

THESIS

PREGNANT WOMEN'S PERCEPTION AND APPLICATION OF HEALTH PROMOTION MESSAGES AT COMMUNITY HEALTH CENTRES

**PREGNANT WOMEN'S PERCEPTION AND APPLICATION OF HEALTH PROMOTION
MESSAGES AT COMMUNITY HEALTH CENTRES**

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ABSTRACT

Introduction

Studies have shown that pregnant women do understand and value information and that of their unborn child. However, those providing HP services often focus on medical procedures and health education messages, ignoring the cultural, socio-economic and psychological dimensions that impact on women's health. This research aims to look at a specific component of HP i.e. the HPMs shared with pregnant women attending Stellenbosch and KCHC Antenatal HPP and their perceptions of how they apply messages in their daily lives.

Methods

A qualitative evaluation study was conducted in two antenatal clinics where a trained health promoter offers regular HP classes during clinic sessions. A purposive sample of nine pregnant women who had participated in the HPP were interviewed using a qualitative interview guide focusing on the following themes: Sources of health information, strengths and weaknesses of the programme, what HPMs they recalled, which messages they had been able to apply and promoting factors and barriers to application of HPMs, sharing of health information learned and perceptions of application of health messages in the community. The interviews were conducted by the primary investigator and recorded and transcribed. Data collection and data analysis were conducted simultaneously. Barnard's fourteen stage methods of analysing interview transcripts were used a system for analysing the data.

Results

The women perceived the programme as wanting "to help us", but note that it does not reach all pregnant women. A specific strength noted repeatedly was the health promoter's ability to make the messages concrete and understandable, such as detail on what to eat and not just general messages to eat better. Weaknesses were that the programme sessions are once off, and it does not address psychosocial context of both pregnancy and the women's lives. HPMs most remembered by the women related

primarily to cigarette smoking, alcohol use and breastfeeding. Messages they were able to apply include improving eating habits and reduced smoking. Support and concern for the child made it possible to apply the HPMs, while stress and being alone were the major barriers cited to applying HPMs. Women would like to continue to reduce smoking and drinking after pregnancy, but note that this will be difficult to do. They share the information they learn with their mothers, and other family members, but find that not understanding and not being able to remember are barriers to sharing and applying messages. There was a perception that some women do not want to be helped and are irresponsible, and that is why they do not apply the information they are given, especially with regard to addictive behaviours such as smoking and drinking.

Conclusions

The antenatal HPP at Stellenbosch and KCHC's is beneficial to many of the participants providing them with improved knowledge. However, the programme does not have the necessary follow-up or community involvement so support application of HPMs for many women. While some women are able to apply the messages for the good of the child, such as improved eating and reduced smoking during pregnancy, others find that life stressors and lack of support prevent them from making desired behaviour changes, or continuing these changes after pregnancy. Recommendations for improving and expanding the programme are based on HP settings and HP empowerment frameworks.

DECLARATION

I declare that this thesis is my own work, that it has not been submitted before for any degree or examination in any other tertiary educational institution, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Roberta Gordon

May 2005



Signed:

Date:

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ACRONYMS

CCHC	Cloetesville Community Health Centre
CCR:	Critical Consciousness Raising
CHC:	Community Health Centres
CHW:	Community Health Worker
FHW:	Farm Health Worker
HP:	Health Promotion
HPE:	Health Promotion Evaluation
HPM:	Health Promotion Message
HPP:	Health Promotion Programme
HPO:	Health Promotion Officer
KCHC:	Klapmuts Community Health Centre
LBW:	Low Birth Weight
NGO:	Non Governmental Organization
WHO:	World Health Organization



CHAPTER I

1.1 INTRODUCTION AND BACKGROUND

HP as we know it today has evolved from health education, an element of primary health care. The main focus of health education was to change individual behaviour. However this endeavour did not bring about noticeable and lasting change in the health and health behaviour of individuals and communities. The reason for this could be that individuals live in communities that are governed by social, economic and political elements, which can be major barriers to behaviour change. These barriers affect the health choices individuals will make.

Health education also puts the responsibility of health squarely on the shoulders of the individual. HP however, includes health education, but recognizes that health is the responsibility of all, and that health problems can have multiple casual factors. Therefore to address a health problem at individual and community level often requires a combined and co-ordinated response from all. All could include government policy makers, educators, well-managed municipalities, law enforcement, Department of Health, town planners, and most importantly the individual and community itself.

HPPs have included group and individual educational lectures, community empowerment projects, support and counselling groups, HIV education in schools and from the media, non-governmental organisations (NGO), community projects, Soup Kitchens (run by churches), health promotion in hospitals, government programmes and public health policies.

HPPs have evolved further in Europe, Canada and Australia, than in developing countries. They have established HP activities in hospitals, schools, cities and work places.

Although HP principles and strategies have been welcomed in developing countries, progress of HP activities have been hampered by shortage of skilled manpower, poor environmental infrastructure and governments undermining the value of HP and its effects on the well-being of communities.

By 1986 a large number of community based HP projects were already established on the African Continent. For example in 1985 the Tanzania Government launched a comprehensive HIV control programme (Klepp et al, 1999). In Uganda combined efforts by government, NGO's religious organisations communities and individuals resulted in a decline in HIV prevalence.

In South Africa research in health promotion is a relatively new field of study. More so is the evaluation of H.P. "initiatives" Yeatman and Nove (2002). This could be due to the fact that H.P. is seen through different eyes by different people WHO (1991) or simply that internationally and nationally the concept is still relatively "new". The chief goal of HP however is to effectively improve health behaviour.



Since the concept is relatively new, it is not surprising that few medical schools "have introduced a substantive course on the subject" Gillies and Elwood (1989). The result is that often those who attend HP courses are left on their own to implement HPPs at grass roots level. Understandably, but unfortunately implementation of HPPs are not necessarily followed by HPP evaluation. Nursing staff has pioneered HP South Africa. One example is the HP unit at Cloeteville CHC in Stellenbosch.

1.2 DESCRIPTION OF STUDY SETTING – STELLENBOSCH & KLAPMUTS

Stellenbosch and Klapmuts are two towns in the Westcoast/Wineland region. There are approximately 15000 households in Stellenbosch. White households predominate with 47,5%, followed by coloured with 30,5% and black households with 20,8%. Stellenbosch is a peri-urban farming area, known for its wine industry and tourist activities. Klapmuts is

primarily a rural wine farming area, known for its wine industry and tourist activities.. In Klapmuts coloured households dominate with approximately 83,7% of households, followed by Black and White households at 8,0% each.

A situational analysis by Hein Odendaal of the Obstetric, Gynaecologic and Neonatal Services in the Westcoast / Winelands region in 2004 revealed the following:

- Severe shortage of health personnel had cascading effects on patient care especially with regard to talking and listening to them.
- Pregnant women that booked late.
- A high percentage of teenage pregnancies.
- Poor communication at most district hospitals between staff doing antenatal care and those staff that manage deliveries.
- Communication with Xhosa patients are hampered because interpreters are not always available.
- Newly appointed doctors lacked practical experience in certain procedures such as tubal ligation after deliveries.
- Large numbers of children are handicapped.
- Transport difficulties such as response time of emergency transport are experienced at most district hospitals.
- Areas of work are not covered when staff is on training.
- Essential programme protocols and guidelines were available in only 53% of district hospitals. Some protocols such as pre-pregnancy counselling, diagnosis of pregnancy in the clinic are not available in any of the 7 district hospitals. Protocol for Better Birth Initiative is only available in 2 of the 7 district hospitals.
- In Municipal Clinics, 52% of the guidelines and protocols were available. For example, protocols for oral contraceptive pill were available in only 2 of the 6 municipal clinics, the protocol for injectable contraceptives is found in only 1 of 6 clinics, and protocol for contraceptive devices in none of the clinics.

The lack of protocols obviously makes it difficult for Health Staff to send a consistent message to those women wanting to prevent pregnancies. It is interesting to note that protocols such as Termination of Pregnancy (counselling) are available in all 6 municipal clinics, and that the Emergency Contraception protocol is available in 5 of the 6 clinics. This gives one the impression that the Health Authorities value a consistent message to a woman with an unwanted pregnancy, but not for women wanting to prevent a pregnancy. This just seem such a contradiction in an area with high teenage pregnancies and where some women are still having a 3rd and 4th child despite their poor socio-economic conditions.

Women in the region are in general economically dependent on men. Women in general, (especially Xhosa women) have little authority with regard to planning pregnancy (that is timing, number and spacing of birth). The factors that can be attributed to this is access to Community Health Centres (for contraception), knowledge, their partner's support and the "cultural construction of gender, that is the worth of motherhood for the culture or community" (Krumeich, in press). It appears that a number of factors dictate the extent to which women can exercise control of their bodies and health. This strongly suggests that women (especially in rural areas and those living on farms do not necessarily have "autonomous choices" (Krumeich, in press). HPPs for pregnant women must reflect this understanding, if it is to be relevant and sustainable and achieve it's goals to improve a womans understanding of health throughout their lives and reduce LBW.

Maart (2003) in her study of childbearing women in the West Coast/Winelands region concluded the following:

- "Women do not have the support or an enabling environment to easily reduce smoking and alcohol use"
- "Women do not have the financial support to improve nutrition during pregnancy"
- "Women do not have support to exercise control over their fertility"
- "Women do not have the support to protect herself from physical abuse"
- A high proportion of pregnancies are unplanned and women could be at higher risk for unhealthy habits if support from the health service and the community is inadequate"

1.3 **THE HPP AT CLOETESVILLE AND KLAPMUTS CHC's**

The HP officer stationed at CCHC in Stellenbosch provides a HP service at the CCHC and since September 2003 has extended her services to KCHC on request of the Community Health Centre CHC manager there. The HPO requested that the HPP be inducted.

In order for the researcher to evaluate this programme (or at least aspects of it), the context in which it is implement and the people involved will be described.

The aim of the HPP is to promote health in pregnant women in Stellenbosch and Klapmuts, in the hope of helping them to acquire health knowledge to improve their health status and that of their unborn child. This is done through the provision of educational messages when they visit the antenatal service at the respective CHC's. HP is conducted using a formal HP unit that forms part of the antenatal programme of the CCHC. From the researcher's observations (of HP activity), interviews with the HPO and perusal of the minutes (dating from 1993) one can describe the HP activity as one that provides health-related information. A file with HP lessons is available; however the HP unit does not have a complete documented HP curriculum.

The HPP in Stellenbosch attempts "to enable" the pregnant women "to make wise health choices (based on the information given to them) and to encourage them to live healthy "lives" so that they can deliver healthy babies. The preventative model of health education appears to apply here. This model implies that the woman's "unhealthy behaviour" (smoking, drinking), or her lack of education is responsible for her poor health and ultimately that of her unborn child.

The programme therefore attempts to educate these women. The content is mostly medical in nature. Should the outcome be undesirable (i.e. poor health of mother or a child is born with low birth weight) the mother would “be responsible”, because she did not follow the advice and medical information given to her (Werner and Sanders, 1997).

1.4 HISTORY OF HP CCHC

Nursing Staff at CCHC started HP. Minutes of staff meetings dated 1, 10 and 24 November and 1 December 1993 in Stellenbosch revealed the following:

Minutes of 1 November 1993:

- Nursing staff was doing individual HP (Health Education).
- The HPO was doing group HP.
- Most pregnant women arrived later in the morning and only then groups could be divided into Xhosa and Afrikaans speaking ones. Early the morning there were too few women.
- A system of record keeping was needed that would indicate the lessons pregnant women attended.
- They were unclear as to which lesson should be given to pregnant women on their first visit.

Minutes of 10 November 1993:

- Staff at the meeting decided that pregnant women should not drink alcohol and smoke, and that pregnant women should be informed of the effect of alcohol and nicotine.
- Staff sympathized with pregnant women who drank alcohol, but found it unacceptable (because of “onkunde”) i.e. the women’s lack of knowledge.
- Young pregnant women were reported wearing tight clothing to hide their pregnancy.
- Pregnant women who did not have food were referred to Social Services.

Minutes of 1 December 1993:

- A member (nursing Staff) pointed out that HP is individual and depended on circumstances
- Teenagers should be approached differently than women who are pregnant with their fourth child.
- A decision was made that individual health promotion must be a continuous process.
- Group HP must strengthen and reinforce individual HP.
- The HP lessons given by Nursing Staff and HPO must be consistent.
- The antenatal sisters must be familiar with the lessons given in the groups although they were not doing the HP groups.
- They were reminded that shortage of staff affected HP and concerns were expressed that the gains made by HP was lost if the service was interrupted when the HPO was away.



1.5 THE PREGNANT WOMEN AT THE CCHC – PERCEIVED CHANGE IN THE LAST 10 YEARS

Initially only Cloetesville CHC existed and large numbers of patients came from the surrounding areas such as Klapmuts and Kyamandie. These areas now have their CHC's.

- Women wanted an average of four children. Some women are now saying they want two or three children. However there are still women who want more children.
- Pregnant women often visited the CHC when they were 7 months pregnant. One reason for this was that women could not get off from work. Pregnant women are now visiting the CHC earlier in their pregnancy.
- Pregnant women often arrived at the CHC dirty and “drunk” (intoxicated with alcohol). This is no longer occurring.
- Very poor follow up initially, pregnant women only attended the CHC once to get their “green card” (an antenatal card for admission to labour wards at Stellenbosch Hospital). The follow up are more regular, however at CCHC attendance of follow up appointments have dwindled while KCHC follow up visits are better.
- New labours policy, such as maternity leave, have contributed to regular follow up after birth, as women now have the opportunity to “rest” and attend to their newborn. However there are still employers who are abusing this policy.
-

1.6 THE HPO

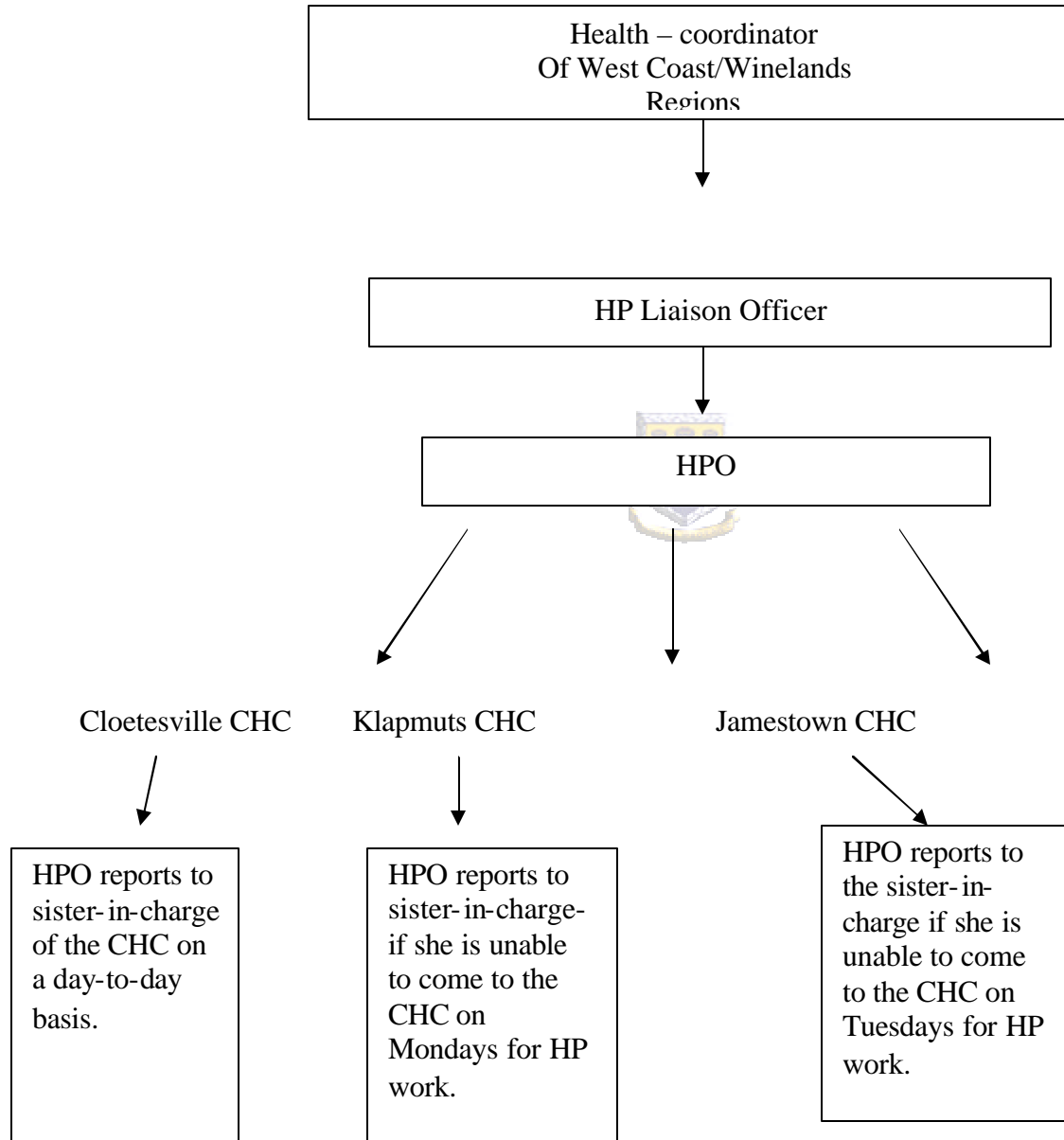
All HP tasks are her responsibility. She attends various HP training courses and incorporates the information into her programme. She shares the health education messages with women. She is able to speak Afrikaans, English and Xhosa. The researcher observed that the HPO blended in, in style and dress, with the women who attended the HPP. Although her approach was democratic, her attempts to draw them into the discussion during a session did not necessarily lead to spontaneous interaction and discussion from the women.

Skills that a HPO needs – working at a CHC according to the HPO:

- Work with people with different cultures and education levels e.g. literate/illiterate.
- Plan and priorities.
- Must be mature – (not to take things very personally or become emotional and yet care).
- “A passion” – value what you do. Be committed
- Driving skills (so that you could go the extra mile).
- Networking with NGO’s.
- “You must have intuition or approach a person in a certain way to help the person” (HPO), or be able to discern “individuals perceptions and construction of events Lincoln (1994), cited by Raphael (2000).



Supervision of HPO



TIME TABLE OF HPO				
MONDAYS	TUESDAYS	WEDNESDAYS	THURSDAYS	FRIDAYS
<ul style="list-style-type: none"> <input type="checkbox"/> Klapmuts CHC: <input type="checkbox"/> ANC Health Pro. <input type="checkbox"/> Malnutrition 0 – 5 yrs N/Prom. For the babies <input type="checkbox"/> Oral hygiene at school with Gr R and Gr 1's – 10h30 – 11h30 <input type="checkbox"/> At school once a month – also in Klapmuts. <input type="checkbox"/> Crèche Oral Hygiene. 	<ul style="list-style-type: none"> <input type="checkbox"/> Jamestown CHC: 08h30 – 09h00 – 10h00. <input type="checkbox"/> Malnutrition for children 0 – 5 yrs 10h00 – 10h30. <input type="checkbox"/> Oral Health at school for Grade R and 1's 2 crèches twice a month 09h00 – 10h30. <input type="checkbox"/> Once a month group discussion for DLAB and HPT patients – diet and exercises. 	<ul style="list-style-type: none"> <input type="checkbox"/> CGGS CCHC 08h00 Diabetics ?? 12h30. 	<ul style="list-style-type: none"> <input type="checkbox"/> I do CARE ARVT Clinic <input type="checkbox"/> Treatment for HIV <input type="checkbox"/> Wellness Support Group for people that are HIV and their families and friends. <input type="checkbox"/> New patients follow ups – starters on ?? follow ups. 	<ul style="list-style-type: none"> <input type="checkbox"/> HPT H/Prom <input type="checkbox"/> ANC – H/Prom
<ul style="list-style-type: none"> <input type="checkbox"/> General ps advice on general issues. 	<ul style="list-style-type: none"> <input type="checkbox"/> Afternoon sort of free Family Planning comes. 	<ul style="list-style-type: none"> <input type="checkbox"/> Admin 14h00 – 16h00 Family Planning – T.O.P's – Mostly school kids. 		
<ul style="list-style-type: none"> <input type="checkbox"/> Walk from Stellenbosch Station to Victoria Street Clinic – take a lift with their sisters 08h00. 				



1.7 THE HP SESSION

The women are approached by the HPO while they are waiting in the reception area of the CCHC. (At KCHC patients are screened and referred by the nursing sister to the HPO). They sit in a half circle in the HPO's room on chairs or next to each other on benches. The groups consist of approximately 8 – 12 pregnant women. The HP session lasts \pm 1 hour. The attendance is approximately one session per month as they attend the CHC for their monthly medical examination.

The information given is related to medical procedures and symptoms that the women are likely to experience at a particular stage of pregnancy. (See Appendix 1). This presents a problem because some of the women are in their second or third trimester before they attend the antenatal clinic for the first time and they therefore miss valuable information. This raises questions with regard to the accessibility of this service for pregnant women. The HPO uses charts, posters and drawing as methodologies to get the health messages across.

The HPO uses a lay approach Williams and Popay (1994) cited by Robertson and Hill, (1995) when she identifies an individual in the group, who she thinks requires individual attention. She meets with this woman privately, immediately after the group. Often her role then changes from educator to counselor and advisor Robertson and Hill (1995). If she feels there is a particular need, she will refer the woman to the appropriate service for further follow up.

Women generally give birth at the labour ward of Stellenbosch Hospital. According to the HPO, HPMs are not reinforced at the hospital because staff there believes that manpower is a problem.

1.8 THE DEMOGRAPHICS OF WOMAN WHO ATTEND THE HP SERVICE ACCORDING TO THE HPO

- Their ages range from 16 – 40 years old.
- The level of schooling – grade 1 to matric.

- The language spoken is predominantly Afrikaans and Xhosa.
- Marital status – approximately 50% are married.
- Socio-economic background ranges from low to middle income.
- Predominantly coloured population.

The women’s occupations range from scholar, university students, in-service worker, and farm labourers to those who are unemployed

1.9 PROBLEM DESCRIPTION

Providing information is the most “commonly adopted HP methodology” according to Downie et al (1996). However they go further by saying that a variety of approaches should be used, and is more effective for attitude changes. One cannot assume that the pregnant women should “ascribe” the same value to the HPMs as the HPO. It could also be regarded as a “stressful event” simply because they cannot comply. It is therefore necessary to examine how these pregnant women appraise the programme Downie et al (1996) or at least the “health messages” that they are advised to follow. This may be relevant for understanding the effectiveness of HPMs for these women.

According to Calnan (1986) health education messages have been “understood and accepted by people from all social classes”, but low socio-economic status acts as a barrier to the practice of “health-related behaviour”. This implies that although women know and understand that certain activities (such as drinking, smoking and poor eating habits) can be problematic for their health, they might for example continue to smoke during pregnancy as it “provides a means of coping with pressures created by the conflict between responsibilities for family care and the shortage of resources” (Calnan, 1986). It is these barriers that the HPO is aware of and her concerns regarding these issues are further described in the problem statement that follows.

According to the HPO, culture and social structure have an impact upon pregnant women’s behaviour, especially the pregnant women living or working on farms in Stellenbosch and Klapmuts. Issues such as the number of children, the use of contraceptives, abuse, and lifestyles habits influence the attention women give to themselves and their health.

Despite the HPO and her management's strong belief in the value of a HPP, and their conviction that it "does work", the HPO queried how much of the HPMs were put into practice by pregnant women at home. From the interviews with the HPO it became clear that her concerns were valid. Previous studies in this project by Public Health Master Students from the University of the Western Cape have found that low birth weight in the West Coast/Wineland region has been identified as a "major public health problem", and that contributing lifestyle factors such as the use of alcohol and smoking during pregnancy are prevalent in the region Maart (2003). LBW is also an indicator that can suggest that the health of pregnant women in the region is compromised. The fact that the attendance of pregnant women at the CCHC's HPP has dwindled, suggests that further investigation into the effectiveness and sustainability of HPP is needed and prompts the question:

"How relevant do these messages appear to these women"?

The purpose of this study is therefore to determine to what extent the HPMs are applied by the pregnant women attending the HPP at the CHCs in Stellenbosch and Klapmuts. HPPs of the HPMs are on pregnancy procedures and symptoms and complications that can occur. This information may therefore be perceived by these pregnant women as relevant only for a particular time period and its lasting effects lost until the next pregnancy. This therefore defeats the purpose of long-term healthy outcomes for women Mora and Nestel (2000). This study will also give understanding as to whether the timing and content of the HPMs are appropriate and what information is valued and used by them and why?

1.10 DEFINITION OF TERMS

For the purpose of this study the following definitions of HP, HPE and messages apply:

HP

WHO (1986) Ottawa Charter defines HP as "the process of enabling people to increase control over and to improve their health".

HPE

According to Nutbeam (1998) "HPE is an assessment of the extent to which a HP achieves a `valued` outcome".

Messages

According to Webster's Reference Library in the Concise Edition English Dictionary (2002) a message is defined as "any spoken, written or other form of communication; the chief idea that the writer, artist, etc. seeks to communicate in a work".

1.11 OVERVIEW OF THE REST OF THE THESIS

In **Chapter two** the literature the meaning of HP is given. A typology of health promoting hospitals defines the type of health promoting setting that is sustainable and more conducive for the practice of "health related behaviour". The key areas and aims in the HP curriculum, makes one aware that it is not only "knowledge" that is required for empowerment, but that "skill, attitude and interest" is equally important.

In **Chapter three** a detail account is given of the study design.

Chapter four describes the results with quotes to substantiate the emergence of various themes.



Chapter Five focuses on the theoretical frameworks of empowerment model Naidoo and Wills (2000), HP Tones and Tillford (2001), and Health Promoting hospitals framework Johnson and Baum (2001) to frame the discussions, conclusion and recommendations.

CHAPTER II

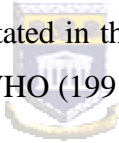
2. LITERATURE REVIEW

2.1 PRIORITIES OF HP

“In 1977 the fourth international conference on HP in Jakarta proposed the following priorities for HP in the 21st century”. (Adelaide, Australia, 1988).

- ❑ “Promote social responsibility for health”
- ❑ “Increase investment for health development”
- ❑ “Consolidate and expand partnerships for health”
- ❑ “Increase community capacity and empower the individual”
- ❑ “Secure an infrastructure for health promotion”

According to World Health Organization “the aim of health promotion is to foster health development. The attainment of the highest achievable levels of health. HP incorporates both individual and societal action for health. It forms an integral part of the primary health care strategy for achieving health for all, as stated in the historic declaration of Alma – Ata and at the forty-second World Health Assembly” WHO (1991).



2.2 HPPs

Target population of HPP

Programmes for women’s health in developing countries are aiming their health messages at women directly, but is often that the true “target” for the information is either the children or the rest of her family, with secondary benefits for women themselves Mora & Nestel (2000).

It is therefore not surprising that women address the well being of their children and families first, while neglecting themselves (whether they are pregnant or not).

It can therefore appear that these well intended health messages might indirectly reinforce this self sacrificing role that women have, and that this is passed on from generation to generation.

One can say this role is observed by their daughters and sons from an early age, and therefore seen as normal, to be passed on to the next generation. The cycle continues.

The problem is therefore not the actual health information given/shared (related to her pregnant condition), but women's perceptions that they are valued **now** that they are pregnant or mothers, not as women in their own right, whose health and well being is important to their community and nation throughout their whole lives.

This makes one wonder whether the health (promotion health) messages are clear to women. Is it clear to them that the messages are intended for their well-being.

In truth the messages of any health program that target women, must leave no doubt in their minds and the minds of others, that **the chief idea** of the HPMs for women is for their well being, and that secondary benefits for their children and family are just that, **secondary**. The **chief idea** (messages) must also be reflected in the choice of appropriate content.

2.3 CONTENT AND CONTEXT OF HPP

Programmes with strong emphasis on medical and health content do not make a serious attempt to address the “environmental stressors” Mamelle et al (1998) and the psychological factors that may affect the health of pregnant women.

A study done by Mamelle et al (1998) with regard to the relationship between psychological factors and pre-term birth identified six “psychological dimensions” namely:

- *Pregnancy's effects on the body;*
- *Feelings of fulfillment during pregnancy;*
- *Attitude towards daily life behaviour while expecting;*
- *The role of the baby's father;*
- *Family ties and maternal identification;*
- *Beliefs and superstitions*

The “Psychological dimensions” influence health behaviour and actions of pregnant women and must therefore be part of the content of HPM.

Once these Psychological dimensions are part of the HPP content for pregnant women, they may actually feel understood. What may previously have been seen as “unreal” health message

demands are placed in “context” the psychological dimensions and physical setting women experience e.g. not resorting to alcohol or smoking to reduce stress because the baby’s father is not supportive (Manelle et al. 1998). Therefore putting the message in “real context” will be more relevant to the women and is also a show of respect and good communication practice in health care to women. Nutbeam (1998) associates good communication practice with individual and community empowerment.

Rowe et al (2002), describes good communications as follows:

- *“Listening to women’s preferences specifically staff listening to them, and responding to new individual needs”.*
- *“A two-way process”.*
- *“Clear and readily available information”.*
- *“Shared decision-making that can improve psychological and other health outcomes”.*
- *“Is information exchange with the purpose of creating a good interpersonal relationship and medical decision making”.*



2.4 HP AND POVERTY

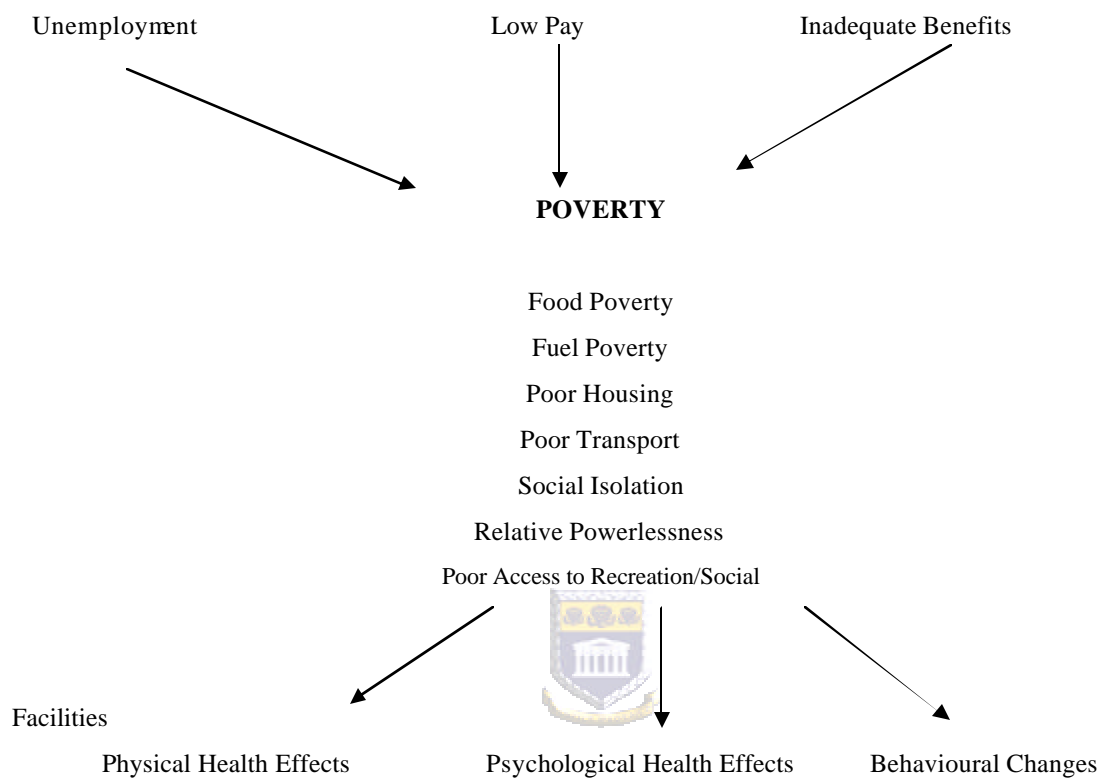
Another “context” that needs attention is that of **HP in poverty**.

Health workers reported that women living on farms in the West Coast/Wineland region live in poverty and often do not have sufficient money to buy food and basic conveniences such as electricity Maart (2003).

People often choose what is considered as unhealthy behaviour, but this should not be considered as a defiant or careless responds to their health, but as their way of coping with the limited choices they have in a poverty situation according to Graham (1987) cited by (Naidoo and Wills, 1998).

If poverty, and not the lack of information, is a major barrier then HPP need to expand their agenda in practice to be effective for individualist communities that come from a poverty setting Naidoo & Wills (1998).

HOW POVERTY AFFECTS HEALTH



Low birth weights		Stress		Smoking
Infant deaths	?	Anxiety	?	Drug abuse
Poor growth in children		Depression		Low exercise levels
Respiratory diseases	?	Low self-esteem	?	Poor diets
Heart disease				
Accidents				

Figure 2.2 How poverty affects health (Blackburn, 1992)

Source: Naidoo & Wills (1998)

From Blackburn's illustration of Poverty, one can make the following assumptions.

Poverty:

- Affects every area of one's life.
- Affects one's health physically and mentally.
- Shapes, distorts and limits the way one feel and think about oneself and others.
- Makes one feel powerless and trapped.
- Affects the way one react to others, the way one cares, shares and live together.
- Can make one react recklessly.
- Invites crime and violence.
- Makes one complacent.
- Makes one unkind, selfish and even jealous of one's neighbours small achievements.
- Is stressful, causing one to resort to temporarily solutions.
- Destroys or limits a person's dreams and future plans.
- Affects the next generation in some way.
- It is a vicious cycle.



In short, poverty is ugly and powerful. It destroys lives, leaving people powerless, with no dignity and hope that tomorrow's struggle will be any different than today's. It is therefore necessary that poverty's impact is understood and strategies to deal with it, be incorporated in health promotion programmes.

2.5 STRATEGIES TO PROMOTE HEALTH IN POVERTY

The strategies to promote health in poverty by Naidoo & Wills (1998) are very similar to the priorities of HP. At a macro level, they emphasize policy changes that increase access to the necessities for life such as a minimum wage and employment policies that enable women to work.

At a micro level they suggest that practitioner clarify ideas of what poverty is and how it affects clients, and how this is or is not acknowledged in everyday work.

At this level adequate training and resources for health promoters need to be made available.

Poverty need to be viewed by practitioners as the fundamental and not as an addition to H.P work

so that HPP can reflect this “Poverty Perspective” and make more sense to the recipients of such a program. For example, facilitating food co-operatives as “health food on a budget” sessions with local mothers might be more effective than repeating healthy food messages to women who knows this information but are unable to act upon it” Naidoo & Wills (1998).

Table 2.1 summarizes points for practices outlined by Laughin and Black (1995), Reproduced by Naidoo and Wills (1998).

Table 2.1 Helpful and unhelpful health and welfare services

Helpful	Unhelpful
An integrated approach	Services that treat financial, health and social problems as unrelated
A co-ordinate response	Individual agencies working on separate sets of problems
Services which offer realistic advice and recognize the limitations that poverty places on people	Providing help only when families are in crisis Interventions which individualize problems
Partnerships between families and workers where families’ contributions are valued	Services based on what professionals think that families want rather than what families say they want Failure to recognize what families do achieve in adversity Blaming families for their poverty
Services that are permanent	Temporary or short term projects
Services that are relevant	Forcing families to define financial problems as emotional problems or personal inadequacy before help is given
Services that are easy to use	Only providing help when families are labeled as a problem

Naidoo and Wills (1998) suggest that health promoters “recognize the importance of equity as a guiding principle. For health promoters this means:

- ❑ *Social commentary – collecting data on how social and economic factors influence health*
- ❑ *Accessible services – recognizing ways in which interventions and services can exclude those on low income*

- *Appropriate services – providing services, which focus on client, defined issues and needs.*

2.6 ANTENATAL HPPs

HP activities have existed in developed and undeveloped countries for a number of years.

Despite advances in medicine and comprehensive health care during pregnancy, weight (LBW) in Canada and the United States have persisted for the last thirty years Newburn – Cook et al (2002).

In order to shed light on reasons why progress is compromised in maternal and childcare, we need to examine what and how HPP are delivered. The researcher will look specifically at delivery of nutritional, smoking and alcohol programmes, because of the relevance of these modifiable factors to this study.

Nutritional and supplementary feeding programmes have focused their HPM on a balanced diet (e.g. eating all food groups) and encouraging women to take their iron and multi-vitamin supplements. Obviously informing them of the various benefits of these supplements. However these programmes are only targeted to women once they are pregnant and may not have the desired and significant biological effects, because nutritional reserves are not built up Mora & Nestle (2000).

Health programme designers also assume that women will use the service during the first trimester. This is however not happening in rural areas. These women often miss out on valuable advice and supplements during their first and even second trimester. An additional problem is compliance in using iron and other supplements. A number of reasons could exist that influence compliance, for example taking the supplement in tablet form could have a physiological response (nausea) or taking the supplement before or after a meal may be difficult to follow if food is not available Mora & Nestle (2000).

Mora & Nestle (2000) suggest that women start from adolescents with iron and multi-vitamin supplements, so that by the time they get pregnant, iron reserves have been built up. Nutritional studies in Guatemala have provided evidence of the benefits of providing improved nutrition

during early childhood. These benefits were evident in the improved physical stature and cognitive function later in adulthood.

Most health education programmes focus on the negative and harmful effects of using alcohol, while neglecting to put the alcohol-related problem into a proper social context. Therefore these programmes often fail to help those who are using alcohol moderately, or those who are already dependent but have a desire to stop completely, because they are aware of the health problems related to alcohol consumption but cannot stop due to social, emotional or other reasons.

According to Goodman, Lovejoy and Sherratt (1995) as cited by Roche & Evan, (1998) understanding “the meaning that alcohol has for its users” is critical. They suggest a shift in focus in promotive programmes from volume consumption to risk situations in which alcohol is consumed.

Roche & Evan (1998) argue that people in communities consume different amounts for different reasons at different times, and that people perceive harmful effects differently. There are those who perceive that alcohol use is harmful, and those who do not perceive it as risky, yet there are others that believe in the health benefits of alcohol consumption. Health personnel must acknowledge all these different viewpoints in a non-judgmental way, so that people will feel less threatened to approach health personnel for help.

A study done by Newburn-Cook et al (2002) in Alberta (Canada), revealed that despite women’s knowledge of the harm of smoking, 28% of women continue to smoke during pregnancy. These researchers estimated that eliminating maternal smoking during pregnancy could have prevented approximately 24% of LBW infants.

This is the reason why HPP need to move beyond trying to improve individual knowledge. Hearman, Sprague, and Stewart, (2001) cited by Newburn-Cook et al (2002) suggested “a population health strategy that focuses on prevention and HP in women of childbearing age to reduce LBW is needed.

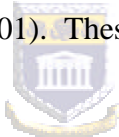
Newburn et al (2002) also identified other modifiable risk factors associated with LBW, namely multiple pregnancy, low pre-pregnancy weight ($\leq 45\text{kg}$), inadequate weight gain during

pregnancy, and older maternal age (≥ 35 yrs), at the time of delivery. According to these researchers approximately one third of infants born with LBW could be attributed to modifiable risk factors.

2.6.1 COMPONENTS OF A PREGNANCY EDUCATION PROGRAMME

The curriculum content covered by the HPO is characteristic of content covered in literature of prenatal care (Alexander and Kotel Chuck 2001). The medical content of prenatal care described in the literature include urine and blood test, blood pressure monitoring, weight measurements, pelvic examination and obtaining a health history (Alexander and Kotel Chuck 2001). The above medical procedures are not performed by the HPO of this study, but she explains how it is performed and why. Any complication of risks that can arise due to e.g. high blood pressure is discussed with pregnant women in HP sessions.

The health education and behaviour messages covered in literature are the use of supplements; proper diet and weight gain, practising health lifestyle habits by avoiding alcohol, drugs and tobacco (Alexander and Kotel Chuck 2001). These above messages are also covered by the HPO of this study.



2.6.2 EFFECTS OF EDUCATION IN PREGNANCY

Alexander and Kotel Chuck (2001), suggest that we seek evidence to determine what prenatal care content are effective. Kogan et al (1994), in their study discovered a weak association between LBW reduction and receiving all health behaviour messages and no association between messages and no association between receiving all medical procedures within the first two visits and LBW.

2.7 WHO DOES HP?

HP is integrated in the roles Yeatman and Nove (2000) of various professions such as nursing, medical doctors, occupational therapists and dieticians. Community health staff (and this can include lay people) spend a tenth of their time doing HP activities Yeatman & Nove (2000). To them HP tasks are secondary to their “actual” roles while the primary role of the HPO should be the proposed priorities for H.P. The fact that it appear to be part of the roles of other’s besides the HP workers, implies that it is recognized as crucial to health issues.

2.8 H.P. IN THE HEALTH CURRICULUM

According to Wear (1986) cited by Gillies and Elwood (1989) “HP appears to be placed in the courses of department’s, such as Community Medicine, which are low-status areas of Medicine and that this presents the topic as something separate, with only minimal impact in the bigger picture of health”.

The content that is predominantly medical in nature does not address the “relationships between beliefs and practices or the socio-economic factors” that impact health. This implies that HP workers are not taught to “look more broadly than behaviour changes” Lopez-Acuna et al (2000), as cited by Yeatman and Nove (2002). The benefit of various teaching methodologies such as role-play and drama are ignored for the more conventional and perceived cheaper methods (and often less effective methods) such as charts, posters and booklets. The value of different teaching methods for a particular audience is not explored and a “one fit all size” approach is adopted.

2.9 KEY AREAS AND AIMS OF A HEALTH PROMOTING CURRICULUM

Gillies and Elwood (1989) in their study of “HP in the Medical Curriculum identified the following key areas and aims. Although they applied it to university student and educators the issues remain relevant for HP educators and consumers as well as the broader community Gillies and Elwood (1989). The key areas are:

“Knowledge”

“Acquaintance with facts or concepts related to community health services and clients which enable students to answer questions about how or why systems or people operate or behave in the way that they do within various context”.

“Skills”

“Development of the ability to collect or obtain important data, organize them, assess them and examine various options; to reach individual and group decisions; to develop social skills through social interactions within the group and with other health professionals and members of the public; and to develop skills in oral communication and in report writing”.

“Attitudes”

“Discuss and consider the nature of personal attitudes towards certain systems or groups of clients; develop autonomy combined with the ability to work co-operatively”.

“Interest”

“Providing a stimulating and enjoyable learning experience. Students are encouraged to adopt an eclectic approach, acquiring information in a variety of ways involving contact with a wide range of health professionals and members of the public”.

2.10 MODELS OF HP

Various Conceptual frameworks have been applied to HP. However for the purpose of this study, only 3 frameworks will be described here, namely the medical model, behaviour change model, and the empowerment model as described by Naidoo & Wills (2000).

Medical Model

This model focuses on prevention using medical intervention to prevent disease and untimely deaths. Prevention takes place at 3 Level namely:

- A Primary Level to prevent the onset of disease through immunization or health education for example.
- Secondary Level, which involves treatment to stop the progress of the disease.
- Tertiary Level – at this level focus in on reducing further illness or/and disability.

This approach is most commonly used because medical personnel normally come face to face with the enormity of a health problem. They are also the ones who initiate the type of intervention that will occur. This is done without consulting individuals or communities, because the solution is seen as medical. This might be the reason why compliance is often problematic. This approach also struggles in a context as poverty, because interpretations of the problem are purely the perspective of medical personnel.

This approach also over-simplifies the problem and does not consider the multi-caused functions involved in a single health problem.

The Behaviour Change Model

This approach associates health behaviour with improved health. This approach tends to motivate and persuade people to choose healthier lifestyles. For example this approach would persuade pregnant women to stop drinking alcohol, because of the negative effects for her health and the impact on fetal growth. This approach would not consider the difficulty if the pregnant women were already addicted to alcohol or if she had visiting neighbours and friends who drank regularly. In other words, this approach does not consider the context in which alcohol was consumed. This approach would also blame the individual because it strongly associates the behaviour choice with improved health.

The Empowerment Model

This approach allows people to become aware of their own concerns, the origins of these concerns and ways that they could deal with it. In other words it builds individual and community capacity so that they are able to participate actively in changing their “social reality”. Here health personnel would facilitate the process of empowerment and not lead the process.

There are a number of different understandings of the concept of empowerment. This includes emotional, intellectual dimensions of empowerment as well as individual (self empowerment) and community empowerment.

Emotional or motivational dimensions of empowerment according to Campell and Macphail (2002) refers to “the access that target audiences have to real symbolic power (defined in terms of perceived respect and recognition from others) and/or economic power” to succeed Tawil, Verster, and O’Reilly (1995) cited by Campell & Macphail (2002).

Intellectual dimensions of empowerment

According to Campell & Macphail (2002), empowerment involves the critical analyses of circumstances.

Community Empowerment is defined as active community participation to gain mastery over their lives in the context of changing their social and political environment, Wallerstein & Benstein (1994) cited by Tones & Tifford (2001).

Individual or self empowerment involves the belief that people can be empowered on an individual level through life skills training, e.g. assertiveness training, Tones & Tifford (2001). It involves elements of self-esteem and perceived focus of control.

From the various understandings of empowerment the following can be summarized:

Through empowerment:

- A sense of control and autonomy is gained.
- Critical reasoning skills develop.
- Individuals and communities can participate actively because of skills gained to change their circumstances.
- Ownership of solutions could lead to a better compliance.
- There is improved and more informed partnership with authorities.
- Improved self-esteem for individuals and communities to realize their goals.

The benefits for choosing this approach is promising, however for an overall effect health services need to be re-orientated to this approach. This might be problematic considering most health service apply the Medical Model and is unaware that there could be another approach to address health problems.



2.11 THE HEALTH PROMOTING HOSPITALS APPROACH

A study by Johnson and Baum observed 4 approaches used in health promoting hospitals – Johnson and Baum (2001), namely:

“Doing a HP project” or first Level

This approach has value initially, especially when the concept is being introduced “to get staff involved in HP”. However sustainability of such a HP approach is questionable “without developing an organizational infrastructure to support the HP effort of staff” ,Johnson and Baum (2001).

“Delegating HP to the role of a specific division, department or staff or second Level”

According to Johnson and Baum (2001), this approach is evident in hospitals “that have HP units”. Staff is aware of these units, but they appear distant and see it as primary the responsibility of the HPO’s. It is not viewed as an integral part to be incorporated in the roles of

all staff members, the system and community as a whole. The problem with this is that it becomes difficult, if not impossible to “re-orient the health service at the hospital” to truly address any social and community barriers that impacts health and it’s effects on individuals, Johnson and Baum (2001).

“Being a health promoting setting or third Level”

This approach is predominately focused on the hospital becoming a health promotion “setting”. The HP service is directed to all that attend the hospital, the staff and the physical environment of the hospital but not to the broader community, Johnson and Baum (2001). Yeatman and Nove (2000) agreed “at an **organizational level**, support for HP needs to be integrated into the policies and pro-activities of the organization”.

Its effects in the broader community are therefore limited, because the problems that arise in a community cannot be solved by addressing only the “setting” in a community (i.e. the hospital).

“Being a health promotion setting and improving the health of the community or fourth Level”

This approach fosters a “commitment” from the organization itself. This approach allows for networks and collaboration to develop “with patients and their families, other service providers and the broader community to achieve the best outcomes”, Johnson and Baum (2001). Here all the role players are involved, so therefore the effects of HP are experienced in the broader community. This also implies that the broader community takes responsibility for success and failure and not only the target population of a HPP.

This approach will be used as the underlying theoretical framework for the evaluation of the HPP at CCHC and KCHC.

The HP unit at CCHC and KCHC has moved beyond the second Level, but has not fully embraced the third Level, although the HP unit is supported by senior management and staff, HP is still seen as primarily the work of the HPO. Even though the HP services have been extended to crèches in the Stellenbosch municipal area, which is part of the Level four function. Support at an organizational Level (Level three) must still be achieved.

The fact that a documented curriculum is not available makes it difficult to send a consistent message. HP protocols, activities and attitudes must be identified and incorporated into the work of all health personnel, including non clinical staff working at the CHC. The physical environment at both CHC's in which HP messages are given, are not convenient and structured for adolescents and adult learning. Therefore the above shortcomings need to be addressed to progress to Level three.

2.12 EVALUATING HPP

It is not always possible to say a particular HP activity is responsible for a particular change in health according to Baum (1998) as cited by Raphael (2000), but that “evaluation of HP activities need to be done to detect changes in the conditions that support health such as community characteristics and social policy contexts”, as well as unanticipated effects” that might further suggest strengths and weakness of a HP activity, Raphael (2000).

According to Tones and Tilford (1994) cited by Macdonalds et al (1996) “evaluation research in HP is not only concerned with outcomes, which may arguably be the case with other forms of evidence – base health care, but must also seek to gain insight into the process involved in programme implementation and the social and environmental context in which they take place”.

Attempting to choose or adopt a HP activity within a particular “setting” for a particular need “is unlikely to be successful” or to “achieve desired health goals”, Wiggers and Sanson Fisher (1998), if the context is not considered and those involved are not consulted and understood.

Evaluation is therefore an “essential tool” for initiating new programmes” adapting existing ones and motivating and “enhancing” professional development. WHO (1991). It is therefore the purpose of this study to evaluate the efficacy of a component, i.e. HPMs of the HPP at two of the CHCs in Stellenbosch to determine the relevance of HPP for the consumers, WHO (1991).

CHAPTER III

3. STUDY METHODS

3.1 THE PROBLEM STATEMENT

The ramifications from literature that can impact on the HPP in Stellenbosch and Klapmuts are multifaceted. Firstly the HPP is defined differently by the very people involved, and this produces its own problems. It is therefore open to one's own interpretation and interventions as to how best to achieve its goals.

The "typology of health promoting hospitals" further highlights possible limitations. One questions whether the "voices and perspectives" of these women and the communities they came from have been considered in the curriculum. This raises questions as to the relevance. Others wanting to start a similar initiative in the West Coast/Winelands region want confirmation that the HPP work. This study is unable to evaluate every component of this HPP because of time. However, information that could contribute to better understanding of this component's impact addresses the "heart" of any HPP. The researcher will therefore determine to what extent pregnant women in their daily lives apply HPM.

The efficiency of the HPP at CCHC and KCHC is unknown. This study can give valuable insight into what information is understood and relevant and is practical in application. This knowledge could contribute to the development of new methods of providing information that might improve for the sustainable health of these women. It could also give us insight into whether the pregnant women should be the only target group, especially since "women's autonomy" in rural and farming communities is a matter that needs consideration.

The HP curriculum's primary focus is on pregnancy procedures, symptoms and complications. This information can therefore be perceived by these pregnant women as relevant only for a particular time period and it's lasting effects lost until the next pregnancy. This therefore defeats the purpose of long-term healthy outcomes for women Mora and Nestel (2000). This study will also give understanding as to whether the timing and content of the health messages are relevant/correct. It is therefore necessary to know how these women view the HPMs and what

information is valued and used by them and why? The aim and objectives are therefore as follows:

3.2 AIMS

- To evaluate the HPP to determine to what extent the HPMs are applied by pregnant women attending the CHC's in Stellenbosch and Klapmuts.

3.3 OBJECTIVES

- To determine the strengths of the HPMs as perceived by the participants.
- To determine the weakness of the HPMs as perceived by the participants.
- To determine the applied benefits of HPMs for the women personally.
- To gain understanding of their perceptions and use of the HPM.
-

3.4 METHODOLOGY: Qualitative

HP interventions are not simple processes. One cannot assume that a particular intervention is solely responsible for a negative or positive health outcome. Health and illness decisions are multiply determined, and it is these many viewpoints that need to be known and understood, in order to make sense of application or compliance after a particular health intervention. It is true that the researcher could have some ideas of why people comply or not, but it is unlikely that she will know exactly what barriers exist that compromise compliance or the meaning participants would put to compliance and non-compliance. A qualitative evaluation was therefore undertaken. According to Pope and Mays (1995), "the goal of qualitative research is the development of concepts which help us to understand social phenomena, in natural (rather than experimental) settings, giving due emphasis to the meaning, experiences, and reviews of all the participants".

As a result they are particularly suited, for example, to understanding how it is that health education messages on stopping smoking can be known to teenagers or young working class women, but not perceived to be relevant to their everyday lives".

Qualitative evaluation researcher asks the questions "how" and "why", and can therefore direct us to a strategy for intervention or improvement. Providing answers to these questions "illuminates"

the process and the outcome and makes it possible for others to compare and repeat successful interventions Macdonald et al (1996).

In addition since qualitative research takes place in natural settings that can alter for any number of reasons during the research process, the researcher can adapt her plans Bryman in Baum (1995) as the research progresses.

3.5 A REVIEW OF DIFFERENT TYPES OF QUALITATIVE RESEARCH FOR THIS STUDY

For the purpose of this study it is necessary to have an understanding of the social and cultural context in which pregnant women are expected to apply HPM's. This information is very similar to what Ethnographers would want, however the research used in-depth interview as the main source to collect data, instead of intensive fieldwork and participant observation that is central to Ethnographic or anthropological research. Katzenellenbogen et al (1997) says that anthropological theory is not concerned with tracing specific correlations between variables but sets out to describe and understand the process and phenomena that make a cultural system.

Culture directly influences the way people reason and decides what benefits there are in health messages. In recent ethnographic work even program or organizational culture have been studied because it is able to provide valuable insight into improving programme outcome or achieve programme goals. The researcher wanted to know how pregnant women perceived these HPM and what their experiences are with regard to compliance and their perceptions of barriers to compliance, a phenomenological perspective was therefore applied. According to Patton (2002), "one can employ a general phenomenological perspective to elucidate the importance of using methods that capture people's experience of the world without conducting a phenomenological study that focuses on the essence of shared experience".

This research arose due to a problem identified by the HPO health systems research (HSR) also has problem identification (either by those providing the service or those using the service) as the main characteristic. The researcher need a comprehensive picture of how HPP was delivered to pregnant women as well as the environmental (political, social and economic) influences that impacted on pregnant women. According to Katzenellenbogen et al (1997), HSR is "research done on the health system and all it's components, parts and activities". HSR can be approached

from a qualitative and quantitative perspective. Katzenellenbogen et al (undated), mentions a number of elements that can be evaluated in HSR. However this study characterized the elements “acceptability” and “effectiveness” in HSR.

The following definitions by Katzenellenbogen et al are:

“Acceptability describes users perceptions of the appropriateness’ of services, and emphasizes communication and mutual respect between staff and patients, continuity of care and convenience”.

“Effectiveness describes the ability of the intervention to work in the messy real world, with ordinary patients under normal health service conditions”.

HSR was used in this study because it generates information that addresses a particular problem at a particular place and time. Katzenellenbogen et al (undated).

3.6 STUDY POPULATION

The participants were pregnant women who attended the HPP in Stellenbosch or Klapmuts at least 3 times (during the same pregnancy). The reasons for the criteria of three times were used because they were “likely to be knowledgeable and informed about the subject under study. Nine pregnant women were selected to ensure that the sample included women with a variety of socio-demographic factors.

- Married or living with a partner/single
- Employed / Unemployed
- 16 – 19 Years 20 – 29 Years 30 – 40 Years
- Income below / above R1000.00 per month
- First pregnancy / more than one pregnancy

These socio-demographic factors were characteristic of pregnant women who attended the CHC’s

The table below lists the socio-demographic of each pregnant woman that participated in the study.

THE SOCIO-DEMOGRAPHICS OF THE PREGNANT WOMEN IN THIS STUDY

	PREGNANT WOMEN								
	Code 001	Code 002	Code 003	Code 004	Code 005	Code 006	Code 007	Code 008	Code 009
Married/Partner		x		x			x	x	
Single	x		x		x	x			x
16-19 yrs		x 18yrs	x 12yrs						
20-29 yrs					x 23yrs	x 28yrs		x 26yrs	x 21yrs
30-49 yrs	x 33yrs			x 33yrs			x 31yrs		
Income above R1000		x		x				x	x
Income below R1000	x		x		x	x	x		
First pregnancy		x	x		x				x
More than one pregnancy	x 6 th			x 4 th		x 2 nd	x 3 rd	x 3 rd	
Race: Coloured-C Black - B	C	C	C	C	B	B	C	C	C
Cloetesville				x	x				
Klapmuts	x	x	x			x	x	x	x
Education Level Grade - Gr	Gr 5	Gr 9	Gr 10	Gr 8	Gr 12	Gr 9	Gr 1	Gr 7	Gr 12

From the above table the following is evident:

- 55% of pregnant women are single
- 44% of pregnant women who attend are between 20 – 29 years old
- 55% of pregnant women earn less than R1000.00 per month or live in households where earnings are less than R1000.00. Not surprising most of the household that do have earnings above R1000.00 are where spouse/partner are present.
- 44% of the women experience their first pregnancy between 18 – 22 years.
- 44% of women have a 3rd or 4th child by the age of 33 years.

Most participants were approached by the HPO on their follow up appointment day to participate in the study. The research initially planned to get more or less the same number of

participants from both CHC's, but struggled to get participants from Cloeteville CHC, because they attended less than three HP sessions. Therefore most of the participants were from Klapmuts. The researcher must add that the same amount of time was allocated for interviews at the two CHC's. At one time the HPO was called to go on a course by the HP coordinator of the region, and asked not to come because it would be difficult in her absence to get participants that fit into the criteria of "3 times at Cloeteville".

By the 9th interview the researcher had covered all the socio-demographic variables and no "new information was being uncovered", Andrew (2004) and the data collection was therefore ended.

3.7 DATA COLLECTION

The data was collected for this study in September and early October of 2004. Data was collected through in-depth interviews. An interview guide was used to ensure that more or less the same questions were asked to the participants.

3.8 IN-DEPTH INTERVIEWS WITH THE KEY INFORMANTS

The purpose of open-ended questions is to allow the participant to use their own words to describe their experience whether it is implicit or explicit. Open-ended questions give more than just a YES/NO response it answers the "why" (through prompts) and here again open-ended questions give: meaning to choices people make and understanding to the way they interpret these experiences. Open-ended questions also have drawbacks in that participants can often go on and on with regard to a sensitive issue for them and the researcher runs the risk of a very long drawn out interview. Although this may indeed be strength of open-ended questions because the participants might not feel limited or asked to frame their experiences, but instead experience a "freedom of expression" that could give rise to "unanticipated" information. That provides thick rich data.

3.9 DEVELOPMENT OF THE INTERVIEW GUIDE

Although the researcher had a rough idea of the type of questions she wanted to ask, she met with two pregnant women from Cloeteville separately in order to test the appropriateness of the questions. From this exercise:

- Suitable questions that were asked arose
- Wording of some questions could be changed to make it more complete for women to understand
- Exploring issues around HPM.
- Questions that were avoided had no value to the research aim and objectives.

3.10 PREPARATION OF THE RESEARCHER BEFORE THE INTERVIEWS

The researcher wanted to fit in, but most of all she wanted the participants to feel comfortable and relaxed in her presence, so that they could feel “free” to converse with her. She therefore “dressed down” and wore less make-up than she normally would. The researcher also attended the HP sessions so she had an idea of the way people dressed and spoke.

3.11 PREPARATION OF THE PARTICIPANTS BEFORE THE INTERVIEW STARTED

The participants were asked by the HPO if they would like to participate in the study. The researcher felt that they would be more trustful of the HPO they “knew” than the researcher who they would be meeting for the first time. The HPO offered the participants coffee and sandwiches; it appeared to the researcher acceptable, as the women were neither offended nor surprised. According to the HPO the women often did not eat before they came to CHC, 40% of the women either had coffee or coffee and bread. The researcher felt that this would put the women at ease and had no objection to the HPO initiative. The Researcher had coffee with each of the women who agreed to drink or drink and eat.

Although the HPO introduced the participants to the purpose of the research, the researcher wanted to be sure that the each participant was fully informed, why information from them would be valuable to the researcher and ultimately benefit the HPP.

The issue of confidentiality was explained and the participants who could read were given an opportunity to read the consent letter and sign. The participants were asked not to mention any names during the interview, as this was a way the researcher used to protect their confidentiality and that of the people they mentioned, at times it appeared that these participants slipped up and

they mentioned a “name” however the researcher perceived this as the participants relaxed state and eagerness to share information that caused this slipup.

The researcher also gave the participants an idea of the questions that they would be asked – this was only done as an attempt to reduce any anxiety they might have and to give them assurance that they had the information to answer the questions. The researcher would like to add that some of the participants initially did appear anxious and it was this observation by the researcher that prompted this action.

3.12 INTERVIEW TOPICS

The data collected covered pregnant women perception of the HPMs for pregnant women. Different questions that could provide answers to the same topics from the interview guide were grouped together Patton (1990).

The questions from the interview guide once “grouped together” covered the following:

- The personal information and contact details
- Who initially shared information regarding pregnancy with them?
- What HPmessages they heard from HPO
- Who they will share the HPMs with?
- What messages they will share with others?
- What messages they will apply?
- Their observation of the application of HPMs by pregnant women in their community.
- Barriers to the application of HPMs for them and other pregnant women.
- Their recommendations to improve CHC’s HPMs.

3.13 INTERVIEW PROCESS

The interviews with the pregnant women were recorded using a tape recorder.

The researcher was aware of the strength of using a tape recorder. Patton (1990) agrees with the following reasons:

- Large volumes of information can easily be recorded.
- The researcher wanted to “be free” to converse with the interviewees and not be distracted because she had to take notes continuously.
- The researcher wanted the opportunity to repeatedly listen to what the interviewees were saying in their own words and tone to assist with data analysis even while data was still being collected.

The researcher although aware of the benefits of using a tape recorder, wanted to prevent any technical failure of this apparatus that would in turn either cause cancellation of the interview or the lost of valuable data.

The researcher therefore did the following:

- Carried extra batteries with in the event that the batteries no longer provided power.
- Used 90 min and 120 min tapes to ensure that any lengthy interview was completely covered.
- Before and regularly during the interview the researcher re-winded the tapes partly to make sure the interview was being recorded. The researcher explained to each interviewee the purpose for this, so that it would not be seen as a disturbance or interruption, but a natural part of the interview process. This action could also send a message to the interviewee that the researcher values the interviewee’s responds and wants to be sure that it be recorded.
- The participants were asked to speak clearly and the recorder was placed as close as possible to the interviewee, and the volume of tape recorder set appropriately, Bester (2002) so that the data could be clear for accurate transcription.
- Although the researcher asked for a quiet room or space to do the interview it was difficult because most of the interviews were done in the morning between 9:00 and 11:00, when the various areas and offices were occupied by nursing staff assessing and treating patients. Distractions were mostly from nursing staff that needed access to the room used for the interview because medical items they needed were in the room. The researcher stopped the interview when someone entered; this was done to respect the interviewee’s confidentiality regarding her responses to questions asked.

3.14 METHOD OF TRANSCRIBING

After each interview the tapes were marked for example code 001- indicated the first person interviewed, code 002- indicated the second person interviewed and so forth. The researcher did 1-2 interviews per morning. The researcher delivered the tapes to her supervisor, who then passed it on to the transcribers at the Ilwini Centre at the University of the Western Cape. The Ilwini Centre transcribed the tapes in the original language (English or Afrikaans) and forwarded them electronically to the supervisor. Printed and electronic copies along with the original tapes were returned to the student researcher for analysis.

3.15 METHODS OF ENSURING RIGOR

Literature suggests “soundness” as a criteria for judging the rigor of qualitative research. It should allow the reader to audit the decision trail in terms of the actions taken by the researcher and the influence or biases that affected the research Holloway (1996). “Truthfulness” in qualitative research includes “credibility”, transferability, dependability and confirmability.

Credibility refers to the “accurate description of why and how the study was done”. In this study it refers to the day to day experience of pregnant women and their perceptions of how they apply HPMs in their every day lives.

This was established when:

The researcher listened to the tapes prior to sending it to be transcribed. The researcher wanted to familiarize her with the data. She jotted down comments the women made. This was done to prepare herself for a meeting with her research supervisor.

Peer debriefing was be used when the researcher discusses the research process and findings with her supervisor, Krefting (1991). The researcher met with her supervisor after every 1 – 2 interviews to discuss the data. This enabled the researcher to better prepare her for the next interview. How to “probe” and get thick rich data was also explored during these meetings. The first two interviews were partly transcribed by the researcher, because she was eager to start with the analysis of the data, although she also had the tapes send to the Ilwini Centre for transcription. The researcher was unsure how long it would take for the transcripts, but most of

all wanted the data “close to her”. In addition, the researcher’s transcripts were compared against the same transcripts done by the Iiwini Centre to verify accuracy of the transcription process.

Recording ideas, observations and personal feeling in a personal diary, is a method to reinforce bracketing so that any bias of the research do not influence analysis and interpretation of data.

Member checking involves checking the data continually with the participants to ensure that it is authentic to their experience. Member checking was done in the original language, so that the reality of what the participants convey was not minimized or misunderstood. This was done during and after the interviews with each participant. The quotes were kept in their original language. The researcher only translated the quotes for her supervisor during the drafting phase of the research document.

Triangulation of data sources

Data was collected from a number of sources which included in depth interviews, literature and document analysis, Andrew (2004). According to Patton (2002), cited by Andrews (2004), triangulation of data sources mean “comparing and cross checking the consistency of information derived at different times and by different means within qualitative methods”.

Transferability refers to the comparison of contextual data by others so that they can generalize it to other settings, Giffords (1998). However, according to Merriam (1991) as cited by Andrews (2004), “the intent of qualitative research is not to generalize findings, but to formulate a unique interpretation of events”. The researcher will however provide a detailed description of the context of this study so that other researchers can “establish whether the proposed receiving context (or ‘population’) is similar to this study”, Seale (1999).

Dependability refers to the exact method of data gathering, analysis and interpretation Krefting (1991), to enable the researcher and other to decide how repeatable the study may be. Dependability also involves accurately recording any deviation that has occurred in the study. According to Andrews (2004), dependability is not about getting the same results because “human behaviour is never static”, but whether “the results make sense, that they are consistent and dependable”. To ensure dependability the researcher provided a thick detail account of the methods of data collection and analysis, Grifford (1998).

Confirmability refers to how well the data is supported. “Comparing it to the wide literature” can strengthen confirmability. The researcher used multiple data sources. This included the curriculum list, minutes of meetings, timetable of HPO, situational analysis report of region, interviews with pregnant women and HPO. The researcher also sat in as observer in some HP sessions.

A reflective journal used by the researcher to jot down her own actions, feelings and thoughts after the interviews was helpful to make sure that the themes that emerged were the perspective of the pregnant women and not the researchers own thoughts and feelings. The fact that the researcher explains the reason for any action taken, also adds to confirmability of findings of this study.

3.16 DATA ANALYSIS

Qualitative analysis involves searching the data for “patterns that connect, and making sense of these patterns with the aim of comprehending the meaning of what has been described, classified and compared”, Gifford (1998). According to Gifford (1998), “Good analysis of qualitative data rests upon a detail description of the information collected: Good ‘thick’ description should include three kinds of information:

- *Description of the context of an event or act,*
- *Descriptions of the intentions and meaning, and*
- *Description of the evolution or consequences following from the act”.*

Hence the researcher’s lengthy description of the context of this study in chapter one.

3.17 ETHICAL CONSIDERATIONS

Informed consent was obtained from the managers of the CHC’s, the HPO and the participants. The researcher explained the purpose and nature of the study to all involved. After each interview the participants were given the opportunity to ask the researcher a question or make comments. However, most of the women preferred to respond to a question than ask their own.

A gift pack was given to each woman as an incentive and as a token of appreciation for participating in the study.

This study was approved and submitted to the Research Ethics Committee of the University of the Western Cape. Copies of the thesis will be made available to the University of the Western Cape and the management of CCHC and KCHC. The National Research Foundation funded this research.

3.18 THE DATA ANALYSIS FOR THIS STUDY

The data analysis began while the researcher was still in the process of collecting the data in this study, Smith et al (1995). The researcher found herself thinking about what was being said, then moving on to why a particular response was made, to trying to understand the interviewee's meaning to what was being said. The researcher was at times confronted by her own judgmental reasoning. She consciously had to assess these thoughts, after all it is not the researchers meaning, but the interviewee's response and meaning that is relevant and need to be understood and categorized.

The fourteen-stage method for analyzing interview transcripts in qualitative research by Barnard (1991) was used as a reference for analyzing the data.

Phase I

After each interview the researcher listened to the tapes to familiarize her with the data. The researcher also transcribed the first two interviews, so that she could begin the process of capturing what the respondents commonly said. At this stage the researcher also jotted down on separate paper any insights or common phrases that occurred in these two interviews.

Phase II

The researcher met with her supervisor and handed her the first two interviews to be transcribed professionally. (The researcher wanted to be sure that none of the data was lost when she transcribed the first two interviews). A discussion followed with regard to the researcher's

interview experience, what the respondents were saying as well as insights and phrases the researcher dotted down in phase one. At this stage the supervisor was listening to familiarize herself with the data and give guidance with regard to how the researcher should prompt in her next interviews so that the respondent could give rich answers to questions asked.

Phase III

The interview guide was initially used as a “framework for analysis” of data, Patton (1990). The researcher made multiple copies of each transcript to maintain the original copies of each transcript to preserve the original text for reference purposes. Each transcript was read line by line, and the response were cut and pasted appropriately under the following headings which reflect study objectives:

- Who initially shared information regarding pregnancy with them?
- What HPMs they heard from the HPO
- Who pregnant women will share HPMs with.
- What HPMs will/or did they share with others?
- What HPMs will/did they apply?
- Their observations of the application of HPMs by pregnant women in their community.
- Barriers to the application of HPMs for them and other pregnant women in the community.
- Their recommendation to improve CHC’s HPMs.
- “Unanticipated” comments that did not fit into the above categories.

Phase IV

The researcher followed the same process as in Phase I and II. After each interview the researcher would listen to the tapes of the latest respondent’s interview, to familiarize herself with what a respondent was saying. This was then discussed with her supervisor often on the same day. This was a valuable learning experience for the researcher as she started to group phrases together as in Phase III, however often rich and more appropriate phrases were found in other areas of the transcripts and not necessary under the questions asked. The researcher also consulted her fieldwork diary so that she could avoid any bias. These notes were also discussed with her supervisor. In this way more phrases or categories were generated and added.

Phase V

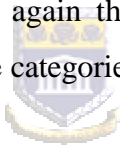
During this stage the transcripts were again re-read to make sure that all the data could be accounted for (especially with regard to the interview guide). Categories were established. The researcher discussed this with her supervisor and the categories were either accepted or rejected or wording altered to best describe the nature of a phenomena. Any ambiguity was also identified and reasons for its existence were sort.

Phase VI

During this stage the researcher looked for any overlapping of the categories and placed them under higher order headings.

Phase VII

The transcripts were again re-read to be sure that the list of categories covered all aspects of the interviews. The researcher particularly used the heading of interview guide in Phase III, because it reflects the study objectives. Once again the researcher looked at her fieldwork diary to determine to what extent it supported the categories.



Phase VIII

The researcher discussed any concerns and discrepancies with her supervisor and a final list of categories was established.

CHAPTER IV

4. RESULTS

This chapter will be organized around the four main study objectives or study questions. **Section A** will review the themes that emerged around the topic of sources of health information as a **background** for the perceptions of the HPP. Section B will focus on the themes around what health information messages were received by the women, including perceived barriers and promoters for understanding the HPMs in order to examine strengths and weaknesses of the programme. Section A and B relate to the first objectives, but have been slightly re-organized in order to better represent the responses from the study participants. Section C examines the application of the HPMs and Section D uses and sharing of the HPMs within the family and community. Finally at the end of this chapter, the themes that emerged throughout the interviews are summarized in Table XX under strengths and weaknesses of the HPP to integrate the concepts and highlight issues around the first two study objectives.

SECTION A



4.1 INITIAL SOURCE OF ADVISE REGARDING PREGNANCY.

THE THEME THAT EMERGED – MY MOTHER

In order to provide context for the impact of the HPP, the interviews exploited other sources of health pregnancy information for the participants. The participants own mothers appear to be the initial advisors regarding information about pregnancy. At least four of the respondents got information before they got pregnant. The knowledge alone did not however result in planned pregnancy. The reason for this could be that the advise given to them was focused on how you can get pregnant and/or the symptoms of pregnancy, and not on the social context and gender relationships that can lead to unplanned pregnancy.

THE FOLLOWING TRANSCRIPTS ARE EVIDENCE OF THE CONTENT OF ADVISE GIVEN

Respondent:

Die heel eerste keer van swangerskap het ek geleer toe ek begin te jong meisie raak het, het my ma vir my gesê as 'n man, seunskinders nou by my gaan slaap of so, dan kan ek nou swanger word. En sy't vir my gesê hoe gaan dit gebeur, wat moet ek dophou en hoe gaan ek weet. En toe die eerste keer, toe ek nou gaan daarvoor en toe't ek gesien hoe dit begin, saamslaap (onduidelik).

Respondent:

*Ek het dit die heel eerste keer by my ma gehoor, en toe't my **ma** nou so verduidelik vir my: "Welna, dit kom nie van iets anders af nie, dit kom van seks van 'n man af". En so het ek nou aangeleer, aangeleer, ja Ma. Toe ek dit oorkom, toe sien ek ook maar, ja, Ma, dit kom daarvandaan. Toe't ek vir my ma gesê "Nee, nou verstaan ek ok waarvandaan... en so het ek nou verder aangeleer dat ek nou op so 'n toestand gekom het.*

Respondent

Okay, when I was fifteen years old, my mother sit down with me and told me about life and everything about boyfriends and pregnancies and all that stuff. So I get information

It appeared that the respondents were not advised of the consequences of unplanned pregnancy, such as possible neglect by baby's father, financial implication, emotional impact and sexually transmitted diseases.

Once respondents were pregnant, they were advised how to care for themselves during pregnancy and informed of the signs of labour by their mothers.

Respondent:

Die heel eerste keer van swangerskap by my ma gehoor. Hoe moet jy sorg as jy swanger is. En hoe moet jy nou maak as die tyd naby is om te kraam.

Comment:

At least three of the four who got information before they got pregnant were still in school, however the fact that they got information early did not prevent unplanned pregnancy. Neither

did the education level of 2 of 4 women (who completed grade 12) prevent their unplanned pregnancy. This at least implies that giving advise of a biomedical nature at ages 13 to 15 years of age who completing high school was not sufficient to prevent later unplanned pregnancies. It appears that other factors need to be considered, for example advice on and access to birth control and the context in which advice is given. Focus on continual female reproductive health issues with age appropriate advise during teenage and early womanhood, would be more valuable, than a once off advise sessions with their mothers.

Other sources of pregnancy advise came from teachers and friends at school, female cousins and one respondent mentioned that she got advise by a nursing staff member after a pregnancy test at a clinic.

Although later unplanned pregnancy was not prevented for adolescents who completed grade 12, it was delayed at least approximately one year after completing grade 12. This highlights the need for continued focus on reproductive health issues throughout the adolescent stages.



SECTION B

4.2 PREGNANT WOMEN'S THOUGHTS, KNOWLEDGE AND UNDERSTANDING OF HPMs

B1

PREGNANT WOMEN'S PERCEPTION OF HPM THEY RECALLED. THE FOLLOWING THEMES EMERGED: CIGARETTE SMOKING, ALCOHOL USE AND TYPE OF FOOD/DIET

Respondent:

Oor borsvoeding (stilte), en oor rook en oor drink, en wat 'n mens moet eet wat gesond vir jou baba is, en dat borsvoeding ppk gesond is en wat die drank in die rol (onduidelik) van 'n mens se baba kan speel.

Respondent :

Die een oor Die eerste een was oor rook en drank en watter kosse moet jy eet. En die derde een het ons nou gedoen oor borsvoeding.

However, when scrutinizing the interview transcripts, during other parts of the interview, they also got information on blood pressure, family planning and signs of labour stress and rest.

The reason why the above information was not mentioned initially could possibly be the strong emphasis the HPO and Health Personnel in the area place on smoking, alcohol use and breastfeeding.

This suggests that key messages are covered by the HPO and are recalled by pregnant women attending the HP sessions. However, none of the respondents mentioned family planning. It is unknown if this is not recalled or the information is not given.



PREGNANT WOMEN'S PERCEPTION OF HPM THAT WERE NEW TO THEM. THE FOLLOWING THEMES EMERGED: BREASTFEEDING, SPECIFICALLY THE BENEFIT OF BREASTFEEDING AND NOT MIXING BREASTFEEDING WITH OTHER METHODS.

Respondent:

Ek het nooit geweet as 'n mens 'n kind wil borsvoed, moet jy geen ander soos 'n bottel tussenin gebruik en 'n dummy nie. Daai is inligting wat ek gekry het.

Respondent:

Soos oor die Eintlik oor borsvoeding. Dat jy die eerste ses maande in Jou baba moet op die bors hou. Day jy eintlik formulas gebruik nie want dit ... gee die ... die borsvoeding gee die ling om die baba se magie. Wat dit nou beskerm teen alle bakterieë en siektes en sulke goed.

Pregnant women acknowledged that the information that was new to them was how to go about breastfeeding exclusively. They learnt that they should not use other feeding methods while breastfeeding.

Knowledge of the protective qualities of breastmilk against disease was information that was new to them.

B3

PREGNANT WOMEN'S PERCEPTION OF HPM THEY KNEW OF, BUT UNDERSTAND IT BETTER AFTER ATTENDING THE HP SESSIONS.

THE FOLLOWING THEMES EMERGED: BREASTFEEDING, SPECIFICALLY HOW BREASTFEEDING MUST BE DONE/ METHODS OF BREASTFEEDING AND ALCOHOL USE SPECIFICALLY NEGATIVE EFFECTS OF ALCOHOL USE

Breastfeeding: Specifically how breastfeeding must be done

Respondent:

..... en dan nou as jou babatjie drink. Die hele deel van jou bors se kop moet binnein die babatjie se mond wees, en dan drink die babatjie volledig. Dan drink nie, sluk nie winde nie.



The proper method of implement breastfeeding, such as putting the entire head of nipple in the mouth of the baby, so that the child does not swallow wind/air, was information that they knew of but understood it better after the HPO used pictures to show them exactly how it must be done.

Alcohol use: specifically negative effects of alcohol

Respondent:

Ja, soos met die alkohol ook.

Interviewer:

Wat van die alkohol?

Respondent:

Dat die baba mos nou ... die kind eintlik laat agter bly in sekere dinge wat hy doen. Soos op skool of hy is agter in sy lewe ... aangaan. Hy is nie soos die ander vriende en so aan nie.

They were aware that alcohol abuse during pregnancy had side effects, but understood better the negative effects for the child's physical development and academic abilities after attending HP sessions. It seems that providing concrete examples, for instance describing a child exposed to alcohol physically and mentioning the psychological problems have a better impact to improve understanding than just to say it hampers the child's growth.

B4

PREGNANT WOMEN'S PERCEPTION OF WHAT HELPED THEM UNDERSTAND THE HPM: THE FOLLOWING THEMES EMERGED:THE HPO ABILITY TO EXPLAIN.

The HPO ability to explain.

Respondent:

Soos sy dit vir my nou uitgelê het en mooi vir my verduidelik het, het dit nou gemaak dat ek dit beter verstaan. Sy het eintlik van A – Z mooi verduidelik.



The women felt her ability to explain and use of visual aids (such as books and pictures) were helpful.

Respondent:

Ja, sy't vir ons dit afgeskrywe ok en verduidelik nou vir ons hoe.

Onderhoudvoerder:

Het sy dit op 'n bord geskrywe?

Respondent:

Ja, op so 'n blaaie, soos daai groot blaaie, Suster, waarop ons geskrywe het, nou't sy vir ons verduidelik dit is nou dit en so.

Respondent:

Sy't vir my 'n boek gegee wat wys van borsvoeding, hoe jy maak en sê vir my hoe om (onduidelik) daar deur te gaan.

Onderhoudvoerder:

Jy't vir my gesê jy kan nie rêrig lees nie. So, was dit prentjies gewees of ...?

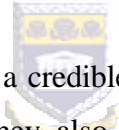
Respondent:

Ja, daar is prentjies wat vir jou wys hoe jy nou die bors moet gee en so.

While other pregnant women felt that explanation combined with the opportunity to ask questions, therefore responding to their individual needs Rachel et al (2002) and the repetition of HPMs, made it easier for them to understand information.

Respondent:

Dit was, Suster, omdat ek dit by die juffrouens ook dit altyd gehoor het. En altyd, hulle begin met die vrae ef met die iets wat hulle vir ons vertel, dan sit en luister ek doodstil. Dan ... en as sy weer klaar gepraat het en sy vra vir my, dan is daar baie kere wat ek nie verstaan nie. Dan sê ek altyd vir die juffrou "herhaal hom net weer vir my". En daarvandaan dan sê ek "Nee Suster" of "Nee juffrou, ek verstaan nou daai som" of "ek verstaan nou wat Suster gesê het".



It appears that the HPO is regarded as a credible source of information, who is able to explain and answer questions adequately. They also felt they could approach the HPO to repeat explanations she gave earlier.

B5

PREGNANT WOMEN'S PERCEPTION OF BARRIERS TO UNDERSTANDING HPMs. TWO OF THE PREGNANT WOMEN HAD PROBLEMS WITH THEIR MEMORY.

The barriers to understanding HPMs for 2 of the pregnant women involved problems with memory.

Respondent:

*Suster het ook al so baie goed ge... met ons gepraat, wat vir my baie kere vir die eerste keer, maar dis woorde wat ek partykeer **nie eens meer kan onthou nie**. Suster het baie met ons gepraat hier.*

Interviewer:

Hoekom is dit moeilik vir jou om dit somtyds te onthou?

Respondent:

Dis omdat, Suster, ek is een wat nie vinning kan uhm ... iets op my gedagtes sit nie. Ek sit altyd ietsie stadig op my gedagtes.

Respondent:

Ek kan nie so lekker onthou nie.

B6

PREGNANT WOMEN'S PERCEPTION OF WHAT THEY THOUGHT THE PURPOSE OF HP SESSIONS, THE FOLLOWING THEMES EMERGED:

To help us know

Respondent:

Die doel van daai is omdat die susters of die dokters wil vir ons help, en hulle help ons dat ons dit moet ok kan reg verstaan. Dis baie mammies wat jonk is, dra nie kennis van swangerskap en van borsvoeding nie. Dis hoekom die mense daar is om dit vir ons te leer. Al is jy nou groot, al het jy nou kinders, maar jy leer nog altyd.

To help us know and understand how to care for our child.

Respondent:

Die doel van die voorligtingsessie is om vir ons wat swanger mammies is, dit makliker te kan maak as ons nou geboorte kan gee. Dat ons moet weet hoe om jou baba, hoe om jou baba te hanteer en alles.

Interviewer:

Is daar enige ander doele wat jy dink?

Respondent:

Leer wat is gesond vir jou baba, en wat om vir die baba te gee om te eet, en wat om vir hom te gee om te drink en so.

Respondent:

Die doel daarvan is wanneer jou kind uhm ... skool toe gaan, dat jou kind nie swaar leer nie, want alkohol kan ook maak dat jou kind iets agterhou, en dan later van tyd 'n probleem is as hy

moet leer. Jy's miskien stadig of ... maar iets agterhou van daai. Of sy gewig is nie goed nie of die kind is baie siek. Daai's ook uhm ...

To help them gain knowledge and understanding to care for their child and themselves, however one pregnant woman perceived the purpose of HP sessions were **to help** those who wanted help.

Respondent:

Die doel van die voorligting sessies is baie goed vir mense wat nou wil gehelp wees.

She firmly held to this viewpoint when asked what recommendations would make the HP sessions more beneficial for pregnant women.

Respondent:

'n Voorstel wat ek het om veral vir die susters te sê kan aangaan met die sessies waarmee hulle mee besig is. En soos mense wat nou wil gehelp wees en dié wat nou nie wil gehelp wees nie kan hulle nou nie steur nie, maar hulle kan dié wat nou wil gehelp wees help.



It was clear that the HPP was not reaching all pregnant women.

The following quote confirms this respondent's view that not all women attend the HPP and seek help. The following quote emphasised one pregnant women's constant request to her 5-month pregnant neighbour to book (register) herself at the clinic.

Respondent:

..... daai vrou daar langsaan ons. Sy's ook nou swanger, sy's ok by my. Nou dan sê ek vir haar "dit lyk vir julle ek stel nie belang in jou wat so lyk nie. Jy moet kom, jy moet kom met jou boek. Kom saam met my". Ek sê "want nou kom jy by die hospital en dis jou tyd". Sê ek vir haar "dan uhm ... hulle gaan jou, hulle gaan jou nie reg behandel daar nie, want jy's nie geboek nie. Jy's 'n niks". Ek praat baie dié goed, en dan sê ek ok vir haar ...

Interviewer:

So sy's swanger, maar sy't nog nie gekom book nie?

Respondent:

Sy't nog nie gekom nie, sy's al vyf maande.

Interviewer:

Sy's al vyf maande al, en was sy nog nie hier by die kliniek gewees nie?

Respondent:

*Sy was nog nie hier nie. Suster ek sê dit elke tyd as ek so kliniek toe kom, dan sê ek dit vir haar!
"Kom! Hier kry 'n mens regte antwoorde wat vir jou kan help".*

SECTION C

4.3 APPLICATION OF HPMS

C1

PREGNANT WOMEN'S PERCEPTION OF WHAT HPMs THEY WERE ABLE TO APPLY NOW. THE FOLLOWING THEMES EMERGED: EATING HABITS AND REDUCE SMOKING.



Eating Habits

Respondent:

Soos byvoorbeeld ek rook en drink nie maar my eetgewoontes het verander.

Interviewer:

Soos wat het jy verander omtrent dit?

Respondent:

Soos gas koeldrank het ek gedrink. Ek drink dit nie meer nie. Ek drink maar nou liewer vrugtesappe en bietjie tee so nou en dan.

Respondent:

I was eating chips. I was eating a lot of food. So I will try now take fruit instead.

Respondent:

OK. Dat ek drink nou elke tyd my pille, ek eet gesond soos wat ek vir my voorgeskryf het en ek doen alles was die Susters vir my sê ek moet doen.

Reduce Smoking

Interviewer:

Ja. Uhm...rook jy nou twee sigarette per dag?

Respondent:

Ek rook nou net `n sigaret en dis nou soggens.

Interviewer:

OK, so jy't dit na een gebring.

Respondent:

Ek het minder gerook suster. Ek rook nou drie keer per dag.

Interviewer:

Jy rook drie keer per dag. Hoeveel het jy...

Respondent:

Ek het... die tyd wat ek nog nie swanger gewees het nie het ek `n twintig in twee dae.

Interviewer:

Okay so jy het omtrent tien sigarette per dag gerook.

One respondent attempted to reduce inhaling cigarette smoke by being alone.

Respondent:

Wat ek kan verander het by die huis deur my swangerskap wat ek geleer het, sit jy nie naby mense wat rook nie, ek is ook nie naby mense wat rook nie. So, ek is alleen.

C 2

PREGNANT WOMEN'S PERCEPTION OF WHAT MADE IT POSSIBLE FOR THEM TO APPLY HPM NOW. THE FOLLOWING THEMES EMERGED: INFORMATION, SUPPORT AND CONCERN FOR THEIR CHILD/CHILDREN.

Information

The HPO provided concrete examples of what she could eat at various times of the day.

Respondent:

Okay, because she told me how... what I must eat. Must I eat in the breakfast. I must eat more something like Cornflakes, bread and for lunch I can eat cheese. I can eat normal food. That's why I want too much.

The respondent gained insight into the negative effects of smoking for her health and not only that of her baby's when provided with information.

Respondent:

Hulle het nou vir my verduidelik hoe gevaarlik is dit vir my is om te rook en so. Behalwe nou dat ek swanger is. Kan ek nou die baba kry en na dit is dit nog steeds gevaarlik.

Family support

Family support in the form of their attitude and financial support appear positive influencing factors for pregnant women to apply HPMs.

Respondent:

Ja! My huismense. Hulle is nie uitsoekergig nie. Hulle sal eet wat vir my ook gemaklik is om te eet nou gesond is. Sal hulle almal eet. So ek hoef nie vir die een dit te maak en vir die een daai nie.



Respondent:

Dit het vir my moontlik gemaak om die rook te los, want my man rook nie. Hy's baie gekant teen rook, en hy sal altyd vir my gesê het "maar moenie rook nie; dis nie goed nie. En veral as jy swanger is, moenie rook nie. Ek gee nie om as jy na die kind wil rook nie, maar nie terwyl jy swanger is nie." So hy't my baie aangemoedig om nie to rook nie.

Interviewer:

OK, so jy't dit na een gebring. Uhm...is daar enigiets by die huis wat ook vir jou help? Jy't vir my gesê jou, jou boyfriend bly by julle. So, help dit darem, want hy gee vir jou geld, het jy vir my gesê, uhm...dat jy sekere dinge kan toepas, sekere dinge kan koop soos goeie kos.

Respondent:

Ja, dit help vir my baie, want ek kan alles nou doen ok en doen wat nie kan gedoen het nie, kan ek ook nou doen. Die wat ek nie kan gekoop het nie, kan ek ok nou koop.

Interviewer:

Omdat hy nou vir jou die geld gee, het y vir my gesê.

Respondent:

Ja.

Information and family support made it possible to change eating habits and reduce smoking.

Concern for their child

Concern for their unborn child appear to be a strong factor influencing pregnant women to follow HPM

Respondent:

Dit wat dit nou vir my moontlik maak is... ek dink maar altyd eerste aan my baba. Eet nou gesond sal wees. Laat ek nou nie as...die tyd as...wanneer ek moet geboorte gee en met die kind nou verder aangaan. Dat ek self probleme optel nie.

Interviewer:

Wat maak dir vir hulle moontlik om nie to rook of nie te drink as hulle swanger is nie?

Respondent:

Want dit is omdat hulle omgee vir hulle swangerskap, vir hulle babatjies.

One pregnant woman wanted her children's respect and she was concerned that if she and her husband was both drunk anything could happen in their home.

Respondent:

Die drink het ek self gelos, want ek het gevoel drink is nie vir my bedoel nie.

Interviewer:

Was dit ná die swangerskap of voor die swangerskap?

Respondent:

Voor die swangerskap het ek gevoel ek moet die drink los. My kinders raak groot en hulle kyk... ek moet kyk na hulle, en hulle sien wat ek doen. En as `n kind sien wat `n ouer doen, sal hy nie respek het nie.

Interviewer:

OK. So, jy't die drink gelos en jy't aan jou kinders gedink en hulle respek vir jou.

Respondent:

Hulle moet my respek en

Interviewer:

Is daar enige iets anderste wat dit vir jou moontlik gemaak het om die drink te los? Dit is mos nie `n maklike ding om te los nie, so...behalwe die kinders, is daar enige ander rede?

Respondent:

Die rede hoekom ek die drinkery gelos het, is omdat my man gebruik ook...drink ook `n bier en ek het net gevoel ek en hy kan nie altwee drink nie.

Interviewer:

Wat gebeur as julle altwee drink?

Respondent:

Wat gebeur as ons altwee drink, is dit lyk vir my dat daar geen orde is dan in die huis nie.

Interviewer:

Wat bedoel jy by orde?

Respondent:

Ons altwee is dronk, enigiets kan gebeur in die huis.



PREGNANT WOMEN'S PERCEPTION OF BARRIERS TO APPLYING HPM THE FOLLOWING THEMES EMERGED: STRESS AND BEING ALONE

Stress: Personal life

Respondent:

Suster, dis al wat ek vir Suster kan sê. Die outjie wat ek het, hy's `n drinker en hy's `n ... die button-roker. Nou het hy, dan sê ek vir hom die oggend "kyk hier, ek gaan nie drink nie. Ek voel nie om vandag to drink nie." Nou kom hy, dan's hy nou dronk. Oe, en dan's dit nou uhm...en Suster weet mos hoe's hulle. Hulle wil soen en dit. Nou dis die ding wat ek oor stress. Dan sê ek "nou gaat ek ok vir julle `n ding wys. Nou gaat ek ok vir my `n dop drink. Dan's ons altwee maar ewe dronk."

The same respondent also related stress caused by her son's conduct.

Respondent:

Soos, hoe kan nou vir Suster sê, met my kink ok, die enetjie wat skool loop. Toe't ek nou so kwaad geraak en ek het aan die bewe geraak, en ek het toe die belt gevat en ek het toe hom geslaan. En hy hardloop onder my hande uit, en ek slat, die belt slat toe per ongeluk hier. En ek bewe, en ek kom in die huis en ek sê vir my ma "ek gaan die kind doodmaak." Toe sê my ma "jy moet ophou stress." Toe sê ek "maar, Mamma, ek kan dit nie meer uithou nie. Hulle skree, hulle baklei, die mense se ouers kom kla. Ek hou nie van die besigheid nie." En net daar haak ek. So, dan's ek heel aan die bewe. Ek moet nou eers weer sit en so. Ek stress baie, Suster, ek stres baie.

Respondent:

By die werk stres ek baie.

Interviewer:

Wat gebeur by die werk?

Respondent:

Uhm...soos as die... daar's 'n vrou by die werk wat my baie kwaad. Sy maak onsmaaklike grappe oor my



Interviewer:

Grappe oor jou swangerskap nou?

Respondent:

Ja

Interviewer:

Uhm...hoekom dink jy doen sy dit?

Respondent:

*Ek dink sy het vir haar mos... voordat sy gesê het sy is swanger, was ek swanger
{fluister/onduidelik}*

Interviewer:

Stres jy miskien oor jou boyfriend? Oor die feit dat hy jou nie ondersteun in hierdie tyd nie?

Respondent:

Ja

Interviewer:

OK, hoe voel jy oor dit?

Respondent:

Ek voel nogal nie so bad daaroor nie, as hy nie wil nie, dan is dit ongelukkig vir hom.

Stress: Related to Community life

One pregnant woman mentioned stress related to personal and community life.

Respondent:

Wat in die huis in gebeur is wat my stress is dat ek en my stiefpa – ek het `n stiefpa – en ek en hy kom nie goed oor die weg nie. En partykeers dan stry ons baie en so.

En in die gemeenskap is dit hoekom die mense drank drink en wat is so lekker daaraan om te drink? En die bakleiery tussen die omgewing is nie goed vir die mense nie. En die verkragtings en sulke goeters, dit laat my stress, want dit voel amper vir my “ wat sal ek gemaak het as dit ek moes gewees het en hoe sal ek gevoel het?” En nou weet ek nie hoekom mense nog met drank kan... dit is nie goed vir `n mens se liggaam nie.

Interviewer:

Is daar enige ander ding wat uhm... mense se reaksie teenoor jou wat ook stres kan veroorsaak?

Respondent:

Daar is party, ja. Dit is, maar nie nou eintlik van my vrinne nie, van mense wat hulle verwonder my baie, en so wil praat nou “haai, maar sy is ook swanger en ons het nooit geweet sy sal ook swanger wees nie.” Dit en, dit is nie dit nie. Dit is net wat die Here vir jou gegee het en, dis amper soos `n geskenk van God af, en jy kan nie help as dit so gebeur nie. En dit maak my dat ek ook baie stress.

Another respondent confirmed the rape occurring in the community and young girls not obeying their parents by the following statement.

Respondent:

Dis dinge wat gebeur. Jong meisies wat verkrag word, doodgemaak word, jong meisies wat danse loop, wat taverns loop, wat nie wil luister vir hulle ouers as met hulle gepraat word nie.

Stress

It appears that their stress in their personal lives is caused by poor partner support (emotional and financial) and by their children's disobedience. It is not surprising since more than half of the women who participated in this study were directly experiencing poor support from their partners.

The children are growing up in a climate and atmosphere where parents and neighbours are abusing alcohol and as one respondent mentioned, she could not be assured of her children's respects and safety if she also drinks alcohol.

Conflict with stepfathers also surfaces. Stepfamily appears to be a reality in these communities, considering that some women have a child from a second or even third partner. It is a issue that needs to be considered when these women are advised with stress coping strategies.

Being alone

Being alone was also a common response by pregnant women as a barrier to following HPM.

Respondent:

Ja, daar is. Ek ... as ek so stress vat, vat ek miskien nou vir my geld of ek stap winkel toe en koop vir my drinks en so. Of ek sit net of 'n plek waar ek alleen kan wees en dit laat my stress dinges.

Respondent:

Wat ek kan verander het by die huis deur my swangerskap wat ek geleer het, sit nie naby mense wat rook nie, ek is ook nie naby mense wat drink nie. So, ek is alleen.

Respondent:

Soos ek vanoggend gehoor het. "Ai, die Suster is al weer hier. Die Suster wil al weer praat." Toe sê ek "nee los haar, sy is hier om vir ons die inligting te gee." Dit was my woorde. En toe staan ek op, gaat ek uit, toe gaat rook ek.

Ja, Suster. Toe gaat ek uit, toe dink ek "ag, hoe's ons mense dan?" Die vrou het toe nie na ons toe eens gekom nie, of die vrou het nou nie een gesê die vrou kom na ons toe nie. Ons weet ok nie, ons moet maar hoor. Maar ons sort nasie kan nie gekom het nie. Dis die ding, Suster, wat ek sommer so eenkant sit daar by die huis ok. Ek is so bang soos môre die heel dag vir die geprater. Dan praat ek liever met my huismense, met Mamma-hulle.

One respondent however reacted to being alone by smoking.

Respondent:

Ek voel baie sleg partykeer want as daar niemand by die huis is nie en ek het nie 'n persoon om te gesels nie so dan rook ek ook. As ek nie nou wil rook nie dan gaan sit ek by die buurmense.

A number of reasons exist, however they can all be placed under the banner of Poor Social Support System, which according to Hulsey et al (2000) affects women's decisions regarding behaviour during pregnancy.

Firstly there is the issue of poor or no partner support, their exposure to a community environment of alcohol and nicotine abuse, and gossip by community members. One respondent also mentioned her perception of the negative attitude of health personnel attitude at one of the clinics (see quote on pg.17). It is no wonder pregnant women in these communities find themselves alone, (physically and emotionally) especially since they are solely targeted and held responsible to produce healthy babies in an environment that appear so hostile.



PREGNANT WOMEN'S PERCEPTION OF HPMs THEY WOULD LIKE TO APPLY AFTER THE BIRTH OF THEIR CHILD.

THE FOLLOWING THEMES EMERGED: BREASTFEEDING, NO SMOKING CIGARETTES AND DRINKING ALCOHOL

Eating habits in C1 do not appear to be mentioned again in C4, something they would like to apply after giving birth.

Breastfeeding:

Respondent:

Spesiaal die borsvoeding

One respondent expecting her 6th child, even mentioned that she had exclusively breastfed her 5 children.

Respondent:

Soos ek vir Suster kan sê, al my kinders, die vyf het aan my gedrink, maar al ek gebruik net een botteltjie, en dis die medisyne-botteltjie waar ek die medisyne sit of sy kookwater of so. Maar verder het hulle al vyf aan my gedrink, Suster. En ek het my, my prama is, as ek 'n baba gekry het, Suster, is hulle vol, vol voeding, kos.

No smoking cigarettes and using alcohol

Respondent:

Okay. Is to quitting. Not drinking and smoking.

Interviewer:

Okay, but you told me you don't drink and smoke.

Respondent:

No, I don't drink anymore.

The above respondent was able to stop smoking cigarettes and drinking alcohol because of her pregnancy. However she feels that she does not want to return to these unhealthy habits after the birth of her child. Support from primary health services are needed for these women who are able to stop during their pregnancy but are vulnerable to these habits after giving birth.

One respondent mentioned her desire to breastfeed and not to return to smoking and alcohol use.

Respondent:

Uhm wat ek hier gekry het, die inligting? Uhm ... borsvoeding sal ek wil toepas en om nie te rook en drink nie. En (stilte).

It is interesting to see that women's eating habits improved during pregnancy, but not after it, following the same pattern. Cigarette smoking does seem to increase again in post-partum women who were able to stop during their pregnancy, but are unable to continue with this positive behaviour. The reasons for this could be that their motivation and perception is that her child is no longer in danger. Once again suggesting that women still undervalue their health.

C 5

PREGNANT WOMEN'S PERCEPTIONS OF WHAT WILL MAKE IT POSSIBLE FOR THEM TO APPLY HPM AFTER GIVING BIRTH. THE FOLLOWING THEMES EMERGED: SUPPORT AND CONCERN FOR THEIR CHILD

Support: Family

Respondent:

Dit het vir my moontlik gemaak om die rook te los, want my man rook nie. Hy's baie gekant teen rook, en hy sal altyd vir my gesê het, "maar moenie rook nie, dis nie goed nie. En veral as jy swanger is, moenie rook nie. Ek gee nie om as jy na die kind wil rook nie, maar nie terwyl jy swanger is nie". So hy't my baie aangemoedig om nie te rook nie.

It appears that spouse/partners habits and encouragement influence pregnant women's decisions to stop unhealthy lifestyle habits.



Support: Work

An employer's willingness to allow the following respondent to bring her child to work makes it possible for her to breastfeed her child. The following transcript is evident of this.

Respondent:

Op die oomblik het ek klaar met my werknemers gepraat en hulle het aangebied ek kan die baba saam met my werk toe bring vir die tyd.

The maternity leave law implemented by the South African Government allows pregnant women to stay at home for 4 months before returning to work which allows them the opportunity to choose breastfeeding for at least 4 months before returning to work. This also highlights the importance of Labour Policies and its impact on health behaviour. The following quote is evident of this.

Respondent:

Die inligting wat wys van die kind (onduidelik). As jy nou borsvoed, dan die baba se brein ... dit versterk die baba se brein, en ek kan sê dit maak hom sterk ook as jy hom borsvoed.

Interviewer:

OK, so daar's 'n goeie rede om te borsvoed, maar gaan dit, jy gaan mos nou natuurlik ook terug werk toe. Weet jy vir hoe lank gaan jy af wees van die werk af?

Respondent:

Vier maande

Interviewer:

Vier maande. Is dit wat hulle vir jou gesê het? Sal jy dan wil borsvoed in daai tyd, né. Wanneer jy teruggaan werk toe, dan is die baba mos nou nog nie ses maande nie. Uhm ... gaan jy dan op die bottle gaan of jou melk soos uitdruk soos wat hulle vir jou gesê het?

Respondent:

Ek sal hom op die bottel sit.



Concern for child or benefit for the child

Respondent:

Wat sal dit vir my moontlik maak? (Ja) Ek sal meer geduldig wees om nou my baba te borsvoed. Ek dink jy sal moet meer geduld het daarvoor, want as jy nie geduldig gaan wees nie en jy's onrustig en so aan. Gaan jy nie die dingese het vir jou kind nie ... die geduld het em met jou kind rustig te sit en te relax eintlik nie. Om vir hom of haar te borsvoed. En dit maak die kind ook meer ... sal die kind ook meer kalmeer. Dat hy nie so lastig is of so aan nie.

Women must learn that their well being after giving birth is as important for their health and for their children, because of implications it has for their own bodies and the message they sending to future generation.

C6

THE PREGNANT WOMEN OF THIS STUDY: THEIR OBSERVATIONS OF PREGNANT WOMEN IN THEIR COMMUNITIES WITH REGARD TO APPLYING HPMs. THE FOLLOWING THEMES EMERGED:

SOME USE ALCOHOL AND SMOKE CIGARETTES, IRRESPONSIBLE BEHAVIOUR.

Some use alcohol and smoke cigarettes

Respondent:

Okay, We are different people mos né. Some of them are using the information. Some of them are not using it. Some of the people are drinking and smoking....

Every pregnant women in the study admitted that some pregnant women were observed using alcohol and smoking cigarettes.

Irresponsible behaviour.

This theme is described in the following transcripts.



Respondent:

Dit pas, en baie van die vroumense pas dit toe, maar sommige gaan mos nou op hulle eie, en hulle doen (praat sag/res is onduidelik).

Interviewer:

Wat sien jy doen hulle, en wat sien jy doen hulle nie in terme van hulle swangerskap?

Respondent:

Dinge wat hulle doen, wat verkeerd is, is die rook en drink en dan met dié outjie slaap en met daai outjie slaap deur die swangerskap wat nie goed is nie.

Interviewer:

Hoe uhm... hoe weet jy hulle slaap by verskillende?

Respondent:

Daar's baie, daar's baie wat aan die hand loop (onduidelik) en dan vanaand is dit hierdie boyfriend, en möreoggend sien jy daar's weer 'n ander boyfriend. Dis nou soos ek dit sien, om deur swangerskap iemand gaan slaap met different mans.....

Respondent:

They are walking at night to midnight. So they are walking in the cold. When it's cold they are walking outside. You see.... Walk to go to the shebeen some place that are not right. Go there lot of people there né....so everyone do what you want to do or what she want to do. If I want to smoke I can smoke. So the pregnant women mustn't go these places but some of the people are using this information.

Some of the pregnant women were observed walking in cold weather late at night to visit shebeens (a place alcohol can be bought). Some pregnant women were also seen acting promiscuously, having sexual relationships with more than one man, while others were not taking their vitamin and iron tablets given to them by nursing staff from the CHC.

C7**BARRIERS FOR PREGNANT WOMEN IN APPLYING HPM IN THEIR COMMUNITIES AS PERCEIVED BY THE PREGNANT WOMEN OF THIS STUDY. THE FOLLOWING THEMES EMERGED: DON'T CARE ATTITUDE, PERSONAL EXPERIENCE, ADDICTION****Don't care attitude:**

The following transcripts are evident of this theme.

Respondent:

Die vitamine-pille en die ysterpille wat ons kry. Party gebruik dit nie, dan het hulle elke keer 'n ander verskoning, maar dan is dit nie so nie. Dan sê hulle "nee, die pille maak dit, die pille doen dit". Dit is nie so ie, want ek gebruik dit en dis goed. As ek nie my pille gebruik nie, dan draai my kop en dis amper so ek móet dit nou drink, want dis amper soos iets force my ek moet dit drink en dit is goed vir my, want dit help jou baba ook om sterk te word.

Interviewer:

Hoekom dink jy hulle drink nie hulle pille nie? Wat... praat jy met hulle dat jy dit weet? Hoe weet jy dat hulle nie hulle vitamine-pille of ysterpille drink nie?

Respondent:

Ek ken iemand ook wat nie haar pille wil drink nie, dit is nie goed nie. En elke keer as sy an haar verskoning praat, “nee man, die oggend is daar iets om te eet, dan kan sy haar pille drink, die middag is daar nie iets om te eet nie, dan voel sy so moeg. Dit is net hulle gee nie om nie. Daar kan maar enige iets gebeur met hulle baba, hulle gee net nie om om hulle pille te drink nie.

Respondent:

Baie van hulle sê dit is probleme. Dis hulle huislewe is nie maklik nie en geld is min. Maa nogtans spandeer hulle die laaste bietjie geld nog op drank en rook. So ek dink nie dit eintlik die probleme wat saak maak nie. Dit is maar jy as persoon wat maar net daai wil doen.

Respondent:

Sommige van hulle doen nog die dinge wat hulle gedoen het. Hulle gee nie eintlik ag op die gesondheid van hulle baba en so aan nie.

Interviewer:

So daar is sommige in die gemeenskap wat jy sien. Behalwe nou die rook is daar ander dinge wat jy ook sien wat miskien... wat hulle nie doen...of wat hulle doen wat nie goed is terwyl hulle swanger is nie?

Respondent:

Ja daar is baie ander dinge wat hulle ook doen soos drink en nou nie gesond eet en sulke goed nie.

It appears that the pregnant women of this study think that barriers to apply HPM for some pregnant women in the community is because of their attitude which is often described as they not wanting to change, because they don't care to change and apply HPM.

It appears that the pregnant women in this study judge their peers who do not apply HPMs. They ignore reasons given by their peers for not applying HPM, even when they are the same reasons they themselves give such as stress, and blame their peers for not taking care of their unborn child. This is very disturbing that pregnant women cannot depend on their peers for support and understanding.

The pregnant women in this study are not considering the effects of political, socio-economic and cultural elements on health behaviour.

Personal experience

Respondent:

kinders al... ek het nog niks gesien nie. So niemand sê vir my wat om te doen nie. Ek besluit self

Respondent:

Ek dink uhm.... Dié wat nou rook, hulle... dis miskien nie hulle eerste baba nie en die eerste baba het miskien nou niks oorgekom het nie, nou hou hulle aan met rook met hulle tweede swangerskap. “Hoekom moet ek dan nou ophou, want my eerste baba het dan niks oorgekom nie”, onder andere.

Addiction to nicotine and alcohol

Interviewer:

Die ander mense wat dit nou nie toepas nie, hoekom dink jy is dit moeilik vir hulle om die drank en die rook te los?



Respondent:

Dis omdat hulle geheg daaraan om elke dag te drink, elke naweek te drink. Dis hoekom hulle nou nie sonder dit kan klaarkom nie deur die swangerskap.

One pregnant woman in this study also admitted this addiction.

Respondent:

Die rede is... ek het...en ek is ‘n sieklike persoon. Ek kry die vallende siekte. Toe dink ek wat dit nou so. Ek is swanger en ek kry die siek en dan rook ek nog. En nou rook ek nog meer as dit ook. So dis gevaarlik vir ‘n kind. En die siekte is ook nog gevaarlik vir ‘n kind. Ek probeer die rook los, maar ek kan dit nou die regkry nie. Dinge sal maar... as dit een keer per dag is as ek gerook het, dan rook ek miskien weer namiddag die tweede ene en saans as ek nou slaap weer.

Don't care attitude/personal experience/addiction

A don't care attitude is perceived because some pregnant women are continuing to smoke cigarettes, drink alcohol, not take their vitamin and iron tablets and spend the little money they

do have on alcohol and cigarettes. However, according to Downie et al (1996), “a person’s attitude may on some occasions not lead to the corresponding behaviour because a strong desire may lead to action inconsistent with the attitude. For example one respondent mentioned that the pregnant friend was not taking her vitamin and iron tablets. From reading the transcripts it appeared that the tablets had an effect and that they did not always have something to eat before taking the tablets. It could be that the desire to take the tablet was outweighed by its “effects” on her. Another respondent for example mentioned that other pregnant women mentioned that they had problems at home and lack of money, and it appeared that their coping strategy was to buy alcohol and cigarettes with the little money that was left. At least it would provide relieve from their problems for a short period of time.

Attitudes appear to be strongly influenced by personal experience, Downie et al (1996). According to the pregnant women of this study, the other pregnant women in the community who did not follow this HPMs, based their decision on their perception that they could not see the negative effects of alcohol and nicotine use on their other children and therefore would not change their lifestyle habits. According to Naidoo & Wills (1994), personal experience is a factor that affects an individual’s perception of risk and how he/she will respond.

Addictions

From the transcripts it is clear that addiction among some pregnant women is evident in the areas and that a new approach in HP is needed for women to feel that the HPP is accessible and want to reach out and help them. It is therefore necessary to know how those addicted feel/think about the service and about themselves. According to Downie et al (1996), there is a strong association between attitude about service provision and attitude towards self, with that of health - enhancing behaviour. The HPO mentioned that some pregnant women initially came to the CHCs intoxicated, and that it was no longer happening. It is unknown if this is because women have learnt not to come to the clinics intoxicated or whether these women are just not coming to the clinics, as women are still observed drinking in the community, both by clinic staff and by participants in this study.

SECTION D

D1

4.4 PREGNANT WOMEN'S PERCEPTION OF WHO THEY WILL SHARE H.P.M. WITH. THE FOLLOWING THEMES EMERGED: IMMEDIATE FAMILY: MOTHERS, IMMEDIATE MALE FAMILY OR HUSBANDS /PARTNERS /BOYFRIENDS/ BROTHERS.

Mothers

Respondent:

Ja, ek het al. En saam met my moeder, ek het haar al alles verduidelik ok wat ons gedoen het en waarom ons praat, en elke keer as ons iets nuuts ok gedoen het, dan vertel ek vir my kêrel, want hy vra en ek verduidelik vir hom hoe en wat ons alles doen.

Immediate male family: Husband/partner/ boyfriend/brother

Pregnant women also share information with the brothers and husbands/partners regarding smoking dagga and cigarettes. The following quotes emphasise this:

Respondent:

Ja, ek het dit met my broer gedeel en vir hom verduidelik nou hoe gevaarlik rook is en toe sê ook vir hom as hy ok wil hulp kry. Dan kan ek met hom praat en sal ek saam met hom tot by die kliniek kom. Toe sê hy ja hy sal as hy kan.

Respondent:

Nee, my boyfriend. Al die persoon waarmee ek dit gedeel het, dit was my boyfriend gewees. Dis al.

Interviewer:

Het jy die inligting oor die rook ook met hom gedeel?

Respondent:

Gedeel en gepraat met hom, maar dit lyk amper asof hy luister nie as ek met hom praat nie.

Interviewer:

Hoekom dink jy gee hy nie aandag aan dit nie?

Respondent:

Dis omdat hy's geheg, hy's nou gewoon al hy rook daar by my huis, ens.

Mother

Pregnant women share most of their HPM with their mothers. This is not surprising since the majority of them admitted that their mothers initially shared information regarding pregnancy with them. It could also be that they feel their mothers could identify with their experience. Most of the women in this study live with their mothers and rely heavily on them for support emotionally, financially and technically, especially in terms of helping them care for their child/children when they return to work. The fact that HPM are discussed with their mothers has benefits, because new and accurate information can be shared with their mothers, who can in turn share the information with their other daughters. They also tend to share all the information with female relatives if they are living with them, which disseminate information across the women in the community.



Immediate male family or partner/husbands/boyfriends/brothers

Pregnant women also tend to share HPM with their husbands/boyfriends/partners/
Brothers, because as one respondent mentioned, her boyfriend wanted to know. However it appears that the HPM shared was limited to the negative effects of smoking cigarettes and dagga. The reason for this could be that this HPM is stressed by the HPO and that the pregnant women are exposed to the secondhand smoke, which is harmful to them and those who do smoke.

D2

PREGNANT WOMEN'S PERCEPTION OF HPM THEY WOULD SHARE WITH A YOUNG WOMAN, PREGNANT WITH HER FIRST CHILD.

THE FOLLOWING THEMES EMERGED:

1. THOUGHTS AND FEELINGS REGARDING THE PREGNANCY
2. ROLE OF BABY'S FATHER
3. ADVISE HER TO SEEK PROFESSIONAL HELP
4. ADVISE WITH REGARD TO SMOKING CIGARETTES AND DRINKING ALCOHOL.

Thoughts and feelings regarding the pregnancy

The following quotes emphasises the importance of dealing with facts and emotions regarding this theme:

Respondent:

Ek sal vir haar aanmoedig om die babatjie te hou, om nie vir 'n aborsie te gaan nie, want dit gaan haar pla, ok na 'n lang tyd gaan dit haar pla hoekom het sy dit gedoen, waarom het sy dit gedoen. Sy gaan hartseer wees daaroor en ek sal vir haar aanmoedig om liewerste die babatjie te hou en groot te maak.

Interviewer:

Hoekom dink jy jy sal vir haar hierdie tipe inligting gee?

Respondent:

Omdat ek ken iemand ok wat vir 'n aborsie gegaan het en sy's baie hartseer ok, en sy't vir my vertel sy sal haar ma nooit vergewe nie, en dit was baie hartseer, want ek voel dit saam met haar.

Respondent:

Ek sal vir haar sê dat sy moet sterk wees, dis almal se paadjie en almal moet daardeur gaan en sy moenie bang wees en met iemand daaroor te praat nie. As sy miskien nou hulp nodig het, kan sy kliniek toe gaan om miskien meer inligting te kry hoe hulle...

The above respondent also emphasised "seek professional help" (that follows).

Seek professional help

Respondent:

Ek sal die beste inligting wat vir haar sal kan gee is om na die voorligter toe te kom. Wat vir haar meer spesifiek sal verduidelik rondom die swangerskap en wat sy moet doen.

Interviewer:

Is daar enigiets anderste wat jy met haar sal deel?

Respondent:

En ek sal vir haar deel van my ondervinding ook. Wat ek ook gedoen het.

Interviewer:

Okay. Hoekom dink jy dit is belangrik dat sy hmm na die voorligter toe sal kom en hoor oor jou persoonlike ervaring?

Respondent:

Ek dink dit is baie belangrik om te kom na die voorligter toe. Om jou te verduidelik rondom jou swangerskap en jou lewe want baie mense kan vir jou verskillende goed sê en dan gaan voer jy dit miskien uit. En dan gebeur dit nou nie so maklik nie. So dit is maar beter om na iemand toe te kom wat die inligting het en wat vir jou die waarheid kan sê. Wat moet jy doen en wat moet jy nie doen nie.

Respondent:

Ek sal vir haar vra of sy 'n drinker of 'n roker is en of sy enige siekte het of so. En as sy nou enige het en dan verduidelik ek nou vir haar hoe ek hulp gekry het. En sy wil ook nou gehelp wees en sulke. Ek sal verduidelik hoe het ek hulp gekry.

Role of baby's father

Respondent:

As sy jonk is en dan sal ek ook vir haar die uhm... ek sal vir haar wil vra oor die kind se pa. Ek sal vir haar wil vra oor die kind se pa, hoe die kind se pa is en of hulle nog bymekaar is en hoe voel sy. Uhm... sy's jonk, hoe voel sy oor die swangerskap. Of hoe het sy gevoel toe sy hoor sy's swanger.

The respondent also puts value to feelings during pregnancy which are not commonly included in the HP curriculum.

Interviewer:

Hoekom dink jy dis belangrik dat sy ook, dat jy sulke vrae vir haar vra?

Respondent:

Ek sal vir haar... die rede hoekom ek dink is, want toe ek swanger geword het, was ek jonk en dit het gelyk ek kan van my kop af raak. En het daai moment gdink ek het nou iemand nodig om mee te praat. En ek het nie iemand gehad om mee te praat nie, en ek het maar met die kind se pa gepraat.

The above respondent also relates her personal experience when she was pregnant and her emotional state at the time, emphasising the “thoughts and feelings regarding the pregnancy” theme.

Smoking cigarettes and drinking alcohol.

Respondent:

Ek sal die inligting met haar deel. Ek sal vir haar vra of sy drink, rook. Dan sal ek vir haar bewys uhm... om dit maar either te los, want dit is vir haar kind se beswil. Dis wat ek geleer het, sal ek vir haar ook wil leer uhm ... dit is hoe dit (onduidelik).

It appears that the advise these pregnant women share with another is based on their experiences, either that which they personally experience or someone close to them.

At least three of the four themes in this section are reflected in the study done by Mamella et al (1998). However, of the three themes women note as important, the current HPP only covers the last one.

HPMs pregnant women in this study would share with a young pregnant woman.

Themes in this study	Mamella et al, study
<ul style="list-style-type: none"> Thoughts and feelings regarding the pregnancy. 	<ul style="list-style-type: none"> Feelings of fulfillment during pregnancy.
<ul style="list-style-type: none"> Role of baby’s father 	<ul style="list-style-type: none"> Role of baby’s father
<ul style="list-style-type: none"> Advise with effects of smoking cigarettes and drinking alcohol. 	<ul style="list-style-type: none"> Attitude towards daily life and behaviour while expecting.

The themes in this study confirm finding by Mamelle et al “Psychological dimensions and the emphasis pregnant women themselves attach to its value. The reason for this could be that many of these women are unable to express their thoughts and feelings, experienced poor partner support during and after pregnancy, and have observed many pregnant women abusing alcohol and cigarettes.

It is interesting to note that the bio-medical content that are shared with the women are not what they regard as information that they would share with a young pregnant women other than advise on alcohol and nicotine abuse.

Studies in region have revealed that the prevalence of cigarette and alcohol use are highest among coloured women. This is well known so it could also be that advise on the negative effect of alcohol and nicotine is emphasized by the HPO. This could have improved pregnant women’s understanding of the negative effects of alcohol and nicotine use, hence the emergency of this theme.



The theme “advise her to seek professional help” emphasises again the perception that they experience the HPP as a means to help us. One respondent believed that she got accurate information from HPO, because information in the community were at times conflicting.

D3

PREGNANT WOMEN’S PERCEPTION OF BARRIERS IN SHARING HPM

THE FOLLOWING THEMES EMERGED: COGNITIVE/INTELLECT PROCESSING AND ADDICTION

- **Cognitive Processing – specifically memory**
-
- At least two of the respondents mentioned problems with memory

•

Respondent:

By die huis gaan dit ok net so. Dan het my ma nou vir my iets gesê, ek gaan nou net hier by die deur uit suster, en ek kom terug, “Mamma, wat het mammie nou weer gesê? Ek kan nie nou onthou nie”.

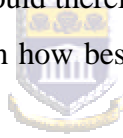
Cognitive processing – specifically ability to understand information

Addiction

Respondent:

Ek dink dis omdat sy gewoonlik rook en sy drink, jy kan sien. Sy is van daai soort wat nie omgee nie.

According to Kalmuss et al (2003), there is a significant link between low cognitive ability and early child bearing in youth. HPMs would therefore be difficult to follow if one could not recall them adequately, or if their decision on how best they could follow HPM were hampered by a limited ability to think critically.



4.5 SUMMARY

Table XX summarises the emerging themes from this study under two general headings of programme strengths and weaknesses. This table provides an overview of the major themes. The next chapter will review these themes and recognize successes and areas in need of improvement in the HPP with regard to the HPMs.

TABLE XX

SUMMARY OF STRENGTHS AND WEAKNESS OF HPP WITH REGARD TO THE HPMS

<u>Strengths</u>	<u>Weakness</u>
<p>1. Mothers are initial source of advise on pregnancy.</p> <p>Pregnant women discuss and share information that they heard by HPO with their mother.</p> <p>New and accurate information can now be shared with her daughter.</p>	<p>1. <u>Content of advise by mothers are not put in context.</u></p> <ul style="list-style-type: none"> • Advise limited to factual medical information on how you can get pregnant and symptoms of pregnancy. • Advise appear to be a once off session. <p><u>Content of HPM also limited to bio-medical content ignoring Psychosocial aspects such as:</u></p> <ul style="list-style-type: none"> • Role of baby’s father • Thoughts and feeling during pregnancy • Stressors • Barriers to HP behaviour • Cognitive problems • Irresponsible behaviour of pregnant women • Children disobedience • Step family dynamics • Recognizing individual needs in groups • Attitudes and recent experiences of some pregnant women are barriers to sharing HPMS with them.
<p>2. HPM also shared immediate uncle/ family/husband/partner.</p>	<p>2. No other help offered by HPP to those who have addiction</p>
<p>3. Positive perspective of purpose of HPP “To help us”.</p>	<p>3. HPP only reaches those who want help, therefore not reaching all pregnant women, esp. those who have problems with addiction.</p>
<p>4. Pregnant women are acquiring new, accurate knowledge of breastfeeding and understanding the negative effects of</p>	<p>4. Understanding and sharing of HPM. are hampered by low cognitive ability.</p>

alcohol during pregnancy.	
5. HPO use a variety of visual aids and uses concrete concepts in her exclaims.	5. More use of concrete concepts in programme over all.
6. Pregnant women are changing their eating habits and reducing cigarette smoking and avoiding passive cigarette smoke.	6. No help for those who want to maintain a no smoke/reduce smoking after giving birth.
7. Pregnant women are targeted and are learning and put some of information into practice.	7. Pregnant women are solely targeted, community involvement (especially mothers) and partners need to be targeted.
8. HP Unit exit at Level 2.	8. Progress to a Level 3 and eventually a Level 4. Health promoting CHC is needed to achieve noticeable results in maternal and pediatric health in the areas.
9.	9. Hostile community environment: Gossip Crime Rape
10. Evidence that pregnant women wanted to reach out to their peers, however, communication skill and knowledge of how to communicate will be critical.	10. Pregnant women are judging and ignoring reasons given by the peers for not applying the HPM and blaming them for not caring for their unborn child.
11. Pregnant women are applying some HPMs.	11. Information emerged as one of the themes that made it possible for pregnant women to apply HPM now. Validating the existence of HPP

CHAPTER V

5. The theoretical frameworks of empowerment model Naidoo and Wills (2000), HP Tones and Tillford (2001), and health promoting hospitals framework Johnson and Baum (2001) will be used to frame the discussions, conclusion and recommendations.

5.1 **STRENGTH OF THE HEALTH PROMOTION AT CHCC AND KCHC**

HP at CHCC and KCHC are perceived by pregnant women to help them gain knowledge. This was also confirmed when they said that they will advise other pregnant women to seek professional help. This implies that the knowledge they gained was helpful and that there were benefits for attending the HPP. Pregnant women are learning new information about breastfeeding and the negative effects of alcohol assumption. Some are even improving their eating habits and reducing smoking after attending the HP sessions.

Pregnant women are reaching out and sharing information with their immediate family, especially their mothers. The HPO's attitude when asked to explain and repeat messages and her ability to explain H.P.M. have emerged as strengths to help pregnant women understand HPMs better. Therefore she is beginning to empower these women by removing barriers that impact their ability to understand and recall messages and by building their confidence through her communication strategy of repeating messages when asked to do so, explaining logically or as one respondent mentioned "from A – Z" and using visuals such as pictures and drawings, to make sure the message was clear to them. Handler et al (1988), confirms how important explanations by prenatal service provider are for low-income pregnant women's satisfaction with care.

The benefits of providing HPMs to pregnant women was evident when the theme "information" emerged as one of the themes that made it possible for them to follow HPMs during their pregnancy. This is both encouraging and worrisome at the same time. Pregnant women seem to value HPMs while pregnant, but this theme did not emerge when asked what would help them apply HPMs after giving birth. This has implications for long-term health of the women and

needs further exploration. It did appear that HPM on breastfeeding and eliminating cigarette smoking had a greater impact, because women wanted to continue applying these messages after giving birth. However, these women were not sure that they would be able to do so.

Support beyond the current clinic based HPP might enable pregnant women to feel less isolated and alone, and by continuing to reinforce the HPM given in the clinic. It might also expand the opportunity to speak about the meaning that smoking holds for them, and ways of reducing or stopping these habits and referring them to appropriate services for nutritional and financial support. Despite the positive aspects of the HPP, LBW persist in the region. The priorities of the HP (WHO) have not been experienced in the CHC by staff or those using the services and the communities. The HPP needs to expand to an organizational level (Level 3) and beyond to include the communities (Level 4) for HPMs to have a lasting impact.

5.2 WEAKNESS OF HPP WITH REGARD TO THE CURRICULUM – CONTENT AND SUGGESTIONS FOR IMPROVEMENT

The HP curriculum focus is on the bio-medical information. Pregnant women however expressed a need to discuss their “thoughts and feelings regarding the pregnancy” and the role of the baby’s father. The emergence of these themes was validated when pregnant women expressed feelings of stress and loneliness as barriers to applying HPM during pregnancy. It is therefore necessary that the psychological dimensions mentioned by Mamella et al(1999), be included in the curriculum of the HPP so that HPMs can be relevant.

Another area of concern was that the curriculum did not emphasise continued behaviour change with eating habits after giving birth, although it emerged as a theme that they applied during pregnancy. This has implications for the women’s health throughout her lifespan, but also for her next pregnancy Mora and Nestel (2000). It will be necessary to influence pregnant women to eat healthy after giving birth (food availability and finances are a problem), the HPP would need to collaborate with social services to look at food parcels, social grants and small business opportunities for women). Social service, in turn, might need to determine how they will incorporate HP in their poverty relieve strategies.

Another concern was that HPM recalled by pregnant women were on alcohol, smoking and eating habits, although important scant mention of other messages did appear in the transcript, but was not necessarily recalled when pregnant women were asked what HP they attended. If these messages were equally important to spend time on, one would wonder why women are not mentioning them. Is it because of their direct contact with the problem on a daily basis (either personally or experience in the community), or is it the only messages they got because they booked late or follow up attendance were poor. Whatever the reason it would be best to use the time to address issues truly relevant and placing it in a social context. For example, the woman wants to breastfeed, but needs to return to work. Questions that can arise from the above problems are as follows:

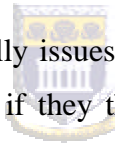
- How long will you be able to breastfeed before returning to work?
- How and when will you start weaning the baby from the breast?
- You want to continue breastfeeding when you start working, what are your options?
- Your mother or husband pressures you to stop breastfeeding. How can you respond?

Creating interesting and non-threatening ways for pregnant women to learn as Gillies and Elwood (1989), suggest, would provide a stimulating learning experience. A single problem situation can improve knowledge (for example, women rights with regards to maternity leave perceptions of other people's viewpoints and alternately one's ability to reason.

Other problems that can be included:

- You want to take your iron and vitamin tablets, you have food for the morning, but not later the day. What can you do?
- Your partner drinks and you join him, but this is not what you want to do.
- You feel stress with regard to gossip concerning you.
- You want to breastfeed, but your mother insists your breastfeeding is not enough. How can you assure her when you live with her?
- Relationships with your other children especially with regards to you being pregnant with your second and third partner's child.
- How to help your other child develop.

- How to go about sharing information with other pregnant women who you know did not book herself at the Clinic. You also know that she has a drinking and smoking problem.
- What can you do if everyone around you smoke and you are pregnant and do not want to smoke passively.
- You are pregnant and your boyfriend deserted you. What are your options?
- Explore feeling and thoughts such as fears of raising a child without father's support and financial help. What can she do?
- Both you and your husband drinks alcohol. What happens at home when you are both intoxicated – issues around support if you want to stop. Explore reasons for consuming alcohol – help that can be offered.
- A young pregnant woman acts irresponsible. What do you think could be the reason she behaves this way? How do you think she can be helped?
- Your brother smokes dagga. What can you do?



Most of the above examples were actually issues taken from the transcripts. Thus they may be more willing to interact in the sessions if they themselves experience the problems or at least could identify with someone in their community who did. Because personal experience emerged as one of the barriers for other pregnant women, it will be beneficial to use personal examples such as the above that are relevant to these women. This again can be both emotionally and intellectually empowering, firstly because women will be able to identify with these life situations either personally or observed in their communities. This identification could be the first step to build their confidence (emotional empowerment) to participate actively in the HP sessions, because they know of these life situations and can therefore talk about it. This could lead to intellectual empowerment, as pregnant women discuss and develop critical consciousness as they listen to each other in the HP sessions, while the HPO facilitates the discussion. However Campbell and Macphail (2002), warns that such participatory approaches imply critical analysis of a health problem and generation of possible solutions to address these problems. This critical analysis seem to be missing or limited for example, they had different reasons they gave for other pregnant women in their communities who did not apply HPMs. Yet these reasons had the same social and economic origins. Therefore explicit training in critical thinking skills and in social

versus medical explanations of poor health outcomes for pregnant women Campbell and Macphail (2002), need to be included in the curriculum content. Once again expanding to the community including critical skills training with regards to social and economic problems in the school curriculum, could possibly better prepare adolescents in developing these skills.

In a HP session, all pregnant women listen to the same message. This includes pregnant adolescents, adults and pregnant women with cognitive deficits. Adolescents needs are often different from adults. They are less empowered to make decisions and dependent on family, about matters affecting their health) Module H – Handout orientation Programme, undated).

All the pregnant adolescents in this study were living at home with their mothers. Single pregnant adolescents may also feel less able to ask questions during HP sessions in the presence of adult women or married women because of feelings of shame. The scope of this study does not allow the researcher to go into the enormous issues associated with providing health care to pregnant adolescents, however it is necessary to highlight that support and a different approach is required to that of pregnant adults. The National Adolescent Friendly Initiative (NACFI) in South Africa can be contacted to improve adolescent health care at clinic level (see Appendix 3). In addition to adolescents pregnant women with cognitive deficits such as memory and those who struggle to understand information might need additional materials to compensate for the memory difficulties or a more concrete approach in order to understand all HPMs. The Women's Health Handbook currently under development for use in the district could be an option to assist these women.

Pregnant women who are already addicted or those who drink moderately, but want to stop might have difficulty admitting to their addiction in the group sessions out of fear of being judged. Therefore these women need to be given the opportunity to disclose their problem without fear of being judged. This together with the general attitude of blame and judgement could be the reason why women attending the HPP have booked late at CHC's.

It appears that the CHC needs to re-orientate to make antenatal services more accessible and approachable for the different needs of pregnant women. An initial step might be to identify pregnant women who have not yet booked by word of mouth and send CHW. or FHW to do home visits and provide support and antenatal care advise and to encourage (not persuade) women to book themselves early.

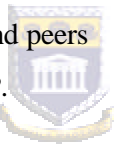
In addition the HP curriculum needs to be documented so that it can be evaluated and used by others in the region doing HP. work.

Even in the health promotion session and a sense of security must be felt for women to start speaking. They have after all experienced distrust/gossip and so they are mindful that in a HP session they must be careful of what they say or even ask. They might experience fear of what others in the group think or might broadcast. Trust and security must therefore be issues that need to be addressed at the beginning of each group even if it is through an icebreaker. They must be made to feel that it is safe to speak, ask questions and make comments. This might engage more active participation of the women in the session. The HPO normally stands in front of the women. She could position herself so that she sits with them in a circle. This non-verbal responds could in fact help women break free of false consciousness by showing them that HP session is not about informing them, but engaging them to find solutions to their health and social issues.

Pregnant women themselves are divided with regards to the root causes and CCR will enable them to develop a “collective identification” of the root causes of their struggle to apply HP messages. Once this collective identification is consolidated, a collective plan of action can be developed with them as key role players. This can result in ownership of the plan and ultimately prepare them for active and economic issues. This will improve attendance at antenatal services and sustain HPPs that could have cascading effects for the entire community.

5.3 RESULTS: STRENGTHS AND WEAKNESSES

**TABLE VI
SUMMARY OF STRENGTHS AND WEAKNESSES OF THE HPP AS PERCEIVED BY
PREGNANT WOMEN**

<u>Strengths</u>	<u>Weaknesses</u>
<p>At Level 2 in Health Promoting Hospitals Framework</p> <ul style="list-style-type: none"> • Perceived HPP was “To help us know” • Are acquiring new knowledge and understanding • Some changing habits, e.g. reduced smoking and better eating • Women reach out to their family and peers to share information gained in HPP. 	<p>Need to move to Level 4 in Health Promoting Hospitals Framework</p> <ul style="list-style-type: none"> • Content biomedical without enough attention to psychosocial aspects • No other help for those with addiction • Only reaches those who want help • Sometimes not targeted for special needs • Only targets pregnant women, not broader community • Does not highlight need to continue behaviour change after birth

From the above table “key areas and aims” of a HPC is being addressed to some extent. Knowledge and skills is improving. The fact that information is shared with family and peers highlights the need that the HPM need to be heard in the broader community and that others besides the pregnant women need to be targeted.

The weakness characterizes problems one has when following the medical model because the solutions or HPMs are from a medical viewpoint and therefore does not consider the needs of all involved. Good communication practices with the purpose of exchanging information to create

good interpersonal and medical decision-making (Rowe et al, 2002), is therefore also compromised. Because the HPP has not expanded to community level, continued behaviour change after giving birth is difficult, because social and community barriers are not addressed.

5.4 OBJECTIVE: BENEFITS OF HPMs FOR WOMEN PERSONALLY

Pregnant women are experiencing intellectual empowerment. They are learning and acquiring new accurate knowledge of breastfeeding as well as understanding the negative effects of alcohol consumption during pregnancy. Some pregnant women however still need to experience emotional empowerment especially with regard to overcoming the problem of drinking alcohol after giving birth. Women are experiencing some emotional empowerment because they have acquired knowledge that they can now share with their mothers, partner or rest of their family and they are doing so. The women also perceived the HPP to be for their benefit, even if it is only while they are pregnant. This perception could provide emotional empowerment.

5.5 PERCEPTION AND APPLICATION OF THE HPMs

Pregnant women perceive the acquisition of knowledge to be for the benefit of caring for their unborn child. Hence the theme “to help us know and understand how to care for our child”. Although scant remarks were made about the value for them personally, it was perceived primarily for the benefit of the child. Therefore undermining the value it has for them. Could this be attributed to what Freire (1993) cited by Campbell and Macphail (2002), calls an adopted consciousness. Pregnant women also perceived the HPM “to help those who wanted help”. It appears that they place their pregnancy care squarely on their own shoulders, mimicking the medical approach with its victim blaming. Maybe here in lies the answer to the persistent pregnancy outcomes, namely LBW and other health related problems in the region. This could possibly be another reason why “information” did not emerge as a theme to what will make it possible for them to apply HPM after giving birth. Neither did pregnant women make any mention of the roles or responsibilities local government or community organizations (NGO) have with regard to their pregnancy outcomes.

5.6 SUGGESTIONS OF HOW TO DEVELOP HP AT ORGANIZATIONAL LEVEL

Management of the CHC need to buy into HP at an organizational level, in other words re-orient the health services towards HP Management together with the HPO will need to convince staff of the benefits of incorporating HP into their roles and policies. In order to do this, staff will need to be:

- Informed of the priorities of HP and its benefits.
- Informed of the findings in this study.

After this, it will be necessary to meet with them to determine how they think HP can be incorporated into their roles and procedures and the barriers they think they might experience in applying HP in their work. This exercise in itself is empowering because staff will be making their own suggestion, while at the same time learning from their colleagues of other ways HP can be applied. This will give them an opportunity to become aware of the many ways HP can benefit their wellness in the workplace and in their lives away from work. Besides being empowered personally, they can also become aware of how they could empower the people they serve who live in poverty at an emotional, intellectual, individual and community level. Health personnel's attitude and their responds to their clients are key elements in empowerment.

Other aspects that is needed at an organizational level (at both CHC's) is the availability of tools such as protocols which already exist in the province especially protocols for women's health with reference to pregnancy prevention. This calls for monitoring by managers of the CHC's of the availability and implementation of these protocols by staff. This is needed to send a consistent message so that unplanned pregnancy in the region can be reduced.

5.7 SUGGESTIONS FOR HP AT THE COMMUNITY LEVEL

HP services will need to be expanded into the community, because it is here that pregnant women face their biggest challenges when applying HPMs. Pregnant women have mentioned that support (from family and work) made it possible for them to apply HPMs. This is information that needs to reach those providing support in the family and work place, because they need to know that they are contributing to the mother and unborn child's well being. This positive

feedback and recognition could itself be empowering Tawil, Verster & O'Reilly (1995), cited by Campbell and Macphail (2002).

At the same time families and community leaders, for example the churches and various other organizations in the community can also become aware that barriers for pregnant women to applying HP are stress and feelings of loneliness. This knowledge could direct empathy and understanding, so that families and the community find ways to help pregnant women feel less stressed and isolated. In other words, pregnant women should not only be the ones targeted for HP, but their families especially their mothers, and husbands/partners as well as the community as a whole. Raising awareness or critical consciousness Freire, 1974 cited by Tones and Tilford (2002), of family and community in groups will require facilitation by skilled HP advocates.

Support groups for pregnant women to raise their critical consciousness need to be held because of the discrepancy of the barriers for pregnant women in this study and the barriers they perceived for other pregnant women in their communities. Pregnant women themselves will need to learn to support each other in the community especially those who perceive themselves as responsible but facing real barriers to implementation of the knowledge they have gained, while at the same time they perceive other women to be “irresponsible” for not applying HPM. They themselves will have to learn not to judge, blame and ignore reasons “irresponsible” pregnant women for not applying HPM. This response by their peers may add to the “irresponsible” pregnant women’s powerlessness, Freire (1993) cited by Campbell and Macphail (2002) would call this “authoritarian viewpoint” of judgement and blame an “adaptive consciousness”. A move towards critical consciousness to empower these pregnant women is recommended Campbell and Macphail (2002).

Gossip in both communities was rife and pregnant women felt that they could only trust family, but especially their mothers. Baum (1999) cited by Campbell and Macphail (2002) says that trust, reciprocal help and support, as well as active participation in community organizations were conducive to health enhancing behaviour change. Trust needs to be developed between pregnant women themselves, but also in the broader community. Church leaders and other religious

organizations could be informed of the findings in the study, so that they themselves find ways to stop gossip that result in mistrust and ultimately contribute to pregnant women's feelings of isolation and struggle to apply HPM. Once again the researcher would suggest that even in private organizations, the HPO or skilled HP advocate facilitate the process of critical consciousness, so that the outcome truly benefits pregnant women.

Various NGO working in the areas also need to become aware of the value that HP can have for their organizations and determine how they will incorporate it into their roles and practise while operating in these communities. Much of the actual HP in the community might need to be done by community organization. The reason for this is that at present there is only one HPO serving both CHC's. In order to expand services in the community, community health worker and the farm health workers can also be co-opted to provide health promotion services that will empower individuals and the communities. Obviously these workers need to incorporate HP in their roles and practises, so that a consistent message of empowerment and trust can develop in these communities.



5.8 STUDY LIMITATIONS

This could be bias in the selection of the study sample, because a purpose sampling method was used. The HPO selected the pregnant women. It is possible that she could have selected women she knew who were following HPMs. However, a range of possible characteristics on page _____ was applied to limit its effects. Also, three of the nine participants were selected by two nursing staff in the absence of the HPO (who attended courses), further minimizing bias of the selection process.

Because the HPP was not reaching all pregnant women, exactly how and why, pregnant women who did not attend the HPP, comply with HPM is not known other than through the eyes of "their judgemental" peers who did attend. Bias of the data can be overcome by including these women in the study sample of future research. The researcher's skill with regard to probing, improved with each interview. However, more skilled probing at the beginning could possibly yield information that could have altered the themes that arose. In the Data Analysis, the researcher

could influence the themes from the transcripts. However, to counter this, member checking the process of bracketing and peer debriefing was applied.

5.9 CONCLUSION

In conclusion CHC's and those organization providing health and social services in the communities need to become HP settings, so that capacity for empowering women and the communities they come from can become a reality. This will require the commitment from the Stellenbosch Municipality. It appears that they have outlined strategies for health promotion and social development in the Integrated Development Plan (2000), which may provide a framework for taking these concepts forward. Finally, the HP session will need to cultivate trust among the women and the topics chosen needs to reflect the personal realities these women experience. It will be necessary that they "search for a collective identification of the root causes of that reality" Tones and Tilford (2001).



HEALTH PROMOTING HOSPITALS

Level 1
Starting HP

Level 2
Establish HP Unit

Level 3
Comprehensive Organization Involvement

Level 4
Collaboration with the Community

WHAT NEEDS TO BE DONE TO REACH LEVEL 4

1. Expanded and documented HP curriculum

- Factual information and empowerment / Biomedical and Psychological Dimensions
- Empowerment and critical consciousness
- Different approaches – Adult Learning/Adolescents/Cognitive Deficits

2. Re-orientation at an Organizational Level

- Incorporate in roles and activities of Health Personnel
- Attitude towards HP and towards pregnant women
- Protocols especially with pregnancy prevention

REACHING OUT TO THE COMMUNITY

Patients and their families

Other service providers

- FHW/CHW/Others: Home visits to pregnant women not attending ANC; Home visits to support women after giving birth, especially those who want to continue not smoking and drinking.
- NGO: Youth services/support sexual health, stress and feelings of isolation

Broader Community

- Churches – gossip/family and partner support/value of womanhood
- Employers – Farms and other employers



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INTERVIEW GUIDE

General Information

Person:.....

Age:.....

Trimester:.....

Number of pregnancies:.....

Marital Status:.....

Income:.....

Lifestyle habits (smoking/alcohol):.....

Education:.....

Number of HP sessions attended:.....

Area:.....



1. (a) Where did you first get information about pregnancy?
(b) What HPO session did you attend (e.g. diet, breastfeeding)

2. (a) The information that you heard from the HPO about pregnancy, do you see it being used/applied by pregnant women in your community?
(b) Prompt: What information do they apply?
Prompt: What information do they not apply?

3. What information about pregnancy could you use this far?

4. (a) Did you make any changes after hearing the information?
Prompt: If yes, what changes did you make?
(b) Prompt: What made it possible (or was helpful) that enabled you to make the changes (note to interviewer – explore why and how of any changes in detail especially in regard to the experiences related to the change including personal, cognitive, feelings, family, environment, reactions of significant others, etc.

5. (a) What information about pregnancy was new to you that HPO told you?
(b) What did the information mean to you when you heard it?
6. (a) What information about pregnancy did you know, but understand it better now that the HPO spoken to you?
(b) What made it easy for you to understand the information?
7. (a) What do you think is the purpose of HPMs?
(b) What do you think is the purpose of HPPs?
8. (a) If a young women, who is pregnant for the first time, what information will you share with her?
(b) Why do you think is it important that she knows this information?
9. (a) Is there information that the health HPO shared with you that you find difficult to do at home?
(b) Why? (Note to interviewer – once again explore in detail experiences around difficulty in using information – personal, cognitive, feelings, environment, family, reaction of significant others, etc.)
10. (a) Did you share any of the information that the HPO gave you with family, friends or others in the community?
(b) What information with who and why?
11. (a) What did you do to care for yourself and your health before you fell pregnant?
(b) What do you do for yourself and your health now that you are pregnant?
12. (a) What information do you think will be helpful to you after the birth of your child?
(b) What will make it possible for you to use this information?
13. (a) How does the information about smoking and drinking make you feel when you hear it in the HP session?
(b) Prompt: Why? (Note to interviewer – very important to explore experiences around these feelings.)
14. What suggestions do you have that the HPO can use to make changes to help pregnant women attending the HPP?



ONDERHOUDGIDS

Algemene Inligting

Persoon:.....

Ouderdom:.....

Aantal weke swangerskap:.....

Aantal swangerskappe:.....

Huwelik Status:.....

Inkomste:.....

Gewoontes (rook/drink):.....

Skoolopleiding:.....



Getal voorligting sessies bygewoon:.....

Area:.....

1. (a) Waar het jy inligting van swangerskap die heel eerste keer gehoor?
(b) Watter inligting sessies het jy bygewoon?
2. (a) Die inligting wat jy oor swangerskap hoor, word dit ook in die algemeen deur die swanger vroue in jou gemeenskap toegepas?
(b) Wat sien jy pas hulle toe?
 Wat sien jy pas hulle nie toe nie?
3. Watter inligting kon jy sover gebruik?
4. (a) Watter veranderings kon jy doen nadat jy inligting by die voorligter gekry het?
(b) Wat het dit moontlik gemaak dat jy die inligting kon toepas?
5. (a) Watter inligting was vir jou nuut?
(b) Wat het dit vir jou beteken toe jy dit hoor?

6. (a) Watter inligting het jy kennis van gehad, maar verstaan dit nou beter?
(b) Wat het gehelp dat jy dit nou beter verstaan het?
7. (a) Wat is die doel van die voorligting sessies?
(b) Wat is die doel van die voorligting program?
8. (a) As daar 'n jong vrou na jou kom wat swanger is vir die eerste keer, watter inligting sal jy met haar deel?
(b) Hoekom dink jy is dit belangrik dat sy dit weet?
9. (a) Is daar sekere inligting wat met jou gedeel word deur die voorligter wat vir jou moeilik is om by die huis toe te pas?
(b) Watter inligting en hoekom?
10. (a) Het jy enige van die inligting wat die voorligter gegee het met ander in jou familie of gemeenskap gedeel?
(b) Watter inligting en met wie?
11. Wat het jy gedoen om vir jouself te sorg voor/terwyl jy swanger was?
12. (a) Watter inligting sal jy graag wil toepas na die geboorte van jou kind?
(b) Wat sal dit moontlik maak dat jy dit sal toepas?
13. (a) Hoe laat die inligting oor rook en alkohol gebruik tydens swangerskap vir jou laat voel?
(b) Hoekom?
14. Watter voorstelle het jy wat die voorligter kan gebruik om verandering in die voorligting sessies aan te bring om swanger vroue meer te help (of om meer toepaslik te maak vir swanger vroue in hierdie gemeenskap)?



The National Adolescent Friendly Clinic Initiative (NACFI) in South Africa

NACFI is a nationwide program developed to improve the quality of adolescent health care at the clinic level in South Africa by making clinics more adolescent-friendly. NACFI provides:

- Services at convenient times for adolescents.
- Acceptable waiting times.
- Adolescent-sensitive IEC materials on sexual and reproductive health.
- Information, counselling and appropriate referral for violence or abuse and mental health problems.
- Contraceptive information and counseling oral contraceptive pills, emergency contraception, injectables and condoms.
- Pregnancy testing and counseling, antenatal and postnatal care.
- Pre- and Post-termination of pregnancy (TOP) counseling and referral.
- Pre- and Post-HIV test counseling and referrals for HIV testing.

Personal communication with staff revealed that when a VCT intervention started at one site, the number of clinic attendees fell. This was reportedly due to clients' fears of coercion to be tested. This feedback demonstrates the importance of adequate community sensitization and promotion when integrating VCT within services. NACFI contact information: Telephone (011) 933 1228; Fax (011) 933 1227

Source: Boswell and Baggaley (2002)