been denied access to other elements of status, including economic ones (South African Demographic and Health Survey, 1998). These women regard themselves as blessed in spite of any costs to their health and that they work 24hours, seven days labouring through reproductive and productive roles.

The South African Demographic and Health Survey (1998) demonstrate that teenage pregnancy prevalence rate is high among these populations, same as maternal mortality. One of the limitations of this study is that the participants were mostly Afrikaans speaking Coloureds, with two Africans. The reason was that, the MOU where the study was conducted are situated in the northern areas of Cape Town, where this population dominates. This has been mentioned earlier on in chapter 3.

In conclusion, feminist theory supports the findings that the reasons that women do not attend maternity care are beyond their control. Using a feminist paradigm strengthened the findings as were interpreted in the context of gender and human rights perspectives. A feminist paradigm supports finding that a problem cannot be isolated from its context. Reasons why women are unable to access maternity services cannot be interpreted in isolation from the social, cultural and political contexts and from the women's position in the society. Lee (1998) argues that women's health can only be understood within these contexts.

6.4.2 The Biomedical model

In the study, though indirect, male partners were barriers to some women accessing maternity services. One woman alluded to her responsibility to cook for her husband's crew as one reason for not attending maternity care late. Another woman was advised by the partner not to attend antenatal care in the current pregnancy.

The interpretation of findings using this model show that women were unable to attend maternity care because of patriarchal approach to health care at the MOU.

However in the study, the health care providers are midwives who were women themselves. The model is making an assumption that maternity care is offered by obstetricians and medical doctors who are men. This might be the true case in the Western world where maternity care is highly medicalised and doctor centred, but not in developing countries (Downe, 1996). In Cape Town where the study was conducted, the primary maternity care is midwife centred with some assistance from visiting doctors who are not necessarily obstetricians.

6.5 Conclusion

In the chapter, the findings of the study were interpreted using literature control, the study's conceptual framework, and by using other perspectives and explanations. The aim was to fulfil and meet two purposes of interpretation of findings, to make the 'obvious obvious' and to make the 'obvious dubious'. The study identified that no one reason was the barrier to accessibility of maternity services, both gender roles and relations together with health system related factors were reasons that women were unable to attend maternity care. These findings were interpreted in the context of South African Constitution Bill of Rights, the International Bill of Rights (UDHR, ICCPR, ICESCR) and Moser's Gender Analysis Framework, WHO guidelines, and also by using United Nations documents on Beijing Women's conference and that of Cairo Programme of Action.

The study used two other perspectives in interpreting the findings. The feminist theory though criticising the human rights approach in addressing women's needs,

supported the findings that reasons women can't access maternity care are multifaceted and rest on the subordinate role of women in the society through patriarchy, among other things. The biomedical model could not support the findings. Women in the study came with experiences and knowledge about pregnancy and childbirth hence they had expectations about health information appropriate for pregnant women, for example. This is contrary to the biomedical model where women are regarded as being ignorant, and that pregnant women have no other needs other than those pertaining to their pregnancy. According to this model, women do not attend maternity care because of physical aspects related to their pregnancy, and this was not found in the study.

In the next chapter, I will present the proposed framework on accessibility to maternity care using gender and human rights approach. This is to meet the last objective of this study.

Chapter 7

DEVELOPMENT OF A MODEL ON ACCESSIBILITY TO MATERNITY CARE

"A thumb working on its own is useless. It has to work collectively with other fingers to get strength and to be able to achieve anything".

African Shona proverb

7.1 Introduction

In the previous chapter, findings were presented and interpreted within the study's conceptual framework and also within other major explanations and rival theories. This chapter deals with the construction and generation of the emergent argument. Developing a conceptual framework on the accessibility to quality maternity care will do this. The aim is to guide maternal health care providers in providing quality maternity care that is accessible to its consumers, namely women and their families. An overview of the framework is presented and major categories are described. It is not the purpose of the study to evaluate and test the model, this will be done elsewhere.

7.2 Overview Of The Model

The framework on accessibility to maternity care is developed to meet the study's objective, '*to develop a framework on accessibility to maternal health care using a gender and human rights approach*'. The major categories that are defined in the model are derived from the conceptual framework that guided the study and from the findings of the study. Data and excerpts from the participants are used, but sparingly, so as to validate some categories presented. The development of this model is based on the criteria suggested by Dickolf, James and Wiedenbach (1968) and by Meleis (1985). Both Meleis and Wiedenbach are regarded as 'mothers' of theory development in nursing, and their guides on theory development have been used across disciplines. For the purpose of this study the following criteria were used to describe the processes in the developing of the model to accessibility to maternity care:

- What is the purpose of the model and why is it generated?. The situation and contexts to which the model can be applied are discussed.
- On what assumptions does the model build? This addresses within which paradigm and context it is located.
- What are the model's concepts and how are these concepts are defined? This is to clarify the meaning of concepts within a model.
- What are the propositions of the model? This describes links among and between concepts.
- What is the structure of the model?
- How can the model be applied in a clinical setting?

For this study, Norwood's (2000) definition of the terms framework, model and theory are used. A framework is the researcher's perspective about how concepts and variables of interest in a study fit together. A theory is an abstract generalization that presents a view of a phenomenon. She describes a model as a symbolic representation of a phenomenon or a diagram of a theory or conceptual framework. The study will use both theory and model interchangeably in defining the framework to accessibility to maternity care

7.3 MODEL DESCRIPTION

7.3.1 What Is The Purpose Of Developing A Gender-Human Rights Model To Accessibility Of Maternity Care?

According to Meleis (1985), the goals and aims of developing a model/ theory are to describe, to explain, to predict and to prescribe phenomena. The proposed model is developed to provide standards to which quality maternity care can be made accessible to maternity women and their families. The model has potential of usefulness in practice and in research within the context of women's health. The model is addressing this through what Meleis (1985,p.156) calls, a 'knowledge of control'. This means "to prescribe a course of action that, when implemented could change the sequence of events in a desired way". Other contexts in which phenomena can be addressed by a model/theory are 'the knowledge of order, knowledge of disorder, and knowledge of process'. It will be beyond this thesis to describe those.

The model proposed provides guidance that may influence maternity clinical practice. The potential usefulness for research lies in the fact that the model is based on empirical evidence from research findings. Theories that are discovered and based on inductive beginnings are 'perfect and substantiated', they are analytical and address the "is" rather than the "ought to be" (Meleis, 1985, p.154). The model has potential also for usefulness for health care planning on a larger scale by providing guidelines and criteria to maternal health service managers and planners on health care quality assurance. Furthermore, the gender and human rights discourses underpin the socio-political atmosphere in South Africa because of the influence of the national constitution. It is appropriate to develop a model based on these discourses that will provide assistance in promoting accessibility to maternity care. The main purpose of this model is to provide a theoretical basis for understanding the reasons why maternity women delay or fail to attend maternity care, and what strategy maternal health care providers can use to make the maternity care accessible to these women. The delay to seek care and failure to attend maternity care in South Africa were identified as the major contributory factors to maternal deaths.

7.3.2 Model Assumptions and Paradigmatic origin

The model is based on assumptions taken from the study's conceptual framework and assumptions gathered from the study's findings. Assumptions are givens that are presumed to be true and are not tested empirically. Assumptions from the gender and human rights theories and my personal ideologies formed the philosophical grounding of this model:

Assumption 1.

The woman has sexual and reproductive freedom, and the right to exercise that freedom without interference. The health care system has an obligation to create an environment in supporting the woman to exercise this freedom.

Assumption 2.

The health care system has an obligation to empower woman with knowledge to have confidence to exercise healthy reproductive and sexual choices, and to take full control of her reproductive and sexual health.

Assumption 3.

The woman is entitled and has the right to quality health care that will enhance her to achieve the highest attainable standard of health.

Assumption 4.

The woman (and her partner/ significant other) is the centre of practice.

She is an important and valuable human being who comes to health care with her own values, experience and her own personal philosophy.

The background of the 'theorist' and socio-cultural context that may have influenced the development of the theory, suggests Meleis (1985), should be available to enhance credibility of the framework. These have already been discussed in chapter 3 under 'self reflexivity' section. Meleis (1985) reinforces that model assumptions could be gathered from an ideological position or from philosophical standpoint of the theorist.

7.3.3 CONCEPTS DEFINITION

The concepts utilised in this model have been derived from the thesis. Norwood (2000) stresses that because concepts paint a picture of a phenomenon, they should be clarified and defined within set boundaries and examples given. Dickolf et al (1968) argues that a well-developed concept is the one with boundaries that are clearly demarcated. Multiple data sources and existing theories have been used to generate meaning to concept characteristics and attributes. The concept attributes or characteristics provide the determinants for the application of the concept in the context, which in this case, is midwife-led maternity service. Literature was also explored to show how these concepts are applied in other studies. Dictionary definitions of the concepts were also used for linguistic purposes. The concepts are defined as follows, starting with major ones:

7.3.3.1 Gender Equity

In this study gender equity is defined within the two attributes, productive and reproductive roles. Reproductive roles arise from biological differences of the two sexes that subsequently impact on gender bias in the distribution of responsibilities related to child rearing. Although both genders are involved in productive roles, women's productive activity impacts on her other responsibilities that arise from social inequality and her subordinate position in the household. Gender equity requires full recognition of these without challenging the existing gender biases and women's subordination within their relationships.

The health care system addresses these by making health services available to women at the times convenient to women through flexible health service opening times, and by reducing long waiting times. The health service physical environment is made conducive to women with other small children by providing separate area for maternity women from sick people and making provision for other resources that will facilitate her comfort (eg. adequate toilets, entertainment for other children).

7.3.3.2 Women's Empowerment

In the research findings, it became apparent that women assigned a high value to reproduction irrespective of circumstances and conditions that compel them to make that 'choice'. One woman, for example, a widow who had three children from her previous marriage, was pregnant with her second child from the current relationship where she was cohabitating with a man who was unemployed and who left them without trace to seek work at another town1500 km from home. The woman and the five children were staying with the current in-laws who were not happy with this arrangement. The observation is that the woman was powerless to make healthy decisions pertaining to her well-being and that of her children.

Cook et al (2003) argue that powerlessness of women is a serious health hazard especially for maternal health. In the model, the woman is empowered for recognition of her reproductive rights (Batliwala, 1994). This differs from other approaches of empowerment where the focus is entirely on contraception and birth

control and termination of fertility. In this study women are being scolded for having too many children and are at times given contraceptives they do not comply to use. The woman has the right to choose to become pregnant and to decide how many children she wants. The health care provider provides information about how the woman can exercise this right freely and safely for healthy pregnancy and childbirth.

In the model, women's empowerment is pivotal to the recognition of gender equity needs. The health care provider empowers the woman by giving information that will enable her to make informed choices to explore different options related to her personal and public life. Empowerment also addresses the right of the woman to take control and protect her body and to make decisions about her reproductive health. The Reproductive Rights Alliance (2002) maintains that informed choice is fundamental to the empowerment of women. Batliwala (1994) explicates that women's empowerment liberates and empowers men too. Men are freed psychologically from the roles of "oppressor and exploiter", and from gender stereotyping when women become equal partners in a relationship (p.131).

7.3.3.3 Human Rights To Health Care

The health care system has a duty and obligation to provide quality care based on the attributes: humanism; health information, education, and communication. These attributes have been empirically identified from this study.

Humanism

Humanity is a fundamental principle of human right. Humanity in the African[9] context entails '*ubuntu*' (humanism) which Haegert (1999) describes as combination of dignity, respect and compassion. The health care provider should provide quality care that is based on the principle of humanism as interpreted within African ethos. Malan cited by Haegert (1999) describe proverbs commonly used to define humanisms in the African caring culture:

*"A person is a person through other persons (*Umntu ngumntu ngabantu, in Nguni language) *";*

*"A person is born for another..." (*Kuyazalelwana, in Nguni language).

Health care workers should mirror the views of the African society where people are united and show respect and compassion for each other. Goduka (1996) defines this in the proverb *"I am because we are. We are because I am"*. In African culture, the health care provider exists because of her/ his community therefore she/he has a 'social contract' with the community to provide the woman with best quality care. The African culture of caring is also captured in the slogan, *"You have touched the woman, you have struck a rock, you have dislodged a boulder..."*. The slogan originated when thousands of South African women of all races marched to parliament in 1960 fighting abolishment of pass laws (carrying identity documents). In this study's context, this entails that health care providers collectively can make a difference in providing humane care if they could acknowledge that the problem is there, and that they are the cause of it.

In the model, the health care providers provide quality care underpinned by humanism by being compassionate, respecting woman's privacy and treating them

with dignity. Women in the study equated the treatment they received from midwives as that of being treated like animals. They were not happy with the lack of privacy from health facility. Kitzinger (1992) shows similarities between the woman whose privacy was violated in childbirth, and the woman who has been raped. She posits :

> *"In childbirth, as in rape, a woman is stripped, forcibly exposed, her legs splayed and tethered and her sexual organs put on display to all comers" (p.113).*

Health Information, Education and Communication (IEC)

This is interpreted in the context of human rights relating to information, education, and decision-making (International BR, South African BR). Health care providers provide the woman with information and education that is based on the woman's lifestyle and her reproductive intentions. The aim, as already mentioned under women's empowerment, is to equip the woman with informed choice so she can be able to review the choice she made previously, if need be. The aim of IEC is to instil a change in behaviours that may put the woman and her child at risk. Since a woman's health is complex and is defined by more than childbirth and pregnancy, this information and education should go beyond reproductive health, because "a woman is not a womb, but has a womb" (Cook et al, 2003, p.17).

Health care providers should take cognisance the woman's well-being in totality. Women need information related to their sexuality and sexual health, for instance, in addition to information on pregnancy and childbirth and its complications. Further more, childbirth cannot be isolated from woman's sexual life as in most instances it is the end result of heterosexual intercourse (Kitzinger cited by Williams, 1996).

Communication entails that listening to the woman is as important as knowing what to say to her. The health care provider communicates with her and this involves physical care and comforting her, allowing the woman opportunity to share and talk about herself.

Findings from the study emphasise how some women were not happy with the information they received from the health facility.

7.3.3.4 Evidence-Based Health Care (EBHC)

The South African Cochrane Collaboration of the definition of EBHC is used for this model. EBHC is the use of current best evidence precisely, scrupulously, diligently, and with good judgement in making decisions about the care of the woman. The health care provider provides quality care that integrates her/his clinical expertise with the best available clinical evidence. The concept of EBHC in the model addresses critics that imply that midwifery is based on intuition and common sense. Ginzberg cited by Flemming (1998) criticises:

midwifery is an incomplete, undeveloped, less successful and less scientific approach to the same scientific problems that obstetrics is trying to solve.

The same applies within obstetrics. Wagner (2001) quotes a Canadian obstetrician who once said "Nature is a bad obstetrician". In this study women were questioning the midwives' clinical judgement skills and their poor organization of the health facility. Including EBHC in the model assures that the scientific and technical

aspects of high quality of care are included in addition to the gender and human rights issues.

7.3.3.5 Support

Pregnancy and Childbirth is regarded as a long journey where the woman needs to be sustained by another human being during the journey. The midwife and or birth partner accompanies the woman on this long, intense and turbulent journey, providing assurance about her condition and that of her baby (Halldorsdottir & Karsdottir, 1996). The woman makes her own decisions regarding her pregnancy and childbirth. The health care provider provides physical, emotional and psychological support. S/he accepts the woman's personal philosophy and her behaviour and does not make assumptions about what a woman wants and expects from childbirth. S/he respects the woman's choice by facilitating it and promoting the woman's autonomy, taking into consideration that s/he is not dealing with the sick client (Frith, 1996).

Pregnancy and/ or childbirth is not a disease, maternity is regarded as part of the woman. Unlike in the biomedical model where pregnancy is seen as external part of the woman, in midwifery, pregnancy is something the woman is, and not something she has, it cannot be separated from the woman's philosophy (Katz, 1990). This argument is supported by the common construct when referring to the pregnant woman that, 'she is pregnant' with same analogy of saying 'she is Jane', instead of 'she has pregnancy', or 'she has TB' or 'she has Jane'. Childbirth is something the woman does (Katz, 1990). The woman comes to childbirth with her own philosophy

and needs related to what she is as a person, including pregnancy. One of those needs is to be supported by another human being, partner, family or the health care provider.

Woman in the study wanted to be supported by their partners but were refused by the health facility if the woman and partner were not married. Williams (1996) explains that the benefit of a partner as support during labour goes beyond to what medical research defines. Childbirth is a sexual event with its beginnings initiated sexually through intercourse between the man and the woman. She quotes studies at which women indicated that having their partners alongside was erotic. Crowning of the head is the most painful phase and normally this is followed by an unbearable scream from the woman. For the women from those studies, a thrilling pain similar to that of orgasm replaced the tearing pain.

In the maternity health service, she describes, the woman and her partner are engaged in a sexual journey that has started when she goes into labour until the birth of the baby. This becomes a life experience that is fulfilling to both the woman and the partner. That's what midwifery is all about, being a partner in woman's experience. One woman in her study is quoted as saying:

> *...I've seen the best way to get a baby out is by cuddling and smooching with your husband. That loving sexy vibe is what puts the baby in there and it's what gets it out, too"* (Graskin cited by William, 1996)

Also, there is also overwhelming evidence supporting a connection between sexuality and breastfeeding, sexuality and pregnancy. The health care provider should take into cognisance that she should provide holistic care and support so to

meet the needs of the whole person, the whole woman.

For women where the father of the baby or the partner is not involved, any kind of support is recommended. Davis-Floyd (2001) supports that the presence of a doula as a support person for women in labour reduces problems of fetal asphyxia and labour dystocia. A study conducted by Klaus, Kennel, Klaus (cited by Davis-Floyd, 2001) show that women who were attended one-on-one by a doula had shorter labour and there was more mother –infant interaction after delivery than those with no doulas. A doula is a female companion 'trained' to give labour support.

Listening to a woman and giving support during childbirth, the health care provider can identify and establish other underlying problems that impact on the woman's well-being that may even impact on parenthood. One woman in the study, a 17 year old who gave birth alone indicated, with a frightened tone, that "*a lot of woman are afraid when the pain comes...and when they are afraid, when the pain comes, then they are really afraid...*". Although she did not want to elaborate, my observation is may that there was an underlying problem beyond the issue of childbirth. Williams (1996) argues that childbirth can bring hidden memories, for instance, those of child abuse. She gives an example of a case study of a woman who panicked during the second stage of labour because the descent of her foetus resembled that of an adult penis that was forced inside her at the age of eight. When she shouted for help, the midwife reinforced her feelings of abuse by using the same words as her abuser, '*Shh- don't cry*' (Williams, 1996, p.114).

7.3.3.6 Accessibility to and Availability of Quality Maternity Care

In the model, the above refers to the woman related factors on accessing the maternity care. In this study it was found that women did not to access the care because of issues in the service that made it unavailable to them. In the literature, availability and accessibility are used interchangeably, with accessibility being excessively used. This often removes responsibility and accountability away from the health service and puts blame on women for not "accessing" maternity care.

Availability on the other hand, refers to health service related factors. Services that are unavailable become inaccessible. For example, early opening times and long waiting hours, which are health service related factors, impact on women to access the services.

7.3.4 MODEL PROPOSITIONS

Propositions, also referred to as relational statements, offer the theory with the powers of description, explanation or prediction and they are fundamental in providing links among and between concepts (Meleis, 1985). The model's propositions are presented below, logically with distinct systematic linkages between the model concepts:

- **Proposition 1**

  Accessibility to maternity care can be improved by addressing factors impacting on the availability of maternal health service, namely, gender equity

and human rights relating to health.

- **Proposition 2**

The health care provider recognises and acknowledges gender equity by providing flexible maternity services that enables the woman to exercise her productive and reproductive roles, whilst at the same time s/he empowers her about informed choices to take control of her reproductive and sexual health, and to explore different options with respect to her personal life.

- **Proposition 3**

The health care provider respects, protects and fulfils the human right relating to access to health care by providing humane care, and offering health information and education that encompasses the woman's well-being in totality, and by communicating with her through listening and touching.

- **Proposition 4**

Evidence based health care (EBHC) is pivotal to quality of care. The health care provider is appropriately qualified with advanced-life saving skills and clinical decision-making skills for prompt clinical judgement. S/he integrates this with the use of best available clinical evidence.

- **Proposition 5**

The woman and her partner (or her significant other) is the centre of practice with her needs and her personal philosophy being supported by the health care

provider.

The model, as already mentioned, is at a higher level of theory development and is both predictive and prescriptive (Dickolf et al, 1968). The theory produced at this level is often referred to as practice theory as it "serves as a norm or standard by which to evaluate activity, activity that furthers the goal" (p.433). The benefit of using this approach is that it does not only say "if A happens then B happens, but also that B is among the things conceived as appropriate to bring into being and so here is how to bring about A, or here is how to facilitate A's production of B" (Dickolf et al, 1968). The accessibility to maternity care is improved when the above- mentioned propositions are addressed. How they can be addressed is already mentioned in the previous section.

Meleis (1985) suggests that a powerful theory is one with more propositions than assumptions. Propositions that are based on the evidence from literature are presented. This evidence has already been discussed extensively in the study. This section is related to the second goal of this model, a predictive goal, that is, "if A happens then B happens". Below is an extension of propositions and these are linked to propositions 1 to 5 as already discussed.

- **Propositions 6**

  By addressing proposition 2, the health care provider is enhancing the woman's position in her family and her status in the community at large. Empowering literally interpreted means 'giving power' for decision making related to reproductive health. The vice versa can happen, powerlessness of a

woman is a health hazard to herself, her family and to her community. "Educating the woman is educating the whole nation".

- **Proposition 7**

Failure to address proposition 3 is defined as infringement and encroachment of human rights, and combining this with poorly-skilled health care providers who are unable to provide care that can save woman's life (proposition 4), becomes a gross violation of human rights, especially when a woman can die from unscientific interventions.

- **Proposition 8**

Involving the woman's partner and putting them at the centre of care empowers the man as well and prepares both for parenthood. The man takes responsibility on reproductive roles which as the study found is currently the woman's responsibility. Some women in the study were minors who wanted to bring along their mothers, therefore, the woman's significant other who can be a family member or a doula, can give support to the woman.

7.3.5 THE DESCRIPTION OF THE STRUCTURE OF THE MODEL

This will be described as shown in Figure 7.3.5:

I. TOP SIDE

Availability of quality maternity care as indicated by arrows, is defined according to gender equity, left side, health and human rights (HHR) attributes on the right, with woman and her partner (significant other) at the centre.

II. LEFT SIDE

Gender equity entails woman's productive and reproductive roles. The foundation of this is woman's empowerment. Meeting the above enhances woman's status and her position as indicated on the side.

III. RIGHT SIDE

The health and human rights (HHR) attributes are characterised by humanism; (health) information, education and communication (IEC). These rest on the maternity care providing quality care underpinned by Evidence Based Health Care. Meeting all the above fulfils the human right to health and right to life.

IV. CENTRE OF THE MODEL

The woman and her partner are represented by the combination of the structure ♀ (resembling a woman) and the arrow inserted to this structure to represent her partner (or significant other). Both are in the centre of the model implying their importance. Support is placed at the centre of the woman's structure (woman's heart) to indicate

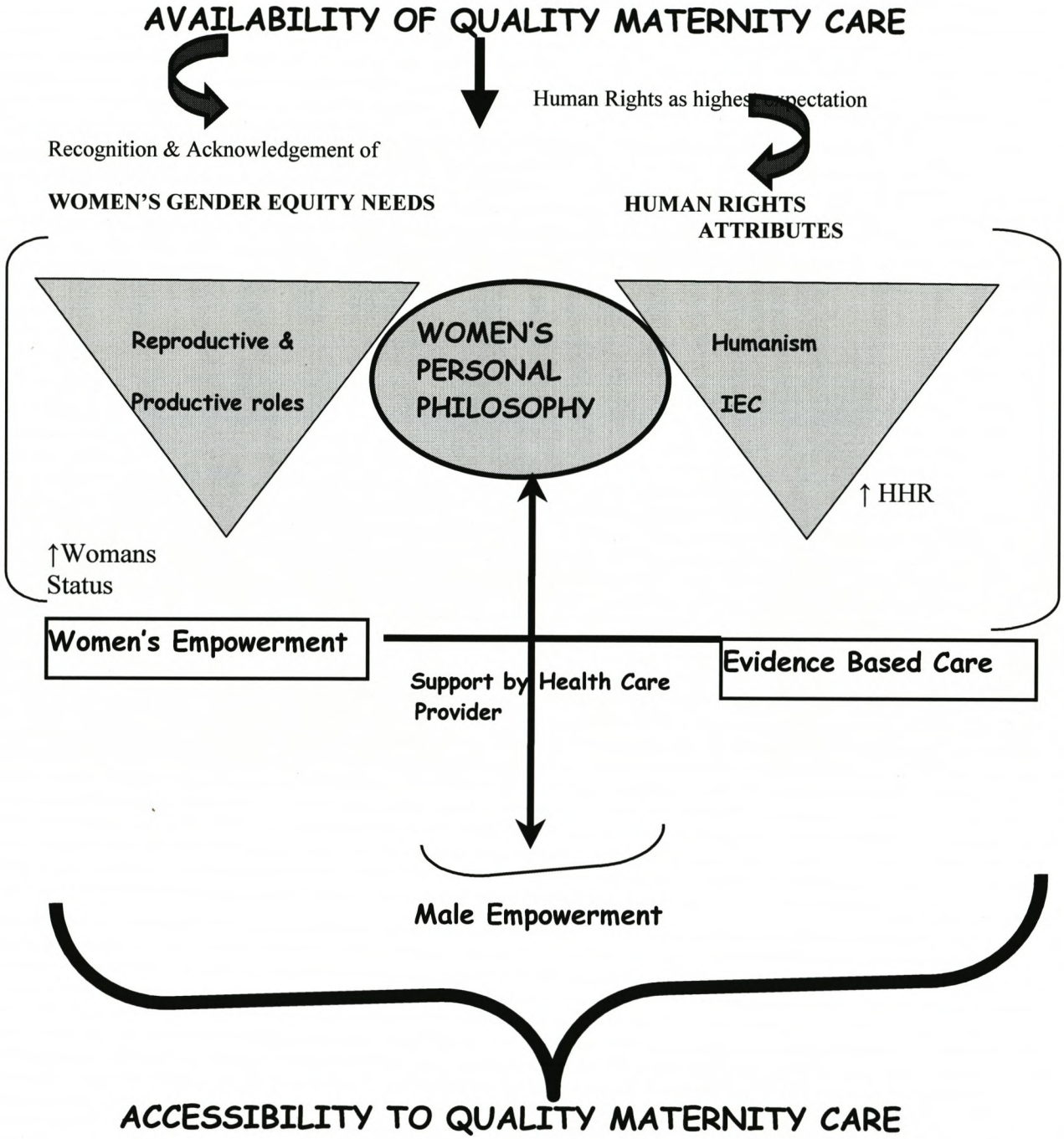
its importance to the woman. Involving the woman's partners in childbirth empowers him too to be responsible for reproductive roles and woman's reproductive health, as shown below the structure.

V. BOTTOM SIDE

All directions to the model lead to accessibility to maternity care. This is shown by arrows originating from the left (gender equity and woman empowerment, right sides being human rights attributes and EBHC, and from the centre of the model being woman and partner.

As mentioned earlier, one of the objectives of this study was to develop a model to accessibility of maternity care using gender and human rights approaches. It will be beyond the study to develop questionnaires related to each construct/theme for testing the model and how to operationalize it. However, this will be pursued elsewhere by presenting it to health care providers and to model experts for their input before testing.

Figure7.3.5 Gender-Human Rights Model on Accessibility to Quality Maternity Care



7.4 CONCLUSION AND RECOMMENDATIONS

7.4.1 Conclusion

This thesis was about using gender and human rights approaches to examine and analyse the major causes of maternal mortality, which result from delay in seeking maternity care and failure to attend antenatal care during pregnancy. It is evident from the findings that maternity women find it difficult to access maternity services because of their unmet gender equity needs, and because of the maternity service not respecting, protecting and fulfilling the human right to access health care. This is infringement and encroachment of human rights when interpreted within human rights law.

It is clear that a strategy is needed to avoid gross violation of human rights which might result from maternal deaths when the women are unable to access quality maternity care. A model of accessibility to quality maternity care is proposed to assist health care providers in promoting availability of maternity services. The development of this model is based on the assumption that when health care providers understand the reasons why women do not attend maternity care and the impact thereof, they will be able to make the services to be accessible to women.

The findings of this study revealed important issues pertaining to health care delivery. Health care providers, planners, managers and health policy makers often complain about under-utilization of services, shifting the blame to consumers

for their carelessness. It is clear that the problem of under-utilization is about unavailability of the service which impacts on inaccessibility, not the other way round. Women are unable to access maternity services because they are not available, and, also because of gender related issues which are result from their living conditions. These, according to the study, are beyond their control.

The proposed model is comprehensive and powerful enough to address all the above aspects. It also goes beyond improving accessibility to maternity care, but also, developing and empowering both the woman and the health care provider. The health care provider who has been basing her practice on common sense is obliged to integrate best clinical evidence as a foundation of her practice, and this subsequently prevents violation of human rights. Violation of human rights in South Africa can be the worst crime committed if the consumer, that is, the women, could take a punitive action.

7.4.2 Recommendations

7.4.2.1 For Research

- There is a need to develop a research questionnaire based on the model themes to validate the findings of this study within a larger sample of maternity women.
- Further research based on the questionnaire should be conducted to test the application of the model to ensure that it does help in the improvement

of maternity care accessibility.

- Other research methods, such as participatory/action research may be used to involve clients and or health care providers.

7.4.2.2 For Clinical Practice

- Health care providers, specifically, midwives need to spend quality consultation time with their clients by organising themselves properly. Taking into cognisance of the understaffing at the health services, the following is proposed: Inside the maternity record, there should be a check list of all activities crucial to maternity care to guide and organise the midwife. For example, women in the study were not happy about the health information and education they received. Instead of conducting 'blanket' health education to all maternity women, health education should be woman-oriented and individualised. Because the woman is likely to be attended to by different midwives throughout her pregnancy, each topic discussed is indicated within the maternity record, and is dated and signed by both the woman and the midwife.
The checklist is proposed to guide the midwife on what important topics to cover per each visit, taking into consideration of other topics that the woman may want to discuss.
- Maternity services opening times should be flexible to accommodate
- women with small children and those with other responsibilities.

For example, there can be an antenatal clinic for women with smaller children, that can occur over weekends, twice a month or can occur in the late afternoon where women are able to bring their children along or for women who are

unable to take time off work during the week when these clinics are normally open.

- All maternity care providers should be trained and educated on EBHC through the Better Birth Initiative currently underway in South Africa.

The health managers should take the process forward. Involving the woman's partner or support person in childbirth is one aspect being promoted by BBI.

- For maternity services where antenatal care services are not in the same facility as the intranatal, women should be physically orientated to the place of delivery before they go into labour.
- Maternity health policy makers should sensitise midwives about the socio-political context of the country so to be aware of the value system that they need to reflect for service delivery. They are representatives of the state, a state that has a constitution that endorses human rights culture.

7.4.2.3 For Education

- The model can be used in the education of midwives, doctors and others who deal with women's issues (eg. family planning) on how to provide quality maternity care that is accessible to women.
- Modules based on the themes of the model can be developed according to programme level and qualification across disciplines

Evidenced Based Care should be taught at the nursing and medical schools.

7.5 Study Limitations

- The study was conducted in six out of eleven MOU in the Cape Town unicity. The findings, therefore, are contextualised within these MOU, but evidence presented from this thesis can allow an interested researcher to use it so to formulate generalization of these findings.

- No attempt made to explore the pathway from social context of women's lives to medical conditions or outcomes.
- No data on health service providers was gathered so as to better assess accessibility and quality of care.

INTERVIEW SPECIMEN:

CASE STUDY K.

VGbooked.3

Venue: MC
INTERVIEWER:
CASE : BOOKED
DATE: 15 /11/2002

I, myself, no my husband, no he doesn't worry (laughing). Each day (thinking, looking around)...um..getting up (laughs uneasily & shfts), then, then I go to the work shop, and then we return around nine o'clock. It depends on whether.. how many cars there are to fix, it's seldom that we get home early.. and we get something to eat there, and then, when we get home we all go to bed... it's night then so there's not really time for..... (tailing off, nothing to say)

(Prompt about children). Yes they are there too, it's only now with the new baby that I feel the baby cannot be there because the smells of petrol and such.... that's why I got somebody, but before I was there all day.

It increased, as there is a new baby now, now that I have more responsibility, with the other baby it wasn't because he can walk unaided so now it is a bit a problem...I cannot come and go as before...as I please, for I must now think of the baby... have to feed him first, and so forth, before I can go.

Yes he helps, he cooks for us while I bath the children, and the family... there's many and they...there's two teenage cousins in the family, they come after school and then looks after my baby, so there's a lot of help from the family. Yes he is supportive, but I feel, he can do more (laughing), like this morning, so I told him "You can at least hold the child for a moment", he does hold the baby, but he also wanted to use the toilet (laughing).. while I was still in the toilet but anyway there is... I am just thinking, he is very busy, with cars & engines..they do get very tired, but he is he does help.

I got used to my own salary, but he brings the money.., brings everything to me, then I see that everything gets

paid.

Yes, (thinking), the… early….. sitting there from early morning.. all day and long waiting when they eventually call you then it's not even such a long story.. the other day I had to see the doctor, the doctor came so, about eleven. Yes there were a lot of people to see the doctor. When the doctor came, they called three women at a time. When I went in, the doctor felt (mimicking auscultation) my chest over my jersey. I wore a jersey and shirt and just like that, I was…. I don't think I was in there five minutes, before I was done, yes without lifting my jersey (indicating auscultation), and then I said to myself… we sat here all day just for this… five minutes, and we were done, I mean, it just sounds incredible (laughing)…. Everybody complained about the doctor who comes eleven o'clock and you are barely in, then you come out again, then some of the women said "What did we have to sit here all day for, they could have started earlier, the doctor could have come earlier, then we would be done sooner.. if we didn't even spend five minutes in there".

And if you go to the clinic to see the sister, it's also not a long story, then you're finished. So what one cannot understand.., what do you have to sit there all day, and I had a problem with…why it's the first hospital that I know of.. where nurses and sisters start half past eight, then of course they first drink tea, and then ten o'clock, half past, only they start calling patients.

No, I don't think there was.. I can't think of anything (anything good happened). No.! nothing that I can remember Ummhh...no, there was… it's uncomfortable because you are not alone in the room, where they.. in the treatment room, whatever, there's three at a time, at the same time, one has her BP taken… the others is urine is tested, so it's a…. because I wanted to know how they go about sterilization, and my husband also wanted to know, but it was such a crowd.. that one didn't really feel like to ask them about it, because there were too many people around, and the sister helping me was telling the other how nice she was going to be.. so one feel… how do you talk to someone like that ..when I went, the first time when I went they did the AIDS test, when we went to the counselor, she said my husband cannot go in with me, he has to wait outside, so he asked… why he has to wait outside, he is also involved… but she said she wants to talk to me only, so I said, leave it, but I don't understand, but we left it there. Ummhh...there are some, a few that treats you well, but there are, the majority, they only do it because they have to, not really because they want to…do the best they can.

They- ummhh.., yes they can do better. They say "are there any more mothers that are pregnant"? then you go, must actually run, and you don't know which way, sometimes you sit, then they say "are there no more mothers" then you think , but they did not say whether you must enter or not, so you don't really know whether or where to go, so you don't know where you stand.

Yes, I think so, for many women don't feel like sitting there all day, for my friend told me that she doesn't feel like going early, for you sit all day, every visit to the clinic, so people don't want to sit there all day, so they rather book late, then they know the time is shorter to delivery.

Umhh....antenatal care is when you attend clinic and they look after you, and how the baby grows, and if there are problems, with your blood or the baby, that's what I think antenatal care is... they you eat well, and look after yourself... like with the previous baby, they gave you a scan once. I see they don't do that at all now, I think, like to say... the doctor's just don't really examine you. I thought she was going to give me a thorough examination, bu that was also cancelled out by the time (looks puzzled). It was ... some women say, yes it's for free, that's why they treat you like that... if you have medical aid then you get the best care, but now it's free, so they don't really care.

It's only what people say (grims) ummhh... there were students and they talked.. actually it was just so by the way, because they had to get a mark. And they came to talk, called a few women and talked about diabetes because she had to get a mark, that's why she talked, but otherwise, there's nothing. HIV or something like that , I think they really should, people sit there all day, it shortens the day.

Firstly if the clinic is kept clean, I don't think they wash the floors, the toilets also don't get cleaned during the day, it makes it uncomfortable for you sit there for long periods and we know that when you are pregnant you need to g to the toilet often, one need to feel that you want to go to the clinic.. look forward to going, but you don't really fee like going to the clinic, for you sit there all day. Like before when they used to scan you, the doctor at least looks, for me I can just as well go to the nurse, when you go to the doctor you at least want to ask questions, but you can just as well go to the nurse and leave the doctor.

The MOU, well, when I got there, I had pains, then the nurse said I must walk to the labour ward and then they saic I must go to the toilet, so L walked down the corridor, but I felt I couldn't pass urine, the pain was too much and I was afraid to sit on the toilet. And then off again and I just felt my pain is just too much. I still had to climb up the the step, then off again, it was a bit too much for me, but it went so quick, it wasn't really a problem. I just feel sometimes women are there much longer, and when you are in pain you don't feel like upping and downing, it's too much.

Yes on the both occasions at the MOU my husband was allowed to stay with me so that wasn't really a problem, and to have somebody with you is always nicer, if somebody supports you.
I think maybe because they don't get treated well, that's why they rather stay away or they go private. Yes, it's more, you pay more, it's more comfortable, and they look after you well. At the MOU if you want a painkiller, they don't have any, but private, you pay for every tablet, so they give you as much as you want, I think that's why people stay away, or go to private.

Because I think many think it's more convenient at home, you can lie down when you want, and you can go to the toilet when you want to, sometimes at the MOU, they say no, you can't go to the toilet, in the labour ward, no you can't go, you must lie still, that's why they rather stay at home.

FIELD NOTES

The lady lived in X place prior to booking, where she also had her previous child delivered. At the time of the first delivery, they had medical aid, so baby was born in a private hospital. She mentioned that her husband was not too happy for her to be interviewed, as it might cause problem". She however was adamant to be heard. She has a niece helping out with the baby, the rest of the family spends most of time at the workshop, about 500m away from home. As she was booked, the first few questions skipped. She spoke easily, kept eye contact, and didn't think much before answering

REFERENCES

AbouZahr C., Vlassoff C., Kumar A. (1996). Quality Health Care for women: A global challenge. **Health Care for Women International, 17** 449 – 467.

AbouZahr C.(1998). Maternal Mortality Overview. **Health Dimensions of Sex and Reproduction** (eds: Murrg C., Lopez A). Boston, Harvard School of Public Health for WHO and Worldbank. 111- 164 (149)

Acosta A., Cabezas E., Chaparro J.(2000). Present and Future of maternal mortality in Latin America. **International Journal of Gynaecology & Obstetrics**. 70. 125 – 131

Batliwala, S. (1994). The meaning of Women's Empowerment: New Concepts from Action. In Sen, G., Germain A. & Chen, L (ed). **Population Policies Reconsidered: Health Empowerment & Rights**. p.128 – 137. Harvard University Press. Boston

Beischer N.A., Mackay E V., Colditz P.B. (1997). **Obstetrics and the Newborn. An Illustrated Textbook** (3rd ed.). WB Saunders. London.

Bender D., Santander A., Balderama A., Arce A. & Medina R. (1995). Transforming the process of Service Delivery to Reduce Maternal Mortality in Cochabamba, Bolivia. **Reproductive Health Matters.** 6, November. 20 - 25

Benn. C. (1994). **An investigation into Antenatal Utilization and Perinatal Outcome in Port Elizabeth.** Unpublished D CUR thesis. University of Port Elizabeth

Berer, M. (1994). The Meaning of Motherhood, Fatherhood and Fertility: For women who do and women who do it have children. **Reproductive Health Matters**. 4 November. 6-19.

Bradley, H. (1994). Gendered Jobs and Social In equality. In **The Polity Reader in Gender Studies.** Polity press. Cambridge.

Brems, S., & Griffiths, M. (1993). Women's Way: Learning to Listen. In Koblinsky M.; Timyan, J. & Gay, J.(ed.), **The Health of Women: A global Perspective**. p.2555 – 271.Westview press. San Francisco.

Brieger, W.R, Luchok, K.J., Eng E., & Earp, J.D. (1994). Use of Mortality services by pregnant women in small Nigerian community. **Health Care for Women International, 15** (2), 101-110.

Briggs, N. (1993). Illiteracy and Maternal Health: Educate or Die. **Lancet 34**:1063-1064.

Bruce, J. (1990). Fundamental Elements of Quality of Care. A simple framework. **Studies in Family planning, 21**, 61-91.

Bryant ,J.H., Khan, K.S. & Thaver, I. (1990). Promoting Maternal and Child Health through Primary Health Care. In Wallace, H.M & Giri, K. (ed), **Health Care of Women and Children in Developing countries.** p.85-126. Third party Publishing Company. California..

Burns, N. & Grove, S. (2001). **The Practice of Nursing Research, Conduct, Critique and Utilization** (4th ed). W.B Saunders Company. London.

Campbell, O. M. & Graham,W. J. (1991). Measuring the Determinants of Maternal Morbidity & Mortality: Defining & Selecting Outcomes & Determinants, and Demonstrating Associations.**Maternal & Child Epidemiology Unit.** School of Hygiene & Tropical Medicine, London.

Campbell, O.M., Kolbinsky, M. & Taylor, P. (1995). Off a Rapid Start: Appraising Maternal Mortality and Services. **International Journal of Gynecology & Obstetrics, 48**. S33-S52.

CDC. (1998). Maternal mortality – United States. 1982-1996. MMWR. 47: 706-7

Christiani, K. (1996). Women Health : Effect on Morbidity & Mortality in pregnancy & birth. **Midwifery, 12**.113 – 119.

Clarke, E. (2000). Obstetric Services in South Africa. South African Health Review. www.hst.org.za Accessed 1/08/2001.

Cohen, L. Manion, L., & Morrison, K. (2000). **Research Methods in Education,** (5th ed). Routlege. New York.

Cook, R. (1994). Human Rights of Women: National and International Perspectives. University of Pennyslvannia Press. Philadelphia

Cook, R. (1998). Gender, Health and Human Rights. In Mann, J.M., Gruskin, S., Grodin, M.A & Annes. **Health and Human Rights: A Reader.** G.J Routlege. USA.

Cook ,R. & and Dickens B. (2001). **Advancing Safe motherhood Through Human Rights**. The WHO publication.

http\\: www.who.int/reproductive-health/publication/RHR.
Accessed 01/07/2002.

Cook R. & Fathalla, M. (1998). Advancing Reproductive Rights: Beyond Cairo and Beijing. OSKA. www.oska.org.pl\english\articles\bl\ . Accessed 05/07/2001.

Cook R. Dickens B. & Fathalla, M. (2003). **Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law**. Clarendon Press. Oxford.

Correa, S., & Petchesky, R. (1994). Reproductive and Sexual Rights: A feminist perspective, pg(107-127). In Sen G., Germain A. & Chen, L. (ed). **Population Policies Reconsidered: Health Empowerment and Rights**, Harvard University Press. Boston.

Davis-Floyd, R. (2001). The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. **International Journal of Gynecology & Obstetrics. 75.** 55-523

De Brouwere V., Tonglet R., van Lerberghe G. (1998). Strategies for reducing maternal mortality in developing countries: What can we learn from the history of the industrialized West? **Tropical Medicine & International Health. 10** .771 – 782

De Larey, C.(1997). South African Feminism, Race and Racism. **AGENDA. 33.**

Delphy, C. & Leornard, D. (1994). The Variety of Work Done by Wives. In **The Polity Reader in Gender Studies,** p.159 – 165. Polity Press. Cambridge.

Denzin, N.K. & Lincoln Y.S. (ed). (1994). Hand Book of Qualitative Research. Sage Publications. London.

Department of Health (2002). Saving Mothers. **Second Report on Confidential Enquiries into Maternal Deaths in South Africa 1999 - 2001.** South Africa

Department of Health (2001). Saving Babies 2001. **2nd Perinatal Care Survey of South Africa.** The MRC Unit for Maternal and Infant Health Care Strategies. South Africa

Department of Health (1998). Saving Mothers. **First Report on Confidential Enquiries into Maternal Deaths in South Africa.** South Africa.

Dickolf ,J., James, P. & Wiedenbach, E. (1968). Theory in Practice Discipline Part I: Practice Oriented Theory. **Nursing Research, 17** (5), 415 – 435.

Donabedien, A. (1992). Continuity and Change in the Quest for Quality. **Clinical Performance and Quality Health Care.1.** 9-16.

Donnay, F. (2000). Maternal Survival in Developing Countries: What has been done, What can

be achieved in the next decade. **International .Journal of Gynecology & Obstetrics, 17.** 89-97.

Downe, S. (1996). Concepts of normality in maternity services: Applications and Consequences. In Frith L. (ed). **Ethics and Midwifery: Issues in Contemporary Practice.** Butterworth & Heineman. Oxford.

Doyal L. (1995). **What makes women sick: Gender & The Political Economy Of Health.** Macmillan, London.

Eagles G., Hayes, G. & Sibanda, T. (1999). Standpoint Methodologies: Marxist, Feminist & Black Scholarship perspectives. In TereBlanche M. Durrheim, K. (ed). **Research in Practice: Applied Methods for the Social Sciences.** p.438-461.University of Cape Town Press. Cape Town.

Edouard, L., Dodd N.& Bernstein S. (2000). The Implementation of Reproductive Health Programms: Experiences, Achievements and Challenges.**International Journal of Gynecology & Obstetrics, 70.** 25-34.

El- Mouelhy, M., El- Helw Mahinez, N.Y, Hind, K.& Huda, Z. (1994). Women's Understanding of Pregnancy Related Morbidity in rural Egypt. **Reproductive Health Matters.** 4 November. 15-25.

Ezechi O., Fasubaa O., Dare F. (2000). Socio-economic barriers to safe motherhood among booked patients in rural Nigerian communities. **Journal of Obstetrics & Gynaecology, 20.** 32 - 34.

Fathalla M.F. (1994). Women's Health: an overview. **International Journal of Gynecology & Obstetrics, 46.** 105 – 118.

Firestone, S., (1970). **The dialectic of sex: The case for feminist revolution.** Morrow. New York.

Flemming, V. (1998). Women-with- Midwives-with –Women: A model of interdependence. **Midwifery, 14,**137 –143.

Flessing, A.(1993). Are women given enough information by staff during labour and delivery? **Midwifery, 9,** 70- 75.

Fonn, S., Xaba, M., Tint, K., Conco, D. & Varkey, S. (1998). Reproductive Health Services in South Africa: From Rhetoric to Implementation. **Reproductive Health Matters (6)** 11.22-23.

Freedman L. , Maine D. (1993). Women' s Mortality . In Koblinsky, M., Timyan, J. & Gey,J. (ed). **The Health of Women. A Global Perspective.** p.150 –164. Westview press. San Francisco.

Freedman L. (2001). Averting Maternal Death and Disability. Using Human Rights in Maternal mortality Programs: From analysis to strategy. **International Journal of Gynecology & Obstetrics, 75.** 51 –60.

Frith, L. (1996). **Ethics and Midwifery: Issues in Contemporary Practice**. Butterworth & Heinemann. Oxford.

Gcaba R., Brookes H. (1992). **The unbooked Patient at an academic hospital.** Unpublished M Soc Sc Thesis submitted in the department of Nursing. University of Natal, Durban.

Graham, W. (1991). Maternal Mortality: Levels, Trends and Data Deficiencies. In Feachem, R., & Jamison, D. (ed). **Disease and Mortality in Sub-Saharan Africa.** p.101-116.Oxford University Press. Worldbank.

Goduka, I.(1996). Challenges to traditionally white universities: Affirming diversity in the Curriculum. **SAJHE/SATHO, 10** (1). 27 –36.

Haegert, S. (1999). A critical Analysis of the concept "Care" in the practice and discourse of Nursing. Unpublished PhD thesis submitted in the department of Nursing. University of Cape Town.

Hallodorsdottir, S. & Karlsdottir, S. (1996). Journeying through labour and delivery: perceptions of women who have given birth. **Midwifey,** February. 48-61.

Hendricks, A. (2001). Patient's Rights and Access to Health Care. **Medicine & Law. 20.** 371- 376.

Hendricks, A. (1999). The Close Connection between Classical Rights & the Right to Health, With special reference to the Right to Sexual & Reproductive Health. **Medicine & Law. 18.** 225- 242.

HERA. (2001). Action Sheets. Health, Action, Empowerment, Rights & Accountability. http://www.iwchc.org/hera/action.htm Accessed 18/07/2001.

Hill Collins, P. (2000). **Black Feminist thought. Knowledge, Consciousness and the Politics of Empowerment,** (2nd ed). Routlege. New York.

Hodnett, E. (2002). Caregiver support for women during childbirth. (Cochrane Review). **The Cochrane Library,** Issue 1. Oxford, Update Software.

Holloway, I. & Wheeler, S. (1996). **Qualitative Research for Nurses**. BlackScience. London.
Jaffre, V., & Prual, A. (1994). Midwives in Niger: an uncomfortable position between social behaviour & Health Care constraints. **Social Science and Medicine, 38.**1069 – 1073

Jewkes. R. , Mvo. Z. (1997). **Study of Health Care Seeking Practices of Pregnant women in Cape Town. Women's use and Perceptions of Khayelitsha MOU**. Medical Research Council. South Africa

Jinabhai. C.;Naidoo. K., dePinho.H. (1994). **Utilization of Maternal Health Services by African women in KwaZulu- Natal. Department of Community Health. Faculty of Medicine**, University of Natal.

Katz, R.(1990). In Labour. Women and Power in the Birth Place. Junction Books. London.

Katzive, L. (2003). Overcoming Fatalism: A Human Rights Approach to Maternal Mortality. http://www.jhuccp.org/popreporter/ Accessed 04/06/2003.

Khosta A.,Dahiya K., Sangwan K. (2000). Maternal Mortality and 'near miss' in rural north India. **Int.J.Gynea & Obst. 68.** 163 - 164

Kirkley, D. (2000). Is Motherhood good for women? A feminist Exploration. **JOGNN,** Sept/ October. 459 –464.

Kitzinger, S. (1992). Birth and Violence against women. Creating hypotheses from woman's accounts of unhappiness after birth. In Roberts, H. (ed). **Women's Health Matters.** p. 63-80. Routlege. New York

Klaus, M. Kennel, J. & Berkowitz, G. (1992). Maternal Assistance and Support in Labour: Father, nurse, midwife, or doula? **Clinical Consultations in Obstetrics and Gynecology, 4.** 211- 212

Koblinsky, M., Timyan, J. & Gey, J. (1993). **The Health of Women. A Global Perspective.** Westview press. San Francisco.

Kwast, B. (1991). Maternal Mortality: the magnitude and the causes. **Midwifery. 7.** 4 – 7

Lee, C. (1998). **Women's Health. Psychological and Social Perspectives.** Sage. London

Lincoln, Y.S.; Guba E.,(1985). **Naturalistic Inquiry**. Sage. London

Lockett C., (1996). **South African Feminisms- Writing, Theory and Criticism (1990 – 1994).** New York.

Loewenson, R. (2000). Equity in Health in Southern Africa: Turning Values into Practice. **EQUINET Policy Series no.7.** Published by Regional network for Equity in Health in Southern Africa.

Lumbiganon, P. (1998). Appropriate Technology? Antenatal care. **International Journal Gynecology & Obstetrics, 63.** (1).S91-S95.

MacDonagh M. (1996). Is Ante natal care effective in reducing maternal morbidity and mortality?. **Health Policy & Planning. 11.** 1- 15

MacDonald J.J. (1995). **Primary Health Care. Medicine in its place.** Earthscan publications Ltd. London

Mann, J., Gruskin, S., Grodin, M. & Annas, G. (1998**). Health and Human Rights. A Reader.** Routlege. New York.

March C., Smyth I., Mukhopadhyay M., (1999). **A Guide to Gender-Analysis Frameworks.** Oxfam. England.

Matamala, M. (1998). Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health. **Reproductive Health Matters, 6** (11), 10 –21.

Maternal mortality Notification.**(1997).** www.polity.org.za/govdocs

Maykut, P. & Morehouse, R. (1994). **Beginning Qualitative Research: A Philosophic and Practical Guide.** The Palmer Publications. London.

Maynard, M. & Purvis, J (ed). (1994). **Researching Women's lives from a Feminist Perspective.** Taylor & France. London.

Meleis, A. (1985). **Theoretical Nursing, Development and Progress.** Lippincott. Philadelphia.

Miles, M. Huberman, A. (1994). **Qualitative Data Analysis. En expanded Source Book** (2nd ed). Sage. London.

Mohanty C.T., Russo A.M., Lourdes. T. (1991). **Third World Women & the Politics of Feminism.** Indiana University. Indianapolis

Moser C. (1993). **Gender Planning in Development: Theory, Practice and Training.** Routlege, London

Munhall, P., & Boyd, C. (1993). **Nursing Research. A Qualitative Perspective.** The Palmer Publications. London.

Nel, J. (1995). **Core Obstetrics & Gynaecology with Examination & Guidelines for MB CHB.** Butterworths. Cape Town.

Ndebele, T. (2000). **Accessibility to Pregnancy Termination services in KwaZulu-Natal Durban Functional Health Region "F".** Unpublished M CUR thesis, University of Natal, Durban, South Africa.

Norwood, S. **Research Strategies for Advanced Practice Nurses**. Prentice Hall Health. New Jersey.

Obermeyer, C. (1993). Culture, Maternal Health Care and Women's Status: A comparison of Morocco & Tunisia. **Studies in Family Planning. 24, 6** , 354 – 365.

Patton M Q. (1990). **Qualitative Evaluation & Research Methods**. (2nd ed). Sage Publications.

Pittrof R.; Johanson R. (1999). Safe Motherhood - an achievable & worthwhile aim. **Progress in Obstetrics & Gynaecology.** 47 – 57.

Potter, J.W. (1996). **An Analysis of Thinking and Research about Qualitative Methods.** Lawrence Erlbaum. New Jersey.

Pittman, P. & Hartgan, P. (1995). Gender Inequity. An Issue for Quality Assessment Researchers and managers. **International Conference for Quality of Care.** February. Bolivia

Shen C., Williamson J. (1999). Maternal Mortality, women's status, and economic dependency in less developed countries: a cross-national analysis. **Social Sciene & Medicine, 49.** 197-214

Talbot, L. (1995). **Principles & Practice of Nursing Research**. Mosby Publications.

Tambyrajia, R. & Mongelli, M.(2000). Sociobiological variables and pregnancy outcome. **International Journal of Gynecology & Obstetrics, 70.** 105 – 112.

Thaddeus, S.; Maine D. (1994). Too Far To Walk: Maternal Mortality in Context. **Social Science Medicine, vol 38. No8.** 1091 – 1110.

Thompson, A. (1999). Poor & Pregnant in Africa: Safe Motherhood & Human Rights. **Midwifery 15.**146 – 153.

Thompson, A. (1996). Safe Motherhood at risk ? **Midwifery,12.**159 – 164.

Tinker, A.(2000). Women's Health: the unfinished agenda. **International Journal of Gynecology & Obstetrics, 70.** 149 –158.

Tomaševski, K. (1995). Health Rights. In Eide, A., Krause, C. & Roses, A. (ed). **Economic, Social & Cultural Rights.** p.125 – 142. Martinus Nijhoff. Netherlands.

Tuana, N.& Tong R. (1995).**Feminism and Philosophy. Essential Readings in Theory, Reinterpretation, and Application.** . Westview Press. Oxford.

USAID.(2000). **Maternal Mortality: A silent tradegy. http://www.usaid.gov/pop_health**

Villar, J., Carroli, G., Khan-Neelofui, D.,Piaggio, G. & Gülmezoglu, M. (2002). Patterns of Routine ANC for low risk pregnancy (Cochrane Review). In: **The Cochrane Library, Issue 1.**Oxford, Update Software.

Wagner, M. (2001). Fish can't see water: the need to humanize birth. **International Journal of Gynecology & Obstetrics, 75.** S25 – S37.

Walker, L.O & Wilging S. (2000). Rediscovering the "M" in "MCH": Maternal Health Promotion after Child birth. **JOGNN. vol 29. no.3.** 229 – 236.

Williams,C.(1996). Midwives and Sexuality: Earth mother or coy maiden?. In Frith L. (ed). **Ethics and Midwifery. Issues in Contemporary Practice.** .p.104 – 119. Butterworth& Heineman. Oxford.

World Health Organization (2002). **Health & Human Rights.** Publication Series Issue no.1 July. Geneva.

World Health Organization (2001). **Transforming Health Systems: Gender and Rights in Reproductive Health.** Geneva

World Health Organization (1999). **Reduction of Maternal Mortality**. Geneva

World Health Organization (1998). **World Health Day Safe Motherhood pamphlet.**

World Health Organization (1997). **Safe Motherhood Action Agenda. Priorities for the Next decade.** Geneva

World Health Organization (1996). **Maternal Mortality: A global Factbook.** Geneva.

World Health Organization (1994). **Mother- Baby Package.** http://www.who.int/reproductive-health/publications/msm. Accessed 01/07/2002.

World Report on women's health (editorial). (2000). **International.Journal of Gynaecology & Obstetrics. 70.** 1-8

Yin R. (1994). **Case Study Research Design and Methods**. Applied Social Research Methods. Sage. London

Young D. (1990). How can we "enrich" prenatal care? **Birth, 17** (1).12 -13

APPENDIX A

THE INTERVIEW GUIDE

TITLE: Exploring the Journey to Maternal Death: Gender and Human Rights Perspectives on the major causes of Maternal Mortality in the Western Cape Province, South Africa.

RESEARCHER/ INTERVIEWER:----------

CASE STUDY NO ----------

CATEGORY

Unbooked	
Late Booked	
Born Before Arrival (BBA)	
Home Delivery	
Booked	

MOU

Kraaifontein	Michael Maphongwana
Vanguard	Elsies Rivier
Bishop Lavis	Other

DISTANCE TO MOU

Walk more 1 hour	
Walk less 1 hour	
Transport	

DEMOGRAHIC DATA

1.AGE

Above 45 years	
36 – 45 yrs	
19 – 35	
Less than 19 yrs	

2. RACE

Coloured	
African	
White	
Indian	

3. HOME LANGUAGE

English	
Afrikaans	
Xhosa	
Other	

4. MARITAL STATUS

Married	
Live in partner	
Single	

5.ETHNICITY: (if applicable)

6.RELIGION: (if applicable)

7. EMPLOYMENT

Employed(occupation)	
Unemployed	
Other Responsibilities	

8. HIGHEST STANDARD PASSED

Post Standard 10	
Standard 10	
Standard 5- 9	
Less than Std 5	

9. HOUSING

Suburb	
Township House/ Flat	
Informal	
Other	

10. NUMBER OF HOUSE HOLD MEMBERS

More than 10	
5 –10 members	
Less than 5	

11. LENGTH OF STAY IN ADDRESS

More than 10 years	
6 – 10 years	
1 – 5 years	
Less than 1 year	

OBSTETRIC HISTORY

12. GRAVIDA

5 and above	
4 – 5	
2 – 3	
1	

13. PARITY

5 and above	
4 – 5	
2 – 3	
1	

14. AGE AT FIRST PREGNANCY

More than 40	
36 – 40 years	
19 – 35 years	
Less than 19 years	

15. CURRENT PREGNANCY SPACING

10 years and above	
6 – 10 years	
1 – 5 years	
Less than 1 year	
N/A	

16. ANC ATTENDANCE IN PREVIOUS PREGNANCY

Good	
Bad	
N/A	

17.MEDICAL HISTORY (name condition)

Previous Pregnancy	
Current Pregnancy	
N/A	

B: GENDER ROLES & RELATIONS

1..What made you to present late for booking (delivered at home etc)?

2. Who makes decision at home in regard to your health, specifically on this pregnancy? Please explain.

3. Describe your workload of a typical day at home and or at work. Do you feel that these responsibilities contributed to your late booking (whatever applicable)?

4. Do you feel that these tasks/ responsibilities are still the same as before you got pregnant?

5. Do you get any support (re- emotional/ financial/ sharing of workload) from other household members (including from your partner)?

6. Do you feel that these responsibilities had any impact on your booking status?

C: HUMAN RIGHTS ISSUES

7. Describe experiences you had at this health facility

8.Are you happy with the treatment you received from the health facility. Explain

9. Do you feel that the treatment you received had any impact on your booking status?

10. How would you like to be treated in a maternity health unit?

11. What procedures were performed to you in a maternity health unit? Were you satisfied?

12. Describe health education you received at this health facility? Were you satisfied?

13. What would you improve about this health facility?

14. What do you understand about antenatal care/ being unbooked etc?

15. In your opinion what makes women not to attend a maternity service? Explain

APPENDIX B

CONSENT AGREEMENT

I.....

on this..... day of.....200.... hereby consent to:

- Participate in the study conducted by Nomafrench Mbombo on the topic:

Exploring The Journey to Maternal Death: Gender and Human Rights Perspectives on the major causes of Maternal Mortality in the Western Cape Province, South Africa

- The use of data derived from this study by the researcher in a research report

I also understand that:

- The researcher will maintain anonymity and that data will under no circumstances be reported in such a way to reveal my identity.
- I am free to terminate my involvement to participate in this research project at any time.
- Information given up to the point of my termination of participation could, however, still be used by the researcher.
- The researcher for information given on participation in this research project will make no reimbursement.
- I may refrain from answering questions should I feel these are an invasion of privacy.
- By signing this agreement I undertake to give honest answers to reasonable questions.
- I will be given the copy of this agreement on signing it.

I hereby acknowledge that the researcher has:

- Discussed with me in detail the aims and objectives of this research project.
- Informed me about the contents of this agreement.
- Pointed out implications of signing this agreement.

In co-signing this agreement the researcher has undertaken to:

- Maintain confidentiality, anonymity and privacy regarding the participant
- Arrange in advance a suitable time and place for the data collection to take place
- Safe guard the original copy of this agreement

Participant:.....

Researcher:.....

Date: .....

APPENDIX C

PARTICIPANT PERMISSION LETTER

Private Bag x17
BELLVILLE
7530
.....2002
Contact no:.....

Dear Participant

REQUEST FOR PERMISSION TO CONDUCT INTERVIEWS FOR RESEARCH PROJECT

The number of deaths of women dying during pregnancy and childbirth is escalating in South Africa. The delay in seeking care by a pregnant women when the complication occurs, and a failure to attend maternity care during pregnancy have been identified as the major common causes of almost half of the deaths that occurred since 1998. It is not known why pregnant women delay to seek care and also why they fail to attend antenatal care during pregnancy. It is the aim of this study to establish those reasons by interviewing women who:

- did not book for antenatal care
- presented late for antenatal care (booked from 28 weeks)
- booked as early as from 20 weeks, delivered at the clinic and attending PNC
- delivered at home
- presented late for delivery (BBA) and those delivered at about 10 minutes immediately arriving at a health facility

Participants will give their perceptions and experiences of why pregnant women delay to seek care and why they fail to maternity care.

You are invited to participate in this research project, titled, **"Exploring the Journey to Maternal Death: Gender and Human Rights perspectives on the major causes of Maternal Mortality in the Western Cape Province, South Africa".**

It is hoped that information gained from the research will help to improve the quality of maternity care and indirectly reduce maternal mortality. The research project and the interview are not part of maternal health service that you have come for. The results of the study will be made available to you on request.

Thank you for your willingness to participate in the study.

Yours faithfully

MRS N.MBOMBO : Researcher.....

APPENDIX D

University of the Western Cape
Department of Nursing
Private Bag X17
BELLVILLE
.....2002

The Manager: CHSO (Dr Bitalo)
Att.to: Ms L. Mzilikazi
CHSO : Midwifery Obstetric Units (MOU)
STRAND

Madame

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Permission is sought to conduct research on : **"Exploring The Journey to Maternal Death: Gender and Human Rights perspectives on the major causes of Maternal Mortality in the Western Cape Province, South Africa"** at Kraaifontein, Vanguard, Elsies River, Bishop Lavis, Macassar, Michael Maphongwana Midwife Obstetric Units (MOU) respectively.

I am located in the Department of Nursing, University of the Western Cape where I am a PhD student at Women and Gender Studies, UWC. I am conducting a study on maternal mortality with the aim to establish why pregnant women delay to seek care and also why they fail to attend antenatal care.

The research questions surface from the South African Maternal Deaths reports (1998, 1999, 2000, 2001) and, Perinatal Mortality reports (2000, 2001) where it is stated that the delay to seek care and non- or infrequent attendance of antenatal care by pregnant women were major common contributory factors to the causes of maternal and perinatal deaths in South Africa, respectively.

I am therefore requesting your permission to access clients in the MOU to collect data by interviewing patients coming for maternal health care.

Data collection will involve the following:

1. Clients will be interviewed from each MOU. The aim is to get the following categories of patients:

- those who did not book for antenatal care but came (comes) for delivery/ post natal care (unbooked patients)
- those who delivered before arrival to the MOU irrespective of their booking status (BBA's) or 10 minutes within arrival at MOU
- those with presented at 3rd trimesters
- those who are currently or have attended antenatal care with more than three visits and also delivered at the health facility

2. The categories of clients is to access clients who can elicit information regarding their experiences and perceptions on delay in seeking care and or non-attendance of antenatal care. Participants will be approached from the MOU waiting room whilst they are coming for antenatal or postnatal care without disturbing the service and routine. Permission will be requested from each client approached for interview, and under no circumstances that an impression will be created that the interview is part of maternal health service. Confidentiality, anonymity and privacy regarding the participant and MOU will be maintained (no names will be mentioned in the report and to anybody). The results of the study will be made available to you (and to MOU on request). For information, please find: the research proposal, participant informed consent and contract.

Thank you for you co operation.

Sincerely

_____

NOMAFRENCH MBOMBO : Principal Researcher
(contact no: .....)

ENQUIRIES
NAVRAE
INGUZU

MRS J HAIR

TELEPHONE
TELEFOON
IFOWUNI

(021) 460 9204

REFERENCE
VERWYSING
ISALATHISO

DATE
DATUM
UMHLA

10 June 2002

PROVINCIAL ADMINISTRATION: WESTERN CAPE
Department of Health
PROVINSIALE ADMINISTRASIE: WES-KAAP
Departement van Gesondheid
ULAWULO LWEPHONDO: INTSHONA KOLONI
Isebe Lezempilo

Ms Nomafrench Mbombo
University of the Western Cape
Department of Nursing
Private Bag X17
BELLVILLE

Dear Ms Mbombo

RE: PERMISSION TO CONDUCT RESEACH

Letter refers.

Please be advised that permission is granted to conduct research at the Community Health Services Organisation (CHSO). Attached MOU's, this excludes Khayelitsha, which is currently managed by Mowbray.

Cognisance needs to be taken of these ethical considerations and that services are not disrupted. It will be appreciated that a feedback session be arranged with our MOU convener Mrs. Adriaans on completion of your study. She may be contacted at Tel: 9463429.

Your co-operation is counted upon.

Yours sincerely

JUDY HAIR
DEPUTY DIRECTOR
12 JUN 2002
PRIMARY HEALTHCARE DIRECTORATE

HAIR (MRS)
DEPUTY DIRECTOR: PHC

ENDNOTES

[1] There used to be pregnant women whom we referred to eg. social workers for disability grants for their closed families or to child protection services for their family problems related child abuse.

[2] I took this within the context where I am coming from as a Black African woman where irrespective of the woman's education, there are social pressures, not necessarily coming from the culture

[3] Using racial terms as defined in the constitution. The races are Indians, Coloureds, Africans and Whites. For affirmative action purposes, the constitution puts the first three under one category, Black inorder to distinguish people who were historically disadvantaged by apartheid.

[4] At the time of conducting the study, this MOU was the only one out the six where the project for HIV/AIDS ante retroviral treatment for prevention of Mother to Child HIV transmission was piloted.

[5] As a midwife, I felt guilty and ashamed when these words were being said. Furthermore, I found it hard to believe that there could be a midwife who could behave like as what the woman said. From my clinical midwifery experience (5years), most midwives I worked with, although sometimes 'harsh', showed dedication to their 'call'.

[6] This is often has racial connotations, but both the woman and the midwife were from same race

[7] She seemed as if there was something else other than childbirth that was frightening her. Did not want to elaborate.

[8] A South African Initiative under the auspices of WHO to educate health care workers on evidence based reproductive health care (EBRHC). This is a collection of database in the form of CD from WHO Reproductive Library, and is updated annually.