

**THE PERCEPTIONS OF WOMEN REGARDING OBSTETRIC CARE IN
PUBLIC HEALTH FACILITIES IN A PERI-URBAN AREA OF NAMIBIA.**

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of
Masters in Public Health at the School of Public Health,

University of the Western Cape

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WESTERN CAPE

03 November 2011

DEDICATION

This study is dedicated to all individuals who made academic contributions to the improvement of public health, my brothers who supported my education, my wife and my children, all the Glory to God for all the mercy shown upon us in our endeavours.

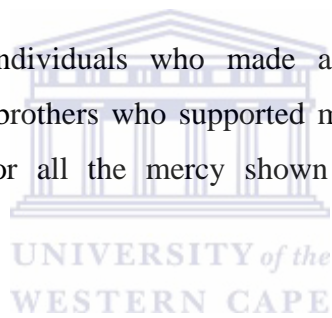


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DECLARATION

I declare that *The Perceptions of Women Regarding Obstetric Care in Public Health Facilities in a Peri-Urban Area of Namibia* is my own work. It has not been submitted for any degree or examination in any other university before. All sources I have used or quoted have been indicated and acknowledged by complete references.

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Signed:



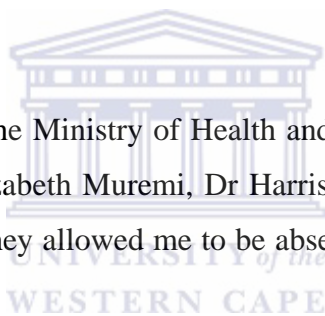
ACKNOWLEDGEMENTS

First of all, I would like to acknowledge my supervisor who assisted me with writing and compilation of this thesis, Dr. Ruth Stern. She gave me hope when I was hopeless. The comments and encouragement she made contributed to the finalization of this study.

I would like to appreciate further the University of the Western Cape staff from the PET division for technical support, Ms. Lucinda, Student Administration department, Ms. Janine Kader and Mrs. Corrine Carolissen who mended the torn nerves during the assignment stage and re-registration periods. Their smiles did it all.

It was cumbersome for people to volunteer for participation as group members in the discussion during data collection. Therefore, the women who volunteered their participation in the focus group discussions from Kehemu community are hereby acknowledged. Their contributions are highly valued.

The efforts from my colleagues in the Ministry of Health and Social Services, Regional and District management teams, Ms Elizabeth Muremi, Dr Harris Wambugu, Ms Timea Ngwira for the moral support and the time they allowed me to be absent from work when I was most needed. I appreciate all.



The support by the research assistants cannot be underscored. Ms. Ndjengwa Roswitha and Mrs. Haiyambo Lucia agreed to assist during identification of the sample and when data was being collected. I thank Ms. Immy Nieboer who assisted with editing of the document. They are hereby acknowledged and their dedication was overwhelming.

Finally I would like to appreciate the support and tolerance shown to me by my wife Foibe, my kids Concy, Venny and Vina. The time for giving them attention was much limited. Their patience and humor when I was stressed with time was a reward and at the same time the source of encouragement. It all culminated in submission of the study report.

TEN KEYWORDS:

- Public Maternity services
- Ante-natal care
- Child birth
- Traditional Birth Attendants
- Quality health care
- Pregnant women
- Risk child birth
- Risk pregnancy
- Service satisfaction
- Rundu district



LIST OF ABBREVIATIONS

ANC	- Ante-Natal Care
MCH	- Maternal and Child Health care
PNC	- Post Natal care Clinic
CBHC	- Community Based Health Care
MoHSS	- Ministry of Health and Social Services
PHC	- Primary Health Care
TBAs	- Traditional Birth Attendants
TCE	- Total Control of Epidemic
NGO	- Non Governmental Organization



ABSTRACT

Namibia has recorded an ascending trend of maternal and neonatal mortality rate from 225 – 449 per 100 000 women from 1992 to 2006, and 38 – 46 per 1000 live births from 2000 to 2006 respectively. Kavango Region in Namibia is one among the top seven regions with high maternal and infant mortality rate. Most pregnant women in peri-urban areas of Rundu District in the Kavango region, where this study was conducted, attend ante-natal care services but do not use public health facilities for delivery. The health records from the public health facilities in Rundu, especially from Nkarapamwe clinic and Rundu Hospital maternity section, reveal that although the pregnant women comply with the required standard policy of a minimum of three visits per pregnancy or more, over 40% of women who attend public ante-natal care clinics do not deliver in the public health facility.

The aim of this study was to explore the perceptions of women regarding obstetric care in public health facilities in Kehemu settlement, a peri-urban area of Rundu town. The objectives of the study were to explore the perceptions of women on accessibility and acceptability of maternity services in public health facilities.

An explorative qualitative study design using focus group discussion as a data collection method was conducted with three groups of women. A purposeful sampling procedure was used to select participants. Ethical approval was obtained from the High Degree Committee of University of the Western Cape and permission to use data from local facilities was obtained from the Ministry of Health and Social Services. Participants were recruited on their own free will and they signed an agreement on confidentiality. A data reduction process was used for analysis.

The study findings indicate that women wish to use public health facilities for deliveries due to perceived benefits, in particular, safety for the mother and the baby and that those services

are affordable. However a number of reasons hinder women to access services including the attitudes of health care providers, inability to afford transport at night and cultural influences. The study recommends that delivery services at the local clinic be expanded from eight to twenty-four hours; an information campaign on pregnancy and birth complications as well as the benefits of delivering in a public facility be implemented; refresher training for nurses to improve their caring practices during delivery should be considered and that a similar research be conducted with care providers to ascertain ways to improve maternity services in the public health facility in the area.



CHAPTER 1: CONTEXT AND DESCRIPTION OF THE STUDY AREA

1.1 INTRODUCTION

Globally, it is estimated that four million babies die in their first week of life and that half a million women die of pregnancy related causes per year (Lawn, Cousens & Zupan, 2005). The rates of maternal and neonatal death are higher in developing countries compared to the developed world. Two thirds (66%) of the world's estimated 536 000 annual maternal deaths come from developing countries (Gruskin, Cottingham, Hilber *et al*, 2008:589). These high death rates are associated with poverty and low socio-economic status of people in the developing countries (Izugbara & Ukwai, 2004:108). Maternal and neonatal deaths are comparatively higher in Sub-Saharan Africa than other African countries (Lawn *et al*, 2005:891). Namibia is part of the Sub-Saharan region and has recorded an ascending trend of maternal & neonatal mortality rate from 225 – 449 per 100 000 women from 1992 to 2006 and 38 – 46 per 1000 live births from 2000 to 2006 respectively (MoHSS, 2000 & 2006). Kavango Region in Namibia where this study took place is one among the top seven regions with a high maternal and infant mortality rate (UNICEF, 2005).

There is evidence to show that a significant percentage of women in Kavango Region deliver their babies at home (MoHSS, 2007-2008). This is despite many of them attending ante-natal services. The Namibia Demographic Health Survey (MoHSS, 2006/7) indicates that 40% of pregnant women who attend ante-natal care services in Kavango region do not deliver in the health facilities.

The use of maternity health services is influenced by both the access to, and the acceptability of the services. Access to services is influenced by several factors. These include the distance that women have to travel or walk to the health facilities and the system of user fees (Simkhada, Van Teijlingen, Porter & Simkhada 2007). Other factors noted by Simkhada *et al* (2007) are the acceptability of the services, the attitudes and skills of the health care providers and the influence of negative exposure of health care services in the media. Acceptability is also influenced by the service environment, with aspects noted including privacy, appropriate equipment and reliability regarding timing as well as availability of skilled personnel in provision of services (Izugbara & Ukwai, 2004). Fear of the unknown and the lack of confidentiality is a further concern, particularly among women with a low level of education (Turan, Miller, Bukusi, Sande & Cohen, 2008).

Maimbolwe *et al* (2003) suggest that women who have negative perceptions of public maternity care services will be more likely make use of alternative choices, because of what they perceive to be the benefits of the alternative services. These benefits include convenience to their circumstances, and importantly their cultural rituals and beliefs. The alternative choices are mainly the use of indigenous skilled persons who provide health care. This is illustrated by Maimbolwa *et al.* (2003) in Zambia where women use delivery services that are convenient for them, including services offered by relatives or neighbors. These indigenous persons who assist pregnant women during pregnancy and child birth without a formal professional training and without registration or a licence to practice (Onah, Ikeako, & Iloabachie, 2006:31) are known as Traditional Birth Attendants (TBAs). The choice of using the TBA services for childbirth poses a risk to pregnant women. The above described situation also applies to Namibia.

1.2. RESEARCH SETTING

Rundu district has an estimated population of 140,547 people. Twenty four percent (24%) of the population are women of child bearing age (15-49 years). The expected pregnancy rate is 4,2% and children under the age of one year represent three percent (3%) of the population (NPC, 2001). There is only one town, Rundu Town, in the District and it serves as a regional centre for the Kavango region. Forty percent (40%) of the town's population reside in Kehemu, one of the three peri-urban settlements of the town.

Rundu town is a modern rural town provided with electricity supply from the national main grid. The main roads in Rundu are tarred but most roads in Kehemu are sandy and this makes taxis impassable in some areas. The town's residents are provided with piped water. About 30% of the adult population are employed and about 80% of the employed are in the public service. Telecommunication is available in Rundu but the public access to a telephone in the peri-urban areas is difficult due to the scarcity and continued malfunctioning of telephone-booths. Those who can afford it, use cell phones to communicate.

There is one public maternity hospital in Rundu which serves as a district and regional referral hospital and is two kilometres away from the clinic that serves the Kehemu community. The maternity ward at the hospital has a bed capacity of thirty-two (32) beds and a monthly uptake of 300 women per month (Hospital records, 2009). The bed occupancy rate for the maternity ward is 94% per month. The maternity hospital receives referrals of

complicated maternity cases from three other district hospitals. Nkarapamwe clinic where this study was conducted refers all women in labour to Rundu maternity hospital. The local public clinic serves the settlement with all preventive health care services including ante-natal care and does not provide routine delivery services, though it is staffed with skilled midwives. Clinic hours are from 08h00 to 17h00, open for emergencies only during the day on weekends and public holidays. The referral hospital, where deliveries take place, supports the clinics and the surrounding settlements with an ambulance service at a minimal cost (N\$35.00, equivalent to US\$6.00 per trip) but only easily accessible when the clinic is operational.. The maximum distance people walk to their nearest public health facility in the settlements is 2.5 kilometres. It is apparent from the records in the public health facility (MoHSS, 2007/8/9) that pregnant women use the clinic more for ante-natal care (ANC) than the hospital for deliveries. Reasons for this discrepancy prompted the need for this study.

1.3 RESEARCH PROBLEM

Most pregnant women in peri-urban areas of Rundu District attend ante-natal care services but do not use public health facilities for delivery. The health records from public health facilities in Rundu, especially from Nkarapamwe clinic and Rundu Hospital maternity section (MoHSS, 2007-2009) reveal that although 80% of pregnant women comply with the required standard policy of a minimum of 3 ANC visits per pregnancy or more, over 40% of women who attend public ante-natal care clinics do not deliver in the public health facility. This is despite a national call made by the service charter of Namibia which states that public servants should provide services to the Namibian population in need with passion and dedication in order to make services more accessible and acceptable. This study was an attempt to answer the question why women do not use the public health facilities for obstetric care as anticipated.

1.4 RESEARCH PURPOSE

Women are in a good position to describe the factors that influence their choices about where to deliver their babies. This study explored women's perceptions about the factors influencing their choice, that is, access to obstetric care and acceptability of services being offered in

public health facilities. The findings will contribute to issues for further research and improvements of maternity health care service delivery in Rundu district.



CHAPTER 2: LITERATURE REVIEW

The problem of accessing health care services is a global phenomenon. It manifests itself through, among other factors, lower utilization of services provided at health facility level. The lower utilization of health services is caused by many factors.

2.1 Socio-demographic factors

According to Simkhada, Van Teijlingen and Porter (2007) important factors that influence access to ante-natal health care services in developing countries include the age, education background, past labour history and the religion of the woman and her partner. Older women use their previous labour history to decide the level of utilization of ANC service. Education of the woman and her partner influence easy uptake of ANC services due to the amount of awareness acquired through education, while religious convictions may influence the use of services either way (Wanjira, Mwangi, Mathenge, Mbugua & Ng'ang'a, 2011).

Mathole (2005) states that younger women prefer to visit the ANC clinics in early stages of pregnancy and with regular intervals because of their concerns about the baby's well being. Older women on the other hand consider the first few months of pregnancy to be "vulnerable" and associate a visit to an ANC clinic with high chances of abortion, relating any negative outcome to "witchcraft". Matole (2005) argues that it is for this reason that older women delay using ANC clinics and consult traditional healers instead during the early stages of their pregnancies.

Turan, Miller, Bukusi, Sande and Cohen (2008) argue that fear and discrimination have an impact on low uptake of delivery in public health facilities. They state that:

Fears of HIV testing; fears of involuntary disclosure of HIV status to others, including spouses; and HIV/AIDS stigma are among the reasons that women avoid delivering in health facilities. Maternity workers ... take into account the HIV status of the women they serve (as well as their own fears of becoming infected ...) but do not seem to be adequately prepared to handle issues related to consent, confidentiality and disclosure. Importantly, it appeared that women of unknown HIV status during labour and delivery were likely to be targets of stigma and discriminatory practices and that these women were not receiving [the due care] needed services [as it was the case for women with known HIV status] (Turan *et al*, 2008:938).

2.2 Economic status of women

Poverty remains the main barrier that hinders utilization of public services in many African countries. According to Izugbara and Ukwai (2004), the practice of user fees is impacting on the use of services by people living in poverty. Limited resources may lead women to receive services from a provider from a poorly organized environment. This view is supported by Morello-Frosch and Shenassa (2006) who state that the poor communities face a high degree of exposure to environmental hazards and psychological stressors which they cannot control. The environmental hazards and psychological stressors are described by Morello-Frosch and Shenassa (2006) as factors that are a “double jeopardy” in the life of mother and child. Their economic status makes them susceptible to the risk of contamination and infections during delivery as they may not be able to afford better facilities to protect themselves. Therefore quality obstetric services may not be accessed readily by these communities. The user fees expand as the level of care increases in public health care systems. These fees may include the outpatient fees pregnant women pay during ANC, ambulance or other form of transportation and hospital (at times called admission) fees during deliveries. This makes the services unaffordable for many (Izugbara & Ukwai, 2004). Once services become unaffordable it becomes unacceptable to those who cannot access it. In Namibia, however, all preventive Primary Health Care (PHC) programs are provided free of charge (MoHSS, 2010). These services include ANC, and PNC. For delivery an admission fee is required, however no one will be denied delivery care if no payment can be made.

2.3 Acceptability of services by women

Acceptability of services has also been demonstrated to influence the uptake of services in public health facilities. The priorities of public health service providers do not necessarily address the expectations of the recipients. Izugbara and Ukwai (2004) argue that there is a mismatch between the values, needs and sensitivities of health care seekers and health professionals in public health care service provision. They state that:

such a mismatch can occur due to social distance between poor local health seekers and health care professionals who are mainly middle class men and women. Cumbersome and inflexible procedures, formidable amounts of paper work, and the literacy requirements of hospitals also dissuade local people [from utilizing public health facilities] (2004:110).

This view is supported by Hodnett (2002), who suggested that health care providers should consider the four factors that influence service satisfaction of mothers, namely the good support from caregivers, a high-quality relationship with caregivers, being involved in

decision-making about care and having better-than-expected experiences (or having high expectations). Dissatisfaction leads women to seek alternative health care.

2.4 Cultural beliefs and preferences of care provider by women

Alternative health care for women during child birth exposes them to poor quality of health care. Evidence exists that relates the levels of education with type of decisions women make when seeking health care. Onah *et al* (2006) reveal that 52.9% of women deliver outside the public institutions. Women with secondary or higher levels of education tend to use institutions and specialist services and prefer to deliver their babies with the assistance of a professional. Their choice is motivated by availability of competent doctors and midwives, access to blood transfusion services, ambulance services, caesarean facilities, proper drugs and professional advice as well as health education (Onah *et al*, 2006). Women with lower levels of education are described as having a different view of the risks and complications of pregnancy and childbirth due to their more limited access to information. The state of ignorance in which they find themselves leads them to make uninformed choices about places of delivery. Both Onah *et al* (2006) and Izugbara & Ukwai (2004) refer to the level of education and awareness respectively as the main reason for the choice of non-professional services during child birth.

Women who use alternative health care provided by TBAs are described as basing their choices on beliefs, cultural preferences or ignorance of pregnancy and child birth complications. Reasons for choosing TBA services during child birth include the "...inability to afford cost of care, religious reason, fear of caesarean delivery, the advice of husbands, promptness of care, fear of blood transfusion and privacy" (Onah *et al* 2006:32). According to Izugbara and Ukwai (2008) ignorance comes as a result of lack of proper education which hinders the utilization of life saving health care services by mothers. Mothers with less education become superstitious about health care providers and this influences their choice of where and how to seek cures for their conditions (Izugbara & Ukwai, 2004). Traditional Birth Attendants based their practice on cultural beliefs and rituals which fit well with the beliefs of mothers with little education. Walsh (2006:154) notes that "...in the past when newborns did not breathe spontaneously, the neonatal death was accepted as God's will, and little effort was made to resuscitate the baby" and that the current formal training may not recognize important beliefs central to the "calling" roles of TBAs. According to Walsh (2006) without additional training TBAs remain ignorant about child birth complications.

In summary, the literature reveals some factors that influence women's utilization of public health facilities for child birth. Among these are the readiness by women to undergo counselling and testing for HIV & AIDS status; affordability and acceptability of services; Health care provider's behaviour and attitudes as well as cultural preferences and level of awareness by women on birth rituals and child birth complications. Although the list is not exhaustive, the author suggests the need to better understand these factors to improve access to health care services by pregnant women during child birth. This study contributes to a better understanding of these factors based on the women's perspective, by using the local context as an example.



CHAPTER 3: STUDY AIM, OBJECTIVES AND METHODOLOGY

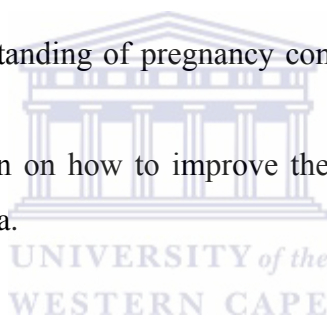
3.1 STUDY AIM

The aim of this study was to explore the perceptions of women regarding obstetric care in public health facilities in Kehemu settlement, a peri-urban area of Rundu town in Namibia.

3.2 STUDY OBJECTIVES

The objectives of this study were to:

- 3.2.1 Explore the perception of women in Kehemu settlement on accessing maternity services in public health facilities in Kehemu settlement.
- 3.2.2 Explore the perception of women in Kehemu settlement on acceptability of maternal health care services provided in the public health facilities.
- 3.2.3 Explore women's views on maternity care provided by non-professional care givers in the area.
- 3.2.4 Explore the women's understanding of pregnancy complications in relation to where they deliver their babies.
- 3.2.5 Explore the women's opinion on how to improve the maternity health care services provided to women in the area.



3.3 METHODOLOGY

3.3.1 Study design

This study used a qualitative method design to gather and analyse data, since qualitative methods allow the researcher to gain knowledge on how local people in a particular environment understand the social problem being studied. According to Durrheim, Kelly and Terre Blanche (Eds.2007:271) qualitative research is when the people's "subjective experience is taken as the essence of what is real for them". It enables the exploration of common experiences of daily social life. Mathole (2005) argues that the most suitable methods to study perception and to generate in-depth understanding based on the respondents' perspectives are qualitative designs. These views justify the choice of the qualitative design.

3.3.2 Study population

The target population were women residing in Kehemu, a peri-urban area of Rundu district, who have given birth, either using a public health facility for child birth services or outside the public facility with the assistance of the TBAs. This ensured that their understanding of the services offered is based on experiences and exposure. These women were part of the study population if they lived within half-hour's walking distance, or not more than five kilometres radius from their health facility in the selected area. This ensured that women who share the same circumstances were interviewed and made the analysis more relevant.

3.3.3 Identifying study sample

Purposive sampling was used to select participants for the focus group discussions. Pope & Mays (2000) describe purposive sampling as a strategy used in a qualitative study where a researcher groups participants according to predetermined criteria relevant to a particular research question. The researcher initially identified twenty participants from the maternity record of all mothers who delivered in the hospital. A similar number of clients were listed from an ANC register from a public clinic. The names from the ANC list found missing in the maternity registers for the expected period for delivery, were identified as non-users of public health facility for deliveries. However, it was not easy to contact the mothers as both registers had only the details of the location in which the mothers lived, and not the specific residential addresses. A further attempt was tried to contact mothers through a local radio announcement. That too was disappointing. Only two women came following the radio announcement, one of them relocated from the area and explained that she visited Kehemu only temporarily at that time to access delivery facility when she was about to deliver. We were therefore left with a single participant to recruit. Despite the friendly nature of the radio information, those who came associated the call with a possibility for them to under go HIV status check even though nothing related to HIV was announced when the call was made. The researcher therefore decided to recruit the maternity hospital users at the post natal clinic (PNC) session, when they came for their follow-up appointment. A total of twenty women were recruited from the PNC. They were briefed about the aim of the study. Their contact numbers or a neighbour's number was recorded and this was used to contact the women later to invite them to the focus group discussion. A date was set and a venue was agreed upon for the focus group discussion.

The non-users of the public facilities were recruited with the assistance of the local midwife at the facility and three known traditional birth attendants in the area. The midwife led the researcher to the TBAs compounds after she was briefed about the difficulties experienced with sampling. She used her good relationship with the local TBAs to link them with the researcher and there was no resistance to get their cooperation. The TBAs used their records and their own memories to recall some of the clients for possible recruitment into the study. The location of these women was identified and the researcher approached the clients and requested their permission to participate in the study. Ten women were recruited from the TBAs list and this made altogether a total of 30 women who agreed to be interviewed. They were divided into three groups. Dates and times were agreed with each group of participants and the researcher agreed to remind participants a day before the meeting with each group.

3.3.4 Data Collection

The data collection method was the focus group discussions. Parker and Tritter (2006:26) explain that “the objective [of the focus group] is not primarily to elicit the group’s answers ... but rather to stimulate discussion and thereby understand (through subsequent analysis) the meanings and norms which [support] those group answers”. The researcher focused on group interaction and at the same time reflected on the meaning of answers provided by the respondents. A focus group discussion was chosen as the data collection technique because of these advantages and because it allowed the researcher to probe for rich data and for respondents to describe their views in their own words. It was also a good method for the researcher to exercise member checking techniques to validate the information collected.

The researcher hosted the three focus group discussions with eligible women as planned. As indicated, thirty (30) women were expected to participate. However only 21 women turned up. Two focus group discussions were held on the first day, one during the morning and another during the afternoon. The first session was with seven women who delivered their babies in a public health facility and the second session was with six women who delivered with the assistance of a non-professional (TBA) outside the public health facility. The third group was with a mixed group of eight women of public health facility users and non-users. The initial intention was not to mix the groups but the researcher decided to accept clients who agreed and made effort to come. The fact that the researcher was not practically involved in clinical services at facility level meant that the participants were comfortable about participating and freely sharing their experiences. It worked out well despite the numbers

being less than intended because it was ideal for the researcher to control the discussion, to give attention to individual comments and to observe the non-verbal clues. It was also a good number for participant interaction.

The researcher used open ended guiding questions during the focus group discussions to extract information from respondents. In addition, he kept a daily diary of events, in which he recorded interaction, verbal clues during each meeting with the women, and he took reflective notes as part of the data collection process.

The focus group discussions were conducted in the Women's Development Centre hall in Kehemu settlement. The site was chosen as it had no connection to the health facilities and so it enhanced confidentiality and reduced anxiety among participants about reprisals by public health care providers. Data was collected within one week. Participants were met 30 minutes before the actual focus group discussion commenced to explain the procedures and the process of the discussion. The planned focus group discussion lasted between an hour and 90 minutes. The discussion was conducted in one of the dominant dialects of the local language. The researcher had an advantage of speaking the local language and needed no translations. This choice of language was agreed upon by the participants. By so doing it facilitated participation and free expression of ideas by the participants.

The focus group discussions were tape recorded, transcribed and translated into English for analysis. Two women research assistants were recruited to assist with note taking and to handle the tape recorder, as well as to observe clues of non-verbal languages from the participants.

3.3.5 Validity

Creswell and Miller (2000) describe validity as strategies employed by the researcher to add credibility to the data collected and it refers to how much the "inferences" made in the data do represent the participants' views. The researcher verified the data collected through the strategies of member checking and audit trail. Member check is described by Creswell and Miller (2000) as a qualitative procedure where the researcher engages research participants to verify whether the data collected represents their view point. Data collected was confirmed with participants in the focus group discussion to check for credibility and accuracy of interpretation of observations. Another validity procedure used is the audit trail. Audit trail

refers to the procedure where the researcher uses external reviewers to establish validity (Creswell & Miller, 2000). The researcher used assistant researchers during data collection to check on his reflections. The research assistants verified the transcribed materials and reviewed the categories during data analysis. The issues that arose during the focus group discussions were discussed with the research assistants at the end of each discussion. Interaction observation notes and diary accounts as well as reflective notes were used throughout the process. Categorised data was checked against literature and these were reviewed by a research supervisor.

3.3.6 Data Analysis

The researcher used the process of data reduction as suggested by Green, Willis, Hughes *et al* (2007) to analyse data. The process was organised into four main steps. The first was immersion of data, the process where the researcher engaged in repeated reading and re-reading of data transcripts and tapes to digest what was said by participants. The second step was the process of coding, where the researcher examined and organized information from the entire interview into meaningful phrases. For example, words or a phrase was attributed to more than one code depending on the context in which it was said. Creation of categories formed a third step in qualitative data analysis and the last step was the identification of themes. This step involved the explanations and interpretation of issues derived from the coded and categorized information. Explanations and interpretations of the research data was supported by the reflective field notes the researcher made during data collection and by reviewing non-verbal and verbal clues collected during the interview process (Green at al, 2007).

3.4 Logistics

Women walked to the Kehemu community hall on the day of the meeting. However, some of them were delayed, even though they lived near the venue of the meeting. A mini-bus was made available as it was anticipated that some kind of transport would be needed before or after the meeting. Some women were picked up after they indicated that they were walking towards the venue, to enable them to arrive punctually. This offer minimized the waiting time by other participants. All women who needed to get home promptly were taken home by the mini-bus after the discussion.

Refreshments were offered at the end of each session. This was necessary as the process took more than one – and-half hours, due to briefings, waiting for other participants to arrive and the discussions themselves. Refreshment consisted of a 500ml bottle of water and a soft drink or juice with a sandwich for each participant.

3.5 Ethics

Ethical clearance for the study was obtained from the University of the Western Cape and from the Ministry of Health & Social Services District Authorities. The researcher requested permission to use the ante-natal care (ANC) clinic and the hospital delivery records as data sources to recruit research participants. The same was required from the TBAs. The participants were recruited on voluntary basis and of their own free will. No participant was held accountable for their statements or act of participation. A consent form was completed prior to their participation in the study. Participants in the study were told that they have the liberty to withdraw from the study at any time if they so wished with no repercussions. Specific consent was solicited from focus group participants to ensure that they keep the content of the discussions confidential. This was signed by participants alongside the consent form for participation in the study.

Personal identification of respondents was not revealed to any third person. The researcher used pseudonyms to identify participants and names used in this study are not their real names. However the opinions and wordings in quotation marks are the direct translation from the transcript derived from the participants verbal expressions during the discussions. All personal data was kept locked and information is used for the intended study purpose only. The tapes and transcripts were destroyed after the compilation of the study report. By doing all these processes confidentiality was ensured throughout the study.

CHAPTER 4: RESULTS

The sitting arrangements for the focus group were made in such a way that the moderator could see all participants face-to-face. Chairs were put in a circle form with a tea-table in the middle where a tape recorder and empty tapes placed on it. Women were asked in group discussions key thematic questions followed by probes as necessary to get their view on the aspect of services in public health facilities.

4.1 Socio demographic information of women

Participants were of different ages and educational background. They shared the basic cultural background though their educational awareness and economic status influenced the way they experienced the situation in their living environments. Half of the participants interviewed were between the age of 16 and 24 years. Table 1 illustrates the age, parity, educational and the economic status of the participants.

Table 1: Socio-demographic characteristics of participants

Age	Parity	Education	Economic status
16 years	1	Primary	Not employed
16 years	1	Primary	Not employed
17 years	2	Primary	Self-employed
17 years	1	Secondary	Self-employed
19 years	1	Primary	Not employed
20 Years	3	Primary	Housewife
21 Years	1	Secondary	Self-employed
22 Years	2	Secondary	Housewife
23years	1	Secondary	Housewife
23 years	3	Primary	Self-employed
23 years	1	College	Teacher
24 years	1	Primary	Housewife
25 years	3	Primary	Housewife
27 Years	1	Secondary	Self-employed
27 Years	1	Primary	Not employed
30 years	1	University	Teacher
32 years	3	Secondary	Not employed
33 years	2	University	Accountant
38 years	3	No education	Self-employed
43 years	7	Primary	Self-employed
47 years	5	No education	Housewife

The participants indicated that the main form of marriages in their settlement were by custom recognition. This means they were living as husband and wife according to the traditional

marriage system. However, there were participants who either married by church with a certificate or never married at all.

Nine participants had only one child by the time the study was conducted and more than half of the participants had two or more children. The women were interviewed between six and fourteen weeks after delivery of their last child.

Half of the participants indicated that they do small businesses for a living. These included selling fat cakes, local seeds and other small household items to neighbours. However there were also women who saw their roles as housewives. Their activities included household chores but not income generation. A small number of participants were formally employed in the public sectors as displayed in table 1 above. There were also participants who did not have any form of employment. They were dependent on the supplies of their relatives in the extended family.

4.2 Why women preferred hospital delivery.

The first question was about the decisions women made about the choice of place of delivery. Women in Kehemu described their preferences as being dependent on the support that was available by the time labour started.

Women who used the public health facility for deliveries based their choices on the information and services they received from the Ante-Natal Clinic (ANC) during pregnancy. These women appreciated the services they received during (ANC) visits. What they appreciated most was the skills of the nurses which were evident during their assessment session. They were satisfied with the activities at ANC and they were informed of the benefits of using a public health facility for deliveries during ANC sessions.

Betty: You never know about the measurement of the blood pressure before you go into labour. Your blood pressure is monitored in the hospital and you know high blood is killing mothers unnoticed if they did not use health facility for delivery.

The information obtained from the ANC clinic during early pregnancy prepared women for feeding properly, exercising hygienic practices and wearing of appropriate clothing like low heeled shoes and loose clothing. They found the information useful as it encouraged them to continue to use the public health facilities for other maternal services such as deliveries and post-natal care (PNC). One of the participants who used a public health facility for delivery expressed herself as follows:

Masela: I decided to deliver in the hospital because there is no skilled attendant to assist me at home. I trust the doctors will help more at the hospital[which will not be possible] at home. There could be complications such as excessive bleeding which cannot be properly managed at home.

The women were also motivated to use public health facilities for delivery because services were affordable. Affordability was described in terms of clinic costs and admission fees payable to the state on registration or during consultation. The women's views on affordability was based on their exposure to other payable services received from the same institutions, which were more expensive than is the case for a pregnant mother. Women were not charged for ANC, PNC, childhood immunizations and other consultations related to pregnancy and post natal care.

Guye: Fees are okay, anyone can afford because when you start at the clinic it is only four [Namibia] dollars¹.

Christine: It is easy to keep a clinic fee aside for the day you will deliver. Any one can help you to afford four dollars. After the first visit the doctors and nurses help you with ... [all other services] required. We also do not pay for family planning [services], it is good!

4.3 **What hindered women from their ideals to deliver in the hospital**

Women who use public health facilities described themselves as being unhappy to deliver outside the public health facility, even if it was not in an emergency. These women worried about the outcomes of the labour process, and wanted to have a safe, properly assisted and dignified birth process. They saw the event of giving birth on the way to the hospital as “degrading” and “ill-timed”. The women related the contributing factors for delivery outside the public health facility as being due to ill timing of labour and the poor advice of the persons who assisted women during ANC and at times, during labour.

Martha: It is not good to give birth on the way. ... The parents asked me to try to give birth at home because it was at night and there was no transport. When transport was available it was time for the baby to be born and I delivered in the taxi.

Martha described the views of women who wanted to use the public health facilities but did not make it for various reasons. Her voice was soft when she made the last part of her statement while others were shaking their heads in disapproval of the event.

For these women delivery outside the public facility occurs in the home, mostly at night when transport is not available in time, or while outside the home on the way to the maternity

¹ One Namibia dollars is equivalent to one ZAR

hospital. In some cases delivery outside the public health facility happened while a woman was out, busy with daily chores.

Karungu: My wish is always to deliver at hospital. When I left home I did not have pain, but while on my way to the river the pains came, no other help [was available] and I had to deliver on the way.

The women described the process of getting to the hospital maternity room as an anguishing journey as they were concerned that anything unexpected could happen while they tried to get to the hospital. It was in rare cases that women accessed an ambulance to get to the maternity hospital. They described the use of an ambulance as not possible because women in Kehemu did not have hospital contact numbers for emergencies. The women therefore got to the maternity hospital by walking or by using public transport. The following statements described the women's experiences of attempting to access maternity care services in the public health facility.

Nangura: Taxi is not reliable especially at night. In the day the taxi takes its rounds as customers are lining up, at times you are dropped last after a number of turns around.

Masela: I never thought of using an ambulance. Taxi is good only if you made arrangement with the owner to call him when you will need him, at night it is difficult to get a taxi. It is better to use an ambulance. My sister in-law assisted me; she stopped a taxi and gave all the history at the reception.

One of the participants gave an expression that "Every birth is a different birth" to indicate the sense of unpredictability of the birth process.

Karungu: Because even if I wished to deliver in the hospital I cannot tell how long the pains will take before the baby comes. Some times shorter another time longer, each pregnancy has its time.

Getting to the hospital included practical aspects such as a vehicle to get them there and a functional telephone to arrange the transport. These were often practicalities that the women did not have. The women also talked about the costs for their transportation being in addition to the supplies needed for the mother and baby, once the baby was born.

The presence of a husband or relatives to support them emotionally and with practical arrangements before leaving home was also helpful. This is something that some had, but others did not.

4.4 **The experiences of women who delivered in the hospital.**

The general view of women regarding services in public health facilities was that it was a good experience. During their deliveries women felt a sense of security because of the skills and abilities of the personnel who were able to respond to birth complications. However, there was a mismatch between the skills that women expected from health workers and the way they were treated in practice. The health workers' skills to cope with emergencies gave them confidence and security.

Kado: In the hospital I felt secure. I saw other women who had problems to deliver and they brought them and their babies from theatre. That was good because there is equipment and doctors who can help you when labour becomes difficult.

Yet the women also described the feeling of hopelessness in relation to the quality of care they received when they went to the maternity hospital because there were fewer nurses on duty. They expected to be treated well or to be given good nursing care but did not get what they wanted as nurses spent little time with each one of them. As a result the women described some of the practices by nurses as reprehensible. They found the attitude of the nurses to be obnoxious and at times unsafe. Women were, at times, left by themselves to deliver without a mid-wife alongside them.

Nangura: I delivered without a nurse attending to me, I called, but was told it is not yet time, I felt the baby is coming and when the new born was out, the nurse rushed to me.

Imelda: ... I was pushed into the labour room and was instructed not to push as the baby was not yet near, but I felt the baby's head was already out and I pulled myself up towards a sitting position and the baby came out.

According to the women's view, slapping and shouting at a mother while in labour was the most disrespectful act committed by nurses in the maternity ward.

Simwabweka: The pain I experienced while in labour was between heaven and earth! You cannot tell if you are yourself. When the nurse shouts at you and slaps you, is when you realize that you are on earth.

Naita: It is true! Women are slapped by nurses in the ward. For me they did not, but I witnessed a mother who delivered in the toilet. She was told to go and shower but did not make it and the baby dropped! The nurse ran to her and slapped her because she was putting the nurses into trouble.

Although not all nurses behave in this way, the general feeling of the women was that nurses were too busy. The respondents claimed that the nurses seemed to be busy with other tasks when the expectant mothers called for help, and only attended to them after the worst had happened. Young women expected nurses to be friendly and helpful since they did not have

experience of the labour process before. They also had expectations based on the awareness created during ANC visits.

When asked if they knew about the customer care desk where complaints from clients about services can be voiced, the women said they knew about it, The women did not use the opportunity to report incidences. They feared other good nurses might be implicated in such abuse and services might still not improve.

There was also uncertainty about the process of childbirth. Many confused the initial signs of onset of labour with other ailments such as stomach-cramps especially by women who experienced labour for the first time. These experiences were illustrated in the responses below.

Naita: When pains came I did not know it was labour pain, but I complained of stomach cramps.

Kasiku: My boyfriend and I did not have parents at home to guide us what to do while I was pregnant. ... We were asking other women who have experienced childbirth before to give us information on how to recognize labour.

The nurses in the maternity ward usually advised them to go back and wait till the signs of “true” labour have occurred. The women describe the act of sending them back to wait for the right time as risky for their lives and that of the unborn baby.

Mate: The problem is when you are turned back to and from the maternity ward by nurses because you are not ready for labour, the taxi fare will be too much, most women will not afford that and may end up not going back in time.

4.5 Views on home deliveries using the services of TBAs

There were distinct views in favour of and against TBAs. The general view of women who were users of public health facility in Kehemu was that the services of TBAs are currently not acceptable due to their limited skills. However their support during childbirth was helpful. The women in Kehemu viewed the services of TBAs as either the choice, or the only option when access to the public health facility was impossible. They noted that the service of a TBA was readily accessible as TBAs were living in their community. The TBAs were within the neighbourhood or even part of the family. TBAs could be called at night and women relied on their support. TBAs were also used as escorts when a mother in labour was transported to the public health facility.

Karungu: We usually do not know when to deliver, at times she can help you with bare hands.

The users of public health facilities who experienced the services by a TBA did not approve of the way the TBAs handled blood and bleeding during labour. They noted that the use of bare hands to catch the baby and their technique of cutting the umbilical cord might harm the baby. The TBAs usually took time to tie the umbilical cord of the baby. The women believed that such practice had a better chance of exposing the baby to a loss of blood and infections. At times women were made to push prematurely. The practice of pushing earlier was encouraged by TBAs especially when a woman in labour had contractions for a duration that the TBA perceived as too long. The women estimated the duration of labour assisted by a TBA to last within four to six hours.

However, in contrast, half of the focus group women believed in TBAs and saw them as preferable.

Memory: The old women (TBAs) who assist us to deliver are really friendly and they stay with you from the time you get the pains till you deliver. I can pay them any amount they mention.

Some of their motivation for choosing to continue to use the service of TBAs was that the TBAs did recognize the position of the unborn baby and they were able to reverse the mal-position of the unborn baby if it interfered with progression of labour. The women who used the services of the TBAs described them as “gifted and skilled women” who knew how to deal with complications during pregnancy and child birth. In their view, TBAs were able to deliver an unborn baby presenting with limbs, shoulder or buttocks, and they delivered a mal-presented unborn baby without an episiotomy. The women who used the TBA services argued that they continued to consult the TBAs because they were not subjected to cuttings and incisions that were done to women who used public health facilities. Sentiments expressed by the women in support of the usefulness of the TBA service were demonstrated as follow:

Karungu: Every one of us knows who supports you during child birth, sometimes a relative, a neighbour or a trained birth attendant. The TBA needs to be thanked.

Hairungu: I never delivered at the hospital, at the hospital you are sutured regularly with every delivery. I am not sutured at all and it is good for a woman. They (TBAs) are the ones who assist you when you did not reach [the hospital]. I was assisted by my mother in-law, why should I pay her? It does not cost me much!

4.6 Knowledge and beliefs about birth complications

There was a range of knowledge, lack of knowledge and traditional beliefs among women who participated in the study. These different levels of knowledge influenced the way women felt about their deliveries. Culturally the women referred to the childbirth process as the one that brave women should pass through. According to the women's believe a pregnancy without any incident of promiscuous behavior by any of the partners or act of witchcraft results in a delivery free of complications. They noted that younger women tend to have problems with deliveries because they were afraid to endure the pain of childbirth process and failed to push hard. Therefore babies born to cowardly women were the ones most likely to die shortly after birth. The following statement served as an illustration.

Eno: Yes, younger women must go to the hospital for their first delivery, but if they feel strong and woman enough to go through the labor pain from beginning to the end then they cannot worry with anything. The TBA will assist them through the process and that is it! Only those who are afraid kill their babies because they panic of pain. A women need to know and master the birth process. This is how we are told!

The birth complications listed by women included the umbilical cord been seen around the neck of the baby during the birth process, which the women believed could kill the baby if not attended to quickly; vaginal bleeding before delivery which led to excessive blood loss; and high blood pressure that they described as being caused by stress and the change in woman's hormones. The most feared complication for women in Kehemu was prolonged labour and seizure attacks during pregnancy and labour. The women related the two conditions to traditional beliefs.

Karumbu: [The TBAs] ... usually call many elderly women to witness the birth process; some of [the elderly women who come] ... may bury their toes in the ground [which] causes prolonged labour if not noticed and stopped.

The women believed that prolonged labour and seizures (known to them as "sivatu") were complications that related to treacherous sexual behaviour of the spouses during pregnancy. Prolonged labour occurred when the pregnant woman had a sexual intercourse with another man and she did not confess to this before delivery. The unborn baby would float till the mother confessed and was treated with a traditional ritual. On the other hand a seizure attack was believed to occur when a husband had a sexual intercourse with another woman while his wife was pregnant. The mother, in this instance, presents with fits during labour. The condition is believed to become fatal if the suspected woman visited the mother while she was in labour. The women believed that this condition could be prevented if the husband confessed before his wife went into labour and a ritual was performed. Women performed

the rituals with their husbands in the presence of a TBA during the last few days of pregnancy for the fear of seizure attacks.

Guye: Seizures during birth (“Sivatu”) cannot be treated at the hospital. You have to drink something before going to hospital. Only some birth attendants who know the herbs can treat it. The women here consult those [TBAs] before they go to the hospital and their husbands accompany them for the treatment because they [husbands] know it is better and safe to do so.

Julia: It [seizures] is a big problem! Even if you trust your partner, you have to make a mutual agreement to consult the older women [TBAs] to treat you as a precaution before you go to the hospital, because “sivatu” can only be treated traditionally.

4.7 Improvements needed in service delivery in public health facilities

Women who had deliveries in the public health facilities had several suggestions for improvements. The attitudes of the nurses in the maternity hospital were repeatedly emphasized by women as the stumbling block in accessing the current services. The women described the attitude of health workers as “rude”, “careless” and “disrespectful”. The women suggested that more nurses be deployed on duty with every shift in the maternity ward. Their suggestion was based on the administrative tasks (paper work) that took the time of the few nurses on duty. The women believed that the attitude of nurses could improve if they were not overworked.

The women also suggested that pain relief be provided especially when incisions and suturing procedures are required. Women doubted whether the basic training and the practice code of conduct for nurses did not allow them to provide pain relievers during painful procedures.

Annastasia: Maybe their training should be improved. Suturing was done on me without any pain killer, it was too painful and it should be improved. You can feel how the pain is pinching when she sticks the needle, the pain goes as she is pulling the string with the needle, and you feel each jerk as she is tying the note of the string between your legs! No, it is painful!

The use and re-use of dirty and soiled linen was generally noted by women as the observed practice in the maternity ward. The women stated that the explanation given by nurses for the used linen was that there was not enough in stock. Based on this explanation the women suggested that enough linen, sanitary pads as well as linen wet-proof covers should be stocked in the maternity ward. The women claimed that they brought some items with them to the

maternity ward, but sometimes they ran out of their own and needed to be supported by the hospital stock, which was not forthcoming.

Kado: At times they turn over the used linen to cover your bed while it is dirty. It is not right to use dirty linen for reuse. No linen to give. When I delivered I was put on a bed with dirty linen with blood spots.

Masela: It is not good for your visitors to see your blood spots after delivery when they come to see you, it is not right.

The women were of the opinion that arrangements should be made around the maternity hospital for a waiting shelter to be used in case they arrived earlier than at the exact time of labor. This could ensure that the mother was able to access the service of a professional midwife or a doctor in time. They further suggested that the maternity unit building could be expanded in order to accommodate mothers who arrived before their time. According to them this extra space could also be used to accommodate mothers who cannot be discharged immediately after the delivery.

Mate: I think the hospital beds are few because they ask you to go home on the same day after delivery. There is no place to sleep! It is better to rest for at least one day more before you are discharged.

There was a suggestion by women who were non-users of public health maternity facilities that TBAs should be linked to the health system. Their suggestion to the Ministry of Health and Social Services was to continue training TBAs, who should be provided with emergency delivery supplies. Some of the supplies mentioned include sterile gloves, linen savers, masks, anti-septic solution or normal saline and umbilical cord strings. The women indicated that these were some of the items already supplied to those TBAs who have links with the health facilities.

Guye: It will be best if they are trained by hospital nurses in terms of hygiene in order for them to prevent harm and infection to the baby.

Even though this suggestion was made by all three groups of women, as noted above, the women who used health facilities for delivery did not consider the practice of TBAs to be safe.

There were no recommendations from the women for improvements regarding transport problems at night. However there was an opinion that the use of an ambulance service could be safer for women as mentioned elsewhere in this report. It was difficult to call an ambulance as the contact numbers were not publicly communicated. The women suggested

that the best way to communicate maternal information was through women's meetings and by using elder women who usually advised their children on child birth, including the TBAs.

In summary, the study results revealed that although maternity services are rendered in the vicinity of the Kehemu settlement, women were not able to access these services as readily as they anticipated. Accessibility was influenced by several factors that resulted in the women not using the public health facilities for deliveries. Prominent factors that hindered accessibility and acceptability were the abusive behaviours in the maternity hospital and the negative attitudes of health care workers; the economic inabilities of women to afford transport to the maternity hospital resulting in women using the unsafe public transport especially at night. Cultural beliefs and positive experiences during labour will mean that women will continue to choose the services of the TBAs. Insufficient information about the process of child birth is a concern of the women and needs to be addressed.



CHAPTER 5: DISCUSSION

The study achieved its objectives. Our findings reflected the experiences elsewhere as shown in the literature review above. These findings, for the most part, confirmed, if not elaborated on the pertinent issues of accessibility and acceptability of service provision in public health facilities for pregnant women in similar settings. The diversity of the women's views could be attributed to the mixture in age, parity, educational background and other social circumstances of participants. The women's views were categorised into three main groupings, namely of those who were users of maternity services, the non-users and of those who used public maternity and services of the TBAs as discussed below.

5.1 REASONS FOR USING THE PUBLIC MATERNITY SERVICES.

The women were motivated to use public health facilities based on the information they received from nurses at the ANC about the benefits of using those services. Their views are discussed into three main categories as follows

5.1.1 Awareness about services provided in Public Health Facility

This study found that women learnt about the services offered in public facilities to pregnant women and their new born babies. The benefits a mother could get from these services were communicated to those women who attended ANC. These women referred to the information as useful and it is likely that this appreciation motivated many of them to continue using the public services. They were appreciative of the quality of services they received at the ANC. Using this information, they were able to list the services they wanted and the supportive investigations they hoped to receive before and after delivery. This finding is supported by Rockers, Wilson, Mbaruku and Kruk (2009), who conducted a study in Tanzania and argued that women who had a high number of antenatal care visits are more likely to deliver their babies in a health facility. The authors listed a range of motivators that will support women, which included effective communication by service providers on "risks of home delivery, increased comfort with the health system and providers" (Rockers *et al*, 2009:884). Their findings could equally be applicable to women who used public health facilities in our study because these women referred to health care providers as knowledgeable and the maternity hospital as being well equipped to respond to maternal emergencies.

In addition to awareness, women are influenced by the skills of the health staff and the quality of the health facilities. Ikeoko *et al* (2006) indicate that the users are motivated by the availability of competent doctors, midwives and other services and facilities. The findings of this study concur with these points because women considered the setting of and the infrastructure provided for the services and the skills of the staff as acceptable. The infrastructure included the ANC, delivery rooms and PNC clinic buildings, the equipment as well as supplies used by nurses and doctors during ANC and for deliveries. These aspects gave women confidence.

Adequate care during delivery motivated the regular users of public health facilities to go to the maternity hospital. This was also found in study by Beake, Rose, Bick, Weavers and Wray (2010) on women's experiences and expectations regarding their post-natal care in a maternity hospital in South England. The authors indicate that women's rating for satisfaction with the care they receive is based on the interaction with their caregiver. It was evident in this study that the interaction at the ANC between women and the medical personnel contributed to the high expectations they had of the competence they could anticipate by the nurses during childbirth. This motivated the users of public health facility to continue using the services. The importance of meeting patients' expectations is highlighted by Hodnett (2002) who suggests that health care providers should consider including better-than-expected experiences in the plans for their patients.

Turan, Miller, Bukusi, *et al* (2008) indicated that fear of medical procedures that women may be subjected to when attending health facilities, such as caesarean sections, impacts negatively on the uptake of deliveries in public health facilities. By contrast, this study's findings indicated that rather than being a deterrent, fear of birth complications motivated women to use the public health facilities for their deliveries. This could imply that encouraging presentations at the ANC about the advantages and disadvantages of medical procedures offered during complicated deliveries was given, with the result that the women understood why such action might be taken. This is supported by Ramvi and Tangerud (2011) who conducted a study on the experiences of women who have a vaginal birth after requesting a selective caesarean section, even though they did not have any anticipated complications. Their findings indicate that the women they studied feared the painful process of childbirth, but were reassured by health workers and were able to deliver vaginally. This made them use the health facilities as they knew they could secure enough support during the delivery. The women in Kehemu who chose the public health facility for their delivery also hoped that the health workers would respond effectively to unexpected and feared birth

emergencies. It was evident that these women viewed medical interventions of any kind as a security measure to counteract their fear of a complicated labour. This view is also supported by Matole (2005) and Siziya, Muula and Rudatsikira (2009) who state that especially younger women, who have not experienced labour before, report earlier to public health facilities and make efforts to access professional services during delivery because of their anticipated difficulties of the labour process.

What was told to them during ANC sessions was mainly information related to personal hygiene, feeding and exercises during pregnancy and other issues the women should avoid while lactating. Little information was given to women on the signs of labour and what to do when labour starts. The reason for this could be that there was no formal communication between nurses at the ANC clinic and their counterparts in the Maternity ward. The nurses at ANC might not brief their client appropriately about the situation in the maternity ward. It was very likely that women were not sufficiently prepared for the labour process. This could be one of the reasons why mothers reported early to the maternity ward and could not afford or call for transport during the night.

Non-users of public health facilities in this study, who did not use the ANC before delivery, did not know about the medical interventions in public facilities regarding prolonged labour and bleeding after delivery. Their knowledge of birth complication was limited to what the TBAs taught them. This confirms the views by Thatte, Mullany, Khatri, Katz, Tielsch and Darmstadt (2009) and Wanjira *et al* (2011) who state that the information source can influence women to make bad choices about the place of delivery.

5.1.2 Affordability of services

While it was found by Izugbara and Ukwayi (2004) that in most other African countries women use traditional birth attendants' services because they cannot afford the user fees payable in public health care systems, this was not the case in Kehemu. The absence of user fees introduced for the maternal health services in Namibia in 1990 (MoHSS 2010) meant that the women described the clinic fee as affordable for everyone. This affordability could be one of the factors that motivated women to continue using public health facilities. Accessibility in this study was described in terms of the distance to the maternity hospital. Shorter distances made it easier for women to walk to the facilities without paying transport fees. However the advantage of the shorter distance was limited especially at night, as discussed below.

5.2 REASONS FOR NOT USING THE PUBLIC MATERNITY SERVICES

There were several factors that prevented women from using the maternity services offered in the public facility.

5.2.1 Previous negative experiences

Negative experiences were an important factor. These included painful procedures, uncaring attitudes of health workers and failure by health care providers to give the needed care and support. Such experiences could lead to difficult relationships between women and the care providers (Izugbara & Ukwai, 2004). These findings were not unique to the women in Rundu. Kruger & Schoombee (2010), in their study in a South African maternity hospital, found that negative practices are sanctioned, viewed as part of the system of patient care and accepted by both the patients (mothers) and nurses as if they are normal. Our study found that the patients in the maternity ward saw themselves as merely recipients of services who did not receive care in time when they requested it. This compares well with the argument by Kruger & Schoombee (2010) that the mothers in the maternity hospital become docile passive bodies in terms of medical care and that mothers were expected to obey rules, commands and not to request or suggest what care to receive. The maternity ward in Rundu hospital with a high bed occupancy rate of 94% could make women compliant to the type of treatment they received during delivery. This could be attributed to the observation women made about the nurses' tasks while they were in the maternity ward. This experience could influence the mother's decision to use alternative services, especially if she did not have enough information on the benefits of facility delivery.

Failure to use the public health facilities was also a result of the women being repelled by the descriptions of negative experiences of others. This was because women who were users of public health facilities would share experiences of painful procedures from the maternity hospital with others through informal gatherings. The women in this study described the attitude of health care providers as not being conducive to care, especially when users felt neglected during the second stage of labour because nurses were preoccupied with other duties. It is likely that the situation where women felt neglected by their care provider could be due to what is described by Izugbara and Ukwai (2004) as the impact of the gap in social standing between the care providers and the women who are from poor background families and of low social status. In the study by Kruger and Shoombee (2010) in South Africa they found

that nurses expected the women to obey instructions because of their superior knowledge, and by contrast, women expected compassionate care as well as respect and guidance through the labour process. Therefore according to Beake *et al* (2010), Izugbara and Ukwai (2004), there was a mismatch between what the women wanted from the health care providers and how they actually were treated. This influenced women's decisions to not use the maternity services offered in public institutions.

5.2.2 Cultural preference for TBAs.

The women in this study reflected on and confirmed occurrences of marriages based on custom laws. This was an indication how traditions and culture could influence the family life of pregnant women in the study area. According to Maimbolwe *et al* (2003) culture plays an important role in child birth among African families. Wilkinson and Callister (2010) confirm that childbirth is influenced significantly by women's cultural perceptions, practices, beliefs and expectations. The findings in this study support the above stated views where some women used the TBAs' services by choice because TBAs used herbs and rituals which satisfied their cultural expectations and beliefs.

Some women in this study were habitual users of TBAs services because they believed that giving birth without medical intervention was a sign of better womanhood. They felt proud not to be associated with the health facility because culturally they held a believe that women should brave the childbirth process with minimum support. These women did not associate the birth process with any complications, but in the event of any obstacles in the labour process, this was associated with a betrayal by elder women who came to witness the process, but had ill wishes. The belief is that this can only be solved by what women referred to as elderly women who knew herbs.

Wanjira *et al* (2011), Wilkinson and Callister (2010) state that there are known cultural taboos and beliefs which are related to pregnancy and child birth complication by TBAs and these consolidate the women's culture. These views are confirmed by women in this study where they associated seizures in pregnancy with promiscuous behaviour of a partner. The belief originated from those held by TBAs in the area and was passed over to women through the interaction they had with TBAs. This view is also supported by Kaingu *et al*, (2011) who argued that women tend to trust their care giver over a time as they build a relationship.

5.2.3 Socio-economic factors

Simkhada *et al* (2007) noted that the use of maternity health services is influenced by the distance that women have to travel or walk to the health facilities and they explained that longer distances would affect utilization of services negatively and vice-versa. It was noted in this study that the women in Kehemu did not have problems reaching the hospital due to distance. The relatively short distance to the maternity hospital was an advantage for them when accessing services in the public health facility. Despite the shorter distance, however, it was a problem at night when women in labour could not find transport to get to the maternity hospital because they could not afford a special taxi fee which was payable on top of the day rate.

It is likely that nurses did not consider the impact of the cost of transport for the women who used their facilities, and the study found that some women went home and did not come back in time when they finally were in labour. According to Morello-Frosch and Shenassa (2006), economic circumstances are an important factor that exposes women in poorly resourced settings to choose the TBAs services. Morello-Frosch and Shenassa (2006), Izugbara and Ukwayi (2004) also pointed out that poverty remains a major barrier that hinders utilization of public services in many African countries. Kaingu *et al* (2011), noting that TBAs still play a role in assisting women in poor resourced settings, suggest that their role should be recognized in maternal health care provision. They further argue that TBAs should be linked to the formal system and that they should be trained in basic life saving skills to provide a better safe service for the women.

5.3 USE OF BOTH THE TBAs AND THE MATERNITY HOSPITAL

In this study the women indicated their strong beliefs in cultural causes of complications during pregnancy and child birth. Yet, as noted above, the women were also aware of the benefits of delivering their babies in public health facilities. To solve this conflict, some women consulted TBAs first and then used health facilities for deliveries. This dilemma has been described by Mpembeni, Killewo, Leshabari, Massawe, Jahn and Mushi *et.al* (2007) in their study on the pattern of use of maternal health services in Southern Tanzania as choices due to wrong perception of causation [of pregnant risks and other medical conditions]. Mills, Williams, Adjuik and Hodgson (2008) emphasized that this could be one of the reasons why women continued to mix usage of both the TBAs' services and public health facility.

According to views by Rockers *et al* (2009) the women who had negative experience when giving birth with the assistance of a specific care giver or birth place tried to avoid giving birth at the same place the next time. This could be a contributing factor as to why some of the women in this study had used both the public and TBA services. They recognised the benefits and limitations of both, and were trying to establish the best care they could receive. However, it seemed that those who used the TBA service after previous negative experience in the hospital became loyal to TBA services. This was because they did not experience the same harsh attitudes from the TBAs as from the nurses, and they did not have medical cuts or incisions during delivery. This was illustrated when they referred to sutures they received with each delivery they had in the public health facility as compared to no sutures at all with the TBA assisted deliveries.

Turan *et al* (2008) indicated that fear of HIV testing and involuntary disclosure of HIV status to others as well as HIV/AIDS stigma is among the reasons that women avoid delivering in health facilities. In this study, this was not so. Women went to the ANC clinic to receive some of these tests and did not associate this with the choice of using the services or TBAs. While fear was at times a useful motivator for public health facility users, there was also a fear related to traditional beliefs. This was another contributing factor for the use of both hospitals and TBAs as it led women to perform rituals with TBAs before they went to the public health facility. It meant that women made sure that whatever the cause might be, the risk would be reduced by means they knew and believed in. This fear made the women in Kehemu stick to some of the basic cultural rituals with which they were familiar. They hoped psychologically that these rituals would secure them against risks that were not solvable by intervention offered in public facilities. Lindgren, Brink and Klinberg-Allvin (2011) described the attitude of the TBAs during delivery as purposeful to reduce fear and anxiety, in so doing letting the women relax before and during the whole process of labour.

5.4 IMPLICATIONS FOR KEHEMU SETTLEMENT IN RUNDU DISTRICT

The study, supported by the literature review, has important implications for Rundu district health services. The strengths and problems identified by the respondents with both the public maternity hospital and the TBAs services provide insights upon which can be acted. The attitude and actions of the health workers as shown from the women's perspective had the

potential of devaluing the quality of care in public health facilities. The women in Kehemu who used the public facility for delivery would not voice their opinion to health workers when they received care. This study created a possibility for women to express themselves about the care they receive in the public health facility.

It has been learnt that although some respondents attended ANC they were not accessing the hospital for their deliveries because they were not properly informed about the labour process. Issues such as early pains and intense labour pains were not well addressed among women who did not experience labour before. As a result they reported to the maternity hospital before they were in labour and were sent back home repeatedly. This made some women opt for the use of TBAs' services. Others made the 'choice' of TBAs opportunistically because of their circumstances, such as going into labour at night and the lack of funds for a transport.

The negative attitudes of maternity care providers featured highly in this study's findings, especially the verbal and physical abuse that had directly influenced women to not use the facility for delivery. It became apparent that cultural beliefs coupled with low socio-economic conditions and the negative attitude of health workers limited women's ability to choose appropriate care in time. It was highlighted in the study that despite the concerns by some women about quality, TBAs services were readily used by women in Kehemu. This indicates that TBAs could play a better role in provision of quality maternity care to women in Kehemu if their standards were improved. This could be achieved if the Ministry of Health and Social Services provided technical support to TBAs.

While the levels of education and awareness, the socio-economic conditions and the cultural beliefs remain the determinants of health care seeking behaviour, it seems likely that there is a need for re-orientation of health care providers in public health facilities in order for them to adhere to policies and guidelines which will facilitate unfolding access to the delivery of health care provision to the most vulnerable populations.

5.5 LIMITATIONS

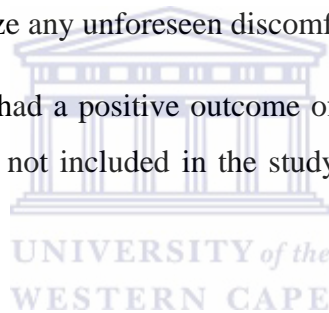
The small sample size used in this study meant that the research findings cannot be generalized. Given that participants were from different dialects of language spoken in the area, difficulties could have occurred with communication within the group. However, the researcher made efforts to ensure understanding and participation by all participants as the

situation arose. One of the main dialects spoken in the region was agreed upon with participants and was used for communication during the discussion.

The researcher is an employee of the Ministry of Health and Social Services with principal responsibilities of supervising maternal care in the region. There was a possibility that participants would be reluctant to express their concerns for fear of possible negative outcomes. However, the researcher reassured all participants about confidentiality by signing an agreement form not to disclose any information or abuse any individuals' contribution made during the discussion.

The fact that the researcher is a male could have resulted in some participants feeling uncomfortable talking about women's issues. For this reason, all participants were asked how they felt to discuss the topic with the researcher prior to the focus groups taking place, and they were told that if they had difficulties they could opt to not participate. This did not occur. The dynamics between male and female were also assisted by the researcher recruiting two female research assistants to minimize any unforeseen discomfort among the participants.

All women in the study population had a positive outcome of their pregnancy. Women who lost a child while giving birth were not included in the study, therefore their opinion is not reflected. .



CHAPTER 6: CONCLUSION

In conclusion the study managed to collect the perceptions of women in Kehemu about the ANC and maternity services provided in the public health facility. The women described services as generally good and acceptable. They also indicated that services were affordable. This was one of the main factors as indicated in the literature that influences whether women are able to access health facilities.

Drawing on the women's experiences the study brought to light factors that influenced their ability to use public health facilities. Three diverse views were given by women in this report regarding the use of maternity services. One view concerned women who used public health facilities from ANC through to PNC services. In this view it became apparent that women did not receive quality delivery services as they anticipated after attending the ANC. A second category was of women who used ANC services but did not use the public health facility for delivery. The reasons for habitual users not using services were mainly circumstantial. There was no link between what was provided at the ANC and the service women receive in the maternity ward of the hospital. The nurses' attitudes at the ANC clinic might be more acceptable than those of the nurses in the maternity ward who were over worked. A third view regarded women who used both the public facility and TBA services. It was clear from this study that the use of services was positively influenced by past experience of the women who used the public health facility and those who used home delivery assisted by a TBA. Their experiences included the reasons for using the public services which were that services were accessible in terms of distances and payments of costs such as taxi and ambulance fees to the public health facilities. The women's view in this category indicated a low level of awareness of birth outcomes for both mother and baby as they have limited maternal information as their only source of information were relatives and the TBAs.

The women who used the TBA services were generally satisfied although they had suggestions about improvement of TBAs' services.

The negative motivators that made women to avoid using public health facility for delivery were in the domain of cultural beliefs and preferences of traditional practices, low socio-economic conditions of women and the negative attitude of health workers, as well as lack of knowledge about birth complication.

It can now be concluded that even though women who were users of public health facilities recognized the expert knowledge and experience of their care providers, the caring

relationship was missing from providers in the maternity hospital. The literature review provided significant similarity in response to the women's views in the Kehemu study. Our findings therefore were consistent with what most researchers have found elsewhere. Therefore the lessons learnt from other studies could be drawn upon and be applied to these findings in order to improve service delivery in Rundu district.

6.1 RECOMMENDATIONS

The women's views on access to and acceptability of maternity care services in public health facilities were explored by this study. The suggestions made by women towards easing their access to public health facilities indicated their continuous desire to receive health care.

Firstly, it was noted in the study that the capacity of the Ministry of Health and Social Services to respond to the demand of women to be attended to by skilled personnel needs to be challenged. The staff compliment in the maternity hospital was inadequate. It is therefore recommended that the staff establishment should be reviewed to address the service challenges that were brought alongside the pro-active policy that encourages women to deliver in the health facilities. The suggested waiting shelter near the maternity hospital based on the views of the women should be considered. This suggestion was based on their view that the space in the maternity hospital is inadequate to accommodate mothers who reported before they were in labour. The nurses in the ANC clinics should be made aware of what is happening in the maternity ward for them to address the information deficits of their clients. This would provide the opportunity for nurses at ANC and in the maternity ward exchange situational challenges women face while under the observations of health professionals before the final hour of labour.

Secondly, women need information about pregnancy and complications of childbirth process as well as the benefits of using public health for delivery. It is recommended therefore that an information campaign be designed and implemented to address the cultural barriers and misinformation about prevention and available medical intervention for pregnancy and birth complications. The use of existing community based structures such as TBAs, TCE brigades and Red Cross volunteers and other relevant NGO partners should be encourage for the proposed campaign. The women themselves suggested that they should have community meeting opportunities, organized with the support of extension workers from the Ministry of Health and Social Services, in order to address the information gap among the women in Kehemu. Such a forum was suggested in order to update women with appropriate information on most health

issues as well as procedures to access emergency transport services at night. This recommendation is in line with the patient charter of Namibia (1998) which gives women the right to be given appropriate information and professional advice from the health care provider.

The third recommendation addresses the attitude of health workers. The public service charter of Namibia (Simataa, 2004) demands that public servants provide services in public institutions with passion, dedication and it requires public servants to show respect as well as to treat clients based on the principles of human rights and dignity. Mechanisms should be put in place by Government and the Ministry of Health and Social Services to communicate this policy intensively to health workers. Ethical codes should be operationalized, monitored and divisions should be rewarded with appropriate sanctions as stipulated in the public service charter document (2004). Training for nurses to improve their caring practices during delivery should be considered. This will also enable them to address the information gap among women during ANC.

Fourth, delivery services at Nkarapamwe clinic in Kehemu should be expanded from the current eight-hours to include a twenty-four hours call-in service for maternity cases with a well published emergency call number for an ambulance service. This would bring services closer to the community and enhance support to women who were unable to secure transport at night. Again quality assurance of infection control would be guaranteed and circumstantial use of TBA services reduced dramatically if not prevented at all. In the interim, the Ministry of Health and Social Services should continue the training of TBAs in strategic locations, and they should be provided with emergency delivery supplies. Some of the supplies that should be included are the sterile gloves, linen savers, masks, anti-septic solution or normal saline and umbilical cord strings.

Lastly, it was inadequate to use this study alone to try to solve the use of public health facility for delivery by non-users. However it could be appropriated to conduct similar studies in future with other groupings such as the care providers and TBAs to obtain their perspectives on the conditions that influenced their health care delivery attitudes and solicit possible solutions. The quality and the impact of TBAs services on birth process outcomes still require further research. Such research will give better insight to decide whether to stop supporting the capacity building of TBAs or not.

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Annex I

COPY OF THE CONSENT FORM

RECORD OF INFORMED CONSENT TO CONDUCT AN INTERVIEW

Date: _____ Interviewer's name: _____

UWC Student Number:

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Tel: _____ Fax: _____

E-mail: _____

Institution: _____

Interviewee's pseudonym: _____

Place at which the interview was conducted: _____

Thank you for agreeing to allow me to interview you. What follow is an explanation of the purpose and process of this interview. You are asked to give your consent for me to conduct a focus group discussion with you and to use this data for an assignment for my studies at School of Public Health, UWC.

1. Information about interviewer

I am *Bartholomeus Mangundu Muntenda*, a student at SOPH, University of the Western Cape. As part of my Master in Public Health, I am required to conduct a mini-research relevant to my topic in public health. I will be focusing on perceptions of maternity health care for women during pregnancy, child birth and after birth by women of the reproductive age in Rundu district. I am accountable to Dr. Ruth Stern, who is contactable at (+27)-21-9592173, or at fax number (+27)-21-959 2872 or by e-mail, [mail to: rstern@uwc.ac.za](mailto:rstern@uwc.ac.za).

Here is some information to explain the purpose and usage of my interview.

2. Purpose and content of interview:

The aim of the study is to explore women's perceptions and experiences about accessibility and acceptability of maternity health care offered to women in the public health facilities. The purpose of the interview is to obtain participants' views on choices they make regarding the place of delivery and how services could be improved to fit their needs. Some of the questions you will be asked include: *How do you describe the care given by health workers in public health facilities?* How feasible is it for women in your area to access maternity services in public health facilities? What is your feeling about the care women receive during pregnancy by care providers? How do you describe the home deliveries using the services of traditional birth attendants? *How can the service delivery in public health facilities be improved?*

3. The interview process:

The interview process will be in the form of a focus group discussion. It will take approximately 90 minutes. You will be given a chance to choose the appropriate slot of time when you can be available for the focus group discussion. A second appointment can be arranged if necessary at a time convenient for you. A tape recorder will be used during the discussions to assist me to recall the discussion during the report writing exercise.

4. Anonymity of contributors

At all times, I will keep the source of information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all time, and destroy them after the data has been collected.

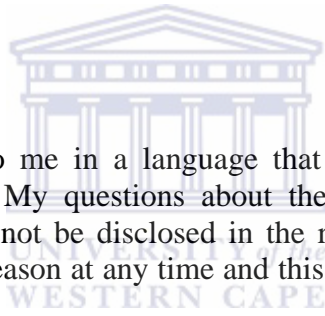
5. Things that may affect your willingness to participate

The interview may touch on issues which is culturally sensitive. If there is anything that you would prefer not to discuss, please feel free to say so, I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see intrusive.

6. Agreement

6.1 Interviewee's agreement

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed in the report and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.



Participant's name.....

Participant's signature.....

Date.....

6.2 Interviewer's agreement

I shall keep the contents of the above research confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by Interviewer: _____

Signed by participant: _____

Date: _____ Place: _____

Annex II:

Focus group discussion guide

Introduce the purpose of the meeting. Introduce the research team and ask participants to make self introduction. Explain the discussion process and the procedures of leading the discussion. Use the following questions as a guide.

1. QUESTION ON THEIR CHOICES:

What decisions have you made about where to have your baby?

2. VIEWS ABOUT CARE SERVICES IN PUBLIC HEALTH FACILITIES:

- a) What is your perception about the care given by health workers in public health facilities?

(Probing questions: Are services acceptable? What services are available? Are these services adequate?)

- b) How feasible is it for women in your area to access maternity services in public health facilities?

(Probing questions: How often are the services offered? What about the timing? Affordability? What aspects are well offered? Aspects for improvements? How satisfied are you with these services? Emergency care adequate? Hygiene aspects? Pain relief? Handling of birth complications? Any follow up care? Referrals to advanced care?)

3. VIEWS ABOUT ALTERNATIVE CARE DURING DELIVERY:

What is your perception of home deliveries using the services of traditional birth attendants?

(Probing questions: Why did you use/not use the services of a TBA? What do you think women consider when a decision is made to use the service? Who uses the services most? When is the TBA services mostly used? How satisfied with service? How about risk pregnancy identification? Management of birth complications? Infection control? Affordability of services? Acceptability? How to access service of TBA? Other?)

4. SUGGESTIONS TO IMPROVE SERVICES:

In your opinion, how can the service delivery in public health facilities be improved?
(Probing questions: Skills of health workers needed? Attitude of health workers?
Space in health facility? Privacy issues? Equipments? Supplies? Timing of services?
Transport/Ambulance services? Cost? Information? Other?)

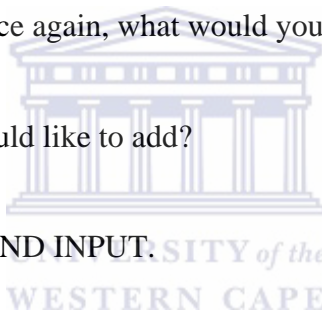
5. INFORMATION NEEDS OF WOMEN

What difficulties may arise to some mothers during pregnancy and or child birth?

(Probing questions: How serious is that condition? What could be the causes? How
can it be solved? How can it be prevented? What is the best source of information on
child birth? What information is needed by women in this community? How best can
it be communicated?)

6. If you were making the choice again, what would you do? Why?

7. Is there anything else you would like to add?



THANK YOU FOR YOUR TIME AND INPUT.