UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DEVELOPING GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION AND LOCAL ACCOUNTABILITY FOR PREGNANT WOMEN'S ACCESS TO BASIC ANTENATAL CARE IN MPUMALANGA PROVINCE, SOUTH AFRICA

Evangeline Xihlamariso Mthethwa

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

Philosophiae Doctor in
Nursing Science in the

FACULTY OF HEALTH SCIENCES
AT THE
UNIVERSITY OF PRETORIA

JANUARY 2017

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DEVELOPING GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION AND LOCAL ACCOUNTABILITY FOR PREGNANT WOMEN'S ACCESS TO BASIC ANTENATAL CARE IN MPUMALANGA PROVINCE, SOUTH AFRICA

Evangeline Xihlamariso Mthethwa

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

Philosophiae Doctor

in

Nursing Science

in the

FACULTY OF HEALTH SCIENCES

AT THE

UNIVERSITY OF PRETORIA

JANUARY 2017

Promoter: Prof MD Peu
Co-Promoters: Dr M De Waal
Dr M Yazbek

DECLARATION

Student Number: 12217825

I, Evangeline Xihlamariso Mthethwa declare that the thesis:

"**DEVELOPING GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION AND LOCAL ACCOUNTABILITY FOR PREGNANT WOMEN'S ACCESS TO BASIC ANTENATAL CARE IN MPUMALANGA PROVINCE, SOUTH AFRICA**"

is my original work. It has not been submitted at any other institution before for any degree or examination. All the sources used and quoted were acknowledged by means of complete references in the text and bibliography.

---------- ----------

Evangeline Xihlamariso Mthethwa **DATE**

ACKNOWLEDGEMENTS

I would like to thank Father God for the ongoing health, strength and wisdom He gave me throughout conducting my study. It is by His grace that I managed to complete my thesis.

I dedicate this thesis to my daughter Colleen and my son Colin Shivambu, as a standard and motivation for their future and my entire family for their support throughout the study.

It is with great appreciation and gratitude to acknowledge the contribution for the following people in the development and production of the thesis:

- My supervisor, Professor DM Peu for her continued guidance and support.
- My co-supervisor, Dr M De Waal, who was always available to provide guidance, support and encouragement throughout my studies.
- My co-supervisor, Dr M Yazbek for her ongoing guidance, support and encouragement.
- All the participants from Bushbuckridge sub-District and Ehlanzeni District in Mpumalanga Province for sharing their experiences, thoughts and feelings with me.
- The members of the group of experts who were involved in the second phase of my study.
- Joyce Mahuntsi for co-coding of data collected.
- Pholile Zengele for editing my thesis.
- My colleague, Dr Thoovakkunon Moorkoth Chandran, for his assistance in formatting the document and accommodating me in his busy schedule.
- Lillian Siziba for the ongoing support at home throughout my study.

The financial assistance from the University-Based Nursing Education of South Africa (UNEDSA) and the University of Pretoria is acknowledged.

ABSTRACT

The study sought to collect empirical evidence on local perceptions, needs, views on and experiences of antenatal care services, community participation and local accountability for health in Bushbuckridge sub-District, Mpumalanga Province with a view of promoting basic antenatal care. The sub-District is located in Ehlanzeni District which one of the districts in the country with the highest institutional maternal mortality rate.

The aim of the study was to develop guidelines to enhance community participation and local accountability for health by exploring ways to involve the community in basic antenatal care to increase antenatal uptake. This would contribute to reduction of maternal mortality and morbidity in the area. It was an exploratory qualitative study to explore and describe the perceptions, experiences and needs in promoting community participation and local accountability for pregnant women to access basic antenatal care in the area. The study was conducted in two phases where purposive sampling was used to select the participants.

In phase 1 data was collected through focus group discussions and face-to-face in-depth individual interviews. The participants were pregnant women, community leaders, members of governance structures and midwives. Data was analysed, category scheme developed and coded resulting into eleven themes. The findings showed perceived barriers which prevented pregnant women to attend antenatal care services. The barriers were related to health systems, socio-demographic factors, cultural beliefs and myths, and pregnant women's unmet financial, physical, psycho-social needs. The governance structures were perceived to be functional and informally accountable to the community. The identified perceived needs were: community involvement and participation in promoting antenatal care attendance; training of the identified stakeholders to be involved in health promotion activities to strengthen their knowledge and skills; collaboration of the facility staff and the

community in identifying local health problems affecting their community and seeking health care solutions.

The eleven identified themes were integrated with Comprehensive Community and Home-based Health Care CCHBHC model in the context of the relevant literature. The process resulted into a modified conceptual framework of the CCHBHC model which served as the basis for, and provided guidance towards formulation and development of the preliminary guidelines by the researcher. The objective for phase 2 was to develop guidelines that could promote community participation and local accountability for pregnant women's access to basic antenatal care. The set of preliminary guidelines were further developed and refined into the final guidelines by involving experts using the Delphi technique which completed the process of guideline development.

Implementing the developed guidelines could contribute in promoting community participation and local accountability for pregnant women's access to basic antenatal care in Bushbuckridge sub-District. A set of recommendations was developed for the Department of Health, policy makers, nursing education and practice and the community as role players in the study.

TABLE OF CONTENT

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
BANC	Basic Antenatal Care
ART	Antiretroviral therapy
APP	Annual Performance Plan
CARMMA	Campaign for the Accelerated Reduction of Maternal Mortality in Africa
CESR	Committee on Economic, Social and Cultural Rights
CCHBHC	Comprehensive Community and Home-based Health Care
CDWs	Community Development Workers
CEMD	Confidential Enquiries into Maternal Deaths
CHWs	Community Health Workers
CTOP	Choice on Termination of Pregnancy
DHIS	District Health Information System
DCST	District Clinical Specialist
DoH	Department of Health
HPCSA	Health Professions Council of South Africa
FGD	Focus Group Discussion
HIV/AIDS	Human Immune Deficiency Virus Acquired Immune Deficiency Syndrome
MDG	Millennium Development Goal

MMR	Maternal Mortality Ratio
MNCWH	Maternal, Newborn, Child and Women's Health
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NDoH	National Department of Health
NSDA	National Service Delivery Agreement
NSP	National Strategic Plan (MNCWH and Nutrition)
PHC	Primary Health care
PMTCT	Prevention of Mother to Child Transmission (of HIV infection)
SADHS	South African Demographic and Health Survey
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nation Children's Fund
WBOTs	Ward Based Outreach Teams
WHO	World Health Organisation

CHAPTER 1

BACKGROUND OF THE STUDY AND PROBLEM STATEMENT

1.1 INTRODUCTION

Globally, parenthood is celebrated and the birth of a baby brings joy to a family and its community. However, in Africa, giving birth is a leading cause of death for women between the ages of 15 to 19 (WHO, 2014; Africa Progress Panel, 2010:6). In addition, every year up to 20 million girls and women who survive childbirth endure chronic ill-health. Every day, approximately 35,000 women experience childbirth complications, about 900 of whom are likely to die (United Nations Population Fund (UNFPA), 2011: iv). The majority of these deaths occur in low-income countries and families with low socio-economic status (Africa Progress Panel, 2010:6). Some of the effects of maternal mortality are that children lose their mothers at an early age. It is also a loss to the family and the community. In general, the death of women in their productive years also affect the socio-economy of the country negatively as they die in their productive years resulting in loss of resources (Population Reference Bureau, 2001:2).

The death of women during pregnancy, childbirth or after delivery continues to be a major challenge in the health care systems of low-income countries and under-resourced communities (UNFPA, 2011: iv). Between 1990 to 2015, all the United Nations Member States made interventions with an aim of reducing maternal mortality ratio (MMR) by three quarters to address Millennium Development Goal (MDG) 5 (WHO, 2015:13). Progress was made during this period as the MMR reduced from 385 to 216 globally. In Developed regions, the MMR reduced from 23 to 12, 430 to 239 in Developed regions while in Sub-Saharan Africa which accounts for 66 % of the global maternal death, the MMR reduced from 987 to 546. However, in South Africa the MMR increased from 108 to 138, showing a complete lack of progress (WHO, 2015: 17;21;55;77).

Despite the key policies that the Department of Health is implementing, such as free access of antenatal care services in all public health facilities and implementing basic antenatal care (BANC), most pregnant women are still not accessing antenatal care until a late stage of pregnancy. The set target was that by 2016, 60 % of pregnant women should have initiated antenatal care before 20 weeks. Late initiation of antenatal care had led to maternal deaths which could be avoided (Amnesty International, 2014:9).

Mozambique is one of the countries in the sub-Saharan Africa with a high mortality ratio (MMR) of 480 per 100,000 live births. Some of the factors attributed to the high MMR are the distance to health facilities, lack of transport, failure of women to make decisions on their pregnancy due to gender inequality (Firoz, Vidler, Makanga, Boene, Chiaú, Sevene et al., 2016:124). According to Lowe, Chen and Huang (2016:2), factors such as social and cultural prejudice, poverty and poor access to health services, cultural barriers, and limited access to and utilization of health services also contribute to poor maternal health.

As a result of these factors, women do not have control over their own bodies. In addition, their access to resources as well as their uptake of services such as those that focus on sexual and reproductive health are compromised. In these conditions, women often have limited educational opportunities and they lack decision-making powers, that contribute to adverse pregnancy and maternal health outcomes (WHO, 2010).

Despite human rights and development interventions, it seems as if women's health status is slow to change in the sub-Saharan countries. The World Health Organisation suggests that family planning services should be integrated into preventive and curative sexual and reproductive health care services, as it has potential to empower women and families and promote gender equality (WHO, 2010).

In 2013/2014, the maternal mortality ratio in South Africa was 310 per 100,000 live births which is still high (DoH, 2015:13). Most of the women who died were located in rural areas and informal settlements where there was a lack of basic health care services and infrastructure (UNFPA, 2011: vi). This is compounded by the effects of the Human Immune Deficiency Virus Acquired Immune Deficiency Syndrome (HIV/AIDS). Data from Trends in Mortality 1990-2015 showed that 32 % of the 2015 maternal death estimations were AIDS related (WHO, UNICEF, UNFPA & World Bank, 2015: xi).

In order to reduce maternal and perinatal mortality, the South African government through the National Department of Health (DoH) adopted the basic antenatal care (BANC) approach when the World Health Organization (WHO) recommended its implementation to fast track interventions to meet the MDG5 for improving maternal health (WHO, 2002:55).

The revised WHO 2016 antenatal care guideline recommends that pregnant women attend a minimum of eight antenatal care visits during the gestation period of pregnancy (WHO, 2016:55). The National Department of Health is in the process of updating the BANC guideline to be aligned to the WHO recommendations before the end of 2017/2018 year. According to the WHO, it is one of the five pillars of safe motherhood initiative. It ensures that risks factors and complications are identified early and managed properly, and health education is conducted (DoH,2015: 15). In South Africa, evidence suggests that BANC contributes to the reduction of maternal mortality and is acceptable to the users (DoH, 2012:12). It is identified as one of the priorities to improve the outcomes for maternal, foetal and new born babies (WHO, 2016:105).

The National Health Act of 2003 (ROSA, 2003) states that community participation and local accountability are principles that underlie the District Health System. While the Act implies that the community should play a role in ensuring quality maternal health care services, this does not automatically translate into support at community level. Ways to identify interventions to bridge the existing gap and those that will improve the uptake of available government health care services across the continuum of sexual and reproductive health at a community level, were sought. Promoting community support to BANC and identifying the relevant role-players and community-level structures and to whom they are accountable, were studied.

1.2 RATIONALE

The lack of antenatal care attendance together with late and infrequent antenatal care by pregnant women contribute to the increase in maternal deaths in South Africa (DoH, 2012:13). Although the antenatal care coverage in 2011/2012 was high (92 % and above), only 56 % of pregnant women attended antenatal care (DoH, 2012:11). Additionally,

despite the high antenatal care coverage, only 44 % of the women attended antenatal care services before 20 weeks of their gestation period which is considered to be late booking for antenatal care (DoH, 2012:46). The WHO 2016 antenatal care guideline recommends that a minimum of eight antenatal care visits be done starting from the first trimester of the pregnancy (WHO, 2016: xvi). Community sensitization was necessary for initiation and timely attendance of antenatal care. In Kigali, Ruanda lack of maternal education and community sensitization contributing towards untimely initiation of antenatal care (Hagey, Rulisa & Pe´rez-Escamilla, 2014:99-100).

The South African Government is currently implementing a number of interventions to improve the state of Maternal and Child Health services, as well as sexual and reproductive health services. The challenge is that the interventions focus on the strengthening of clinical interventions, health care providers and health systems strengthening. Less attention is given to health-promotion programmes or to projects that involve local communities in the improvement of maternal health. This is despite the fact that about 46 % of maternal deaths could be prevented if the community were involved and engaged to participate in maternal, neonatal and reproductive health issues (DoH, 2008:11).

According to an independent assessment conducted by the Human Rights Watch (2011:13), women in South Africa continue to die as a result of pregnancy-related issues and shortcomings in the health system. This can be ascribed to the failure of provincial departments to take ownership of policy decisions related to recommendations made over a number of years and the lack of enforcement of policy decisions, effective oversight and accountability at national level (Human Rights Watch, 2011:17; DoH, 2008: 20-35).

All five triennial reports (1999-2013) on confidential enquiries into maternal deaths (CEMD) in South Africa recommended involving and empowering of the community on the activities, projects and programmes that could improve maternal, neonatal and reproductive health (DoH, 2014:3). Therefore, the awareness of communities, families and households, including men, needs to be raised and encouraged to participate in projects that aim at the prevention and reduction of maternal mortality and morbidity. It is important for the community to know that it is imperative for pregnant women to regularly

attend antenatal care services, and to know the potential complications that can arise. They should also know how they can contribute to the prevention of maternal deaths. The community, including pregnant women, should be involved in taking the necessary actions to prevent women from not attending or delaying attendance of antenatal care services and delaying to seek medical help during pregnancy (DoH, 2008:17). However, a gap exists, as the existing recommendations do not provide guidelines on how the community can be involved and empowered to participate in projects that will improve maternal, neonatal and reproductive health (DoH, 2008: xi, 35; DoH, 2012:49).

The framework for accelerating community-based maternal, neonatal, child and women's health and nutrition (MNCWH) of 2012 outlines how Maternal and Child Health services will be delivered to pregnant women, mothers and young children at community level only but it is silent on interventions in the form of community projects or community-based programmes (DoH, 2012:4). To address the gap, the developed guidelines in this study seek to promote community support for basic antenatal care services that will improve the state of Maternal and Child Health as well as sexual and reproductive health.

1.3 PROBLEM STATEMENT

The National Department of Health (NDoH) has an obligation to discharge its mandate by delivering effective and efficient health care services equitably and without bias to all population in all areas of the country (NDoH, 2003:17). Section 27 of the Bill of Rights in the Constitution of South Africa (1996) entrenches the right to health (Department of Justice and Constitutional Development, 1996:28). In addition, South Africa is a signatory to various international and regional human rights and women's rights treaties that specifically protect women's sexual and reproductive health as stipulated in chapter 14 (Department of Justice and Constitutional Development, 1996:20). The importance of providing a continuum of care from households through the community to the health care setting is also stressed (UNFPA, 2011: iii; 9-10). The aim is to improve the standards of and access to health care that is envisioned to change the landscape of maternal health care provision. The National Health Act of 2003 provides for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address

questions of health policy and the delivery of quality health care services. Community participation and local accountability are principles underlying the District Health System.

The Minister of Health signed the Negotiated Service Delivery Agreement (NSDA) 2010-2014 which has, as one of the strategic objectives, to decrease maternal and child mortality. Despite the enabling legislative and policy framework, and advances in knowledge and practice guidelines, the National Department of Health (NDoH) acknowledges that the South African health system has not adequately facilitated community participation and inter-sectoral collaboration to deal with the social determinants of health. The lack of integration in different spheres of government and at different levels of care remains a challenge that results in poor access to and poor quality of health care. In South Africa, there is currently no defined basket of services that responds to the needs of pregnant women at household and community level (DoH, 2010:9).

The South African Government has been offering free health services at Primary Health Care (PHC) level since 1994. This includes maternal, new-born, child and women's health (MNCWH) and nutrition services as well as sexual and reproductive health services. In addition to this, is facility revitalization and the increase of the number of facilities that have improved access to health services, especially in the rural areas. Despite these interventions in South Africa, during the period 2008 to 2010, 16.5 % of pregnant women did not receive antenatal care, 7.1 % received infrequent antenatal care and 28.8 % delayed accessing medical help (DoH, 2012:20).

The NDoH believes that these patient-oriented problems can be avoided if necessary interventions are implemented at community level. Interventions will include involving and educating communities on health messages that promote early and regular attendance of antenatal care clinics by pregnant women. It is anticipated that these community-level interventions will contribute to identifying and managing risk factors to prevent maternal deaths (DoH, 2008: xi, 36; DoH, 2012:49). However, at present no clear guidelines exist to facilitate and enable community-level interventions.

The re-engineering of PHC has been taking place since 2009. It has included extending the health care services to the community level and building on existing services to ensure

the strengthening of MNCWH and Nutrition interventions at community and hospital levels (DoH, 2012:4;5). The use of the BANC approach was initiated in 2009 at PHC facilities to ensure that all pregnant women receive four focused antenatal care visits beginning in the first trimester. Unfortunately, the DoH's monitoring and evaluation framework for MNCWH (2012-2016) excludes process indicators, making it difficult to monitor interventions on community involvement in improving maternal health and the lack of effective exercising of oversight and accountability at national level (DoH, 2015:23-26). The findings of the Human Rights Watch (2011:17) assessment have shown that the provincial departments did not implement the recommendations made after the Confidential Enquiries into Maternal Deaths (CEMD) were first published in 1997. This is despite the fact that the CEMD national committee recommended their integration into the provincial and district health manager's key performance areas to ensure implementation and accountability. All of this has had serious consequences for the implementation of interventions to improve maternal health.

The effect of non-implementation is particularly evident in Mpumalanga Province. Mpumalanga is one of the rural provinces in South Africa. It has a population of 4,039, 939 of which 88 % do not have health insurance (DoH, 2014:20; StatsSA, 2011). The province is characterised by poverty, as 34 % of the population is unemployed (DoH, 2014:20; StatsSA, 2011). According to the National Committee for the Confidential Enquiries into Maternal Deaths (NCCEMD), 150 of the 1646 actual institutional deaths reported in the country in 2010, occurred in Mpumalanga Province. Between 2008 and 2010, Ehlanzeni District had a maternal mortality ratio of 174,2 per 100,000 live births and was rated as having the eighth highest institutional maternal mortality rate among the 45 districts in the country (DoH, 2012:70).

While rural-urban disparities are more obvious, disparities also exist within rural areas. In the Ehlanzeni District, the Bushbuckridge sub-District accounts for almost 90 % of maternal deaths, and there are no projects that aim at raising community awareness or educating the community on the importance of pregnant women accessing antenatal care services. Relevant and accessible interventions may contribute to the prevention and reduction of maternal morbidity and mortality (DoH, 2012:70).

The researcher recognised that an increase of maternal mortality and morbidity is a complex problem and that to identify and eliminate the range of contributing factors requires a comprehensive approach. Thus, this study focussed only on BANC as one of the important but under-researched variables associated with maternal mortality and morbidity. Compliance with BANC can be regarded as an entry point to community-based primary health care initiatives of reducing maternal mortality (DoH, 2012:12).

Not much research is available on community-level stakeholders, barriers and contributory factors to the successful implementation of national primary health care programmes at community level, with specific reference to interventions that lead to reduced maternal mortality.

The major problem is that pregnant women do not attend antenatal care services as they should. Although births attended by skilled providers and facility deliveries have increased by 13 % from 1998 to 2016 in South Africa, those who received antenatal care from skilled providers remained the same at 94 % and 95 % consecutively. In Mpumalanga Province, 28 % of women still have less than four antenatal visits throughout their pregnancy (STATSSA, 2017:21-22).

There is lack of community involvement in interventions that encourage pregnant women to attend antenatal care services; also, there are no existing guidelines for promoting community involvement in antenatal care. Furthermore, it is unclear how functional the existing governance and accountability structures are or what capacity they have to promote community participation in health. Most importantly, there is a lack of empirical evidence to inform the guidelines for implementation of policies on community participation and local accountability for maternal health.

To be able to bridge the identified gaps, a health systems approach was implemented in the study. The study identified the role-players, barriers and contributing factors for involving the community as a system in interventions that would encourage pregnant women to seek BANC, therefore contributing to the reduction of maternal mortality and morbidity at community level. In addition, the level of functionality of the existing governance and accountability structures within the health system were assessed in

terms of its capacity to promote community participation and to ensure improved access to, and quality of, care for pregnant women.

1.4 SIGNIFICANCE OF THE STUDY

Community involvement in antenatal care could contribute to the promotion of basic antenatal care and the reduction of maternal mortality and morbidity. As research shows that pregnant women often attend antenatal care facilities only once during pregnancy, opportunities continue to be missed for them to receive care (DOH, 2012:45). The outcomes of the study could benefit pregnant women, adolescents, families, communities, health care practitioners, programme development, policy makers and the country at large.

The results informed the development of guidelines which could improve community participation and local accountability for health as envisioned by the South African National Health Act of 2003.

1.5 RESEARCH QUESTIONS

The research was guided by the following general research questions: 'What factors can promote community participation in and local accountability for basic antenatal care and what barriers exist that hamper access to and uptake of basic antenatal care (ANC) services in Bushbuckridge, Mpumalanga Province'?

The following specific questions supported the general question:

a) What are the perspectives, perceptions, experiences and needs for pregnant women regarding access to antenatal care services?

b) What are the perceptions, contributing factors associated with community participation and local accountability of local governance structures for antenatal care services?

c) What are the perceptions of health workers on community participation in supporting pregnant women to access antenatal care services?

d) What are the perceptions of health workers on the accountability of local governance structures for accessing antenatal care services?

e) How do local governance structures perceive their roles in and local accountability for health in local communities as required by the National Health Act of 2004?

1.6 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to develop guidelines to enhance community participation and local accountability for health by exploring ways to involve the community in basic antenatal care to reduce maternal mortality and morbidity in Bushbuckridge sub-District, Mpumalanga Province.

Specific objectives were:

1.6.1 Phase 1:

- To explore and describe *factors* associated with pregnant women's access to antenatal care services.
    - To explore and describe the *perceptions* of pregnant women regarding antenatal care services.
    - To explore and describe the *experiences* of pregnant women of antenatal care services.
    - To explore and describe the *needs* of pregnant women regarding antenatal care services.
- To explore and describe *factors* associated with community participation *and* accountability of local governance structures for antenatal care services.
    - To explore and describe the *perception*s of local community leaders regarding their role *in and* accountability for support of antenatal care.
    - To explore and describe the *perceptions* of members of local community structures regarding their role *in and* accountability for antenatal care.

- To explore and describe the *perceptions* of health workers about community participation in supporting pregnant women to access antenatal care;
- To explore and describe the *perceptions* of local health workers about the accountability of local governance structures for antenatal care.
- To explore and describe the functionality and accountability of governance structures in health within local communities.

1.6.2 Phase 2:

To develop guidelines that may promote community participation in and local accountability for pregnant women's access to basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province.

1. 7 CONCEPT CLARIFICATION

It is necessary to explain the meanings of certain key concepts as they will be used in this study:

Basic Antenatal Care (BANC) is an approach that is used for the antenatal care provided to pregnant women. The WHO antenatal care model recommends that pregnant women should have a minimum of eight contacts with a health care provider. The first contact should occur within the first trimester (within 12 weeks of gestation), two contacts in the second trimester i.e. between 20 to 26 weeks of gestation; and eight contacts in the third trimester which should occur at 30, 34, 36, 38 and 40 weeks of gestation. This is done to improve the women's experience of care and for the improvement of maternal, foetal and new born outcomes (WHO 2016:55;105).

Community participation in health care refers to the community's active interaction, as individuals or collective engagement in assessing or identifying their health problems, taking ownership and responsibility to identifying activities or developing strategies to address identified problems through implementing problem solving techniques (Friedman, Machedi, Ngubo & Southgate. 2006:50; Peu, Tshabalala, Hlahane, Human, Jooste, Madumo, et al., 2008:118). Its rationale is to empower the community to enable

members to promote their health and encourage positive behavioural change. It can be achieved through health education and health promotion.

Local accountability is a basic aspect of governance related to how relationship is managed between health and the stakeholders. The examples of the stakeholders are communities, households, individuals, businesses, government and non-governmental organisations. It includes other entities which have the responsibility to finance, monitor, deliver and use health services (WHO, 2010:86). Accountability particularly, involves:

- good understanding of how the services are supplied;
- availability of adequate resources is ensured for service delivery;
- the delivery of the services is ensured;
- all relevant information is received for monitoring and evaluation of performance;
- performance is enforced such as imposing sanctions should a need arise or the provision of rewards for performance (WHO, 2010:86).

Pregnant women's access to health care is a socio-economic right (section 27) recognised as a human right in international law and protected in the South African Constitution Act No. 108 of 1996 (Constitution of South Africa, 1996). There is an obligation on the State to remove barriers that prevent people from accessing these rights, to empower people and communities so that they can benefit from the services, to fulfil these rights, and to adopt special measures to assist vulnerable and disadvantaged groups to have access to these services. Pregnancy is a listed ground for non-discrimination in the Bill of Rights (section 9) and the State has a duty to respect, protect, promote and fulfil the rights in the Bill of Rights according to section 7(2) (Constitution of South Africa, 1996). Therefore, special measures need to be taken to ensure that pregnant women from under-resourced and disadvantaged backgrounds have access to health care services (Khoza, 2007:34).

1.8 RESEARCH PARADIGM AND PHILOSOPHICAL ASSUMPTIONS

1.8.1 Research paradigm

A paradigm is regarded as a collection of concepts, assumptions and propositions which are logical and related, and provides guidance to research and how researchers think (Bogdan & Biklen, 2003:22). It is based on beliefs, values, methods and practices which clarify the researcher's philosophical assumptions on the topic under study (Jackson, 2015:3). The interpretivists and constructivists research paradigms were used to guide this research study which are explained below.

The interpretivist paradigm seeks to understand people's values, beliefs and their social realities in the world they live in (Guba & Lincoln, 1994:118). The assumptions of the interpretivists paradigm guided the research process. It provided a framework for conducting the study and informed the process of defining the research question, data collection, analysis and interpretation of the results (Botma et al. 2010:40; Guba & Lincoln, 1994:107). This was done in the form of, for example, concepts and models which are continually tested and modified to bring new experiences (Schwandt, 1994:197).

The interpretivist paradigm was selected as it is appropriate to qualitative studies. It allows the study to be conducted in a natural setting and focuses on humans' lived experience (Gray, 2004:36). It also helps to understand people's values, beliefs and their social realities in the world they live in when investigating a phenomenon (Guba & Lincoln, 1994:118).

Interpretivism was developed in reaction to positivism (Chowdhury, 2014:434) which originated from a values-free scientific approach seeking to establish absolute truth (Jackson, 2015:4). Positivism assumes that true knowledge is created by using scientific method to predict or explain phenomena. This is in contrast with post-positivism in which interpretivism is rooted from which recognized that absolute truth cannot be determined; and to understand the relationship between variables, contextual factors are important (Jackson 2015:4). In interpretivism, a phenomenon is examined through the eyes of individuals who lived it as their experience. Understanding of the event is important (Jackson 2015:6). Additionally, when making an enquiry, researchers use their own

preconceptions to guide the process of engaging the human subjects in an interaction which changes the perceptions of both. It also looks into presence or absence of causal relationship, how it manifests and the context in which it occurs (Chowdhury, 2014:434).

To the interprevists, understanding action, the intention for the action, time and context where the action occurred needs to be determined through objective inquiry as social action is meaningful (Shwandt, 1994:191). In this interpretive study, the paradigm guided the process of determining the scope, the tools used for data collection, methods for data collection, where data was collected, the context, who the participants and the facilities were, how they were selected and the criteria used for their selection.

Constructivism originated as a countermovement to positivism and came from postmodernism which emphasizes that old ideas should be deconstructed and reconstructed to bring new ideas (Polit & Beck, 2012:12). The constructivists paradigm was selected for the study because it guides the process of creating new knowledge. It assisted the researcher to think, understand, reflect test and modify existing constructed knowledge (Educational Broadcasting Corporation, 2004). When a person encounters a new thing, it is reconciled with the previous ideas and experiences, changing what was believed or discarding the new information if found to be irrelevant (Educational Broadcasting Corporation, 2004). This is done through asking questions, exploring and assessing what is known and creating own knowledge. These processes result in the construction of, for an example, concepts, models and abstracts (Educational Broadcasting Corporation, 2004) which are continuously tested and modified (Schwandt, 1994:197). In constructivism, people who participate in the research construct reality which exists in a context. It allows the study to be conducted in a natural setting which is similar to the interprevists as they both focus on human lived experiences.

Constructivism also helps to understand people's values, beliefs and their social realities in the world they live in when investigating a phenomenon (Gray, 2004:36). To create knowledge and understand the phenomena, the researcher should closely interact with the participants at a close range to listen to their voices which will result into findings (Polit & Beck, 2012:12). All these occur within a set up where there is common language, practices and understanding (Schwandt, 1994:197).

Since the interpretivists and constructivists research paradigms allow the study to be conducted in a natural setting and focus on human lived experiences (Gray, 2004:36), the constructive approach was used. The study followed a qualitative, exploratory, descriptive and contextual design, which was used to explore and describe the participant's beliefs, values and their social realities on their perceptions, experiences and needs regarding pregnant women's access to basic antenatal care services in Bushbuckridge sub-District. This was to get their lived experience and perspective on the factors associated with pregnant women's access to antenatal care services and the factors associated with community participation and local accountability for antenatal care services in the area.

The researcher developed an interview guide and interview schedule which was used to collect data from pregnant women using focus group discussions and individual in-depth interviews for community leaders, members of clinic committees and midwives. All the participants were members of the community in the catchment areas of the three Community Health Centers selected from Bushbuckridge sub-District.

The current study was an exploratory qualitative study as it sought to investigate the factors associated with pregnant women's access to antenatal care services and the factors associated with community participation and local accountability for antenatal care services in the area. It was a quest for in-depth knowledge and understanding of the participant's perceptions, intentions and experiences (Venkatesh, Brown & Bala, 2013:24; Knudsen, Laplante-Lévesque, Jones, Preminger, Nielsen, Lunner et al., 2012:90) about the phenomena. The information was recorded, transcribed and documented using quotations which were their own words.

This resulted in gaining understanding of the existing barriers which hamper access to and uptake of basic antenatal care services, factors which could promote community participation and local accountability for basic antenatal care in Bushbuckridge sub-District. The philosophical assumptions of the interpretivist paradigm, which are ontology, epistemology and methodology, are described below (Guba & Lincoln, 1994:105).

1.8.2 Philosophical assumptions

Ontology, epistemology and methodology were the three relevant and applicable philosophical assumptions underlying the interpretivist paradigm, which were used to guide the study and are briefly described. These assumptions drew the parameters when an inquiry was made. It determines what to include and what to exclude when conducting a research study. The philosophical assumptions presented below are considered to be reflecting an order of logical primacy (Guba & Lincoln, 1994:108).

Ontology

Ontology refers to the nature of social reality. It is how the world is viewed by individuals (Polit & Beck, 2012:11;13). It denotes what is available in the real world, what can be investigated and what can be known about it (Guba & Lincoln, 1994:108). Following the interpretivist paradigm, reality is subjective and could be interpreted differently by individuals (Polit & Beck, 2012:11;13). In the study, the reality was that pregnant women were not accessing basic antenatal care services despite the fact that the services were free in Primary Health Care facilities in South Africa. Ontology guided the researcher on development of the topic to be researched (Gray, 2004:17), describing the rational of the study, problem statement, significance of the study, and defining the aim and the objectives of the study. It determined all the decisions that were taken when conducting research (Botma et al., 2010:40) and how the research was conducted.

Ontology guided the amount of information which was collected on factors associated with pregnant women's access to antenatal care services and the factors associated with community participation and local accountability for antenatal care services in the area. Further to that, it determined the need for triangulation to cross validate the collected qualitative data by collecting data from multiple sources in this study. Interpretive paradigm allows triangulation (Gray, 2004:36) when gathering gather data to establish the truthfulness of the study as it seeks to explore people's views and their experience.

Epistemology

Epistemology is the theory of knowledge regarding reality. In the interpretivist paradigm, epistemology focuses on construction and explaining knowledge (Botma et al., 2010:40).

It explains the nature of knowing and brings understanding of social reality. It provides a framework for conducting research (Mason, 2002:16, Polit & Beck, 2012:13). In the study, the researcher sought to understand the reasons for pregnant women not to access basic antenatal care (BANC) services when the services are provided free of charge to all pregnant women in all Primary Health Care facilities in South Africa. It was assumed that there were reasons which made them not comply with BANC which needed to be known and investigated.

Epistemology provided parameters for guiding the adequacy of the study, legitimate knowledge required, and how to gain knowledge, understanding and explain it. It guided the scope, design and the methodology used (Gray, 2004:17) in the study. In phase 1 of the study, the researcher used qualitative, exploratory, descriptive and contextual design to explore and describe perceptions, experiences and needs of the selected participants regarding pregnant women's access for basic antenatal care.

Additionally, epistemology is associated with the interpretivist paradigm which informed designing of the tools that were used for data collection. It guided the kind of data collected and the process used for data collection, data analysis and interpretation. Focus group discussions and in-depth interviews were used to engage participants in an interaction when collecting data which Polit and Beck (2012:13) consider to be crucial in understanding the participant's world view.

Methodology

Methodology focuses on the structure of the processes used to gain knowledge and understanding about reality when making an enquiry (Guba & Lincoln, 2004:108). In the study, a qualitative approach to the study was used. The researcher understood and described pregnant women's perceptions, experiences of barriers and their needs on antenatal care; and the perceptions on community participation and involvement in promoting pregnant women’s uptake of basic antenatal care in Bushbuckridge sub-district.

Data was systematically gathered in the form of words from participants using qualitative approach to explore and describe their perceptions, experiences, insight, feelings, thoughts, behavior and actions (McMillan & Schumacher, 2010:23) related to pregnant

women's access to basic antenatal care. Focus group discussions and individual in-depth interviews with pregnant women, community leaders, members of the health facility governance structures and midwives were held to collect data using an interview guide. This was focused, systematic and comprehensive to explore the different topics (Jamshed, 2014:87).

Data was analyzed and interpreted. The results brought insight and understanding of the existing barriers which hamper pregnant women's access to and uptake of basic antenatal care services, and factors which could promote community participation and local accountability for basic antenatal care in the Bushbuckridge sub-District.

The results of the empirical study formed the basis for and informed the development of the guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal in Mpumalanga Province in phase 2 of the study. The choice on the methodology used for the study was based on the researcher's assumptions which reflected her paradigmatic perspective.

1.8.3 Conceptual framework

A conceptual framework is a visual or narrative which explains the key concepts and factors to be studied and the presumed relationship (Vaughan, 2008). It is the theories and beliefs which guide a study (Maxwell, 1998:216). In this study, the comprehensive model for home/community-based care (CCHBHC) model (WHO, 2004:3) was selected to guide the development of the guidelines.

The CCHBHC is an integrated system of care which is designed to cater for the health needs of individuals, families and communities in their own settings. The aim of the model is to implement affordable, accessible, equitable, and efficient health care and enhance the clients, families, and community's collective capacity through the use of health education provided by professionals to enable them to cope with the gradually more dependent clients in their families and their communities (Peu et al., 2008:77). It involves the provision of health care services by different health care providers, including community health workers. The healthcare services include preventive, promotive, curative and rehabilitative services. The services may be offered in a home setting or in

institutions such as clinics, Community Health Centres, hospitals etc. (Peu et al., 2008:77).

To inform the process of developing the guidelines in this study, the components which underpin the CCHBHC model and the core elements the of the CCHBHC model were selected. These are the three levels of prevention of diseases were selected and not the entire model was used. These are: primary, secondary and tertiary prevention of diseases which are depicted in Figure 1.1. The core elements of the model were selected because they focus on three levels of disease prevention. The levels of diseases prevention are part of health promotion, rehabilitation, palliative and long term care. These services are provided at a community and household level (WHO, 2004:10), which is relevant to the context of the Bushbuckridge sub-District where the study was conducted. The core elements were recognized as closely related to the current empirical findings of the study and were integrated and used to inform the process of developing preliminary guidelines.

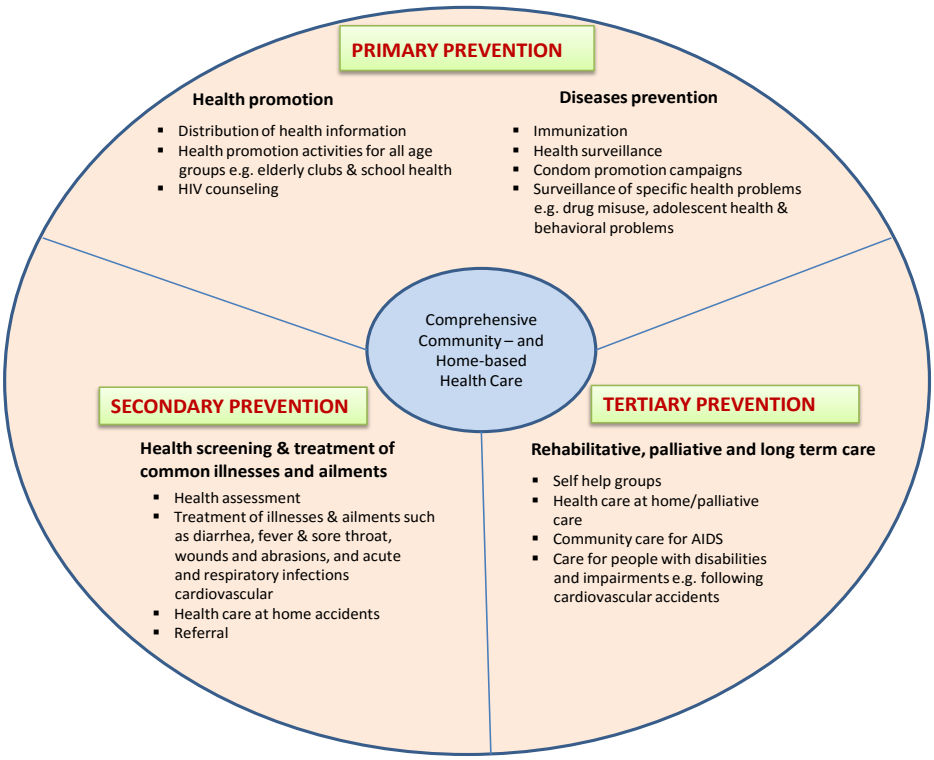


Figure 1.1: Example of care delivery of the core elements of the CCHBHC Model (Source: WHO, 2004:11).

Primary prevention focuses on preventable diseases before they occur through health education and health promotion activities such as Human Immune Deficiency Virus (HIV)/ Acquired Immune Deficiency Disease (AIDS) and Sexually Transmitted Infections (STIs).

Secondary prevention refers to early detection of diseases before the symptoms are visible. The treatment provided is done to slow or stop the progress of the diseases. It includes referral to the next level of care where it is necessary for the conditions that cannot be managed at a community level (WHO, 2004:10-11; Peu et al., 2008:77; 79; uOttawa, 2015).

Tertiary prevention is stopping the progress of the disease to prevent or reduce complications such as putting HIV positive pregnant women on Highly Active Anti-Retroviral Therapy (HAART) to reduce maternal mortality. Rehabilitation is done to prevent further complications (WHO, 2004:10-11; uOttawa, 2015) such as risk behaviour modification. These levels of prevention can be provided in any setting in the community such as Primary Health Care (PHC) facilities, schools, and churches including at a home setting or household level which is similar to the setting in Bushbuckridge sub-District.

For the three levels of prevention to be successful, there are components which are required for the delivery of service in the community which underpin the CCHBHC model which are the following: involvement of other stakeholders; forming partnership; linking formal and non-formal caregivers; empowering individuals, families and community for self-care and self-reliance; bridging the gap between the individual, family, the community and the health care system; and consideration of the local context (WHO, 2004:1). The components act as enabling factors to facilitate health education and health promotion in the community and at home.

For the purpose of developing guidelines, the researcher chose the CCHBHC model as a framework for developing guidelines because it ensures accessibility of effective and efficient health care services by the community and at household level. The core elements serve as a health care service delivery model for Primary Health Care using the three

levels of prevention (WHO, 2004:10-11; Peu et al., 2008:77; 79; uOttawa, 2015). This resulted in "developing the guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province, South Africa". The details are discussed in chapter 4 and 6. The findings from phase 1 of the study were integrated with the core elements of the CCHBHC model which resulted in the development of the stated guidelines.

1.9 DELINEATION

1.9.1 Geographical demarcation

Mpumalanga Province is divided into 3 district councils. These are Ehlanzeni, Gert Sibande and Nkangala District Councils. Ehlanzeni District is further sub-divided into five local municipalities or sub-Districts. These are Bushbuckridge, Mbombela, Nkomazi, Thabacheu and Umjindi. The study was conducted in Bushbuckridge, which was chosen because it is rural in nature, has poor access to health services, and has poor infrastructure such as roads, water supply and transport system. It is situated in the north eastern part of Mpumalanga and borders on Limpopo Province and the Kruger National Park in the north. The sub-District is further sub-divided into 34 wards.

1.9.2 Focus on BANC

The study focused on BANC as one of the important, yet under-researched variables associated with maternal mortality and morbidity. This emanates from studies that show that maternal mortality and morbidity can be reduced through early identification of risks, intervention and planned follow-up strategies, all measures that increase positive maternal outcomes (DoH, 2012:12).

1.10 RESEARCH DESIGN AND METHODOLOGY

A qualitative descriptive method was followed to answer the research questions. This was a qualitative study to explore and describe various phenomena related to promoting community participation in and local accountability for the local health system so that pregnant women can access basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province.

In qualitative methodology, the regularities and relationships to universal laws were examined. Since the aim was to discover meaning and multiple realities, participants who have experienced the phenomenon under study were identified. In Phase 1, the researcher explored and provided a rich and detailed description of the phenomenon being studied. This was achieved by interviewing the participants in their natural setting, listening to them and building understanding based on what they have experienced.

The researcher sampled participants who were rich sources of information and who maximized, confirmed, or challenged the understanding of the phenomenon. A qualitative study allowed the subjects to share their detailed experiences, opinions, facts, points of view and perceptions of their own world with regard to the phenomenon. This provided rich in-depth information and a greater understanding of the phenomenon (McMillan & Schumacher 210:325; Polit & Beck, 2012:279).

Phase 2 of the study utilised the Delphi technique, which is a structured communication process used to gather opinions when resolving complex problems. The technique involved using a group of experts from the domain of maternal and child health, community participation and involvement to provide opinions without any physical meetings. Purposive sampling was used to select the panel of experts from different disciplines. The panel consisted of experts who understood the South African context from national level to ensure that the content of the guidelines is clear, applicable and valid. The experts were sent a set of questionnaires to collect data over a series of rounds to generate expert opinions anonymously. The process was repeated until consensus on the content of the guidelines was reached (Hsu & Sandford, 2007:3).

1.10.1 Phase 1 : Exploration and description of perceptions, experiences and needs to basic antenatal care to reduce mortality and morbidity in Mpumalanga Province

The qualitative design supported the researcher to conduct the study in a natural setting to analyse the detailed experiences and perspectives of participants, and to build a complex, holistic picture of the phenomenon (Botma, Greeff, Mulaudzi & Wright, 2010: 50; Polit & Beck, 2012:505). The second phase entailed the development of a set of

guidelines that could promote community participation and involvement in projects aimed at encouraging pregnant women to attend BANC to reduce maternal mortality and morbidity in the communities.

1.10.1.1 Methodology

The context and study population comprised of the following:

1.10.1.2 Context

Bushbuckridge Sub-District was chosen as a research site because it is a rural area that is under resourced with poor access to health care services. It has an estimated population of 541 248 (StatsSA, 2011), high unemployment with only 15 % of the population being employed. Several PHC facilities serve the community under the Department of Health. There are 34 PHC facilities of which three are Community Health Centres (CHCs), two District Hospitals and one Regional Hospital that refers patients to the Provincial Hospital. The community is also served by five mobile clinics, which deliver PHC services at 71 mobile points.

The facilities are poorly equipped, understaffed and have a lack skilled health professionals who have midwifery competencies and who are able to manage obstetric emergencies. There is a lack of transport especially at night, with no dedicated transport for emergency obstetrics and poor communication networks. The sub-District has recorded the most maternal deaths in the Ehlanzeni District. The researcher originates from the area and understands the local language, culture and values; factors that facilitated entry, acceptance and eliminated misconceptions. The local leadership knows the researcher. The subjects had the same characteristics and share the world of experience in which they live.

1.10.1.3 Study population and sampling

The study population was pregnant women, community leaders, members of the governance structures (clinic committees and the District Health Council) and various health workers who form part of the local health system. Participants in the focus group discussions and the in-depth interviews were selected by using purposive sampling. The

researcher used personal judgment to select participants who were most informative and had the greatest possible insight into the phenomenon being studied. This enabled her to gain rich and comprehensive data related to the subject (McMillan & Schumacher, 2010:489; Polit & Beck, 2012:279).

The selected Community Health Centres (CHCs) were valuable as they are all referral centres and multiple sites for testing cross-site consistency because of their geographical locations within the sub-district. Focus group interviews were conducted with pregnant women who were selected in the community but attend antenatal care services in the selected facilities. Each focus group consisted of six to ten participants for effective participation and to elicit a range of responses. The recruitment of the sample size was exceeded by 20 % to allow for participants who might not attend because of various reasons (Botma et al., 2010:211). The three-step strategy for recruitment was carried out by contacting the participants two weeks before the group session, ensuring that they received confirmation letters a week before and followed up by calling each participant the day before the group session.

Face-to-face, in-depth interviews were held with the following participants in each selected site close to each CHC: one community leader responsible for the local area; two members of governance structures in which the Community Health Centres are located; health workers: one midwife per Community Health Centre, an advanced midwife or a doctor or clinical manager per District Hospital; and one available member of the District Clinical Specialist teams (an obstetrician and gynaecologist, an advanced midwife, a Primary Health Care nurse) in the province.

1.10.1.4 Data collection

The study's qualitative descriptive approach focused on understanding the experiences and perspectives of pregnant women, community leaders and health workers on antenatal care, from the point of view of the participants. Person triangulation was used to validate data through multiple perspectives on the phenomenon under study by using focus group discussions (FGDs) and face-to-face in-depth interviews. Focus group interviews were conducted with pregnant women using a semi-structured interview guide.

As there were determined issues that needed to be tackled in a focused and sequenced manner, the guide ensured that all the specific information required for the study was discussed.

All FGDs in each site preceded the face-to-face in-depth interviews. Two broad questions that were asked for the FGDs were: What are the factors that influence the access of pregnant women to antenatal care services (personal, family, financial, physical, psychological etc)? What are the barriers, perceptions, experiences and your needs regarding accessing antenatal care and involving the community in the promotion of antenatal care? The role of the facilitator was to direct the discussion, write field notes and keep the discussions flowing. The moderator, who was well trained, assisted the facilitator, handled destructions, and acted as a back up to the taped conversation.

Each FGD in the selected site was followed by face-to-face in-depth interviews with health care providers, community leaders and members of the governance structures who were based in the local areas and who formed part of each of the selected site's health system. The interviews started by asking a single open-ended question that was well-planned and broad. For health workers and community leaders the question was: *What are your perceptions, perceived barriers and contributory factors regarding involvement of the community to promote pregnant women to attend antenatal care services*? For the governance structures, the following two broad questions were asked: *What are your perceptions, perceived barriers and contributory factors regarding community involvement to promote pregnant women to attend antenatal care?* and *How do you view your roles and accountability as required by the National Health Act with regard to your involvement in health?*

The questions were reviewed with experts in the field and selected participants to check if they were appropriate and applicable before they were used (Botma et al., 2010:209). The themes that were covered were perceptions, experiences, needs, reasons for not attending ANC and functionality of the governance structures. The interviews were audio-recorded with the aid of a tape recorder (Botma et al., 2010:214; Polit & Beck, 2012:534).

1.10.1.5 Data analysis and interpretation

In descriptive qualitative studies, it is considered a good practice to start analysing the data while still collecting it and everything is still fresh in the minds of the researchers (Polit & Beck, 2012:557-560). This also allowed the researcher time to go back to participants to obtain more information when there were uncertainties of the information or lack of saturation of information. Information was analysed per community health centre and the local areas per dataset, and comparisons were made across datasets.

The basis for analysis was the transcripts, recordings, field notes and observations. The researcher considered the words, contexts, internal consistency, frequency of comments, extensiveness of comments, specificity of comments, what was not said, and finding the big idea. The central task during the data analysis stage, was to identify common themes in the participants' descriptions of their experiences and perspectives. After transcribing the interviews, data analysis involved the following steps:

- Identified statements that related to the topic, and breaking the relevant information into segments that each reflects a single, specific thought.
- Divided group statements into "meaningful units" by categorising the segments that reflect different aspects or meaning of the phenomenon as experienced or described by the participants in the interviews.
- Sought divergent perspectives as presented by the participants.
- Integrated different categories into themes leading to an integration of all data.
- Constructed a composite picture by using the various meanings to develop an overall description of the phenomenon as the participants typically experienced and described it (Botma et al., 2010: 222-227; Polit & Beck, 2012:557-560).

The result was an integrated general description of the phenomenon of seeking basic antenatal care during pregnancy from the perspective of the different categories of participants in a local health system.

For each of the datasets and the categories of participants, the analysis of the data involved a process of making and uncovering meaning, integrating different categories to

develop themes, comparing cases and the emergence of patterns, and building a typology of challenges, barriers and enablers for community-based implementation of basic antenatal care.

Upon completion of the data analysis, the researcher drew conclusions about the experiences and perspectives of the participants (the phenomenon), and related the findings to the body of theory and research referred to elsewhere in this thesis (Botma et al., 2010, 235; Polit & Beck, 2012:576). The findings of the study were used to develop a set of guidelines for involving community interventions to improve basic antenatal care uptake in the Bushbuckridge sub-District, Mpumalanga Province.

1.10.1.6 Trustworthiness

To ensure that the findings were of good quality, the integrity of the findings were evaluated using Lincoln and Guba's (1985) criteria for developing trustworthiness in qualitative enquiry. The criteria are credibility, dependability, transferability and confirmability. Data was collected by conducting several focus group discussions and individual face-to-face in-depth interviews. Sufficient time was allocated for fieldwork to allow prolonged engagement with participants in order to enable them to provide specific details, basic facts and understanding of why and how certain things happen so as to provide a broader picture of the phenomena under study. In order to establish truthfulness of the study, data triangulation was used i.e. collecting data using space and person triangulation. The same data was collected from multiple sites to test for cross-site consistency. In addition, data was collected from different levels of people, individually and in groups, to validate data through multiple perspectives on the phenomena under study. To enhance confidence in the data, all focus group discussions and individual in-depth interviews were recorded with the aid of a tape recorder to ensure that all the information was captured during the discussions. Member checking was done during focus group discussions as data was collected by probing to ensure that participants' meanings were clearly understood.

For the face-to-face interviews, member checking was carried out after the data was completely analysed. The researcher kept a reflective journal and a logbook of decisions

made during the focus group discussions. Field notes were also taken on the participant's demeanours and behaviour during the interaction, which included description of the interview context (Polit & Beck, 2012:591-592).

1.10.1.7 Ethical considerations

To fulfil the research ethical obligations and for ethical evaluation (Botma et al., 2010:56; De Vos, 2002:64; Polit & Beck, 2012, 152-156, this study's proposal was submitted to the Ethics Committee of the University of Pretoria for review and approval. Once approved, the researcher requested permission from the Departmental Research Committee of the Department of Health in Mpumalanga Province to conduct the study. The permission letter from the Department of Health was used to gain access to the selected facilities. Letters requesting their participation in the study were written to the prospective participants in the qualitative study as well as to the panel of experts who contributed to the development of the implementation guidelines. The letters outlined the objectives of the study and their rights as participants.

Three ethical issues that were relevant for consideration in the study were:

1. Protection from harm: One of the respondent categories was pregnant women. Although the study did not involve any physical examination, there might have been a risk of psychological harm. The researcher took care not to subject the participants to unexpected stress, embarrassment or loss of self-esteem. To further reduce the risk of psychological harm, the researcher conducted a de-briefing session with the pregnant participants immediately after the interview (De Vos, 2002:73; Polit & Beck, 2012, 163-164).

2. Informed consent: Research participants received information on the nature of the study, and were given the choice to participate or not to participate. If they agreed to participate, they had the right to withdraw from the study at any time. Participation in the study was strictly voluntary. Every respondent was given a consent form that described the nature of the research project and the nature of participation in the project (Botma et al., 2010:56; De Vos, 2002:65; McMillan & Schumacher, 2010:15; Polit & Beck, 2012, 157-158).

3. Right to privacy: The nature and quality of participants' information were kept strictly confidential. Respondent numbers or pseudonyms were used to protect the identities of participants and clinics. The focus group discussions began with a statement of ground rules, which included the confidentiality clause for the participants to ensure that the information discussed was not revealed outside the group (De Vos, 2002:67; Polit & Beck, 2012:156).

1.10.2 Phase 2 : Developing guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province

1.10.2.1 Objective

The objective of Phase 2 was to develop guidelines that may promote community participation in and local accountability for pregnant women's access to basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province. One of the principles of developing guidelines is that they should be based on available evidence. The guideline development process was based on the findings of the empirical data collected in Phase 1.

1.10.2.2 Research design

The Delphi technique is a method used to gather opinions of a particular phenomenon from a group of experts within their area of expertise without meeting with them physically (Hsu & Sandford, 2007). Questionnaires were used to collect data from the selected panel of subjects over a series of rounds to generate expert opinions anonymously until consensus was reached (Hsu & Sandford, 2007). The technique was used to pool intelligence and convergence of opinions from the responses received, thus building consensus on the phenomenon under study in this case, namely the further development of a set of implementation guidelines.

1.10.2.3 Population and sampling

To enhance credibility, purposive sampling was used in the selection of expert participants for Phase 2. For participants to make a meaningful contribution on the target issue they needed to have expertise in different disciplines and experience in the field of

Maternal and Child health, and or Primary Health Care (PHC) reengineering. The panel comprised of national experts who understood the South African context to ensure that the content was clear, applicable and valid. They were willing to revise their original judgments in order to facilitate consensus (Hsu & Sandford, 2007).

1.10.2.4 Data collection

The researcher drafted a set of guidelines based on the findings of the empirical data collected in Phase 1 of the research methodology. In every round of the Delphi process, data was collected by sending a structured questionnaire to the panel of experts, who used it to assess each draft guideline statement against the set criteria. The questionnaires were sent back to the investigator once they were completed (Hsu & Sandford, 2007).

1.10.2.5 Data analysis of guidelines

The experts read each guideline and completed the rating scale in accordance with the set criteria, which included validity, reliability, flexibility, clarity and applicability. Where applicable, suggestions for re-formulation of the guidelines were provided in the space for comments at the end of each section. The researcher then completed a table reflecting the professional and academic experience of the participants. The data was analysed in an intelligible and interpretable form to make inferences from the suggestions. Unanswered questions were regarded as indicative of a lack of instruction, unclear wording, or just neutral feelings. Disagreement among experts raised concerns, and the comments were reviewed to reveal evidence of why incongruence had occurred. The content of the guidelines was adapted using the received feedback and were sent back to the participants. The process was repeated continuously until consensus was reached. It was anticipated that three rounds of the Delphi process would be sufficient to obtain consensus (Hsu & Sandford, 2007).

1.11 ORGANISATION OF THE REPORT

The thesis is organised as follows:

Chapter 1: Background to the study and problem statement.

Chapter 2: Methodology of the study.

Chapter 3: Discussion of research findings and literature control.

Chapter 4: Discussions of empirical findings of the research with reference to the Comprehensive Community and Home-Based Health Care model.

Chapter 5: Development of guidelines to promote community participation in and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province, South Africa.

Chapter 6: Review and summary of findings, description of the guidelines, limitations, implications, recommendations and conclusions.

1.12 SUMMARY

The aim of the study was to explore ways of involving the community in basic antenatal care, thereby reducing maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province and enhancing accountability of governance structures to the community. A qualitative study was undertaken in two phases in three community health centres and three hospitals in Bushbuckridge sub-District. The first phase was a qualitative study using purposive sampling to select the informants. See chapter 2 for the details. The second phase entailed the development of a set of guidelines to promote community participation and involvement in basic antenatal care with the aim of reducing maternal mortality and morbidity. The details are discussed in chapter 5.

CHAPTER 2

METHODOLOGY OF THE STUDY

2.1 INTRODUCTION

This chapter provides a description of the research methodology used for collecting empirical evidence to explore and describe perceptions, experiences and needs of stakeholders regarding basic antenatal care for the purpose of developing the guidelines to promote community participation and local accountability for antenatal care in Bushbuckridge sub-District, Mpumalanga Province, South Africa. The chapter covers the research design and methodology, including the context, study population and sampling, data collection, ethical consideration, data analysis and measures to ensure trustworthiness.

2.2 RESEARCH DESIGN AND METHOD

The study was conducted in two phases: **Phase1** consisted of the pragmatic part of the research which emphasised the exploration and description of perceptions, experiences and needs to basic antenatal care to reduce maternal mortality and morbidity in Bushbuckridge sub-District, Mpumalanga Province. **Phase 2** was the development of guidelines to promote basic antenatal care aiming at reducing maternal mortality.

2.3 PHASE 1

In Phase 1, a qualitative, exploratory, descriptive and contextual design was used to explore and describe perceptions, experiences and needs of stakeholders regarding pregnant women's access to basic antenatal care to reduce maternal mortality and morbidity in Bushbuckridge sub-District, Mpumalanga Province.

2.3.1 Qualitative design

Qualitative research design involves systematic gathering of data in the form of words on phenomena which occur in a natural setting. Qualitative research is used to explore people's experiences, insight, feelings, thoughts, behaviour and actions (McMillan & Schumacher, 2010:23). It gives a better understanding of the perspective of the phenomenon under study (Knudsen, 2012:90). In this study, the qualitative design was a fruitful way to gain a broad understanding and perspective on the perceptions, experiences and needs for basic antenatal care to reduce maternal mortality and morbidity in Bushbuckridge sub-District, Mpumalanga Province, which were explored and described. Qualitative research is about examining the qualities or characteristics of a phenomenon being investigated. It is about understanding the situation as it exists and is experienced. It provides a rich and thick description of the phenomena under study. Data is collected in the real world. It produces data that reflects how the participants feel, behave, think, act and their insight (Botma et al., 2010:182; Polit & Beck, 2012:489).

In this study, the researcher sought to explore and describe various phenomena related to promoting community participation in and local accountability for the local health system, so that pregnant women can increase access to basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province.

Qualitative research is associated with interpretive and constructivist studies which emphasises the intrinsic complexity of humans and their ability to create and shape their own experiences, and that the truth is a combination of realities (Gray, 2004:36; Polit & Beck, 2012:14). It is associated with how people construct their social reality and how they view and interpret the world they live in and their communication relationships (Daymon & Holloway, 2011:16). Both interpretive and constructive enquiry using qualitative approach were conducted to understand human lived experiences (Polit & Beck, 2012:14). Data is, therefore, collected and carefully analysed for the purpose of capturing human experiences from their natural environment which is their lived experience. The emphasis on the individual aspects of life in their totality within the context of including the dynamics that are involved, hence it occurs in the naturalistic setting (Polit & Beck, 2012:14). The aim is to understand human perceptions based on

their experiences and point of view and how they create a meaning (Williams, 2007:69; Castellan, 2010). The aim of this study was to explore and describe the perceptions, experiences and needs in promoting community participation and local accountability for pregnant women to access basic antenatal care in the area.

2.3.2 Exploratory design

Exploratory design is used to investigate phenomena where little is known about the subject or not previously studied (McMillan & Schumacher, 2010:53). It is a quest for in-depth knowledge and understanding of a selected population's perceptions, intentions and experiences. It is used to provide deeper understanding of the phenomenon under study and generate hypothetical insight (Venkatesh et al., 2013:24; Knudsen et al., 2012:90).

In this study, the perceptions, experiences and needs for basic antenatal care to reduce mortality and morbidity were explored. The exploration of perceptions, experiences and needs for basic antenatal care to reduce mortality and morbidity in Bushbuckridge sub-District, Mpumalanga Province, was central to this scientific study. These were explored until data saturation. It was important to use the design as it shed light on the diverse ways the phenomenon manifested. The purpose of using exploratory design was to gain insight and develop an initial rough understanding of the situation as there was lack of basic information about the phenomenon under study (Botma et al., 2010:50; De Vos, 2002:109).

2.3.3 Descriptive design

The descriptive method seeks to describe the phenomenon under study as it exists by identifying and obtaining information of a particular problem where data is collected in the real world, which is a naturalistic setting**.** According to Burns and Grove (2001:248), it is utilised to provide a picture of situations in the natural setting. It provides answers to questions on what the situation is or was in the past (McMillan & Schumacher, 2010:25). Descriptive qualitative studies provide a comprehensive synopsis of the phenomenon under study (Polit & Beck, 2012:505). In the study, the descriptive approach focussed on

understanding the experiences and perspectives of pregnant women, community leaders and health workers on antenatal care, from the participants' point of view.

2.3.4 Contextual design

Studies conducted in qualitative research are always contextual in nature. According to McMillan and Schumacher (2010:322) researchers are supposed to have context sensitivity as "the meaning is bound by social, political, gender-based, racial, class and technological factors". The research took place in a natural setting which is in Bushbuckridge sub-District in Mpumalanga Province. The sub-District was chosen because it is a rural area which is under resourced and has limited access to health services.

The context of the situation was taken into consideration as human behaviour and actions are influenced by the environment in which they occur (McMillan & Schumacher, 2010:322). When conducting the current study, the location, environment, circumstances and the culture of the participants were taken into consideration in order to understand their behaviour which influenced how the researcher interpreted the behaviour of the research participants. The data collected is valid to the specific context and cannot be generalised as the researcher focused on a specific phenomenon.

2.4 THE SETTING / CONTEXT

Mpumalanga Province is one of the nine provinces in South Africa. Its population has grown by 20 % from 3,365, 554 in 2001 to 4,039,939 in 2011 (Statistics South Africa, 2011). The Province has the 6th largest share of South Africa's population which has approximately 7,8 % of the national population of 5,177,0561 in 2011 (DoH, 2016:19). During the same period, it was estimated that about 88 % of the population in the Province was medically uninsured and relied on public health facilities. This placed an excessive burden on the existing Primary Health Care (PHC) facilities. The unemployed population is 1,696,448 with 1,634,353 earning less than R3,200.00 per month in 2011(DoH, 2016:24). Approximately 23 % of the households had no regular income and the poverty rate (index of 50.5 %) was higher than the national average in 2011 (DoH, 2016:25).

The Province is divided into 3 district councils namely Ehlanzeni, Gert Sibande and Nkangala districts, with 18 sub-Districts. Ehlanzeni District is sub-divided into five sub-Districts. These are Bushbuckridge, Mbombela, Nkomazi, Thabacheu and Umjindi. Bushbuckridge sub-District is situated in the north eastern part of Mpumalanga and borders on Limpopo Province and the Kruger National Park in the north. The sub-District is further sub-divided into 34 wards (DoH, 2016:23).

The study was conducted in Bushbuckridge sub-District which was chosen because it is a rural area. The area is inhabited by various ethnic groups namely Tsonga, Sothos, Zulus and Swazis with the majority speaking xiTsonga, sePulane and siSwati. According to the researcher's observations when working in the Province, there are other ethnic groups that have recently migrated to the area which include foreign nationals from countries such as Pakistan, Sudan, Zimbabwe, Mozambique and others. The foreign nationals settled in most areas of Bushbuckridge in the past few years. As a consequence, there is challenge in planning for adequate resources in the health facilities due to over utilisation of existing health services and exhaustion of healthcare resources such as treatment drugs and surgical supplies.

There are three townships in Bushbuckridge sub-District. These are Dwaarsloop, Thulamahashe and Mkhuhlu, together with rural villages. There is electricity in most areas including some of the villages but they are still experiencing a problem of lack of water or constant water supply in some areas. Most of the roads were dirt roads and where there were tarred roads, most of them had a lot of potholes at the time of the research. Based on the researcher's experience of having lived and frequently visiting the area, the transport system is poor, making it dificult to access health services especially at night.

The means of communication that is used in the area is public telephones, land lines that are in some of the family homes whilst others use mobile phones. The postal services are an additional means of communication that is commonly used. Transport is a problem and most people rely on taxis. There are bus services in some areas that are mostly erratic. The area has an estimated population of 541 248 (StatsSA, 2011) and a high unemployment rate with only 15 % of the population being employed (DoH, 2014:20).

The PHC facilities that serve the community are administered by the Mpumalanga Department of Health. There are 38 primary health care facilities, wherein four are community health centres (CHCs), two District Hospitals and one Regional Hospital that refer patients to the Provincial Hospital in Nelspruit. One of the District Hospitals is semi-private as it is a Public Private Partnership with the Department of Health and Netcare. The policies and procedures used are different from those of the public hospitals. The community is also served by five mobile clinics, which deliver PHC services at 71 mobile points.

The researcher's experience of working and providing technical support in Mpumalanga Department of Health showed that the facilities were not well equipped, understaffed and had a lack of skilled health professionals who had midwifery competencies and who could manage obstetric emergencies. Mpumalanga Province had one nurse/midwife to every 309 persons in 2011, which was the lowest nurse-population ratio in the country. The Western Cape Province compared to Mpumalanga Province had a nurse-population ratio of one is to184. This shows the shortage of staff experienced and the disparities between rural and urban areas (Public Services International, 2011:11). There is also lack of transport especially at night, with poor communication networks. During March 2015, there were ten ambulances in the Bushbuckridge area with no dedicated transport for emergency obstetrics in the sub-District (DoH, 2015).

The Annual Performance Plan (APP) 2016 - 2017 for Mpumalanga Department of Health shows that 66 % of the population lives in the rural areas and 88 % of the population in Mpumalanga are uninsured, placing an extreme burden on the Primary Health Care system as they depend on the public health system (DoH, 2016:24-25). Only 50.6 % of the population is employed. The unemployment rate in the population is 12.4 %; 4.1 % are discouraged work seekers, whilst 32.7 % are not economically active (DoH, 2016:26). The high unemployment rate translates directly to poverty which is a predictor of health outcomes. This exacerbates the burden on Primary Health Care system. Given the current status of the Province, those who are poor and lack basic resources tend get more ill and die sooner than those who are more privileged (DoH, 2016:26). They are affected

by diseases such as Tuberculosis, HIV and AIDS, Non-Communicable Diseases, high maternal and child mortality, injuries and violence (DoH, 2016:27).

The reason for selecting Bushbuckridge sub-District for this study was that the researcher originates from this area. She grew up in the area and has served the community as a Primary Health Care (PHC) service provider and working on other community projects for more than fifteen years. She speaks the local languages, and understands the cultures and values. These factors facilitated entry, acceptance and eliminated misconceptions when conducting this study. The sub-District had recorded the most maternal deaths in Ehlanzeni District (DoH, 2012:70). The intention of the study is to collect empirical evidence to develop guidelines that will be used by policy makers to improve the health and wellbeing of pregnant women by involving the community in antenatal care, thus contributing to the reduction of maternal morbidity and mortality.

2.5 POPULATION AND SAMPLING

Polit and Beck (2012:59) define population as “all the individuals or objects with common, defining characteristics”. According to McMillan and Schumacher (2010:129), population is “a group of elements or cases, whether individuals, objects, or events that conform to specific criteria and to which we intend to generalize the results of the research.” The study population was comprised of four groups of people in Bushbuckridge. The first population group was comprised of pregnant women who attend antenatal care services in the selected sites. The second group was community leaders and members of the governance structures (clinic committees) who had a responsibility for oversight of the local communities and form part of the local health system; the third population group was the midwives wherein some specialised in advanced midwifery and were responsible for Maternal and Child Health services in the community health centres and the hospitals; and fourthly a member of the District Clinical Specialist Team (DCST) who was an advanced midwife and responsible for improving Maternal and Child Health services and educating health workers on such services.

This was done to detect convergence of data and convergence of findings using different methods of collecting data among different sources. These sources are located in the

same geographical areas, but different locations of the sub-District (McMillan & Schumacher, 2010:379; Polit & Beck, 2012:585).

In qualitative research, purposive sampling is used where cases such as individuals, groups and reports, which are information-rich, are selected (McMillan & Schumacher, 2010:325). It is a technique where the researcher used her personal judgement to select people who were knowledgeable, had the greatest insight and were most informative about the subject being studied (McMillan & Schumacher, 2010:138; Polit & Beck, 2012:279). Additionally, Botma et al. (2010:201) noted that purposive sampling can be used to hand pick a population sample based on the knowledge or expertise or lived experience on the issues under study (Mcmillan & Schumacher, 2010:138; Polit & Beck, 2012:515). It could be participants who have specific experiences and characteristics (Knudsen et al., 2012:85).

The inclusion criteria were different for the different population groups as described below:

- All study population groups had to reside or work in the catchment area of the facilities that were selected, and understood and communicated using one of the local languages including English.
- Pregnant women who were the beneficiaries of antenatal care services.
- Community leaders and members of the governance structures who had a responsibility for oversight of the local communities and formed part of the local health system.
- A member of the District Clinical Specialist Team within the Province who was responsible for improving the knowledge and skills for service providers on Maternal and Child Health services in the sub-District and provided oversight to the services.

These participants were rich sources of information and have maximized, confirmed, or challenged the understanding of the perceptions, experiences and needs for basic antenatal care to promote community participation in and local accountability for the local health system to promote access to basic antenatal care by pregnant women in Bushbuckridge sub-District, Mpumalanga Province.

The approach allowed the subjects to share their rich detailed experiences, opinions, facts, points of view and perceptions of their own world in this regard which maximised and provided comprehensive data related to the subject and a greater understanding of the phenomenon (De Vos, 2002:335; Mcmillan & Schumacher, 2010:138; Polit & Beck, 2012:515).

2.6 DATA COLLECTION

Data collection is the process that was used to gather information from participants. It involved the selection of the study participants and actual data gathering (Botma et al., 2010:199) for the purpose of analysis and discovering results**.** An interview guide was used to guide the interview process to keep it focused when exploring different topics in a systematic and comprehensive way (Jamshed, 2014:87). A tape recorder was used to store data during the interviews. Recording was considered to be the most effective way of capturing data and provides the researcher with an opportunity to focus on the interview and observe the non-verbal cues than taking notes during the process (Jamshed, 2014:87).

An interview was used to collect data from participants through in-depth enquiry allowing the researcher to gain deeper insight into the phenomenon under study (Venkatesh et al., 2013:32). It can take many forms such as individual in-depth interviews, focus group discussions, observations and collection of participants' experiences in the form of documents (Knudsen, et al., 2012:86). In the current study, focus group interviews were found to be the most suitable method for collecting data with the pregnant women. The individual in-depth interviews were conducted with the community leaders and members of the governance structures, midwives and a member of the DCST.

2.6.1 Focus group discussions

Polit and Beck (2012:728) define focus group interviews as a group of individuals assembled together and are interviewed to answer questions on a particular topic. Botma et al. (2010:210) describe focus group interviews as some kind of collective activity and discussion that is carefully planned by the researcher. Similarly, McMillan and Schumacher (2010:487) define it as an interview of a selected individuals forming a small

group to assess issues of concern, a problem, a new product, an idea or a programme. It is a carefully planned interview that engages a group of about five people or more in an in-depth discussion to explore perceptions, feelings, opinions, validate conceptions and share experiences in a structured way (McMillan & Schumacher, 2010:487).

Focus group discussions provided an opportunity for the participants to share their lived experiences within the group which gets validated and stimulate memories and ideas. Their consciousness becomes raised on certain issues and they learn from each other (Tracy, 2013:167). The purpose of using focus group discussions was to obtain a large amount of rich concerted data of multiple view points in a short time using group dynamics (Botma et al., 2010:210; Polit & Beck, 2012:537-538) which helped them to express their views.

The aim of using this approach was to engage the participants in a conversation to gain in-depth understanding of the participants' perceptions, experiences, and needs of pregnant women regarding antenatal care services to gain thick and rich information about the subject. The goal was to have the participants provide trustworthy answers to the study objectives. In the study, data was collected through focus group interviews with pregnant women who were selected in the community.

The advantage of focus group interviews is that it is an efficient way of data gathering and getting many viewpoints in a short space of time. The group dynamics created a platform where participants shared their views, opinions and also took advantage of reacting to what was raised by others within the group and which stimulated a deeper expression of opinions and views. This enabled the researcher to explore and describe the perceptions, experiences and needs of pregnant women regarding access to antenatal care services.

According to Polit and Beck (2012:538), some of the disadvantages of focus group interviews are that some participants may be uncomfortable to express themselves in a group and the group dynamics may force a culture that can inhibit the participants to express themselves. However, in this study, participants were able to express themselves during the interviews without experiencing these challenges.

2.6.2 In-depth interviews

In-depth interview is one of the methods used in qualitative research to explore individual or group experiences on a specific phenomenon. It is a method used to obtain data from participants and make an effort to understand how the participants view their world and lived experiences and how they make meaning out of it to make scientific explanation (Botma et al., 2010:207; McMillan & Schumacher, 2010:355). It can be described as a conversation with purpose where an interview or topic guide is used to probe and cover selected topics but not using standard questions (McMillan & Schumacher, 2010:487; Polit & Beck, 2012:537). It allowed the participants to use their own voices when sharing their stories (Knudsen et al., 2012:5)

Open-ended questions are used to gain understanding of how individuals make meaning, explain and make sense of the world they live in (McMillan & Schumacher, 2010:355). It allowed exploring the experiences of individuals and the groups which revealed, to the researcher, the understanding and perspectives of the participants from how they view their world based on the phenomenon under study (Botma et al. 2010:207). It allowed the participants to share their experiences and express them in their own words (Venkatesh et al., 2013:5).

Semi-structured interviews allow participants to give open-ended responses (McMillan & Schumacher, 2010:355). The researcher engaged the individuals and the group of individuals into a purposefully directed conversation which sought information they were knowledgeable about. It provided guidance on which questions to be explored in a more comprehensive and systematic manner (Jamshed, 2014:87). The role of the interviewer was to encourage the participants to express themselves by narrating their stories about the topic under discussion, in their own words (Polit & Beck, 2012:537).

The aim was to get a clear, detailed picture and understanding of the perceptions of local community leaders, members of governance structures and that of health workers on community participation, accountability of local governance structures and the role of local community leaders for supporting antenatal care services. This enabled the researcher to explore and describe these factors for supporting antenatal care services in detail.

2.6.3 Gaining trust

It was easy for the researcher to gain, maintain high level of trust and be credible with the participants because she spoke the participants' language and shared their culture, values and local customs. She used a dress code that was similar and acceptable to the participants. She was cautious not to take sides, should controversial issues emerge or support any sub group of the culture. In order to promote trust and mutual understanding, a moderator was appointed from the local area with the same cultural background. She spoke all the local languages and had a local cultural understanding and dressed according to the local expectations. This is in line with Tracy (2013:172), who finds it necessary to recruit moderators from the same cultural group as the focus group as they already understand the local culture and dynamics.

2.6.4 The interview process

The approach that was used was similar for both the focus group interviews and the semi-structured in-depth interviews. The researcher welcomed the participants with a warm smile and greeted them. This was aimed at building an interpersonal relationship and mutual trust. The interviews commenced by introductions and stating the aim of the study, the purpose of the interview and sharing the role of the interview in research (Botma et al., 2010:212). The researcher informed the participants about the estimated interview time, confidentiality of the information and indicated that participation was voluntary and that they were free to withdraw from the study at any time if they wanted to. It was also explained that notes would be taken during the session and the conversation would be audio recorded to ensure that all information shared was captured. Services for debriefing or referral for counselling were made available should the need arise. Then the participants were issued with the voluntary consent forms to sign (Botma et al., 2010:207).

In the first facility, the interview venue was an enclosed room at the local clinic which was spacious, well ventilated and conducive for the audio recorder. However, this varied from facility to facility as some of them had limited space where each time the participants were moved from one room to the next, depending on the availability of space. With the individual in-depth interviews, the venues varied from conducive to non-conducive

environment as some of the interviews were held in the homes of the participants. Some of the interviews were held in the streets, under trees to give the family their privacy while the one held with the DCST was conducted in an open space outside the office building due to lack of office space.

On the first day of conducting field work, the time taken whilst engaging participants in focus group discussions for data collection ranged between an hour and an hour and a half. The time improved as days went by and the researcher got acquainted to the process where the interviews took about an hour each. This was done to avoid long waiting times by adhering to the schedule times for other participants who were waiting to be interviewed and to avoid stress as the process was exhausting.

2.6.5 Emotional involvement with participants

To ensure that the data collected remained meaningful and trustworthy, the researcher always guarded against being emotionally involved with participants during the interviews as this could compromise the data collected.

She was always aware that she is bringing her social and professional identity with a unique background including some set of values which could affect the research process if not guard against (Polit & Beck,2012:589)

2.6.6 Reflexivity

As the researcher was part of data collection process she continuously had self-awareness and introspection by isolating her fears, preferences, biases and speculative preferences throughout the data collection process and noted them in a journal to ensure that her behaviour did not affect the data collected and interpretation (Polit & Beck, 2012:585). The researcher's self-awareness and identity is important and respect for the participants and other stakeholders should be maintained (Tracy, 2013:233). In this study, the researcher was aware of her identity, maintained her behaviour and carried an attitude that continuously respected the participants and the research approaches used.

2.6.7 Use of tape recorder

Polit and Beck (2012:535) strongly recommend the use of a tape recorder as a way of storing data in qualitative interviews as notes tend to be incomplete and may be biased because of the interviewer's personal views. Recording is considered to be the most effective way of capturing data as it provides the researcher with an opportunity to focus on the interview and observe the non-verbal cues than taking notes during the process (Jamshed, 2014:87). This is also to ensure that the data collected is the actual verbatim responses of the participants.

According to Botma et al. (2010:214), recording qualitative data during an interview allows the interviewer to concentrate on the interview. The researcher was granted permission by the participants to use the tape recorder during the interviews. Additionally, the researcher had included the use of a tape recorder for data collection in her doctoral degree proposal which was submitted to the Ethics Committee of the University of Pretoria for ethical evaluation, and which was approved in 2013 (Annexure B). Further to that, permission was requested from the Departmental Research Committee of the Department of Health in Mpumalanga Province to conduct the study and permission was granted (Annexure C).

2.6.8 The use of the interview guide

An interview guide was used to guide the interview. Interview guides are used to keep interviews focused when exploring different topics in a systematic and comprehensive way (Jamshed, 2014:87). The main question was "What factors can promote community participation and local accountability for basic antenatal care and what barriers exist that hamper access to and uptake of basic antenatal care services (health services for pregnant women) in Bushbuckridge, Mpumalanga Province?"

The questions posed were limited to only two to three broad questions per target population group. The questions that were asked moved from general to specific and were asked in such a way as to elicit in-depth information using probes. This was done to ensure that the responses provided rich, detailed description of information about the

phenomenon under study; exploring ways to involve the community in basic antenatal care to reduce maternal mortality and morbidity in the selected area.

As the researcher was well acquainted with the interview guide, she was able to concentrate and pay attention to what the participants were saying and ensured (monitored) that all the questions that were in the guide were covered. The questions asked were well worded and were posed in a logical manner. Sensitive areas were taken into consideration when asking questions. The participants were encouraged to talk freely about all the topics that were discussed and were also encouraged to tell stories in their own words, making illustrations and explanations as they wished. The interviews were intense, involving and took a substantial amount of time (Botma et al., 2010:209; Polit & Beck, 2012:543).

2.6.9 Focus group interview process

The interviews were audio-recorded with the aid of a tape recorder. Focus group interviews were conducted with pregnant women by using a semi-structured interview guide. The participants of both groups had homogeneous characteristics because the women were pregnant and had a potential to be affected by maternal deaths. To be able to tackle the determined issues in a focused and sequenced manner, a guide was developed to ensure that all the specific information required for the study was discussed. Participants were encouraged to think deeply about the issues discussed and were free to question and cross-examine the issues raised by each other in order to reach common outcomes.

It is recommended that the size of the focus group be within the range of 3 to 12 participants (Tracy, 2013:167). The size of the focus group discussions ranged between 6 and 7 participants as complex issues were tackled**.** The researcher, who is skilled in conducting interviews and group dynamics, facilitated the focus group discussions. The role of the facilitator was to direct the discussions, write field notes and keep the discussions flowing. A well trained moderator was also available to assist the facilitator and was responsible for recording the conversation, observing the body language of the participants and noting nuances that the facilitator may not have been aware of. She also handled destructions, and acted as a back up to the tape-recorded conversation. She

was also responsible for preparing the venue and soft drinks that were offered. She was recommended to the researcher by some researchers who used her services in the past from the Health Systems Development Unit, a research site for the University of the Witwatersrand in Bushbuckridge, as a skilled moderator who was young and unemployed.

Two broad questions were asked for the pregnant women's focus group discussions which were: *What are the factors that influence the access of pregnant women to antenatal care services (personal, family, financial, physical, psychological etc.)? What are the barriers, perceptions, experiences and your needs regarding accessing antenatal care and involving the* community in the promotion of antenatal care? Participants were asked to respond in the language that they were comfortable with. They responded in Tsonga, Sotho, Swazi and Zulu. However, some participants also used English mixing it with the local languages which was later translated by the researcher into English during transcription.

The focus group interviews continued until the point where there was no new important information emerging, which meant that saturation was reached, after having had five focus group interviews with pregnant women in all the selected sites (McMillan & Schumacher, 2010:347). Saturation refers to getting to a point where there is no new significant data that is emerging from the group (Venkatesh, 2013:89).

Additional to the focus group interviews, a supplementary technique of in-depth individual interviews was used to increase the validity and credibility to the study as what is crucial is the richness of the data but not the amount of the data collected.

2.6.10 In-depth individuel interviews process

The focus group interviews were preceded by face-to-face, in-depth interviews that were held with the following participants in each selected site. In each community health centre: one community leader responsible for the local area; two members of governance structures in which the community health centre is located; health workers: one midwife per community health centre, an advanced midwife per district hospital; and one member

of the District Clinical Specialist Teams (DCSTs) who was an advanced midwife in the District.

The questions asked were first reviewed with experts in the field, for the appropriateness and applicability before they were used (Botma et al., 2010:207). The themes that were covered were perceptions, experiences, needs, reasons for not attending antenatal care and functionality of the governance structures.

An interview schedule which had limited questions for each group was used to guide the interview. The nature in which the questions were asked started from general to specific and probing was used to bring out the desired rich and detailed information (Botma et al., 2010:209).

Each interview was started by asking a well-planned and broad single open-ended question. For health workers and community leaders the question was: *What are your perceptions, perceived barriers and contributory factors regarding involvement of the community* to promote pregnant women to attend antenatal care services? *For the governance structures, the following two broad questions were asked: What are your perceptions, perceived barriers and contributory factors regarding community involvement* to promote pregnant women to attend antenatal care? and *How do you view your roles, responsibilities and accountability as required by the National Health Act with regard to your involvement in health?*

2.7 DATA ANALYSIS

According to Morse and Field (1995) (in Polit & Beck, 2012:557), data analysis is a "process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence". Data analysis is a dynamic and interactive process of critically examining the collected data. The transcribed data and field notes were understood, interpreted and synthesized to create meaning (McMillan & Schumacher, 2010:367; Polit & Beck, 2012:557). The objective of this process was to organise data into themes, categories and subcategories and develop a structure that would explain the meaning of the data (Polit & Beck, 2012:556; Woods, 2011). The

qualitative research data analysis started during data collection and continued simultaneously. Data analysis was conducted using the three steps of qualitative data management and organization as outlined in Polit and Beck (2012:557-560); which are transcribing qualitative data, developing category scheme and coding. All processes and procedures followed during data analysis were clearly documented for the purpose of evaluating the credibility of the findings (Woods, 2011).

2.7.1 Transcribing qualitative data

During transcription, the recorded tape was replayed for note taking and transcription to ensure accuracy and reliable data analysis. To facilitate data analysis, the researcher transcribed the recorded data from audiotapes and the field notes into verbatim data. Since the participants and the participants were using different local languages and the researcher was collecting data herself, she took the responsibility of transcribing the interviews herself. This was translated from the different local languages into English. At the beginning of transcription of recorded data into verbatim mode, the researcher conducted quality control of the translated verbatim data by subjecting it to her peers for verifying the correctness of the translation from the local languages used by participants to English. The verification was deemed accurate. The researcher demonstrated her commitment to transparency, which is one of the attributes of a quality minded outlook that researchers should be committed to (Polit & Beck, 2012:596).

During the process of transcription, the researcher indicated who was speaking in the written text by using the symbol “P” for participants and also indicated which participant was speaking by using “P1” for participant one and “P2” for second participant and so on (Polit & Beck, 2012:557). The overlaps in speaking turns, the time elapsed between utterances, non-linguistic utterances were noted down thus, taking them into consideration and reflecting them on the transcripts. To enhance validity, confidence, quality and accuracy, the researcher listened several times to ensure that what was said, together with the non-verbal cues, was captured correctly and accurately (Polit & Beck, 2012:557).

2.7.2 Developing category schemes

When the process of transcription was complete, the researcher read and re-read the data, examined it to gain understanding and identified concepts and clusters of concepts that were emerging. These were classified and a directory was developed. The data was classified in smaller manageable units that were easy to retrieve and review as the process unfolded. The identified concepts and clusters of concepts are descriptive phrases of the needs, perceptions and experiences of the participants and the participants informing the development of conceptual categories (Polit & Beck, 2012:558). The clustering of concepts translated into developing themes, categories and sub-categories that were derived from the data, producing four data sets from pregnant women, men, community leaders, governance structures and midwives.

2.7.3 Coding qualitative data

When the category scheme was developed, the researcher read the entire data more than five times in order to comprehend the meaning of the different aspects of the data. To ensure the highest possible coding consistency across the interviews, the researcher coded the entire data sets (Polit & Beck, 2012:559). The transcript was sent to an experienced co-coder who had performed co-coding for other qualitative researchers from the University of Pretoria in the past. She independently analysed the data and co-coded the entire data sets and came up with her own themes, categories and sub-categories. A meeting was held between the researcher and the co-coder to compare, discuss and make adjustments to all the four sets of coded data.

2.8 TRUSTWORTHINESS OF THE STUDY

Trustworthiness is the degree of confidence that researchers have in their data which is assessed by using the criteria of credibility, transferability, dependability, confirmability and authenticity (in Botma et al., 2010:230; Polit & Beck, 2012:745). To ensure trustworthiness in this qualitative study, criteria was used. It is an alternative framework for validity and reliability in qualitative research and parallels the positivists' criteria of internal validity which are reliability, objectivity and external validity (Sikolia, Biros, Marlys & Weiser, 2013:2-3). The integrity of the findings was evaluated using the epistemological

standards, strategies and criteria. Below is the description of the strategies and the activities conducted for the study to ensure trustworthiness (Sikolia et al., 2013:2-3).

2.8.1 Credibility

Credibility refers to striving to establishing confidence in the truth of the data and the findings for the participants and the context to increase believability by taking steps to demonstrate credibility (Polit & Beck, 2012:584-587). To increase the credibility of the findings, the following criteria were used: prolonged engagement, reflexibility, member checking, triangulation, researcher credibility, peer examination, authority of the researcher (Sikolia et al., 2013:2). It meant that the findings expressed the reality and the truth of the data and was believable (Tracy, 2013:235; 248).

- **Prolonged engagement**

The researcher allocated sufficient time for data collection to allow prolonged engagement with participants in their natural setting in order to enable them to provide specific details, basic facts and understanding of why and how certain things happen so as to provide a broader picture of the phenomena under study. The researcher started engaging with the participants telephonically four months in advance. It was done to request their involvement in the study before the actual study commenced. The phone calls were to gain access, identify the participants, make appoints and confirm them which contributed in setting up the interviews. An additional three months were spent on data collection and transcribing the interviews from the recorded verbatim form to transcribed data. Many hours were spent each day interrogating data during data analysis generating themes, categories and sub-categories thus providing comprehensive and luminous recording of information.

- **Reflexivity**

Reflexivity is a process where a researcher consciously performs a self-examination and analysis of personal values and biases that can affect data collection and interpretation and note it in a personal journal or memo. To enhance the quality of the study and achieve credibility, the informants were allowed to speak for themselves on the tape recorder to

ensure accurate capturing of their responses to ensure neutrality, objectivity and always being detached and free from bias (McMillan & Schumacher, 2010:333; Polit & Beck, 2012:179). As the researcher was part of data collected, she continuously had self-awareness and introspection by isolating her fears, preferences, biases and speculative preferences throughout the process and noted them in the journal to ensure that her behaviour did not affect the data collected and interpretation. This was done to guard against personal bias and enhance the quality of the study (Polit & Beck, 2012:179) and achieve the study's credibility.

- **Member checking**

During data collection, the researcher was constantly checking with participants on the correctness of the findings. The transcribed and translated verbatim responses were verified with some of the participants to confirm the content of the data collected, the context and the correctness of the data (Loh, 2013:6).

- **Triangulation of data, method and space**

To establish truthfulness of the study, data triangulation was done by collecting data using site and person triangulation. The same data was collected from multiple sites to test for cross-site consistency. Data was collected through conducting nine focus group discussions and through individual in-depth interviews conducted with eight community leaders, members of governance structures and nine midwives who were located in three geographical areas that are the same in context (Noble & Smith, 2015).

- **Researcher credibility**

The researcher personally collected the data, transcribed it from verbatim form into a transcript and created the analytic process (Botma et al., 2010:232).

- **Peer examination**

After the researcher had transcribed and translated the interviews verbatim from local languages used to English, the data was subjected to colleagues or peers to verify the meaning of translated data. This was done to check the accuracy of the findings for the

purpose of credibility, to establish confidence in the truth of the data and the findings for the participants and the context to increase believability.

- **Authority of a researcher**

The researcher has a Master's degree in Public Health and had conducted qualitative research in the past, thus she was experienced in research. She also attended workshops on methodology in 2012/13 organised by the University of Pretoria. Support was also given to the researcher by her supervisors during supervision.

2.8.2 Transferability

This refers to the extent to which the findings can be applied in other settings or groups of participants. If the particular case is studied, it can provide a contextualized understanding of human experience (Polit & Beck, 2012:524; Sikolia et al., 2013:3). It is evaluating the extent to which the research findings may have the same meaning to others who are in a similar situation. It is to unearth out how the findings can be extrapolated to other settings (Polit & Beck, 2012:585). To increase the credibility of the findings, the criteria used were sampling and thick description.

- **Sampling**

A purposive sampling was used to select participants who were knowledgeable, most informative and had the greatest possible insight into the phenomenon. This was to gain rich and comprehensive data related to the subject (McMillan & Schumacher, 2010:489; Polit & Beck, 2012:517).

- **Thick description**

The researcher provided a dense description of the data to enable the consumers to evaluate the applicability of the data to other contexts. Multiple sources were used to collect data using different methods of data collection. The researcher provided a dense description of the data to enable the consumers to evaluate the applicability of the data to other contexts (Sikolia et al., 2013:4).

2.8.3 Dependability

It refers to the reliability of the data over time and different conditions (Polit & Beck, 2012:585). This is to check if the findings would be consistent if the enquiry was replicated with the same participants in a similar context (Sikolia et al., 2013:3). The criteria used were audit trail, member checking, peer evaluation, code-recode and triangulation.

- **Audit trail**

An audit trail is a systematic collection of materials and documents used in qualitative studies to draw conclusions about the trustworthiness of the study by an independent auditor (Botma et al., 2010:234; Polit & Beck, 2012:591, 720). The sources of data were identified and the steps followed were traced. There was a dense thick description of the methodology used. In the current study, the recorded data and field notes were transcribed into verbatim data. The identified and emerged clusters of concepts were classified and translated into developing themes, categories and sub-categories summerised in table 3.4, page 71 The process produced data sets from pregnant women, community leaders and governance structures and midwives.

The researcher collected raw data using individual in-depth interviews and focus group discussions from the participants. Data was analysed and quotes were used. Verbatim data was transcribed from local languages into English. Data analysis was done using code-recode and conclusions were drawn.

- **Member checking**

The researcher was doing member checking throughout the interviews by repeating the participants' words and or paraphrasing what was said where necessary to ensure that it was captured correctly and the meaning or interpretation was not lost. This was done by asking the participants if the interpretation was a true reflection of their viewpoint.

- **Peer evaluation**

Peer evaluation was done to assess the consistency and accuracy of the information that was obtained from the study by a colleague. There was some consensus and consistency on the findings of the researcher and that of the peers. The process assisted with corroboration of data and interpretation (Loh, 2013:6; Polit & Beck, 2012:175; 334).

- **Code-recode**

Discussions were held with a co-coder who independently analysed data and coded it into themes, categories and sub-categories. This was followed by discussions with the researcher who jointly agreed on the themes, categories and sub-categories that were used.

- **Triangulation (data, person, method and space)**

To establish truthfulness of the study, data triangulation was done by collecting data using space and person triangulation. The same data was collected from multiple sites to test for cross-site consistency. Person triangulation was used to validate data through multiple perspectives on the phenomenon under study by using focus group discussions (FGDs) and face-to-face in-depth interviews. Data was collected through conducting nine focus group discussions and through individual in-depth interviews conducted with eight community leaders and members of governance structures and nine midwives who are located in three geographical areas that are the same in context (Noble & Smith, 2015:2). The researcher worked as a health care service provider in the area for more than 15 years.

2.8.4 Confirmability

It refers to the extent to which the data collected was objective and represented what the participants had provided; and if the findings reflected the participants' voices and the context in which the enquiry occurred (Polit & Beck, 2012:585; Sikolia et al., 2013:3). This was to check if the findings were free from bias and were a product of the informants and the context of where the enquiry was made. To enhance credibility, an audit trail, triangulation and reflexivity were used as criteria. They are briefly discussed below.

- **Audit trail**

The researcher used focus group interviews and individual in-depth interviews, using an interview guide to ensure that the same data was collected. A tape recorder was used during interviews and was transcribed to verbatim data. From the transcribed data, there emerged clusters of concepts which were classified and translated into themes,

categories and sub-categories producing three data sets. All the recorded data and the documents with the themes, categories and subcategories were kept safe as a means of verification for audit trail purposes, should the need arise. Participants' quotes were also used. Raw data was used for analysis and conclusions were formulated.

- **Triangulation**

Triangulation is cross validating qualitative data by collecting it from multiple sources using different strategies and different time periods (McMillan & Schumacher, 2010:491; Noble & Smith, 2015:2). In the study, different methods were used to collect data and different data sources were used to generate data. Data was collected through conducting focus group discussions with pregnant women and through individual in-depth interviews conducted with community leaders and members of governance structures and midwives. The participants were located in three geographical areas of the sub-district which were similar in context (Noble & Smith, 2015:2).

- **Reflexivity**

Reflexivity is a process where a researcher consciously performs a self-examination and analysis of personal values and biases that can affect data collection and interpretation and note it in a personal journal or memo. The informants were allowed to speak for themselves whilst recording them to ensure accurate capturing of their responses. This was done to ensure neutrality, objectivity and always detaching the researcher and being free from bias (McMillan & Schumacher, 2010:333). As the researcher is part of the data that was collected, she had self-awareness and continuously did an introspection to ensure that her behaviour did not affect the data she was collecting and interpretation by isolating from the process her fears, preferences, biases and speculative preferences. The researcher noted these in her journal. This was done to enhance the quality of the study (Polit & Beck, 2012:179-180) and achieve its credibility.

2.8.5 Authenticity

Authenticity refers to the degree to which the researcher has given a reasonable, honest and accurate description of the realities of participants' lived experiences which can be understood by the readers (Polit & Beck, 2012: 585). The report conveyed the needs,

perceptions and experiences of participants regarding pregnant women's access to antenatal care services and the perceptions on the role and accountability of the governance structures for antenatal care, which reflect what was said by the participants.

2.9 PHASE 2

In phase 2 of the study, the guidelines named **"Development of guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal care in the Mpumalanga Province, South Africa"** were developed. The process and methodology used to develop the guidelines was briefly described. The guiding attributes used to appraise the developed guidelines were explained. More details are described in chapter 5, page 286.

2.10 THE PROCESS OF GUIDELINE DEVELOPMENT

According to the WHO, guidelines refer to any document that contains recommendations on health interventions which could be public health, clinical or policy and who should use them (WHO, 2010:4; 2012:1). Guidelines assist health care practitioners and patients to make decisions from a foundation of improving health care (Woolf, Schunemann, Eccles, Grimshow & Shekelle, 2012). They are tools designed to improve the quality of health care and when used effectively, they can improve health outcomes (DoH 2014:16). They are systematically developed and are applicable to prevention, diagnostic procedures, treatment or follow-up of policies. Guidelines are propositions which assist healthcare practitioners in making decisions on the appropriate care which is needed in a specified clinical setting (Fevers et al., 2010: e342). In the current study, the guidelines could be used as a framework to assist the formal and non-formal health care providers to engage on health education and health promotion activities in the community and homes which could result in improving the antenatal care uptake by pregnant women if implemented. They have a potential to inform the development of the various educational information, education and communication materials for promoting antenatal attendance among pregnant women.

The objective of phase 2 was to develop a set of guidelines to be used in Primary Health Care facilities for promoting basic antenatal care attendance in the local communities

through community involvement and participation, with the aim of reducing maternal mortality and morbidity. The guidelines could be used by nurses in collaboration with the clinic committees in Primary Health Care facilities to promote basic antenatal care attendance in the local communities.

The empirical research results from phase 1 of the study were integrated with the Comprehensive Community and Home-based Health Care (CCHBC) model to inform the process of developing the guidelines. This was done by merging the 11 themes with the empirical research results in phase 1 and integrating the components and core elements of CCHBHC model. The process resulted in a modified conceptual framework of the CCHBHC model which is described in detail in section 5.2, page 235. The modified CCHBHC model guided the development of the guidelines described in detail in section 5.6, page 257. Table 4.1 in page 227 shows the formulated preliminary guidelines and figure 5.1 in page shows the modified CCHBC model.

The aim, scope and the process of developing the guidelines was described (see details in chapter 5). The preliminary guidelines were further developed and refined through the process of Delphi technique using a panel of experts. The methodology for developing the guidelines using the Delphi technique was described and presented in section 5.5 of chapter 5 and the guidelines were described and presented in section 5.6 in page 257.

2.11 GUIDING ATTRIBUTES USED TO APPRAISE THE GUIDELINES

When developing guidelines, there are many attributes that could be used as criteria to evaluate the quality of the guidelines. The attributes are validity, reliability, clarity, applicability, completeness or comprehensiveness, effectiveness, flexibility, relevance, acceptability, rigor and editorial independence (Scottish Intercollegiate Guideline Network SIGN, 2011:28). In this study, validity, reliability, applicability, flexibility and clarity (SIGN, 2011:27) were used as criteria to evaluate the developed guidelines to ensure that they are of good quality. See table 2.1.

Table 2.1: Attributes used to appraise the developed guidelines.

ATTRIBUTES	EXPLANATION
1. Validity	The strength in the development of the guidelines is that they are evidence based because they are informed by the empirical research results of the current study and the application of the CCHBHC model. Helps to assess where the guidelines improve health outcomes (NHMRC,1999:14,21,24,45).
2. Reliability	The preliminary guidelines are evidence based as the integrity of the current findings was evaluated using the epistemological standards, strategies and criteria. According to SIGN (2011:2), when applied in similar circumstances, the guidelines should yield similar results (SIGN, 2011:2). The current preliminary guidelines emerged from a process where the 11 identified themes were integrated with the components and core elements of Comprehensive Community and Home-based Health Care (CCHBHC) model in the context of the relevant literature which served as the basis and provided guidance towards formulation and development of the guidelines. Additionally, the preliminary guidelines were appraised by a panel of experts using reliability as one of the criterion for evaluating the guidelines. If the same process is followed in similar circumstances, the results should be the same.
3. Clarity of the presentation	Clarity of the presentation: The guidelines are clear, written in simple language, understandable, without ambiguity and are specific. All the terms are clearly defined and the intention of the guidelines is stated. The process that was followed when developing the guidelines should be clearly stated including how the results of the empirical study were integrated with the Comprehensive Community and Home-based Health Care model. The panel of experts also affirmed the clarity on

	the presentations of the guidelines during iterations (NHMRC,1999:25; SIGN, 2011:31-32).
4. Applicability	The guidelines should clearly indicate who the target audience is and be easy to apply. The target audience for the guidelines in the current study is pregnant women and they could be used by nurses in collaboration with the clinic committees. The end users of the guidelines are clearly defined. They were developed for poor resource setting which is Bushbuckridge sub-district hence the possible cost implications could be minimal should there be any. Possible barriers for implementing the guidelines also need to be identified and discussed. To set a criterion for reviewing the guidelines, and monitoring and evaluation (SIGN, 2011:36-39). When the guidelines are implemented, the impact should be measurable. They were exposed to the panel of experts for review and to assess if they are applicable as applicability was one of the criterion to assess the guideline statements during the Delphi rounds.
5. Flexibility	The guidelines should be flexible and adaptable to suit diverse local settings or contexts which could be geographical or cultural based. To take into consideration the benefits of resources, costs and constraints (NHMRC,1999:2,13,19).

Sources: NHMRC,1999:2, 12-14, 21, 24-26; SIGN, 2011:2, 31-32, 36-39

2.12 RESEARCH DESIGN AND METHOD FOR GUIDELINE DEVELOPMENT

The research design, the population, sampling, data collection and data analysis is briefly described. The details of the research design are described in detail in chapter 5, section 5.5.1 and 5.5.2 in pages 247-248.

2.12.1 Research design : The Delphi technique

In this study, the Delphi technique was followed when developing the guidelines. The Delphi technique is a method used to gather opinions of a particular phenomenon from a group of experts within their area of expertise without meeting with them physically. The technique was successfully used to gather data and seek consensus from a panel of experts (Keeney, Hasson & McKenna, 2006:205**;** Hsu & Sandford, 2007).

In this study, the technique was used to gather data from a panel of experts and seek consensus on their opinions about Primary Health Care reengineering and Maternal and Child Health issues in a series of three rounds. Data collection instruments were used to collect data from the panel of by sending them to the panel of experts by email in a series of three rounds (Hsu & Sandford, 2007). The process facilitated convergence of the expert opinions and pooled their intelligence from the responses received to further develop the preliminary guidelines into final implementation guidelines. The use of emails facilitated confidentiality and involvement of many participants located in different areas at the same time, with minimal resources. A detailed description is provided in chapter 5, 5.5.1 in page 248.

2.12.2 Population and sampling

To enhance credibility, the population was selected using purposive sampling (Polit & Beck, 2012:515; Warner, 2014). The criteria for selection of the participants who formed a panel of experts was based on the experts' potential to make legitimate contributions into the study. The requirement was for them to have up to date knowledge, extensive experience and be within their clinical field (Hsu & Sandford,2007; Powell, 2003:379). They were willing to revise their original judgments in order to facilitate consensus (Hsu & Sandford, 2007).

The participants were formally invited with a letter requesting them to participate in the development of the guidelines (see Annexure E). The descriptive information of the participants' positions, professional qualifications, current employer, professional experience and their involvement in Maternal and Child Health and PHC reengineering is reflected in table 5.2 in chapter 5, page 249.

2.12.3 Data collection tools

A data collection instrument was developed in which a Likert scale was employed (see table 2.2 in page 63). This was to enable the experts to evaluate the formulated guideline statements against the set criteria based on its clarity, validity, reliability, applicability and flexibility (Warner, 2014). Space was provided at the end of each guideline statement for the panel of experts to comment and or rephrase the guideline and the action statements, should there be a need. The instrument was pilot tested among three experts in Maternal and Child Health and or Primary Health Care reengineering who were excluded in the formulation of the actual guidelines.

Table 2.2: Data collection instrument, criteria and rating scale for evaluating guidelines.

DELPHI ROUND																				
NOTES: You are requested to read the guideline and complete the rating scale using the described criteria by using an '**X**' in the columns provided. Space is provided at the bottom of the table for comments and or suggestions to improve the statement you disagree with.																				
RATING SCALE	**CRITERIA**																			
1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	**Clarity:** The guideline is clear, simple and unambiguous				**Validity:** Will assist the community to promote antenatal care utilization amongst pregnant women				**Reliability:** When applied in similar circumstances, the guideline will yield similar results				**Applicability:** The target population of the guideline is clearly stated				**Flexibility:** The guideline may be adapted to suit diverse contexts, e.g. geographical, or cultural			
GUIDELINE	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
COMMENTS																				

Sources: AGREE, 2009:11; NHMRC,1999:2, 12-14,21,24-26; SIGN, 2011:2,31-32, 36-39; Warner, 2014

2.12.4 Data collection and data analysis

In the second phase of the study, data was collected through a series of three rounds where data was analysed for each round. The process of data collection and data analysis is described in detail in section 5.5.2.3, page 253.

- **Data Collection**

The first round of the Delphi technique was a generative round. Data collection instruments with guideline statements were sent by email to the expert participants. They used the set criteria to evaluate each guideline statement based on its clarity, validity, reliability, applicability and flexibility. They indicated their level of agreement for each guideline statement which ranged from strongly disagree to strongly agree (AGREE, 2009:11). Space was provided at the end of each guideline statement where they made a qualitative input or comment as needed, where applicable, provided suggestions to re-formulate them (Warner, 2014).

In the second round, the revised guidelines which were informed by the feedback from the first round and revised, were sent to the participants for the second round of review for further refinement using the same process as in the first round. Space was provided below each guideline statement where the rationale for the choice of the rating, improved guideline statements and or comments were provided. The revised guidelines were sent out again for the last time following the same process. The third round of the Delphi process was the last iteration because more than a third of the participants were already agreeing with the guideline statements at the end of the second round. This showed that sufficient evidence of consensus among the participants was building up.

- **Data analysis**

The data was analysed in an intelligible and interpretable form to make conclusions from the suggestions. Data received was consolidated, categorised and compared. The guideline statements were revised accordingly, based on the comments received. In the first round, there were no disagreements among the experts but there were comments and suggestions which were incorporated into the guidelines before the second round of the Delphi process. The findings were quantified according to the set criteria and

summarised in the initial summary sheet. In the second round, the feedback received from participants was used to further refine the preliminary guidelines. More than a third of the experts agreed on the guideline statements, showing that consensus was emerging.

The third round was the final iteration. The results were summarised in a final summary sheet (see Annexure J). The results of the third round showed that more than 90 % of the participants were in agreement with the guideline statements showing consensus amongst them. The analysis of the third round concluded the section on data collection and data analysis using the Delphi process.

2.12.5 Trustworthiness

The process of preliminary guideline development was informed by the empirical research results from phase 1 which were integrated with the CCHBHC model and discussed in the context of the relevant literature to enhance validity. To enhance credibility, purposive sampling was used to select the panel of experts as participants in the Delphi process to refine the preliminary guidelines. The selection of participants was based on their knowledge and experience on Maternal and Child Health and/ or Primary Health Care reengineering. The participants' descriptive information was outlined in table 5.2 in page 252.

The qualifications and experience could be verified for audit purposes should a need arise, as the source documents and the participants' contact details could be available on request. The process followed when formulating the guidelines using the Delphi process was valid and reliable. Empirical evidence on the methodology employed on the development of the presented guidelines on population sampling, data collection and data synthesis exist. A detailed discussion was provided in section 5.5.2.1 to 5.5.2.3 in page 248-253.

2.12.6 Review of guidelines

It is a requirement that after developing guidelines, the dates and the strategy for review should be stated as they are subject to change (SIGN 2011:16:). The intention of the

researcher is to update the guidelines after three to five years following adoption and implementation. The pace in which the research topic could have changed will also determine the need for review which is in accordance with the WHO Handbook (2012:52).

2.13 SUMMARY

In this chapter, the research context, research design, population and sampling, data collection, data analysis and trustworthiness of the study were dealt with in Phase 1 of the study. In phase 2, the process of guideline development using the Delphi technique was discussed. The reasons for developing guidelines and the guiding attributes for appraising guidelines were explained. Further to that was the explanation of the Delphi process which is the methodology used in this second phase of the study. The research design, population and sampling, development of the data collection tools, pilot testing, the process of data collection and data analysis, trustworthiness and review of the guidelines were described.

CHAPTER 3

DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

The previous chapter dealt with the research context, research design, population and sampling, data collection, data analysis and trustworthiness of the study. This chapter discusses the findings from the first phase of the study and serves as a platform on which phase 2 of the research is based, as described in chapter 4.

The chapter provides the analysis of the participants' interview transcripts as well as the recorded observational and personal notes which are the researcher's experiences and reflections from the data collection period.

The aim of the empirical phase was to explore and describe the various factors to promote community participation and local accountability for the health system so that pregnant women can access basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province. The empirical phase of the research elucidates the needs, perceptions and experiences of pregnant women, healthcare providers and community leaders regarding antenatal care services and the role, functionality and accountability of governance structures for support of basic antenatal care by the participants in the selected area.

3.2 DATA COLLECTION AND ANALYSIS

In this section, the methods for data collection and how data was analysed will be described.

3.2.1 Data collection

To generate the data, the researcher personally conducted focus group and face-to-face in-depth individual interviews with pregnant women, community leaders, midwives and members of the governance structures. Interviews were conducted until saturation was

reached. The participants were selected purposively due to their involvement in antenatal care, as described in Chapter 2.

In phase 1 of the study, five focus group interviews were conducted with pregnant women, forming thirty-four participants. Eighteen face-to-face in-depth individual interviews were conducted wherein seven were held with community leaders, four face-to-face in-depth individual interviews with members of local governance structures and eight face-to-face in-depth individual interviews with midwives. The focus group discussions and the in-depth interviews were based on the following research questions: What factors can promote community participation and local accountability for basic antenatal care and what barriers exist that might hamper access to and uptake of basic antenatal care services in Bushbuckridge sub-District, Mpumalanga Province*?*

Participants were asked to respond in the language that they were most comfortable with. They responded in Tsonga, Sotho, Swazi and Zulu. However, some participants also used English mixed with the local languages, which was later translated into English during transcription. Quality control of the translated verbatim responses was done to verify correctness of the translation from the local languages to English.

3.2.2 Data analysis

Data analysis was conducted using the three steps (transcribing, developing category scheme, coding) of qualitative data management and organization as outlined in Polit and Beck (2012:557-560), which is data transcription, developing category scheme and coding the data. The steps which resulted in the development of themes, categories and sub-categories. Themes are a recurring regularity of concepts, ideas, phrases that emerge from analysing qualitative data used in creating headings when reporting findings (Botma et al., 2010:225; Polit & Beck, 2012:744). Categories are the groupings of concepts into identified units that represent meaning of sets of related topics which act as a quick reminder of its referent (De Vos, 2002:347; McMillan & Schumacher, 2010:485). Subcategories are subsets of the categories and the details are discussed in chapter 2.

During data analysis, eleven themes emerged that were used to create the study's findings. Twenty-one categories were identified which represent the meaning of the

related themes that were further subdivided into subcategories. The findings of the study are described in the themes, categories and subcategories.

The content of this chapter consists of the descriptive data analysis of the following data sets: pregnant women, community leaders, members of the governance structures and midwives which culminated to various themes and phenomena related to promoting community participation in and local accountability for basic antenatal care and the existing barriers that hamper access to and uptake of basic antenatal care services in Bushbuckridge.

Data analysis is the process of critically examining the data collected to find meaningful answers into the research question under investigation (Mc Millan & Schumacher, 2010: 367; Polit & Beck, 2012:557).

Qualitative data analysis process was followed which is defined by Morse and Field (as cited in Polit & Beck, 2012:557) as a “process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence”. Data was systematically fitted together, coded, categorized and put into broad themes, categories and subcategories. It was then synthesized and interpreted to make meaning about the barriers and the factors to promote community participation and local accountability for basic antenatal care in Bushbuckridge. The analysis of the data was conducted concurrently with data collection. The various themes that emerged during the course of the study will be discussed in the research findings and discussions below.

3.2.3 Population

The following tables 3.1 to 3.4 outline significant details for the four population groups involved in the study.

Table 3.1: Profile for pregnant women

Participants	Age	Number of participants
Pregnant women	30 – 40	35
Total		**35**
	Cultural background	**Number of participants**
Pregnant women	Tsonga	33
	Sotho	2
Total		**35**

Table 3.2: Profile for Community leaders and Governance structures

Participants	Age	Number of participants
Community Leaders & Governance structures	40 – 50	3
	51 – 60	5
	60 <	3
Total		**11**
Participants	**Cultural background**	**Number of participants**
Community Leaders & Governance structures	Tsonga	11
Total		**11**

Table 3.3: Profile for Midwives

Participants	Type of staff	Number of participants
	CHC staff	5
	Hospital staff	3
	DCST	1
Total		**9**
Participants	**Years of experience**	**Number of participants**
Midwives	0 – 10	1
	11 – 20	2
	21 – 30	6
Total		**9**
Participants	**Cultural background**	**Number of participants**
Midwives	Tsonga	6
	Sotho	2

	Zulu	1
Total		**9**
Participants	**Qualification**	**Number of participants**
Midwives	Student midwives	1
	Registered midwives	3
	Advanced midwives	5
Total		**9**

Table 3.2 shows the participants' profiles who were selected purposively due to their involvement in antenatal care.

The specific objectives of the study guided the discussion of the findings. These objectives are to explore and describe the:

- Factors associated with **pregnant women's** access to antenatal care services.
- Factors associated with **community participation in and accountability** of local governance structures for antenatal care services.
- Perceptions of **health workers** about community participation in supporting pregnant women to access antenatal care;
- Perceptions of local **health workers** about the accountability of local governance structures for antenatal care.
- Functionality and accountability of **governance structures** in health within local communities.

3.3 RESEARCH FINDINGS AND DISCUSSION

Three datasets were developed for pregnant women, midwives, and community leaders and governance structures which resulted in the identification of themes, categories and sub-categories. The identified themes are authenticated by the categories and their sub-categories. These summarize and represent the factors associated with pregnant women's access to antenatal care services and the factors associated with community participation and local accountability for antenatal care services.

The research findings are linked with the objectives of the study as stated above. The discussion addresses the study's major findings. The literature that supports or differs from the major findings is interwoven throughout the discussion. The similarities and differences are indicated to demonstrate the extensive knowledge on the subject and are tied with the other sections of the report to provide meaning. In conclusion, the implications of the results to the profession are emphasized and recommendations for further research are made (Botma et al., 2010:312).

Table 3.4 contains a summary of the themes, categories and subcategories that emerged from the study. Further tables will provide summaries of themes, categories and subcategories per objective. In this section, the verbatim quotations of participants will be presented using italics.

Table 3.4: Summary of themes, categories and subcategories that emerged from the study

THEME	CATEGORY	SUBCATEGORY
1. Perceptions of antenatal care attendance	1.1 Knowledge and benefits of antenatal care	1.1.1 Determine mother and baby's health 1.1.2 Health education and counselling 1.1.3 Determine progress of the pregnancy, date of birth and deliver mode 1.1.4 Preventative care, disease screening and treatment
2. Perceived barriers to accessing antenatal care	2.1 Geographical location	2.1.1 Distance and cost of travel
	2.2 Fear of HIV stigma	2.2.1 HIV testing deters client's access to ANC services
	2.3 Perceived nurse-patient relationship	2.3.1 Discrimination and stereotyping of some clients by nurses 2.3.2 Discrimination against pregnant foreign nationals 2.3.3 Fear of harassment and embarrassment

THEME	CATEGORY	SUBCATEGORY
3. Perceived culture, beliefs and myths	3.1 Keeping pregnancy secret	3.1.1 Fear of witchcraft
	3.2. Cultural inertia	3.2.1 Cultural resistance hinders support
4.Perceived limiting socio-demographic factors	4.1 Elderly pregnancy and high parity	4.1.1 Judged/embarrassed for being pregnant 4.1.2 Family responsibilities 4.1.3 Previous experience of uncomplicated pregnancies and avoidance of frequent antenatal care visits
	4.2. Family circumstances	4.2.1 Lack of education and ignorance 4.2.2 Poverty and lack of basic necessities
	4.3. Unwanted pregnancies	4.3.1 Unplanned and teenage pregnancies
5. Experiences of health care system barriers	5.1 Limited resources	5.1.1 Inaccessible health services 5.1.2 Long waiting times
	5.2 Poor quality of care offered	5.2.1 Lack of privacy and confidentiality at service points 5.2.2 Patient ill-treatment, disrespect and neglect 5.2.3 Missed opportunities to educate clients 5.2.4 Reluctance to use mobile health services
	5.3 Feeling disempowered	5.3.1 Nurses conflicting messages delay early antenatal care attendance
6. Supportive needs during pregnancy	6.1 The role of family members, friends and partners	6.1.1 Provision of financial and basic needs 6.1.2 Provision of emotional and psychological support 6.1.3 Accompany partner to the clinic 6.1.4 Lack of family support

THEME	CATEGORY	SUBCATEGORY
		6.1.5 Initiate men's support group to educate other men
	6.2 Expected health care needs	6.2.1 Unhurried individualized care with meaningful health education 6.2.2 Seeking alternative method of redress
7. Perceptions on community participation, and accountability of governance structures	7.1 Expand health education efforts	7.1.1 Collaboration of governance structures with Department of Health and their accountability to the community on antenatal care
		7.1.2 Expand maternal health education through available human resources and mobile health services
		7.1.3 Using various methods of media to educate and disseminate information to the community.
	7.2 Strengthening use of existing community based structures	7.2.1 Empower and use existing and functional community based structures for health education
8. Identified needs	8.1 Strengthening health education in antenatal care	8.1.1 Community to accommodate science in their culture by learning to trust modern Science
		8.1.2 Governance structures to take a leading role in community education on the importance of antenatal care
	8.2. Strengthen men's support in pregnancy	8.2.1 Men need to learn supporting their partners in pregnancy
9. Perceptions on community participation in antenatal care	9.1 Strengthening health education efforts on antenatal services	9.1.1 Community participation and involvement using community leaders to promote health education on antenatal care attendance in the community
		9.1.2 Empower and use existing community based structures for health education (HBC, church, social clubs)

THEME	CATEGORY	SUBCATEGORY
		9.1.3 Utilize media to educate the community on antenatal care
10. Community participation through governance structures	10.1 Perceived roles and responsibilities of governance structures	10.1.1 Resolving health systems challenges in facilities and accounting to the community
11. The functionality and accountability of governance structures in health within local communities	11.1 Perceived roles and responsibilities of the governance structures	11.1.1 Resolving health system challenges experienced by the facilities and their positive achievements

3.3.1 Factors associated with pregnant women's access to antenatal care services

The first objective of the study: **To explore and describe factors associated with pregnant women's access to antenatal care services** is summarised with all the identified themes, categories and subcategories that emerged from the analysis in Table 3.5.

Table 3.5: Summary of themes, categories and subcategories of factors associated with pregnant women's access to antenatal care services.

THEME	CATEGORY	SUBCATEGORY
1. Perceptions of antenatal care attendance	1.1 Knowledge and benefits of antenatal care	1.1.1 Determine mother and baby's health 1.1.2 Health education and counselling 1.1.3 Determine progress of the pregnancy, date of birth and deliver mode 1.1.4 Preventative care, disease screening and treatment
2. Perceived barriers to accessing antenatal care	2.1 Geographical location	2.1.1 Distance and cost of travel
	2.2 Fear of HIV stigma	2.2.1 HIV testing deters client's access to ANC services

THEME	CATEGORY	SUBCATEGORY
	2.3 Perceived nurse - patient relationship	2.3.1 Discrimination and stereotyping of some clients by nurses 2.3.2 Discrimination against pregnant foreign nationals 2.3.3 Fear of harassment and embarrassment
3. Perceived culture, beliefs and myths	3.1 Keeping pregnancy secret	3.1.1 Fear of witchcraft
	3.2. Cultural inertia	3.2.1 Cultural resistance hinders support
4. Perceived limiting socio-demographic factors	4.1 Elderly pregnancy and high parity	4.1.1 Judged/embarrassed for being pregnant 4.1.2 Family responsibilities 4.1.3 Previous experience of uncomplicated pregnancies and avoidance of frequent antenatal care visits
	4.2 Family circumstances	4.2.1 Lack of education and ignorance 4.2.2 Poverty and lack of basic necessities
	4.3 Unwanted pregnancies	4.3.1 Unplanned and teenage pregnancies
5. Experiences of health care system barriers	5.1 Limited resources	5.1.1 Inaccessible health services 5.1.2 Long waiting times
	5.2 Poor quality of care offered	5.2.1 Lack of privacy and confidentiality at service points 5.2.2 Patient ill-treatment, disrespect and neglect 5.2.3 Missed opportunities to educate clients 5.2.4 Reluctance to use mobile health services
	5.3 Feeling disempowered	5.3.1 Nurses conflicting messages delay early antenatal care attendance

THEME	CATEGORY	SUBCATEGORY
6. Supportive needs during pregnancy	6.1 The role of family members, friends and partners	6.1.1 Provision of financial and basic needs 6.1.2 Provision of emotional and psychological support 6.1.3 Accompany partner to the clinic 6.1.4 Lack of family support 6.1.5 Initiate men's support group to educate other men
	6.2 Expected health care needs	6.2.1 Unhurried individualized care with meaningful health education 6.2.2 Seeking alternative method of redress

Tables 3.6 to 3.11 show the identified themes, categories and sub-categories on the factors associated with pregnant women's access to antenatal care services.

3.3.1.1 Theme 1: Perceptions of antenatal care attendance

The first theme identified is perceptions of antenatal care attendance. Out of the theme, one category on knowledge and benefits of antenatal care emerged. It focused on four subcategories which determine mother and baby's health, health education and counselling, determine progress of the pregnancy, date of birth and delivery mode and preventative care, disease screening and treatment.

Table 3.6 shows the theme, category and the subcategories which emerged from the theme on perceptions of antenatal care attendance.

Table 3.6: Theme 1 - perceptions of antenatal care attendance

THEME	CATEGORY	SUBCATEGORY
1. Perceptions of antenatal care attendance	1.1. Knowledge and benefits of antenatal care	1.1.1. Determine mother and baby's health
		1.1.2. Health education and counselling
		1.1.3. Determine progress of the pregnancy, date of birth and delivery mode
		1.1.4. Preventative care, disease screening and treatment

Category 1.1: Knowledge and benefits of antenatal care

The category knowledge and benefits of antenatal care focused on four subcategories which are to determine mother and baby's health; health education and counselling; determine progress of the pregnancy, date of birth and delivery mode; and preventative care, disease screening and treatment. Each subcategory is discussed below.

Determine mother and baby's health

Related to the determination of the mother and the baby's health, the participants knew that some of the reasons for attending antenatal care were to assess the health of the mother and the baby and treat identified problems: Their comments included *"To check if the baby and the mother's health is good…"*. *"To check for any health problems from the mother and baby…."* The nurses check the mother to identify illnesses and also check if the baby's heart is beating well: *"Last Sunday I came several times because the baby was not playing well and they checked me and said the baby is well'*.

The participants knew that some of the reasons for attending antenatal care were to assess the health of the mother and the baby and treat identified problems. "…*Check what can affect both of them to ensure she gets a live baby…." "…. Know how the baby is growing, detect problems early and have a successful delivery".* The nurses check the

mother to identify illnesses and also check if the baby's heart is beating well. *"To check if the baby's heart is beating well".*

The above quotes show women's understanding of the reasons for attending antenatal care and the benefits by indicating that the care they receive helps to determine the health of the mother and the baby, which is similar to what was indicated by Mail et al. (2013:10). Ha et al. (2015: 699) confirms by indicating that when women attend antenatal care, they get interventions such as deworming, immunization, vitamin supplements which should reduce maternal and new born mortality. Further to that, Simkhada et al. (2007: 245) indicate that antenatal care determines safe delivery and it is a good strategy for reducing maternal mortality; yet millions of women do not receive it in developing countries.

Sohag et al. (2013:17) also indicate that early initiation of antenatal care before fourteen weeks, allows early treatment of possible complications of pregnancy, labour and puerperium. Attending antenatal care enables health care professionals to identify possible pregnancy risk factors and make necessary interventions for delivery (Titaley, Dibley & Roberts, 2010:1). The current findings show that the participants have an understanding of the reasons and benefits for attending antenatal care. This fulfils what is stipulated in the Bill of Rights that patients have the right to have access to information about their conditions and receiving counselling without any discrimination (HPCSA, 2008:2).

Health education and counselling

The participants indicated that pregnant women also received health education and counselling during their antenatal care visits. Included in the comments were *"At the clinic they are able to counsel you if you have some problems and help you".* They are educated on the importance of attending antenatal care and the diet they should follow. **"***Nurses also educate us on various things that will help us during our pregnancy"* Those who are HIV positive are taught that they should use protection during sex to protect themselves and the unborn baby. ***"…****they teach us and encouraged us use protection in case you tested positive when having sex to prevent infecting the child".* They are taught how many times a baby should "play" per day which is a sign that the baby is alive. *"At the clinic they*

educate the young mothers on how the baby is supposed to grow and how many times the baby should be playing per day"

The information received enables them to respond to the problems they experience during pregnancy. **"***Having knowledge of what to do when faced with problems e.g. bleeding during pregnancy".* Participants considered the information received when attending antenatal care as valuable and beneficial to them.

Anya, Hydara and Jaite (2008) indicate that the aim of health education in antenatal care is to ensure that pregnant women are able to make choices that will lead to best possible pregnancy outcomes including care of the new-born baby. The current findings show that health workers give effective health education and counselling in antenatal care clinics. *"Last Sunday I came several times because the baby was not playing well…."* Berhan and Berhan (2014:101) confirmed by indicating that attending antenatal care gives a pregnant woman and her family an opportunity to get information and education on the danger signs of pregnancy and other obstetric emergencies which could occur during pregnancy. They also get counselling on maternal health issues which include emergency preparedness and birth (Ha, Tac, Duc, Duong, & Thi, 2015: 699). This is supported by Simkhada et al (2007:245) who indicate that antenatal care offers information on health issues and services to improve the health of the mother and baby. Sohag et al (2013:17) further indicate that early antenatal care before fourteen weeks helps women to get educated and counselled on the changes that occur physiologically during pregnancy and the possible complications that are likely to occur during pregnancy, labour and delivery. Antenatal care is used to offer information on health issues and services to improve the health of the mother and baby. It also acts as a platform where pregnant women share information informally amongst themselves, like in a situation where a high risk woman had a successful delivery in a health facility (Berhan & Berhan, 2014:101). The findings from the current study show that participants had knowledge on some of the potential pregnancy complications that may arise and they knew when to seek medical care. This shows that they have been receiving the information which is in accordance with the Bill of Rights (HPCSA, 2008:2).

However, Titaly et al. (2010:4) find that in Indonesia, women who were less exposed to mass media were those who came from poor rural households and had low educational levels. They lacked knowledge about pregnancy complications which still indicate the need for more education, especially in the rural areas. Sohag et al. (2013:17) asset that women had limited information regarding the reasons for attending antenatal care when asked. They had vague responses and described it in terms of the procedures that were done such as being given an injection or tablets and weighed. This was attributed to the limited information given by the health workers. Attending antenatal care early in pregnancy has a potential for positive maternal and foetal outcomes.

Determine the progress of the pregnancy, date of birth and delivery mode

During antenatal care, the midwives inform women how far they are with the pregnancy, determine the date of the baby's birth and position of the baby.

Comments of the participants included that *"To determine when the baby was conceived and when the baby will be delivered". "To detect if the baby is sitting well inside and if not sitting they take corrective measures to prevent complications."*

They are also told the mode of delivery. *"To detect if the baby is sitting well inside and if not sitting they take corrective measures to prevent complications." "To be checked if she will deliver normally or by operation." "Know how the baby is growing, detect problems early and have a successful delivery."*

The quotes show that women understand that one of the benefits of attending antenatal care is to know how far they are with the pregnancy. Mail et al (2013:10) affirm that women attended antenatal care to monitor progress of the pregnancy and to check the position of the baby. Their findings showed that knowing the gestational age was important to women in Kenya and Malawi, which influenced their initiation of antenatal care. Women were motivated to attend antenatal care although at times they were returned by health workers due to lack of resources such as equipment to confirm the pregnancy prior to twelve weeks of gestation.

Antenatal care saves the life of both the mother and baby and assist with ensuring that there are no detrimental effects which will affect them (Berhan & Berhan, 2014:93). It

determines safe delivery and it is a good strategy for reducing maternal mortality, yet millions of women do not receive it in developing countries (Simkhada et al., 2007:245).

Preventive care, disease screening and treatment

The participants indicated that preventative care, disease screening and treatment were additional reasons and the benefits for attending antenatal care. Their comments were as follows: *"They test the blood to detect diseases and give us treatment. To check if the mother has enough blood and if not she can be treated or given blood".*

They mentioned that during antenatal care visits, nurses conducted a thorough examination and conducted tests for early detection of certain diseases. *"To prevent mother to child transmission for HIV by treating the mother". "The unborn child can be affected by a lot of things and going to the clinic will help prevent the child from contracting the mother's illnesses. To get pills, prevent baby not to get viruses. Check what can affect both of them to ensure she gets a live baby".* If they are found to be ill, they are treated on time before the baby and mother are affected.

This is done through taking blood from pregnant woman to test for HIV and if found positive, they were started on treatment and initiated on the prevention of mother to child programme to protect the unborn baby. **"***During these times that we live in, there are many diseases like HIV. If diseases are detected, they will be treated on time".*

They were also given pills depending on the need such as those that add more blood in the body in a case where the woman has insufficient blood in the body. **"***I also get some pills like calcium gluconate and ferrous sulphate that helps me and the baby"." If not, they will give you pills so that you can have enough blood to avoid the risk of dying".*

However, there were some women who had wrong beliefs about the pills received at the clinics which are believed not to be good for them making them not to attend antenatal care. It was expressed as follows: *"Some people do not want to take pills from the clinic because of their beliefs in myths".*

The current findings were confirmed by Doku, Neupane and Doku (2012) who indicated that women attend antenatal care in order to get immunisations, get advice on lifestyles

which can affect their health. Attending antenatal care act as an encouragement and support for pregnant women. Midwives were also responsible for screening and managing diseases such as HIV, STIs, and TB and provide counselling (Odendal, 2011). Antenatal care attendance helped with screening of women with high risk pregnancies (Sohag et al., 2013:17; Titaley et al., 2010:1).

Giving pregnant women tetanus immunization can save the life of both the mother and baby. The management of anaemia and the treatment of sexually transmitted infections (STIs) during pregnancy can improve maternal and foetal outcomes (WHO, 2003). Amongst other activities which are effective and are a requirement in antenatal care are screening for conditions such as pre-eclampsia, iron deficiency anaemia, blood typing and antibody screening (DoH, 2015:19). Mail et al (2013:10) find that women in Kenya, Malawi and Ghana wanted to identify potential problems in pregnancy. They took treatment to ensure that the baby developed well and tested for HIV. This was described in terms of the procedure done or how it was experienced like being given an injection or tablets, or being weighed.

The current findings on the women who have a negative attitude towards taking the treatment issued at the clinic can be attributed to cultural beliefs which inform people's perceptions and their response towards attending antenatal care services. Cultural factors influence and shape the way individuals think, perceive their bodies and the health services they use. Such was noted in the South Asian culture where antenatal care, which is preventive in nature, is perceived as only providing curative services (Simkhada et al., 2007:257). Cham, Sundby and Vangen (2005:6) assert that culture influences the way people think and behave based on traits such as knowledge, beliefs, and religion. These inform people's decision to act or not to act in a particular way.

Titaley et al (2010:1) indicate that several research studies showed close association of inadequate antenatal care attendance and adverse pregnancy outcomes. Women who attended antenatal care were likely to have institutionalized deliveries or use of trained delivery attendants.

3.3.1.2. Theme 2: Perceived barriers to accessing antenatal care

The second theme identified is perceived barriers to accessing antenatal care. Out of the theme emerged three categories which are geographical distance, fear of HIV stigma and perceived nurse-patient relationship. The three categories focused on five different subcategories which are distance and cost of travel, HIV testing deters client's access to antenatal care services, discrimination or stereotyping of some clients by nurses, discrimination of pregnant foreign nationals and fear of harassment and embarrassment.

Table 3.7 shows the identified theme, emerged categories and subcategories within the theme, perceived as barriers to accessing antenatal care.

Table 3.7: Theme 2 - Perceived barriers to accessing antenatal care

THEME	CATEGORY	SUBCATEGORY
2. Perceived barriers to accessing antenatal care	2.1. Geographical location	2.1.1. Distance and cost of travel
	2.2. Fear of HIV stigma	2.2.1. HIV testing deters clients' access to antenatal care services.
	2.3. Perceived poor nurse - patient relationship	2.3.1. Discrimination/ stereotyping of some clients by nurses
		2.3.2. Discrimination against pregnant foreign nationals
		2.3.3. Fear of harassment and embarrassment

Category 2.1: Geographical location

Geographical location is the first category that emerged from the theme, perceived barriers to accessing antenatal care which focused on distance and cost of travel subcategory which is discussed.

- **Distance and cost of travel**

The participants indicated that some of the pregnant women are unable to attend antenatal care as they should because they live far away from the clinics. Some of their

comments were *"Distance also plays a role in women not coming to the ANC for treatment."* Due to lack of money for transport they have to walk for a long distance". *"Some pregnant women cannot walk for a long distance and if they do not have money they fail to go to the clinic".*

Their health status could also be a limitation to antenatal care attendance as they are unable to walk for a long distance due to their state of health and therefore fail to honour their return dates as booked. **"***Some have financial problems. I use two taxis when I come here and if I did not have money it would be difficult to come". "Some come from disadvantaged families and have no money for transport to go to the clinic".*

The current findings are similar to those of Kulkarni and Nimbalkar (2008:99) who found that the distance between the women's home and the health centre has a negative influence in the utilisation of antenatal care services which decreased where the distance was longer. The distance to be travelled, the availability of money to travel and the times at which the services are offered are important factors that influence antenatal care attendance (Tlebere et al., 2007: 346).

The lack of physical access to most Primary Health Care facilities poses a serious challenge in women accessing antenatal care especially in South Africa's rural areas, despite the availability of mobile services (Myer & Harrison, 2003:271). The distribution of health care services in the rural and urban areas of South Africa are skewed, which deters women from accessing antenatal care services (Phillips, 2002:70). From the quotes, it is clear that health services in rural areas are not accessible to enable pregnant women to attend antenatal care as they should, because of the distance they have to travel and the financial constraints involved**.**

Similarly, Ye et al (2013:31) find that in Kham District, Xiengkhouang Province, Laos, there was the lowest rate of antenatal care visits among pregnant women who lived far from the facilities. Seventy percent of pregnant women did not attend antenatal care because they lived far from the clinic and had limited transport to get to the clinic. This is acknowledged in the Lao Health Plan that pregnant women were not attending antenatal

care because the clinics were far and the transport was limited for them to access the services (Ye et al., 2010: 24).

Naledi, Barron and Schneider (2011:20) assert that the gap between policy formulation and implementation was still a significant issue related to service delivery challenges. It has resulted in the existing inequity in the access, coverage and quality of services which has been an obstacle in the effective response to the burden of disease in South Africa.

Further to that, a study conducted by Simkhada et al (2007:255) showed that it was statistically significant that the place of residence had an influence in antenatal care attendance. Women who stayed in the rural areas were forty-five percent less likely to attend antenatal care than those who lived in urban areas. In areas where more time was spent traveling to the nearest facility, resulted in fewer antenatal care visits and antenatal care uptake. Older women in Kenya and Malawi started antenatal care at about the sixth or seventh month so as to attend a few times before delivery and cut down travelling and related costs (Mail et al., 2013:15).

However, the Department of Health (DoH) in South Africa is in the process of implementing the Community-based Primary Health Care model through the Primary Health care reengineering where the ward-based outreach teams (WBOT)support and facilitate the preventive, promotive, curative and rehabilitative continuum of care through referral and follow-up from home to health facilities and back (Naledi, Barron & Schneider, 2011:24).

Failure to access health care is a violation of health rights for pregnant women. According to the patient's rights charter, every citizen has the right to access health care which includes timely emergency care, treatment and rehabilitative care. There should be provision of their special needs, counselling, palliative care and health information in the language that they understand. Such services should be provided by the health care providers who are compelled to provide it in a dignified, empathetic and tolerable way, whilst displaying a positive viewpoint (HPCSA, 2008:1-2).

Category 2.2: Fear of HIV stigma

Fear of HIV stigma is the second category to emerge from the theme perceived barriers to accessing antenatal care which focused on one subcategory; HIV testing deters client's access to antenatal care services which is discussed.

- **HIV testing deters client's access to antenatal care services**

The participants indicated that the resolution by the Department of Health of wanting all pregnant women to be tested for HIV is acting as a barrier for accessing antenatal care services. Women feel that they are not left with a choice but have to be tested for HIV as it is mandatory even if they are not willing to test. Some of their comments were **"***People feel pressurized because testing for HIV is mandatory by the Department, as there is no choice but forced to test, they feel that they are put under pressure and choose not to go to the clinic".* Women tend to think that if they test HIV positive, it will be the end of their world, not knowing how they will live thereafter. **"***If a person tests positive she thinks that the world has come to an end. There is also stigma attached to it".* To avoid testing, they prefer not to attend antenatal care *"Some do not want to test and find out that they are HIV positive. They do not want to know their status because they do not want to think too much".*

However, some women recognize that it is beneficial to test and know their HIV status as there is treatment available and the unborn baby will be protected through prevention of mother to child transmission (PMTCT) programme. This was expressed as follows: **"***They fear of the knowing their HIV status especially testing positive. They do not find it easy".* **"***Yes it is, testing is not that simple but it is important to test when you are pregnant. The results are scary because when you have tested positive it is hard and this make them not come for ANC. It is important to test so that you can be treated and protect the baby. If a person tests positive she thinks that the world has come to an end. There is also stigma attached to it".*

The current findings show that there is a perception that mandatory HIV testing deters women from attending antenatal care. Simkhada et al (2007:256) found that women feared to test for HIV and get positive results which are recorded in their antenatal card.

In Uganda, nurses reacted differently to patients with HIV and AIDS by refusing to take care of them. They had minimal contact with HIV positive patients who experienced rejection with inappropriate isolation (Walusimbi & Okonsky, 2004:92).

The discrimination of the HIV positive patients was also experienced in the Eastern Cape where nurses did not want to touch them (Human Rights Watch, 2011:26). Women indicated that health care workers were insulting and rude to them. Some were denied access to emergency transport for maternity care. Health workers publicly humiliated and mocked HIV positive women in front of other patients for falling pregnant. The abuse suffered by these women has enduring psychological effects which deters the use of health facilities (Human Rights Watch, 2011:34-35).

This is confirmed by Mail et al (2013:16) who found that women in Kenya were cautious of attending antenatal care for the fear of testing HIV positive which could have serious consequences such as being accused by their husbands of adultery and deserted if they knew their status. This made them to delay antenatal care attendance in order to delay knowing their HIV status.

Furthermore, in another study conducted by Turan et al (2008:940) in Kenya showed that pregnant women avoided going to the clinic because they feared being forced to take the HIV test. They feared that if they tested positive, they may fall into depression and commit suicide or experience early death due to stress from their results. Some feared that their partners can have a negative reaction resulting in marital problems where they could be divorced or denied economic support for them and their children. They could be accused of promiscuity and could lead to violence (Turan et al., 2008:940).

Some other form of discrimination was identified by Bharat and Mahendra (2007:99) who found that some health care professionals refused to care for pregnant women who came for delivery at the clinic because of their positive HIV status, while some had witnessed their colleagues refuse to admit them at the hospital. Tyer-Viola (2007:399) confirmed by indicating that women with HIV reportedly delay in seeking antenatal care as they fear discrimination by the service providers who are not willing to care for them. This was due to the service provider evaluative judgment that women are responsible for their infection

and the attitude about their lifestyles. However, the findings are in contrast with those in Ghana and Malawi where women described knowing one's status as important and were not found to be a reason for delaying antenatal attendance.

The nurses' discrimination of women who tested HIV positive is in contrast with the Nursing Code of Ethics which obliges nurses to care for their patients in a dignified manner, without prejudice, respecting their needs and values (Tyer - Viola, 2007:399). Service users have the right to access good quality of nursing and health care. Nurses are required to treat them with kindness and dignity. They should apply their professional competencies and positive emotions by demonstrating the art of nurturing to benefit the health care user and the nurses which is the ethical principle they must always uphold (SANC, 2013:5). The service users should also be informed and know that they have a right to complain about the services they received if they are discriminated against based on their HIV status. The complaints raised will be investigated and a full response will be issued (HPCSA, 2008:2)

Category 2.3: Perceived poor nurse-patient relationship

The third category which emerged under the theme perceived barriers to accessing antenatal care is perceived poor nurse-patient relationship. The category focused on three subcategories which are discrimination or stereotyping of some clients by nurses, discrimination of pregnant foreign nationals and fear of harassment and embarrassment. Each subcategory is discussed below:

- **Discrimination / stereotyping of some clients by nurses**

The participants indicated that as pregnant women, they experienced the nurses' tendencies of discriminating the patients who are poor and treat them differently from the other clients. When they react to such treatment, they are provided with substandard care by not being examined as expected. This was expressed as follows: *"Nurses look at how people are dressed and treat you differently. If you are not well dressed, they will harass you and when you talk back you will not get the necessary care that you need". "If you are poor and come to the clinic on the same dress and under wear, the nurses will say that you smell and you are not bathing".*

The findings are similar to those of Simkhada et al (2007:256) which showed that there is shame associated with being pregnant and visiting the clinic wearing tight dresses which is considered to be inappropriate. Such women are likely to be treated differently, looked down upon and discriminated against by the health workers. The findings in Mail et al (2013:14) further showed that health workers treated women who came to their facilities differently according to their wealth, education and relationship. Those who are wealthy, educated and have a familiar relationship or friendship with them were addressed on relatively equal terms during interaction as opposed to women who were aloof, quiet with “head - down” characters. Such treatment by the nurses violates the patients’ constitutional human and health rights. It is also a breach of the Code of Ethics. According to the Code of Ethics, all nurses have a responsibility to protect individuals who are under their care and respect their human and health rights irrespective of their social status (SANC, 2005:3).

In the South African constitution, it is stated that every citizen has the right to an effective and caring health care that is free from harm. Additional to that, the Health Rights charter further states that health care providers should provide health services in a courteous, dignified, empathetic and tolerable way with a positive attitude (HPCSA, 2008:1-2; Khoza, 2009:15; DOH, 2011:4).

As a way of enhancing professionalism and adherence into the nursing ethics, nurses undertake an oath where they commit themselves that the patient will be their first consideration and will practice their profession with conscience and with dignity to protect the patients (SANC, 2005:3). The Batho Pele principles also require public servants to treat service users with courtesy and consideration by always being helpful (Department of Public Service and Administration, 1997). The above findings show the breach of the code of conduct (Department of Public Service and Administration, 2001). The ethical values and the standards for good practice also requires that health care providers should, at all times, show compassion to their patients by being responsive and empathetic to their individual or social needs. They should device means to create comfort and be supportive whenever there is a need and whenever it is feasible (HPCSA, 2008:2).

It is, therefore, imperative that patients should be taught about their rights and responsibilities to enable them to effectively lodge complaints about the poor quality of services they receive from nurses for investigation. It is also their right to receive a full response on the complaints lodged (HPCSA, 2008:3).

- **Discrimination against pregnant foreign nationals**

The participants indicated that there are some community members who tell pregnant women who are foreign nationals' information which discourages them from attending antenatal care. They are told that if they do not have South African identity document they cannot be seen at the health facilities and their babies will not get birth certificates. *"At times we give wrong people wrong advices to the people who are from outside the country. So some end up thinking that because they do not have South African identity document (ID) they will not get help and have problems from the myths that their child will not get any certificate if they do not have ID's". "Some have wrong information given by others to the expecting mothers".* Unfortunately, such myths are believed by the foreign nationals, deterring them from accessing antenatal care services which is inappropriate and needs to be addressed.

The current findings show that there is discrimination of non-South African nationals in the country which is entrenched in some South African members of the community, which deters them from attending antenatal care as they should. Based on the fact that health care providers are also members of the community and are sharing the same sentiment, the current findings are similar to what was found in a study conducted in the Eastern Cape by the Human Rights watch. The study showed that there is discrimination of patients who are not South African citizens. The foreign nationals are denied basic and emergency treatment by health care providers and included are women who are in labour as they do not have South African identity documents (Human Rights Watch, 2009:7). Further to that, in another study, the Human Rights watch (2011:27) confirmed that migrants, refugees and asylum seekers were discriminated by individual health care providers which was a serious barrier for accessing health care.

This is in conflict with the South African Constitution (Department of Justice and Constitutional Development, 1996) which stipulates that the right to health is for both citizens and non-citizens of the country as long as they are within the South African borders. Unfortunately, the asylum seekers and the refugees are denied that right by the health care providers who fail to implement the policy. They suffer because they lack knowledge about the services they are entitled to and available for them and the health risks that they are facing (Human Rights Watch, 2009:8).

Nurses have a responsibility to "... protect, promote and restore health to prevent illnesses, preserve life and alleviate suffering" which should be carried out without discrimination in terms of race, colour, creed and nationality (SANC, 2005:3). In order to create confidence in the public sector, all public servants have an obligation to serve the community in a friendly and professional manner. They should always be proficient and unbiased. The uniqueness of the individuals and their diversity should always be taken into consideration (Public Service Commission (PSC), 2002:15).

- **Fear of harassment and embarrassment**

The participants indicated that the negative attitude of the nurses towards the clients is chasing pregnant women away from the clinics. Some of their comments were *"The attitude of nurses chases them away. Personal questions are asked to young women like "were there no condoms when you fell pregnant?"* Nurses are inclined to be judgmental towards women, causing a strain on their interpersonal relationship. **"***Yes, nurses scold people. They ask questions like "why did not you come for family planning"? "This makes make them feel uncomfortable".*

At times personal, offensive and embarrassing questions were asked in front of others, particularly those who are young and older including the HIV positive. **"***The way the clinic staff treats the HIV positive expecting mothers is very harsh, so they run away".*

They get scolded and asked the reasons why they fell pregnant because there are family planning services available which are free to access. *"She is speaking the truth. The nurses sometimes speak ill of the people and they judge you and the community will comment badly about you especially if you are an older woman".* "*It is true that some*

nurses are aggressive and scold young pregnant mothers for being pregnant at an early age". "By the time you come the nurses will scold you. They will embarrass you by asking offensive questions in front of other clients".

The discrimination and ill-treatment of HIV positive clients is inappropriate and unacceptable as clients need to be treated with respect. *"The attitude of the nurses towards the clients must change, and they must be able to communicate with each other well. They should talk to them in a good way". "Nurses should give information to all clients in a good way but not according to their HIV status and not treat them as animals". "Instead relevant advice should be given and correct timing is needed. They should approach them well and not judge others"*

To effectively provide relevant advice to the clients, the environment in which they operate need to be conducive with good interpersonal relationships between the clients and the service providers.

The above quotes show that the negative attitude of nurses impacts negatively on the services rendered on and the utilization of the antenatal care services. It emerged in several patients' satisfaction survey that health workers are often rude and uncaring to their patients. The patients feel that they are not treated well at all times (DOH, 2011:4). Cham et al (2005) found that having past history of bad experience with the health providers delayed seeking of antenatal care. When assessing the friendliness of the staff in health facilities, Khoza (1999:55) found that about 50 % of the professional staff, including doctors, were not friendly and were disrespectful. They were found to be rude, spiteful and short tempered, and also shouting at some of the patients in front of the others. Such behaviour is a violation of human dignity and courtesy as described in the Bill of Rights and Batho Pele principles.

The negative attitudes of the nurses also deter pregnant women from attending the health services as confirmed by the following quote: "They don't know [how] to speak to a person, they are rude and they hurt your feeling[s]" (Tlebere et al. 2007:346). Additional to that, in the study conducted by Mail et al (2013:14) it was identified that health workers chastised and socially discriminated women who were perceived to have inadequate birth

spacing, such that some women with young children avoided going to health facilities leading to delayed initiation of antenatal care. Included on the chastisement were women who delayed attending antenatal care but immediately arrived for delivery. These women also feared being reprimanded by health workers.

Simkhada et al (2007:256) assert that in Zimbabwe, antenatal care services were affected by the uncaring health workers who were unfriendly, displayed a rude and negative attitude. The poor relationship between the service providers and patients led to poor provision of quality of care which affected the utilization of antenatal care services. The findings confirm the evidence from other research studies conducted which showed deterioration of the image and the status of the nursing profession (DOH, 2013:23).

Tlebere et al (2007:348) revealed in their study that the WHO has acknowledged that the interpersonal and intercultural competence of the service providers needed to be improved as they are not of high standard. This supports other studies, which shows that health providers in South Africa contribute to poor interpersonal treatment of women in maternal health services.

The Department of Health acknowledged the existence of these challenges and introduced the national core standards to improve the health care system in addressing the challenges. According to the national core standards, nurses should treat the patients in a caring and respectful manner. They need to display the values, attitude and show respect for privacy and choices of the patients (DOH, 2011:6). Caring is one of the ethical principles which nurses should always uphold. They should demonstrate their professional competence and positive emotions (SANC, 2005:5). Managers in facilities are to ensure that health workers who violate patient's rights are held accountable. Professional development plans should also include re-enforcing patients' rights to enhance and ensure compliance to the national core standards.

3.3.1.3. Theme 3: Perceived culture, beliefs and myths

The third identified theme is perceived culture, beliefs and myths. Out of the theme emerged two categories: keeping pregnancy a secret and cultural inertia which focused on two subcategories which are fear of witchcraft and cultural resistance hinders support.

Table 3.8 shows the theme, categories and the subcategories within the theme perceived culture, beliefs and myths.

Table 3.8: Theme 3 - Perceived culture, beliefs and myths

THEME	CATEGORY	SUBCATEGORY
3. Perceived culture, beliefs and myths	3.1. Keeping pregnancy a secret	3.1.1. Fear of witchcraft
	3.2. Cultural inertia	3.2.1. Cultural resistance hinders support

Category 3.1: Keeping pregnancy a secret

Keeping pregnancy, a secret is the first category that emerged from the theme perceived culture, beliefs and myths and focused on the subcategory fear of witchcraft which is discussed. In Mpumalanga Province, there is a cultural practice and a belief that pregnant women should keep their pregnancy a secret. It is believed that if other people know it, they might be bewitched and the pregnancy could fail to reach full term. This results in late initiation of antenatal care as women wait until the pregnancy is visible to access care. Similar findings were reported in a study conducted by Ngomane and Mulaudzi (2012:4) which confirmed the cultural practice of keeping the pregnancy a secret for the fear of bewitchment, which may result to miscarriage or a malformed infant.

- **Fear of witchcraft**

The participants indicated that there is a high level of lack of trust in the community when it comes to pregnancy and witchcraft. Participants made the following comments **"***Some people believe in witchcraft; people do not say that they are pregnant. There is distrust between neighbours, they believe in witchcraft".* Culturally, pregnancy has to be kept a secret until the time when the pregnancy shows and cannot be hidden. *"As Africans we believe in witchcraft. If we tell at 1month, they will count the months and "Tsimba me" ("Tie"- block you from delivering a baby) block me when my time for delivery comes. You have to keep it a secret to save yourself"*.

Some go to an extent of keeping it a secret even from members of the family. "*Due to witchcraft, we do not trust each other. Sometime they will bewitch you and do things that*

you never know. I hid my pregnancy until 7 months". This is done to protect the pregnancy and the life of the baby because it is feared that if it is known, the woman will be bewitched and will not be able to deliver a live or healthy baby. These women are therefore not able to attend antenatal care because that will expose the pregnancy and make the pregnancy and the baby more vulnerable to witchcraft.

The current findings show how cultural beliefs affect and impact negatively on health seeking behaviour for pregnant women. In Kenya, Mail et al (2013:13) found that pregnancy is kept a secret until four months for the fear of it being interrupted by witchcraft, although it was not considered to be the reason for late antenatal care initiation. Women in Ghana also acknowledged that dangers of witchcraft existed, including personal threats, but they were reserved to openly talk about them. Additional to that, pregnancy disclosure was found to be a sensitive issue for women who had experienced unexplained interruptions in their previous pregnancies. Women who had previous history of not bringing pregnancy to term or had problems in conceiving also kept their pregnancy a secret. This was related to the stigma attached to infertility and childlessness. They had to wait until the pregnancy is visible (Mail et al., 2013:12).

Cultural beliefs can negatively affect the health of pregnant women. In Rwandan culture, pregnant women are supposed to attend antenatal care when they are eight or nine month pregnant which affect initiation of antenatal care on time (Hagey et.al., 2014: 99). When they are ill they have to say that they have "swallowed a cockroach" because they are not allowed to openly talk about the pregnancy. Simkhada et al (2007:256) had similar findings in Zimbabwe which showed that the failure to attend antenatal care in the first trimester of pregnancy was associated with the vulnerability to witchcraft.

This confirms what the participants said that pregnancy is traditionally kept a secret, which limits the chances of the pregnant woman being advised or encouraged to go for antenatal care. However, nurses should be trained to improve their communication to enable them to understand women's cultural and traditional beliefs as they are sensitive in nature (Simkhada et al., 2007:256).

Nurses should be able to embrace the uniqueness of the health care users and also acknowledge their cultural diversity which is one of the values in their Code of Ethics (SANC, 2013:5). Ngomane and Mulaudzi (2010:9) in their study, identified lack of cultural tolerance of the service users amongst nurses and midwives. It is recommended that indigenous beliefs and practices should be included in the training of nurses and midwives in order to meet the health needs of the community members. Ngunyulu (2012:129) asserts that South Africa is one of the developing countries which has an increasing number of people who come from diverse cultural backgrounds. To be able to provide a culturally congruent care, the nurses need to be culturally competent to meet the cultural needs of the patients coming from the diverse cultural backgrounds. However, the training of nurses that is currently provided in the country lacks aspects which provide sufficient knowledge regarding cultural congruent care as it originates from the western point of view. The incorporation of "indigenous" care practices into midwifery is recommended (Ngunyulu, 2012:130). It is one of the World Health Organization's principles to make caring for pregnant women to be family centred and culturally appropriate (Banda, 2013:7).

Category 3.2: Cultural inertia

Cultural inertia refers to the resistance to change in one's culture irrespective of the force exerted. It becomes evident when people stick to their culture despite the changes that occur in their environment. It was the second category that emerged from the theme perceived culture, beliefs and myths and focused on the subcategory cultural resistance hinders support which is discussed.

- **Cultural resistance hinders support**

Participants indicated that culture plays a major role on whether a pregnant woman will be supported on not. Men who are still traditional and practice their culture are not involved in maternal health care issues especially the older generation. Their comments were *"Traditional men only want a report back when you come back from the clinic. They do not want to know much"* If a woman is pregnant, all they are looking forward to is the birth of the baby but not to be involved with what is happening with the pregnancy or what

women do when they go for antenatal care. The resistance to change on such practices hinders men from providing the necessary support that pregnant women need. *"Start to involve men as well educate them on how they should support their pregnant partners by doing door to door campaigns and visiting the churches".* Men need to be involved and enhance their support to their pregnant partners by educating them through community outreach programmes.

The above findings show how culture limits the involvement of men on maternal health issues which restrict their support and involvement in antenatal issues. Simkhada et al (2007:256) found that some women from the male headed household in Nigeria are refused to attend antenatal care by their husbands. This shows lack of knowledge and understanding on the importance of antenatal care in men, leading to lack of support.

Simkhada et al (2007:247) found that the level of education of the husbands was a strong predictor of antenatal care utilisation. Strategies to address ignorance and cultural resistance need to be developed focusing on men. Ediau et al (2013), in a study conducted in Tanzania indicated that as men are the gatekeepers of women's reproductive health, they are critical partners in improving maternal health and reduction of mortality. They need to be involved in the maternal care of their partners.

There is correlation on antenatal care utilisation by pregnant women with the increased educational level of the husbands which was found to be a strong predictor of antenatal care utilisation than the education of the women (Simkhada et al. 2007:247). The current findings show the need for men to be involved and enhance their support to their pregnant partners by educating them through community outreach programmes. The findings are supported by the study conducted across nine provinces in Vietnam showed that women who were likely to attend antenatal care more than four times during pregnancy were those who received financial support from their husbands (Ha et.al., 2015: 704)

Ediau et.al. (2013) assert that male involvement and community interventions in antenatal care had a positive impact on antenatal care attendance in Northern Uganda where the number of first antenatal care visits in the district increased from 56 % in 2009

to 93.7 % in 2011, while the male partner counselling and testing in antenatal care moved from 0 % in 2009 to 89.6 % in the third quarter of 2011.

3.3.1.4 Theme 4: Perceived limiting socio-demographic factors

The fourth theme identified is perceived limiting socio-demographic factors. Out of it emerged three categories which are elderly pregnancy and high parity, family circumstances and unwanted pregnancies. The categories focused on six different subcategories.

Table 3.9 shows the theme, categories and subcategories within the theme perceived limiting socio-demographic factors.

Table 3.9: Theme 4 - Perceived limiting socio-demographic factors

THEME	CATEGORY	SUBCATEGORY
4.Perceived limiting socio-demographic factors	4.1.Elderly pregnancy and high parity	4.1.1.Judged and embarrassed for being pregnant
		4.1.2.Family responsibilities
		4.1.3.Previous experience of uncomplicated pregnancies and avoidance of frequent antenatal care visits
	4.2.Family circumstances	4.2.1.Lack of education and ignorance
		4.2.2.Poverty and lack of basic necessities
	4.3.Unwanted pregnancies	4.3.1.Unplanned and teenage pregnancies

Category 4.1: Elderly pregnancy and high parity

Elderly pregnancy and high parity is the first category identified which focused on three subcategories, judged and embarrassed for being pregnant, family responsibilities, previous experience of uncomplicated pregnancies and avoidance of frequent antenatal care visits which are discussed.

- **Judged and embarrassed for being pregnant**

The participants indicated that nurses have a tendency of talking ill about pregnant women and criticizing older women who fall pregnant. Their comments included that *"Sometimes they will say" Year after year a person is attending ANC appointments" and are told that they are tired of her, she must stop conceiving".* The quote refers to the women who become pregnant every year that they should stop having babies. They are told that they love sex and they should stop conceiving. *"Some other people when they see older women coming to ANC, they talk bad things like why does she fall pregnant at that age because she is old. It means she likes" swa masangu" (sex)…small laugh…the people here sometimes talk bad here".*

This makes them feel judged and embarrassed. The attitude that they are treated with by the health care providers make them not to return for antenatal care. *"The nurses sometimes speak ill of the people and they judge you and the community will comment badly about you especially if you are an older woman".*

On hearing such experiences, those who have not started with attending antenatal care decide to stay away from the clinic than to come and experience such ill treatment. They said: **"***Judgment by the community, older women are afraid of the community's comments. That they got pregnant whilst they are too old". "Some people think ahead and foresee problems they will encounter when they come to the clinic. They think a lot and afraid of being judged by others about their pregnancy".*

The current study reveals that health workers have a negative attitude towards women with high parity and tend to ill-treat and embarrass them during their antenatal visits which deter pregnant women from attending antenatal care. However, some pregnant women experienced self-embarrassment for being pregnant which is contradictory to the current findings that women feared to be embarrassed by the health workers (Ye et al., 2010:31).

The negative attitude demonstrated by the nurses is in contrast with the ethical principle of altruism which requires nurses to always show health care users that they are concerned about their welfare and their wellbeing. They should respect the wishes and

actions of the pregnant women at all times. Nurses should always demonstrate the art of nurturing by applying positive emotions to create harmony (SANC, 2013:5).

Further to that, a close association of low utilisation of antenatal care with high parity was identified by Titaley et al (2010:9). Women with high parity tend to think that they do not need to attend antenatal care based on their previous history of healthy pregnancies.

- **Family responsibilities**

The participants indicated that one other reason for pregnant women not to attend antenatal care as they should as they might have other smaller children who cannot be left alone at home when she goes to the clinic. There is no one who can take care of them in her absence The following was said: *"The woman might have other younger children to take care of or fell pregnant too soon and afraid to be embarrassed." "The woman might have other younger children to take care of".* As a responsible mother, she chooses not to go for antenatal care but take care of the children. Titaley et al (2010:9) assert that some women fail to attend antenatal care due to lack of time as they are responsible for their other children. Others bring their children to the clinic and buy them food whilst waiting to be seen as they cannot be left alone (Mail et al., 2013:15).

According to the current findings, women fail to attend antenatal care due to family responsibilities which is similar to the findings in Kenya and Malawi where women work with their husbands in the field including other family members. They are also responsible for preparing meals for the family (Mail et al., 2013:15). Failure to perform such tasks was considered to be an opportunity cost which is not easy to miss because they feel obliged to do it as it is their family responsibility. Other reasons for not attending antenatal care were limited financial resources, family responsibilities, not being aware that they are pregnant and failure to be released from work to attend antenatal care (Mail et al., 2013:15).

In a study conducted by Titaley et al (2010:7), in the West Java Province of Indonesia where some pregnant women had to walk for about two hours to access health services, physical accessibility of health services was found to be a major problem compounded by the long waiting hours before they were attended to. The situation made it difficult for

women to attend antenatal care as most of them were agricultural workers during the working hours of the day which meant suffering loss of income. The findings were affirmed by the demographic and health survey conducted in Indonesia which showed an association of demographic and socio-economic factors and the utilisation of Maternal and Child Health care services (Titaley et al., 2010:2). Mubyazi et al (2010) also found that long waiting times for services at clinics seriously affected the domestic responsibilities of pregnant women which affected their health seeking behaviour in a major way.

- **Previous experience of uncomplicated pregnancies and avoidance of frequent antenatal care visits**

The participants indicated that older pregnant women tend to use their previous experience of having had healthy pregnancies and successful deliveries without any complications as a bench mark for all the subsequent pregnancies. Some of the comments were ***"****Older women sometimes do not see the importance of going to the ANC appointments because they think that they know too much about pregnancy".* Women lack understanding on the importance of antenatal care. *"They think that there is no valid reason to go to the clinic and give birth at home".*

The absence of physical problems or illnesses is used as a reason for not attending antenatal care. *"Some say they do not want to get tired of going to the clinic many times. They decide to start late so that once they start they are close to their time of delivery"***.** *"They tell themselves that they will start late at 8 months".* Some of the women intentionally start antenatal care when they are about to give birth because they are avoiding to go to the clinic many times. *"… they will start ANC at seven months when they are closer to the date of delivery so that they can rest".* They want to attend once or twice before they deliver the baby.

Mail et al (2013:13) found that it was a common practice in Kenya and Malawi for older multiparous women to attend antenatal care late as they have past experience of successful pregnancy and delivery. Their objective is to get antenatal card and are less concerned about the objective of antenatal care. Findings from Simkhada et al (2007:247)

showed that higher parity was identified as a barrier for women to satisfactorily use antenatal care. Women would not visit antenatal care early if they have not experienced problems with the previous pregnancies (Simkhada et al., 2007:256). Women with high parity may not feel the need to attend antenatal care as they have a tendency of relying on the experience of their previous pregnancies (Titaly et al., 2010:9).

This is consistent with the findings that older women who did not have physical problems are inclined not to be concerned about frequent antenatal care visits. They were not utilising antenatal care early in pregnancy particularly when they are not seeing a direct benefit of antenatal care (Simkhada et al., 2007:256).

Additional to that, findings in Kenya and Malawi showed that most high parity women from peri-urban and rural areas had confidence with their pregnancy as they were more accustomed to it and were likely to feel less need for antenatal care. The dangers of complacency among multiparous women needed to be raised (Pell, Men˜aca, Were, Afrah, Chatio, Taylor et al., 2013). The feeling of being well during pregnancy may be perceived as a deterrent from attending antenatal care (Titaly et al., 2010:6). However, this is in contrast with the findings in Ethiopia which showed that multiparas used antenatal care more than primiparas (Simkhada et al., 2007:247).

Category 4.2: Family circumstances

The second category which emerged from theme perceived socio-demographic factors was family circumstances. The category focused on lack of education and ignorance, and poverty and lack of basic necessities which are discussed below:

- **Lack of education and ignorance**

The participants indicated that women feel uncomfortable at times during antenatal care visits when those who went to school speak and understand English which could be attributed to the family circumstances such as poverty which resulted to illiteracy. The following were some of their comments *“Sometimes it is because you did not go to school and when you get to the clinic, others who went to school will talk in English, and you do not understand. Lack of education is a problem”.*

The lack of knowledge and ignorance makes them to be apathetic, lazy and lead to starting antenatal care late to shorten the number of visits before they deliver. *"Some people are lazy to walk since they do not have transport. So they may say that they will start ANC at seven months when they are closer to the date of delivery so that they can rest". "some do not see it as important. They don't understand this thing of getting pills"*. The lack of interest and understanding on the importance and benefits of antenatal care result in poor attendance of antenatal care. *"Those who do not attend ANC are just Ignorant which is a major problem". "If they don't want, there is nothing you can do. My cousin sister was pregnant but did not share with any one about her pregnancy. She started attending ANC late and delivered a baby who later died. How could you have helped such a person because she is the cause of the problem?"*

Findings from Titaley et al (2010:3) showed that there is underutilization of antenatal care services in the rural areas when compared with those in urban areas. Underutilization of such services was found in to be significantly high in women with low educational levels.

There is a correlation of antenatal care attendance and the level of education. Simkhada et al (2007:247; 257) found that better educated women were more likely to attend antenatal care as recommended than the less educated women. This could be attributed to their increased understanding of the importance of attending antenatal care.

In developing countries, women who are educated are more likely to utilize antenatal care services than the less educated because they better understand the benefits of antenatal care. Such women are autonomous and insightful which enables them to make decisions regarding their own health. Titaley et al (2010:4) also find that the lack of knowledge on complications of pregnancy was among women who came from poor households with low levels of education. The low educational level is correlated with low household income which signifies poverty. Women do not attend antenatal care because they do not have the knowledge on the importance of antenatal care (Titaley et al., 2010:8).

Sohaq et al (2013:18) assert that women who are educated and live in urban areas had better attendance of antenatal care than the low educated women who lived in rural areas. Education enhanced their thoughts to seek better health during pregnancy and child birth.

The educational level of the husbands was also found to be a strong predictor of antenatal care utilisation in the Philippines (Simkhada et al., 2007:247; Kulkarni, 2008:101). There is a significant correlation between low education and antenatal care underutilization (Simkhada et al., 2007:247; Titaley et al., 2010:8). Lack of understanding of health and pregnancy health related risks contributed to late antenatal care visits. This was confirmed by the study that was conducted in the Upper Eastern Region of Ghana, Kenya and Malawi which showed that it was only the respondents from Ghana who cited identifying health problems during pregnancy as one of their reasons for attending antenatal care when asked a question on their perceptions and reasons for antenatal care attendance (Pell et al., 2013).

However, this is in contrast with the findings in Pakistan that showed no association of level of education and antenatal care utilization, although educated women appreciated the importance of antenatal care (Simkhada et al., 2007:247). This could be attributed to the fact that some studies are context or country specific (Simkhada et al., 2007:257).

- **Poverty and lack of basic necessities**

The participants indicated that poverty contributed to poor attendance of antenatal care because the health facilities are far away from where they live. This is exacerbated by lack of basic necessities such as proper clothes to wear when going to the clinic. Some of the comments were *"If you are poor and come to the clinic on the same dress and under wear, the nurses will say that you smell and you are not bathing. So every sister in the clinic will know you and talk badly about you. They will not give you proper examination but they will just fulfil so that you leave. If you have discharges they will say you that you smell. So you rather stay home and go to the hospital for delivery".* At times, women who are not well dressed experience discrimination, ill-treatment and are offered poor quality of nursing care by the nurses.

The quotes expressed the need for government to provide pregnant women with regular transport to the clinic in areas where there is a need. Poverty and lack of money is a challenge for women who need to attend antenatal care. They need basic necessities such as proper clothes when they go to the clinic. There are other indirect costs women

experience, which are the expenses to buy food for themselves or for the children who accompany them while they are waiting to be attended to at the clinics. There are also opportunity costs such as taking time away from the day to day activities such as cultivating land and cooking for the family (Mail et al., 2013:15).

Titaley et al (2010:3) found a close association between low educational level and household wealth index which influenced underutilization of antenatal care services. Mail et al (2013:15) find that women with financial resources made an effort to look smart when they go to antenatal care by going to hair dressers to have their hair done and dressing well to look smart. This is different from those who are from poor families who cannot afford to dress properly and have no money for transport to go to the clinic. Further to that, they experience discrimination because they are not properly dressed. The poor and illiterate women get different treatment from health workers who communicate well with women who look financially stable and are either educated, have a familial relationship or friendship, who address health workers on a relatively equal terms.

The current findings show a violation of the women's health rights as nurses have ethical obligations to provide health care without discrimination. They have a responsibility to discharge their services according to the professional values where everyone is treated equally without any discrimination (Jormsri et al., 2005:585; 586). In addition, nurses should be trained to improve their communication to enable them to understand women's cultural and traditional beliefs as they are sensitive in nature (Simkhada et al., 2007:256).

Category 4.3: Unwanted pregnancies

Unwanted pregnancies were the third category that emerged from the theme perceived limiting socio-demographic factors which focused on unplanned and teenage pregnancies subcategory which is discussed.

- **Unplanned and teenage pregnancies**

The participants indicated that women who fall pregnant by mistake tend not to attend antenatal care because they do not want the baby. Their comments were *"Denial of being*

pregnant, not accepting the pregnancy"; "At times they are not decided as to whether they want to keep the pregnancy or not".

This gets exacerbated by lack of support from the family or the partner. *"My friend is always talked badly about falling pregnant and accused of things at her home and they always have misunderstandings because of that. She is fed-up and does not want the baby anymore because at home there is no peace because of her pregnancy".* **"***At times you find that your partner is not supporting you and wants an abortion so that makes it a problem because you want to keep the pregnancy. And when you go home he calls you back but fails to accept the pregnancy".*

If the woman is struggling to accept the pregnancy, she will not want to attend antenatal care which also applies to girls with teenage pregnancies. The nurses tend to have a negative attitude towards pregnant teenagers by judging and disapproving their pregnancies, which drives them away. The following comments were further presented: *"Young mothers are afraid of being discouraged and asked uncomfortable questions by the nurses. At times they are not decided as to whether they want to keep the pregnancy or not".*

"*I started ANC late when I was advanced because I feared that the nurses will scold me and tell me that I'm still young although I knew that I was pregnant".*

"*It is true that some nurses are aggressive and scold young pregnant mothers for being pregnant at an early age".*

"They fear the attitude of the staff. We are told that we are still young to fall pregnant so we end up not coming for ANC".

The current findings are similar to those of Mail et al (2013:12) who found that unmarried and adolescent women initiated antenatal care late because they hid their pregnancy to avoid the stigma attached, hearsay, being expelled from their biological home or school. This is in contrast with older women who made no effort to hide the pregnancy but had limited disclosure to those close to them as they feared to be accused of being boastful

about the pregnancy and preventing potential gossip and embarrassment if the pregnancy was not successful.

This is supported by Simkhada et al (2007:247) who find that having intended pregnancy was a statistically significant determinant for antenatal care attendance than those with unwanted pregnancies. There is a likelihood of underutilization of antenatal care in women with unwanted pregnancies. They are also associated with starting antenatal care late and less frequent visits when compared with intended pregnancies (Titaley et al., 2010:9).

3.3.1.5 Theme 5: Experiences on health care system barriers

The fifth theme identified is experiences on health care system barriers. Out of it emerged three categories which are limited resources, poor quality of care and feeling disempowered. The first category focused on two subcategories, the second category focused on four subcategories and the last one focused on one subcategory.

Table 3.10 shows the theme, categories and subcategories within the theme health care systems barriers.

Table 3.10: Theme 5 - Experiences on health care system barriers

THEME	CATEGORY	SUBCATEGORY
5.Experiences of health care system barriers	5.1.Limited resources	5.1.1. Inaccessible health services
		5.1.2.Long waiting times
	5.2.Poor quality of care offered	5.2.1.Lack of privacy and confidentiality at service points
		5.2.2.Patient ill-treatment, disrespect and neglect
		5.2.3.Missed opportunities to educate clients
		5.2.4.Reluctance to use mobile clinics
	5.3. Feeling disempowered	5.3.1. Conflicting messages delay early antenatal care attendance

Category 5.1: Limited resources

Limited resources emerged as the first category of the fifth theme, experiences of health care system barriers. The category focused on inaccessible health services and long waiting times which are discussed.

- **Inaccessible health services**

The participants mentioned that some of the villages do not have clinics, which limits pregnant women from accessing antenatal care services as they should. To be able to reach a clinic, they need to have money for transport as they cannot walk the long distances. Some of their comments were "*Transport might be a big problem; if there can be regular transport that takes pregnant women to the clinic."*

Some of the pregnant women who have money use two connecting taxis to reach the nearest clinic. Should money be unavailable, it becomes impossible to return to the clinic for follow ups. They suggested that the government should build more fixed clinics in disadvantaged communities as they do not want mobile clinics because they are not accessible at all times. *"The government should add more clinics so that they clinics are not full and they can walk a short distance. Mobiles are not good because they come and go". "They should also provide mobile clinics in areas where there are no clinics so that the services are closer to the people".*

Fixed clinics will provide health services which will always be available and will always be there and within a walking distance. *"To build more clinics in the community not mobile clinics because mobile clinics are not always there when needed, they come and go". "These problems can be reduced because some villages do not have clinics"*.

They also indicated that providing antenatal care services at household level would be another option and ideal to increase access and address the challenge of unaffordable transport that was experienced. The participants indicated that: *"The government should provide transport to the people. Clinic staff can go around providing the ANC services at household level".*

The current findings are confirmed by Odendal (2011) who found that although health care for pregnant women is free in South Africa, women who do not have money to reach the available health services and still die at home. Women also incurred costs which included levies for cards, laboratory services, medical supplies they were expected to bring, transport and indirect costs for food they have to eat whilst waiting and that for the children accompanying them (Pell et al., 2013).

The study conducted by Simkhada et al (2007:255) showed similar findings that accessibility of health services had an influence on how antenatal care is used. This includes issues such as the distance, the place of residence and the transport involved to the facility (Titaley et al., 2010:4). The fact that women who stayed in the rural areas were forty-five percent less likely to attend antenatal care than those who lived in urban areas was found to be statistically significant. This is because urban areas are better resourced than the rural areas. In areas where more time was spent traveling to the nearest facility, resulted in fewer antenatal care visits and antenatal care uptake (Titaley et al., 2010:4; Simkhada et al., 2007:255). Other contributory factors to poor utilization of antenatal care services were poor road infrastructure, uncomfortable transport and difficulties in crossing the big rivers which made services to be inaccessible (Simkhada et al., 2007:255).

Cham, Sunby and Vangen (2005) find that another limiting factor for pregnant women to attend antenatal care in the rural Gambia was the provision of antenatal care services on specific days during the week. It gave women an impression that maternal health services were only available on those specified days. It made clients to stay away from the clinic even when they had challenges because they wait for specific days when the services are available.

Myer and Harrison (2003:271) find that evidence existed confirming that access to most Primary Health Care facilities was a barrier especially in the rural areas of South Africa, which needs more health facilities. One of the participants indicated that in areas where health services are not accessible, nurses should take the services to the people. The current findings show that accessibility of health services is still a challenge in some areas in the country especially in the rural areas. The patient's right of access to health services

are also violated which is contrary to what is stipulated in the Patient's right Charter and the South African constitution (HPCSA, 2008:2).

- **Long waiting times**

The participants identified that they waited for a long time at the clinic before they are seen by the health workers which was another barrier experienced by pregnant women for not accessing antenatal care services. They arrived at the clinic very early in the morning with the hope that they would be attended to and go back home on time only to find that they leave very late. At times they get hungry and some of them do not have food to eat whilst waiting. Some of their comments were *"People are lazy to go to the clinic because in some other places you will wait for too long and sometimes you are seen at 12 midday mean while you came very early at about 6am and go home at about 5pm, so people get bored".* "*The long waiting time is also a problem. You have to wait for a long time and get hungry whilst waiting". "Some feel that they are ignored by nurses. They come early and end up leaving late. They do not want to be delayed".*

The nurses are not managing their time efficiently, which prolongs the waiting time. *"Time management by the nurses is not efficient and they use it irresponsibly. Tea time is extended instead of attending patients. The tea time is not used for tea anymore but it is time for conversations. The staff should not all go together out during lunch and tea time".*

Participants suggested that nurses schedule their tea time instead of going for tea at the same time to allow an easy flow to the services. The government should increase the number of nurses by offering people bursaries to study nursing so that the work force can be increased to cater for the services that are needed. The long waiting time retards antenatal care attendance. This was expressed as follows: *"They have to employ more staff so that the work is easy. The government should give more bursaries for people to train as nurses to avoid waiting for a long time before being seen".* More staff should be employed so that patients are seen on time to avoid long waiting times. The study conducted by Mason, Dellicour, Kuille, Ouma, Phillips-Howard, Were et al (2015) showed that pregnant women in Western Kenya experienced long waiting times when attending antenatal care and it was one of the four barriers to antenatal care attendance.

This is supported by Tlebere et al (2007:347) who indicated that the long waiting times of women before they are seen in health facilities needed to be improved as quoted:*" facilities could improve on the long hours' people (sick people) endure before being attended [to]."* Simkhada et al (2007:249) also affirmed that some studies showed that the use of antenatal care services was associated with the time women had to wait before they are attended to.

Antenatal care attendance is associated with availability of services, availability of health workers and the waiting time. Waiting time hampered the utilization of antenatal care services which shows close correlation of long waiting times and antenatal care utilisation. Titaley et al (2010:4) assert that the distribution of health services and personnel should be prioritised in order to increase access of health services in the rural areas.

Category 5.2: Poor quality of care offered

The second category that emerged from the theme health care system barriers is poor quality of care offered which focused on; lack of privacy and confidentiality at service points, patient ill-treatment, disrespect and neglect, missed opportunities to educate clients and reluctance to the use of mobile clinics which are discussed.

- **Lack of privacy and confidentiality at service points**

The participants indicated that nurses are not providing privacy at the service areas such as where the vital signs are checked. They also fail to keep their client's information confidential. At times they openly talk about sensitive patient's information which should be kept confidential. This was expressed as "*Lack of privacy is also a problem. There is no privacy at the area the nurses are checking vital signs"* "*Confidentiality does not exist amongst nurses. Nurses should keep information about people confidential".* "*There is no secret in the clinic, there is no confidentiality".* All clients deserve to be treated in privacy and their information treated as confidential at all times and never divulged to anyone. Such actions impact negatively on the antenatal care attendance. This renders the services and the care offered as of poor quality, resulting to the services being underutilized and needing improvement.

The lack of confidentiality is identified as a major problem amongst health workers contributing to poor attendance of antenatal care making the services and the care rendered to be of poor quality, resulting to the services being underutilized and needing improvement. Kulkarani et al (2008:102) found that women who received good quality of care had a significantly higher utilization of antenatal care which emphasizes the importance of providing good quality of antenatal care in health facilities.

These actions are a breach to the code of ethics for the service providers. By providing sub-standard care, they are violating women's rights. In the Patients' Rights Charter, it is stated that health care personnel have an obligation to ensure that every patient has a right to a healthy and safe environment that ensures their physical and mental well-being. The privacy of the patient should be protected at all times during examination and interviews. Further to that, any information concerning health and treatment of a patient may only be disclosed with informed consent from the patient. This information can only be disclosed in terms of law or a court order (Khoza, 1999:16; HPCSA, 2008:2).

There is research evidence which shows that the status of nursing is declining. There is deterioration of the image and the status of the nursing profession (DOH, 2013:23). Nurses have a feeling of resentment on the community views about their bad attitude. However, they admittedly recognise that it is an unsatisfactory ethical behaviour that needs to be corrected. However, their overwhelming working environment makes it difficult to resolve the problem (DOH, 2013:23).

It is further stated that the South African Nursing Council (SANC) professional conduct cases have increased. Statistics shows that complaints against nurses have increased 300 fold since 1996 with the majority of cases having an indication of negative attitude of the nurse practitioners that led to an act or omission constituting a misconduct. There were 135 maternity related conduct cases that occurred between 2003 and 2008. There were 394 cases of poor basic nursing care recorded showing the magnitude of the problem during the same period which is clear that the rights of patients continue to be violated (DOH, 2013:24). It is the responsibility of the nurse to ensure that patients' privacy and confidentiality is maintained including their personal information (SANC,

2005:5). However, the lack of privacy can be argued as to whether it is considered to be moral distress or not.

Moral distress refers to the painful and psychological imbalance which is experienced when nurses are confronted by a situation where they are consciously aware of the correct action to take but fail to do so due to institutional obstacles (Corley et al., 2005:381). Corley et al (2001:250-251) defines it as "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations". At times, the physical structure of the facility cannot allow the health care providers to maintain privacy where they have limited space in the area they provide the services. However, that does not limit them to be creative or initiative in maximizing the use of available space to ensure that privacy is maintained.

- **Patient ill-treatment, disrespect and neglect**

The participants indicated that another health care system impediment for accessing antenatal care services is the ill-treatment of HIV positive women who attend antenatal care services by some of the nurses. Some of their comments were *"The way the staff is treating pregnant women is sometimes bad; if it is bad then they will decide never to come back to the clinic".* They are asked offensive questions and get reprimanded in front of other women. *"The way the clinic staff treats the HIV positive expecting mothers is very harsh, so they run away".*

Such actions are to an extent that they end up giving up their follow up visits. Additional to that, women who come to the clinic and not well dressed are harassed. *"They will embarrass you by asking offensive questions in front of other clients" If you are not well dressed they will harass you and when you talk back you will not get the necessary care that you need".*

"Yes, nurses scold people. They ask questions like "why did not you come for family planning?" This makes make them feel uncomfortable".

If they react to such treatment, they are not examined as they should which makes them never to come back. The quotes show that the rights of the patients are violated. Health care personnel have an obligation to ensure that every patient has a right to a healthy and safe environment that ensures their physical and mental well-being. The privacy of the patient should be protected at all times during examination and interview. Further to that, any information concerning health and treatment of a patient may only be disclosed with informed consent from the patient. This information can only be disclosed in terms of law or court order (Khoza, 1999:16; HPCSA, 2008:2).

Nigenda et al (2003:7) also found that in Saudi Arabia, pregnant women attending antenatal care were frequently experiencing bureaucratic attitude by the staff which had a negative impact on the services provided.

The findings are similar to those of the patient satisfaction surveys and the patient's complaints which showed that health workers are often impolite, uncaring and are insensible to the patients. They feel that they are not treated well at all times (DOH, 2011:4). Poor interpersonal relationship between the service providers and the patients was also identified as a problem in Zimbabwe. The health providers were unsociable, rude and displayed a negative attitude which was a barrier to utilization of health services (Simkhada et al., 2007:256).

This is confirmed by what is mentioned in the nursing strategy that nurses have a feeling of resentment on the community views that their attitudes are bad but they recognize that it is unsatisfactory ethical behaviour that needs to be corrected (DOH, 2013:23). This is attributed to their overwhelming working environment that makes it difficult to resolve the problem (DOH, 2013:23).

Despite the fact that South Africa has invested a lot in improving the Primary Health Care physical infrastructure, there were still some major deficiencies in the physical infrastructure and security which was exacerbated by the introduction of new services such as HIV counselling and testing (HCT), Antiretroviral therapy (ART) and existing demands of services such as prevention of mother-to-child transmission of HIV(PMTCT) and Tuberculosis (TB) (Naledi, Barron & Schneider, 2011:20).

According to the public services code of conduct, employees are expected to be polite and helpful at all times. They always have to be accessible in a sensible manner in performing their duties. They should render a high standard of services to their customers in a friendly and efficient manner (PSC, 2002:17).

The current findings show that nurses are neglecting their "duty to care" by not doing good and failing to act in kindness. They should always uphold the values of respect and act in kindness and in a dignified manner (SANC, 2005:5). The Code of Ethics requires them to promote an environment where human rights and the values of the individuals are respected when providing care at all times (ICN, 2006:2).

- **Missed opportunities to educate clients**

The participants indicated that nurses were giving clients ambiguous information at times which was not helping them to access the available services and get the necessary help. This was expressed as follows: *"A good example is that this morning an announcement was made that the person who was doing CTOP services has surrendered but we should not ask any other thing related to CTOP services. If there is someone who came for that reason what does that mean to her? Where should people go? It would be better if they were saying that such services are no longer available but this is what you should do or where you should go. This is what makes people to end up doing back street abortion because health workers are not helping them".*

The information on the available services in all facilities should be freely and clearly given to the clients so that they are able to access and use the services by clinic staff. Nurses are also missing a lot of opportunities for giving them meaningful health education when doing physical examination. At times, nurses are not approachable. Women come to the clinic with the hope that their concerns and questions will be answered only to find that they are not able to divulge their problems to them due to an unconducive environment. Nurses miss the opportunity to listen to their clients, help them and educate them on various issues especially those who are HIV positive. This is how it was expressed: *"Nurses miss a lot of opportunities to advice clients when they are being examined.*

Sometimes people come to the clinic and go back home with their challenges not being addressed by the health workers especially those who are HIV positive".

The current findings show that there are instances where pregnant women present at the health facilities with concerns and challenges that are not addressed by the health workers, making the health services to be user-unfriendly preventing them from opening up. The findings in Tlebere et al (2007:347) showed that better services are needed which was expressed as follows: "*It is not nice to go to the clinic seeking help and you end up not getting that help you needed".*

This is in contrast with the findings in Mail et al (2013:16) which showed that, pregnant women in Kenya were not taking advantage of the available opportunities on the one-on-one dialogue with the health workers during consultations, although they were asked directly about the health concerns they have. They only relied on the health education that was conducted in groups which is considered to be limited information and a missed opportunity to educate women on possible complications of pregnancy.

Mail et al (2013:23) assert that women in sub-Saharan Africa receive limited information about possible pregnancy complications during health education which is in contrast with the patients' right charter that indicates that everyone has the right to health information, counselling and provision of special needs (HPCSA, 2008:2). The lack of satisfaction in one component of the quality of care could be a most important de-motivator for women in the utilization of maternal services (Simkhada et al., 2007:257). According to the World Health Organization (WHO), principles for effective prenatal care are that caring for pregnant women should be based on privacy, dignity and confidentiality (Banda, 2013:7). It is also important to reinforce the ethical principle of veracity which requires the nurses to ensure that the provision of information to and on behalf of the health care users is provided with truthfulness and honesty for the best interest of the user (HPCSA, 2008:5).

- **Reluctance to use mobile clinics**

One participant indicated that as pregnant women, they acknowledged that mobile clinics are available in some other areas where there are no fixed clinics. They are, however, not satisfied with the antenatal care services that are provided in the mobile clinics

because they are different from those that are offered at the fixed clinics because some of the procedures are missed. In the mobile clinic, nurses render poor quality of care. They do not examine the clients and listen to the baby's heart whether it is beating or not; which is considered as sub-standard care. This is what she said: *"What they are doing in mobiles is wrong. They do not even listen to the heart of the baby. When they give you pills what are they for because listening to the baby's heart is important? A mobile clinic should have all the necessary services that people need otherwise they are useless".*

The expectation is that mobile clinics should provide similar services as those that are rendered in fixed facilities. They, therefore, prefer not to attend such services as they consider it to be useless**.** However, the challenge experienced with using mobile clinics is that nurses do not provide the services similar to those provided in fixed facilities which are not meeting their needs. The services provided focus mainly on child health services which was expressed as follows: *"The mobile clinics should also cater for pregnant women but not focus of child immunization only".*

Pregnant women do not get palpated and the foetal heart is not listened to. The nurses only take history, check the blood pressure, test the urine and give them pills. This is what was said: *"The problem with mobile clinics is that they do not palpate you. They just take history which is not good because a lot can be missed. They check BP, test urine, then go and collect treatment. That is the reason we are avoiding mobile clinics and come to the fixed clinics because we are not well examined. What they are doing in mobiles is wrong. They do not even listen to the heart of the baby".*

Based on these grounds, it shows that pregnant women intentionally and consciously make a decision not to use the mobile services but rather go to fixed facilities where they get fully examined irrespective of how far they have to travel. Those who cannot manage to reach fixed facilities due to the distance and lack of transport money choose to stay at home without attending antenatal care. Such could be attributed to the omission by nurses to provide the expected services. It could also be the challenges facing the health system such as lack of resources, which is unethical.

The current findings show that the poor quality of care rendered by the health workers in mobile clinics make pregnant women to develop a negative attitude towards them and their utilisation. The study conducted by Simkhada et al (2007:256) showed similar findings in Zimbabwe where poor quality of care was found to be one of the factors affecting utilisation of ANC services.

The above shows a violation of patient's right of access to health services. According to the Patient's Rights Charter (Department of Public Service and Administration (DPSA). 1997), the right to access of health care includes the provision of persons with special needs of which pregnant women are part of. Health care providers are compelled to treat the patients with dignity, empathy, courtesy and patience (HPCSA, 2008:2; Khoza, 1999:15). This is supported by what is indicated in the nursing strategy, that the status of nursing is declining. Nurses are facing challenges such as staff shortage, irregular staff patient ratio, lack of equipment, shortage of drugs and supplies and work place violence which impacts negatively on the quality of services delivered and erodes the nursing moral (DoH, 2013:23)

Category 5.3: Feeling disempowered

Feeling disempowered was the third category to emerge from the theme, the experiences on health care systems barriers which focused on one subcategory, conflicting messages delay early antenatal care attendance which is discussed.

- **Conflicting messages delay early antenatal care attendance**

The participants indicated that pregnant women are sometimes given conflicting messages by the midwives. They are told that they have to start attending antenatal care immediately when they realise that they have missed a period, which they do. On examination, they are told that they cannot feel the baby. They are told to go back home and stay for a longer time as there is nothing felt on palpation. It was expressed as follows: *"They told us that we should come immediately when we see that we have stopped menstruating. But when we get there they tell us that they do not see anything". And "So they give some months to stay at home and tell you when you are supposed to come back".*

Women find it confusing and disempowering because they no longer know how to respond to the messages they are given. It makes them stay at home without coming back for antenatal care. They are discouraged to report early in future pregnancies for antenatal care as they find it invaluable. The quotes show that women are motivated and respond positively by presenting to the health facility as soon as they experience amenorrhea.

The current findings are supported by Mail et al (2013:13) who find that although women in Kenya attended antenatal care in the first trimester, nurses would tell them to return in the second trimester because they could not confirm the pregnancy. They were told to come back when the pregnancy was visible and palpable. This is in conflict with what the health workers advise, that pregnant women should start antenatal care as soon as they realize that they are pregnant. This was confirmed by the researchers during data collection in Malawi where they witnessed three women being transferred from the health centre to the hospital because the pregnancy could not be confirmed (Mail et al., 2013:13).

Palpation after twelve weeks of pregnancy was often used as a method of confirming pregnancy in the absence of equipment to conduct pregnancy tests, which are only done in district hospitals. The health workers instructed pregnant women to return to the clinic when the pregnancy could be confirmed by palpation leading to late initiation of antenatal care (Mail et al., 2013:13).

Pell et al (2013) assert in their study in Kenya that health care providers gave pregnant women information that is not clear. This was demonstrated in cases where pregnant women indicated that health providers sent women who came in their first trimester back home and instructed them to come back when their pregnancy was visible and palpable to confirm the pregnancy. This was in conflict with the information that they have to attend antenatal care as soon as they are aware that they are pregnant.

Based on these facts, the study shows that conflicting messages and the interaction that occurs between the women and the health workers, causes confusion that contributes in women delaying their antenatal care attendance. Failure to provide pregnant women with

the necessary information is a breach of the code of ethics. The Code of Ethics for Nursing in South Africa stipulates that nurses have a responsibility to act with truthfulness and honesty at all times and ensure that they provide health care users with information that is in their best interests (SANC, 2005:5).

3.3.1.6 Theme 6: Supportive needs during pregnancy

The sixth identified theme is supportive needs during pregnancy. Out of it emerged two categories which are the role of family members, friends and partners and expected health care needs. The categories focused on six subcategories.
Table 3. 11 show the theme, category and the emerged sub-categories within the theme supportive needs during pregnancy.

Table 3.11: Theme 6.-. Supportive needs during pregnancy

THEME	CATEGORY	SUBCATEGORY
6. Supportive needs during pregnancy	6.1. The role of family members, friends and partners	6.1.1. Provision of financial and basic needs
		6.1.2.Provision of emotional and psychological support
		6.1.3.Accompany partner to the clinic
		6.1.4.Lack of family support
		6.1.5.Initiate men's support group to educate other men
	6.2.Expected health care needs	6.2.1.Unhurried individualized care with meaningful health education
		6.2.1.Seeking alternative method of redress

Category 6.1: The role of family members, friends and partners

The role of family members, friends and partners was the first category which emerged from the theme supportive needs during pregnancy. It focused on five subcategories which are provision of financial and basic needs, provision of emotional and psychological

support, accompany partner to the clinic, lack of family support and initiate men's support group to educate other men. Each subcategory is discussed.

- **Provision of basic needs and financial needs**

The participants indicated that their partners, biological mothers and grandmothers are the basic providers of support to meet their basic and financial needs such as food and money to go to the clinic. They are provided with food, fruits and money for transport to go to the clinic. This is what they said: *"My mother cooks me "morogo" (relish) and my husband always brings something nice to eat from the shopping centre like bananas and apples".*
"I stay with my husband who encourages me and to be on a strict diet so that the baby can grow well. He gives financial support for the woman to go to the clinic anytime if there is a problem or pain. He buys me fruits and vegetables to eat". "My husband supports me financially and asks me when I come back and ask for feedback". "My biological mother encourages me and provides financial support. She gives me money for transport to go to the clinic when I do not have it". "I'm supported by my grandmother. My mother would also ask me if I started to attend antenatal care".

The above findings are similar to Mullick, Kunene and Wanjiru (2005:124) who found that, as the head of the family a man rules, protects and provides for his household. The family depends on him for economic and political protection. He uses the available resources as he chooses. Mail et al (2013:15) also found that women relied on their husbands and family to meet their direct and indirect costs for antenatal care such as antenatal costs and transport.

In Kenya, the means of transport to the facility for some women are the husband's bicycles. Odimegwu et al (2005:65, 68) assert that husbands provided their wives with money, food, clothes, shelter and ensured that they are fully booked to attend antenatal care services. In Western Kenya, husbands accompanied their wives to pay the fees for antenatal care services (Onyango et al., 2010:34).

Titaley et al (2010:5) findings assert that one of the reasons women were not utilizing antenatal and post-natal care in some districts of West Java Province, Indonesia, was the

cost of health services that were unaffordable. This made them to resort to traditional birth attendants which they found to be cheaper and accessible to them physically than the health service providers. The cost of transport was viewed as an additional burden to them.

In the rural areas of Tanzania, Mubyazi et al (2010) also found that out-of-pocket monetary costs limited women from accessing antenatal care. These are costs related to transport to and from the clinic and the money to buy food and drinks when they are waiting to be attended to, which was unavoidable due to the prolonged waiting time they experienced at the clinic. The long waiting led to prolonged waiting time of the rented transport which also had direct cost implication to the renter to an extent that at times they had to leave the clinic to go back home without being attended to by the service providers, for the fear of incurring the extra unanticipated costs.

- **Provision of emotional and psychological support**

The participants indicated that the members of the family provided emotional and psychological support such as words of encouragement that things will be fine and requesting feedback when they return from the clinic. They find out what transpired at the clinic, remind them to go back for follow up and to take the tablets as advised. They find out how they are progressing and when the next appointment is scheduled to enable them to provide the necessary support.

Some men are so interested in their partners' pregnancy to an extent of wanting to know if the baby is kicking, which is a sign that the baby is alive. Men also showed them love, understanding and reassurance. They take walks together; rub their tummies as a way of showing care and affection. Some go to an extent of cooking for them if they are not feeling well. The following are some of their comments expressed as follows*: "I live with my sister and she is the one who encourages me to come for ANC, advise me and tell me the risks of not going to the clinic. "My parents give encouragement because sometimes as a young person you do not even know that you are pregnant". "I get support from both families from the partner's side and mother's side in all ways including my friends".*

"Some partners also give advice and guidance and contribute towards the pregnancy. They want to know about the first kicks as they know that if the kicks are there the baby is alive". "My husband brushes my tummy. He is happy with my pregnancy". "My mother supports me by asking what transpired at the clinic and if I have any problems. Some people have very good support, from my family until time of delivery they get engaged and ask all questions regarding what they said at the ANC and follow up on my appointments".

"I need support, love and understanding. If I have pain they cook for me. The father of my baby tells me that I should not worry, soon it will be over. We take walks together". "I get support from my husband and his parents. They remind me to go to the clinic and to take the pills that I get from the clinic". "My mother and my mother-in-law play a very important role because they encourage me to come to the clinic".

The quotes show that the family plays an important role by providing psycho-social support during pregnancy. They encourage pregnant women to attend antenatal care. They are reminded on when they should go back to the clinic for follow-up and to take their tablets as advised in the clinic. According to Deave et al (2007) pregnant women got their support from partners, parents, friends, colleagues, health professionals and antenatal care or post-natal care groups with the support given by the mother considered to be exceptional**.** This is similar to the findings by Simkhada et al (2007:256), which showed that the available social support for a woman determined the use of antenatal care services. Odimegwu et al (2005:65) found that husbands showed affection, ensured that women are emotionally stable, and reminded them to go to the clinic and comply with treatment.

Women who lacked support from friends or family were twice unlikely to attend antenatal care than those who are supported (Simkhada et al., 2007:256). This is in contrast with the experience in Bangladesh where older women such as mothers-in-law were not finding antenatal care as essential and discouraged their daughters-in-law from attending (Simkhada et al., 2007:256).

- **Accompany partner to the clinic**

The participants indicated that some men accompany their partners to the clinic which enabled them to know and hear for themselves what is happening with the pregnancy. Their comments included that *"It is good to go to ANC together so that both of you know what is happening". "He came with me to the clinic and reminds me to go to the clinic".* The participant's wish is for this kind of support to continue throughout the pregnancy and beyond, when the baby is born. *"My wish is for partner to be always there for me even after delivery. When we go for birth certificates we should go together".*

The quotes show that women appreciate the support and encouragement they get when their partners accompany them to the clinic. The current findings are supported by Ediau et.al. (2013) who find those young, educated, non-Muslim Tanzanian men and those in monogamous marriages supported their wives by accompanying them to antenatal care services. This was asserted by Adewuyi et al (2005:65) who indicated that husbands ensured that they are fully booked and took them to the clinic. Men were the gatekeepers of women's reproductive health and are critical partners in improving maternal health and reduction of mortality. They need to be involved in the maternal care of their partners.

However, in a study that was conducted in South-West England where men were involved in their partner's pregnancy, they felt excluded in their antenatal care because the topics that were covered in the classes focused on the woman only; which is pregnancy and child birth with little or no discussion on parenting (Deave Johnson & Ingram, 2008).

The findings were similar to those of Nigenda et al (2003) who found that men felt that they were inadequately prepared for parenthood as the content of antenatal care education was always targeting pregnant women which made them feel excluded in antenatal care education. Deave et al (2007) assert that although there was some excitement about being parents, both men and women felt that the antenatal care classes were mainly focusing on women, pregnancy and birth with little to do with men. This made them feel excluded from the woman's pregnancy, antenatal care appointments and the classes and was not preparing them to be parents. Additional to that was the fact that the classes were conducted during awkward times when the men are busy. Nigenda et al

(2003) identified that there is a need to improve service provision, restructuring of the antenatal care services and policy changes.

- **Lack of family support**

The participants indicated that lack of family or partner support was a contributing factor for pregnant women not to attend antenatal care as expected. This was expressed as follows:

"At times you find that your partner is not supporting you and wants an abortion, so that makes it a problem because you want to keep the pregnancy. And when you go home he calls you back but fails to accept the pregnancy. It becomes very hard when you are in that situation and you are married, you have to live with stress but it eventually passes".

The participants indicated that the lack of partner or family support and failure to accept the pregnancy means lack of support to the woman. There are parents of pregnant teenagers who deny them money for transport to go to the clinic because they are upset about the pregnancy. Their comments included that **"***I do not get any support from my family members as they want you to* regret *every day that you fell pregnant and they are not happy about it".* "*If you have a problem they must help you to resolve the problem but not leave you without assisting you".*

Women are at times in stressful situations similar to when they have tested HIV positive and thus lack support. *"If you have a problem they must help you to resolve the problem but not leave you without assisting you. Like if you have tested positive, the stress that you are ill, at home they do not care about me". "Sometimes at home they no longer provide for you and leave you stressed".* They are not given the love that they were expecting. *"Love is the most important thing to receive from family and friends to be comfortable e.g. HIV positive mothers should get all the care at home and support like those who tested HIV negative".*

The quotes show that women are not getting the support that they need which leads to poor antenatal care attendance. Some women lack support from the decision makers such as husbands or relatives they are dependent on, who then object their antenatal care attendance (Mail et al., 2013:15).

Further to that, the experience in Bangladesh shows that older women such as mothers-in-law were not finding antenatal care as essential and discouraged their daughters- in-law from attending. Women who lacked support from friends or family were twice unlikely to attend antenatal care as those who are supported (Simkhada et al., 2007:256). The likelihood of underutilization of antenatal care services is also noted in women who are not involved in making decisions about their own health which is in contrast with women who make decisions about their own health and or are involved in the decisions (Titaley et al., 2010:9).

In cases where a man is the head of the family, it depends on him how to provide financial support. He uses the available resources as he chooses (Mullick, Kunene & Wanjiru, 2005:124). He may not prioritise antenatal care attendance and may not provide resources to support for his partner which may deter the woman from attending antenatal care. In a study conducted in Witkoppen Health and Welfare Centre in Johannesburg, most (38 %) men cited their reasons for not attending antenatal care with their partners as they were not getting time off from work. Other reasons cited were transport costs, no other men at the clinic and services not provided over the weekend. (Yende, Van Rie, West, Bassett & Schwartz, 2017:5). Antenatal care utilization is significantly affected by lack of support (Simkhada et al. 2007:256).

Nigenda et al (2003) find that although it was a cultural practice in Thailand for men to stop doing all other things and focus on the pregnant women throughout the pregnancy and for some days after delivery, men were not practicing it due to personal or work reasons. Pregnant women demanded understanding from the people around them especially their husbands and their mothers due to the physiological changes occurring in their bodies, but were not getting their attention**.** This is in contrast with findings in Pakistan where antenatal care utilization is associated with being accompanied by another adult (Simkhada et al., 2007:256).

Women who lacked support from friends or family were twice unlikely to attend antenatal care as those who were supported (Odimegwu et al., 2005:65). It is evident that the lack of support from the family or partner contributes towards low antenatal uptake especially in cases where the woman is dependent on the family members. Titaley et al (2010:9)

assert that support of the family is vital in accessing and utilization of antenatal care services. The social support that a pregnant woman receives determines her success in attending antenatal care. It is supported by the study conducted by Ha et.al, (2015: 704) across nine provinces in Vietnam which showed that women who received financial support from their husbands were likely to attend antenatal care more than four times during pregnancy.

Messages on antenatal care attendance should also target friends and relatives, as they have an influence on decision making related to antenatal care attendance (Mail et al., 2013:20). Education about male involvement in maternal health should be prioritized especially in cultures where it is not recognized as important (Simkhada et al., 2007:258). There is a need to involve the family and the community at large in raising awareness on the importance of antenatal care attendance (Titaley et al., 2010:9).

- **Initiate men's support group to educate other men**

The participants indicated that they acknowledged that some men do not support their pregnant partners. It is recommended that such men be taught how to support their pregnant women which was expressed as follows: *"Start to involve men as well educate them on how they should support their pregnant partners by doing door to door campaigns and visiting the churches". "Doing door to door is the most important thing and involving the male figures so that they are able to encourage and support their expecting partners and easily support them".*

Based on the fact that in Kenya, pregnant women who tested HIV positive faced stigma from their partners who perceived them as promiscuous (Turan et al., 2011:1119) suggested that men must be engaged in antenatal care including HIV counselling and testing to address this challenge. Ediau et.al. (2013) affirm the findings by indicating that involvement of men on maternal health issues has been identified as a need. However, barriers to male involvement that are related to structural and cultural issues exist. Mullick et al (2005:124) also found that the factors mitigating men's involvement in maternity care are cultural and health systems norms.

A man is considered to be the head of the household who rules, protects and provides for the family. The norms of the society and those of the health systems mitigate men's involvement on maternity issues despite their willingness to be involved (Mullick et al., 2005:124-125).

Onyango et al (2010:33, 34) asserted that the factors which influence men's involvement were negative cultural practices, parenting practices related to reproductive health, perceptions and challenges related to accompanying partners to the health facility. Men are considered to be gatekeepers who restrict their family members from accessing health services by neglecting and abusing them, contributing to decreasing health**.**

Ediau et.al. (2013) indicate that men as gatekeepers of women's reproductive health are critical partners in improving maternal health and reduction of mortality and they need to be involved in the maternal care of their partners. Their awareness and sensitization needs to be prioritized. They can be used as change agents to increase male involvement if they are trained to mitigate such challenges by community sensitization and improving client-friendliness in the clinics (Onyango et al., 2010:33, 40).

Ediau et.al (2013) suggest that men need to be empowered with knowledge on antenatal care services by using strategies such as men's seminars, edutainment activities, men to men discussions, mass media and mobile phones village health markets are the strategies that can be used. Additional to that, advocacy to restructure clinics and reproductive health services to be male friendly is essential. This would impact positively on the men's knowledge (Onyango et al., 2010:33, 40).

Shirani, Henwood and Coltart (2009) assert that men who were experienced with involvement in antenatal care felt more confident as partners and accessed good quality of information in antenatal care.

Category 6.2: Expected health care needs

The second category that emerged from the theme, support available and needs in pregnancy focused on two subcategories which are unhurried individualized care with

meaningful health education and seeking alternative methods of redress. Each subcategory is discussed:

- **Unhurried individualized care with meaningful health education**

The participants indicated that when pregnant women visit the facility, they are expecting the service providers to give them proper attention, take their time to thoroughly examine them and listen to their concerns. Their experience is that most of the time they are rushed and not all their needs are met. The comments made included that *"The staff should give proper care to pregnant women and not make them feel uncomfortable at the clinic";* "*They must not always be in a hurry to address your concerns".*

Women would like to receive individualised care and attention to enable them to voice their concerns instead of being hurried. Nurses need to start utilizing the opportunity to promote antenatal care attendance through educating members of the community as it continues to be a challenge. The participants noted that: *"Give maternal education in the community so that they understand the importance of ANC". "Nurses can teach people who are here at the clinic so that they go home and encourage their people to go to the clinic".*

The current findings indicate that women are not satisfied with the care that they receive from service providers as it does not meet their individual needs and the health education given is not individualized. The findings are similar to those in Mail et al (2013:10) who found that women were not receiving all the procedures in antenatal care as recommended by the WHO standards, due to shortage of staff and problems related to the infrastructure. Additional to that, health care workers in Kenya and Malawi gave health education in groups only without one-on-one education during consultation. They were not maximizing the utilisation of the time and the opportunity they had during consultation with pregnant women. When asked about the specific procedures that were done during antenatal care, they gave a vague explanation as they were less informed. However, this was different from what was found in Ghana where one-on-one consultations were used (Mail et al., 2013:14).

Mail et al (2013:23) assert that in some parts of the sub-Saharan Africa, women received limited information about possible pregnancy complications in both group health talks and one-on-one consultation which was described as a missed opportunity. This is in contrast with what is stipulated in the patients' right charter that everyone has the right to health information, counselling and provision of special needs (HPCA, 2008:2).

However, the current findings show that although opportunities were missed, participants knew some of the potential pregnancy complications which they were taught during their antenatal care visits such as bleeding in pregnancy. One of them had experienced low foetal movement and had sought help on time (subcategory 1.1.2).

The lack of understanding of health risks in pregnancy led to late seeking of antenatal care which exacerbates avoidable perinatal deaths (Myer & Harrison, 2003:272). Simkhada et al (2007:257) find that lack of satisfaction in services provided was one of the most important components of the quality of care that could be a de-motivator for women in the utilisation of maternal health services.

- **Seeking alternative methods of redress**

The participants indicated that although suggestion boxes existed in facilities where patient's complaints and compliments are dropped, they feel that the system of addressing complaints is flawed and subjective. Their complaints are not addressed appropriately and they need a more effective forum of lodging complaints as they found it difficult to address the problem of the nurses' attitude which they continue to experience even after reporting it. It was expressed as follows: *"Dealing with the attitude of nurses is not easy. There are suggestion boxes that are there but they are not helpful. It would be better if there was an SMS number where we can send the complaint".* They need an alternative way for redress of their complaints which was expressed as follows: *"We need SMS number and if there was a face book page where you can write back to the department. We need numbers where we can send complaints about the staff because the suggestion box is irrelevant, it doesn't work".*

The above quotes show that the current system of redressing complaints by using the suggestion box is not effective. In the national patient's rights charter it is stated that every

patient has a right to complain about health care service which are provided. The raised complaints should be investigated and a full response on such investigation should be received by the complainant (HPCSA 2008:3).

In the Eastern Cape, it was found that migrant women and those living with HIV and AIDS were discriminated and denied care. This showed that there were many health care delivery failures leading to poor maternal health outcomes due to lack of oversight and accountability. These needed to be addressed by effective complaints mechanisms (Human Rights Watch, 2011:2) as it is a breach of ethical practice and violation of patient's rights.

Health care workers who violate patient's health rights should be held accountable and avoid future recurrence. All health care users need a way of lodging complaints on their mistreatment and get redress (DOH, 2011:4). According to Batho Pele principles, the South African citizens have the right to seek redress if the promised standard of service is not delivered. Health care users should be given an explanation of the reasons why the service was not delivered and they should be given an apology and a full explanation. They should also be told as to when the problem will be resolved (DPSA, 1997).

This is supported by what the Minister of Health, Dr Aron Motswaledi who warned the nurses at the launch of Mom-connect initiative in August 2014 that health officials working at Primary Health Care level need to improve the quality of care and the services they are providing to pregnant women. The initiative is operating twenty-four hours a day and seven days a week (24/7), to enable pregnant women to seek support from the National Department of Health and lodge complaints and ill-treatment by staff (DOH, 2014:2). This will ensure that complaints are dealt with in a minimum turnaround time.

3.3.2 Factors associated with community participation and accountability of local governance structures for antenatal care services

The second objective of the study: **To explore and describe factors associated with community participation in and accountability of local governance structures for antenatal care services** is summarised with all the identified themes, categories and subcategories that emerged from the analysis in table 3.12.

Table 3.12: Summary of themes, categories and subcategories of factors associated with community participation and accountability of local governance structures for antenatal care services.

THEME	CATEGORIES	SUBCATEGORIES
7. Perceptions on community participation and accountability of governance structures	7.1. Expand health education efforts	7.1.1. Collaboration of governance structures with Department of Health and their accountability to the community on antenatal care
		7.1.2. Expand maternal health education through available human resources and mobile health services
		7.1.3. Using various methods of media to educate and disseminate information to the community
	7.2. Strengthening use of existing community based structures	7.2.1. Empower and use existing and functional community based structures for health education
8. Identified needs	8.1. Strengthening health education in antenatal care	8.1.1. Community to accommodate science in their culture by learning to trust modern Science
		8.1.2.Governance structures to take a leading role in community education on the importance of antenatal care
	8.2. Strengthen men's support in pregnancy	8.2.1. Men need to learn to support their partners in pregnancy

Tables 3.12 to 3.14 show the identified themes, categories and subcategories on the factors associated with community participation and accountability of local governance structures for antenatal care services.

3.3.2.1 Theme 7: Perceptions on community participation and accountability of governance structures

The seventh theme identified under governance structures and community leaders is perceptions on community participation, and accountability of governance structures. Out of the theme emerged two categories which are to expand health education efforts and strengthening use of existing community based structures. The categories focused on four subcategories which are collaboration of governance structures with the Department of Health and their accountability to the community on antenatal care, expand maternal

health education through available human resources and mobile health services, using various methods of media to educate and disseminate information to the community and empower and use existing and functional community based structures for health education.

Community participation refers to the mobilization and involvement of the community who actively participate in activities that help to solve health problems that affect them to become part of the solution African Medical and Research Foundation (AMREF, 1995:34; Rosato et al.,2008:967). "Community participation or involvement is the active interaction of people (both as individuals and as members of groups) that have social links in processes such as direct democracy or local neighbourhood action. Community participation or involvement tends to make decision-making continuous, active and accessible to the participants**"** (Friedman et al., 2006:50). Community participation can also be informal where members of the community interact with the service providers as individuals or groups such as women's groups who voluntarily offer their health and welfare services to those in need in their community (Friedman et al., 2006:51).

Accountability is concerned with how the governance structures are held responsible for their actions by the community, District Health Council (DHC) and the health personnel (Ngulube et al., 2004: 24). According to WHO (2010), local accountability is an intrinsic aspect of governance that concerns the management of relationships between the various local stakeholders in health. Stakeholders include individuals, households, communities, businesses, government, non-governmental organisations and other entities that have the responsibility to finance, monitor, deliver and use health services. In particular, it involves delegation or an understanding of how services are supplied; ensuring that adequate resources are available to deliver the services; ensuring performance in the delivery of the services; receipt of relevant information to evaluate or monitor performance; enforcement such as the imposition of sanctions or the provision of rewards for performance. The governance structures should be accountable both upward to the higher administration and downward to the local population to provide mutual feedback. They have an obligation of being responsible and answerable to the results of the activities they are engaged with in a manner that is transparent (WHO, 2010).

Table 3.13. Shows the theme, categories and the subcategories which emerged from the theme on perceptions on community participation, and accountability of governance structures.

Table 3.13: Theme 7 - Perceptions on community involvement.

THEME	CATEGORIES	SUBCATEGORIES
7. Perceptions on community participation, and accountability of governance structures	7.1. Expand health education efforts	7.1.1. Collaboration of governance structures with Department of Health and their accountability to the community on antenatal care
		7.1.2. Expand maternal health education through available human resources and mobile health services
		7.1.3. Using various methods of media to educate and disseminate information to the community
	7.2. Strengthening use of existing community based structures	7.2.1. Empower and use existing functional community based structures for health education

Category 7.1: Expand health education efforts

Expand health education efforts is the first category that emerged from the theme perceptions on community involvement. The category focused on collaboration of governance structures with the Department of Health and their accountability to the community on ante natal care, expand maternal health education through available human resources and mobile health services and using various methods of media to educate and disseminate information to the community subcategories which are discussed:

- **Collaboration of governance structures with Department of Health and their accountability to the community on ante natal care**

The participants acknowledged that there is an existing challenge in the community that pregnant women are not attending antenatal care as they should. They indicated that there is need for health workers to educate the community and the community leadership

on the importance of attending antenatal care. Some of their comments were:" In *all the areas there are block leaders who can work with health workers and governance structures to organize meetings and educate people on the importance of attending ANC."*

"The Department of Health should involve the staff, community leaders, Home-based carers etc. and conduct campaigns where the community can be addressed at the stadium about the importance of attending ANC".
"Community leaders should educate older women in the community who in turn should educate everybody in their families. Community leadership and health workers should work together to send out the information that is needed" "Get the health committees together as well and work together on these issues".

To have an effective health education intervention, the governance structures should collaborate with the Department of Health, community leadership including other relevant stakeholders and existing structures so that their voices can be heard. As they are elected by the community, they need to be accountable to them. They said: "We *can work with councillors, the municipality and other structures like the clinic governance structures and business people who can also assist. I do my work as a Pastor and as a member of the civic. Business people should also be involved in educating the community as their voices can be heard".*

"We can involve the clinic and the governance structures to help in feeding the community with the information".

"All stakeholders should be involved so that everywhere it is only one voice that is spoken. Each department should go back to their basics and solve the problems. All departments should have solutions and should share the same message and the solutions".

They mentioned that it is important for the government and the community to work together by enforcing community participation where they will jointly identify problems affecting them and seek solutions together. They suggested that *"The government and community must identify the problems and work together to solve them". "Collaboration with all other relevant departments, traditional leaders and educate the community through campaigns and awareness programmes".*

Additional to that, the Department of Health should make the health services accessible to the community members through outreach programmes such as mobile clinics and school health services in areas where people are far from the clinics. "*The department of health should take antenatal care services to the community by mobile clinics or create a visiting point at the community as the facilities that are far from the people. The services should always be there but not on specific days".*

Antenatal care services should always be accessible at all times to enable people to use the available services. According to Mail et al (2013), the message on antenatal care attendance should also target friends and relatives as they have influence on decision making, related to antenatal care attendance.

With regard to accountability, the participants indicated that they are accountable to the community as they are selected by them. They also account to the higher authorities within the Department of Health administration. They also have a right to contact the Member of Executive Council for Health (MEC) if needs be. Another participant said: "*The members of the community have elected us to be in the community health committees and have given us the mandate to represent them in the facilities. They are the people we are accountable to hence we have an obligation to report back to them of the problems resolved or the progress made. We are also accountable to the sub-district, district and the province through the facility manager who is a member of the committee. We are also allowed to refer our problems directly to the MEC for Health for the things that can take a long time to go through the administrative channels up".*

In order to have a positive impact in improving antenatal care attendance by pregnant women, there should be collaboration between the government and the governance structures, who are the community representatives in the government health services in the Bushbuckridge sub-district. Governance structures act as a link between the primary services and its users. To expand health education in the community, the governance structures need to take a lead in facilitating the process of community involvement and participation. There should also be collaboration with the Department of Health, other departments and other sectors. Collaboration can be defined as a process where two or more people jointly form an alliance for the same purpose. Manandhar et al (2004:970),

view community participation as a vehicle for improving the quality of primary services which also act as a link between the primary services and its users. The communities need to be mobilised to actively participate in resolving health problems that affect them. Manandhar et al (2004:970), view community participation as a vehicle for improving the quality of primary services and it acts as a link between the primary services and its users. Families play an important role in supporting pregnant women and they are part of the wider society.

Although development of policy on collaboration with the community is complex, forming partnerships at various levels of government services, NGOs, community, men, and women's organisations can collaborate to do the work. To achieve this, common objectives and strategies should be set. The leadership within the Department of Health needs to influence policy and programme implications by engaging in a dialogue to empower health workers who render antenatal care services to start involving the families and forming partnerships with the communities (Gerein et al., 2002:179). Community participation and collaboration should be included in the training of midwives to improve their competency in dealing with issues such as group education, traditional practices and gender approaches (Mail et al., 2013).

There should also be inter-sectoral collaboration where different departments and stakeholders participate in service delivery at different levels including planning, decision-making on implementation and management of planned projects. This should be done in a way that the community representatives are empowered for the purpose of sustainability (Friedman et al., 2006:51).

According to the Alma-Ata Declaration of 1978, it is important for the community to be involved in shaping their health services to ensure that the services are shaped according to the needs and the living conditions of the target population. The health services provided should be able to address and meet the needs of the community (Gorgen, Kirsch-woik & Schmidt-Ehry, 2004:212). Community involvement and partnership enhances communication and understanding between the community and the health service providers which is an equal relationship for all stakeholders (Gorgen, Kirsch-woik & Schmidt-Ehry, 2004:212). Rosato et al (2008:963) found that in countries such as India,

Guatemala and Indonesia, community participation was successfully used as a primary health care component. Ethiopia is also another country where women's groups were mobilized to recognize and treat malaria resulting in the 40 % reduction of under - 5 mortality.

As husbands are members of the families, they were targeted in a study that was conducted in India where it was noted that men lacked understanding of the risks of child birth and the consequences. Male outreach workers were used to reach husbands of pregnant women. They were given reminder cards on antenatal care attendance to take home to their wives who increased the antenatal care uptake (Manandhar et al., 2004:970).

In terms of the local accountability of the governance structures to the community, the National Health Act (61 of 2003) provides a legislative framework which requires the community to participate in health through the governance structures and how the structures should be constituted (Gibbs & Campbell, 2012:16; Boule, 2007:16; DOH, 1997:69; DOH, 2004:69). Governance refers to the way in which control is exercised over health facilities by using the power that is vested in the governing body (Gibbs & Campbell, 2012:16). The Act outlines that the membership of a clinic or community health centre "must at least include a) one or more members of local government councillors b) one or more members of the community served by the health facility and c) the head of the clinic or health centre" which are governance structures (DoH, 2004:69). In this study, clinic committees or community health centre committees are also referred to as community health committees (CHCs) and the words are used interchangeably. The governance structures in Bushbuckridge sub-District are constituted in accordance with the legislation which requires that there should be councillors, members of the community and the official in charge of the clinic.

The CHC is a mechanism which enables the people living within the area served by that health facility to collaborate with government health services to improve their own health. This is in accordance with the Primary Health Care (PHC) principle which stresses the importance of people actively participating in improving their own health by supporting the formal health service providers (Friedman et al., 2006:52).

Boulle (2007:6) further indicates that the aim of forming the governance structures is to ensure that the community is involved in planning, provision of health services and promoting accountability. They are encouraged to take greater responsibility for health promotion. Without active participation and involvement of the local communities, it is impossible to achieve health promotion and effective primary health care (Friedman et al., 2006:49).

The National Health Act further stipulates that "the functions of the committee must be prescribed in the provincial legislation in question". It is, therefore, the responsibility of the provinces to develop the Provincial Health Act that will provide further direction and details on how Community Health Committees will operate including clarifying their roles and responsibilities (DOH, 2004:69; Berger, Heywood, Krynauw, Hassim, Honermann & Rugege, 2013:69).

Friedman et al (2006:52-53) stress the importance of a CHC to have clear functions for it to achieve its purpose and be successful. He further indicated that the functions of the community health committees are to: conduct regular meetings where they discuss health issues affecting the community they live in; support and advise facilities and other health services on issues that facilitate improvement of the services provided; they identify and communicate problems and the progress they are making in resolving them together with the health services through regular feed-back meetings in the community; They are also involved in identification, selection and appointment of community health workers including their supervision; they also plan and implement health projects that cannot be addressed by the service providers within the formal health system.

The above functions are similar to the functions of the CHCs in Bushbuckridge sub-District with the exception that they are not involved in the appointment of the Community Health Workers as they are employed by the local Community Based Organisations (CBOs), which are independent entities although they are working very closely with the Department of Health (DoH).

The White Paper for the Transformation of the Health System in South Africa of 1997 stipulates the importance of the community being given a chance to participate in planning

and provision of health services. This includes establishment of mechanisms for public accountability and promoting dialogue and feedback between the health providers and the members of the public. It further encourages the community to take a greater responsibility for their health promotion and care (DoH, 1997).

The governance structures who were participants in the study indicated that, like most of the other provinces, Mpumalanga Province has not yet developed the provincial legislation as required by the National Health Act and the District Health Councils (DHCs) are not yet established. The DHCs are structures which governance structures were supposed to report and account to as required by legislation. They further indicated that their channel of communication to the higher administrative authorities was currently through the facility managers upward, to the district office and provincial level. Additional to that, they were also accountable directly to the Member of the Executive Council (MEC) for Health as he was the one who formalizes their appointment by issuing letters confirming their appointment once they were nominated by the community. Reporting to the MEC occurred in cases where there were issues that could not be addressed urgently through the existing administrative channel. They had the authority to take it up directly with the MEC without going through the District office as they were appointed by his office. An example of such a case was when a new Community Health Centre was opened and it could not operate 24hours a day, as it was initially planned due to shortage of staff. They contacted the MEC directly who sent the Head of Department of Health to work with them to resolve the challenges by employing more staff. The Community Health Centre started providing services as planned.

The participants indicated that clinic committee meetings were chaired by local councillors or someone from the traditional community leadership who had the powers to call community meetings if there was a need other than the regular meetings they had for giving feedback to the community. The challenge was that although they report back to the community, the lines of reporting and accountability are not formalized due to the lack of the provincial legislation in Mpumalanga. According to the current findings, the governance structures in Bushbuckridge sub-District have many achievements and were

seen to be functional but had not reached the required level of accountability as implied in the definition and as required by the Health Act.

- **Expand maternal health education through available human resources and mobile health services**

The participants acknowledged that the current health education on the importance of antenatal care attendance was inadequate as it is done in the clinics only. They indicated that there is a need to maximize the use of available human and material resources to intensify and expand health education to focusing more on the importance of attending antenatal care. Some of their comments were: *"People need to be educated on the importance of attending ANC. They should also be encouraged to test for HIV and that being HIV positive is not a death sentence because there is treatment available for free". "The clinic can work with schools where there are teachers who are responsible for such things".*

School teachers need to be involved in outreach programmes to reach out to the teenagers in schools to teach them about HIV and teenage pregnancy. The Department of Health should collaborate closely with the Department of Education to be able to reach the targeted schools. The participants noted that: *"Teenage mothers should be given information about the importance of attending ANC in their families and at the community".*

Additionally, the Department of Health should ensure that the health services are accessible especially in the rural areas by increasing the number of clinics and mobile clinics. The participants expressed that: "*The Department of Health should take antenatal care services to the community by mobile clinics or create a visiting point at the community as the facilities that are far from the people".*

The participants indicated that although health education is provided to pregnant women on the importance of attending antenatal care and HIV testing, it needs to be strengthened. The following was said: *"To raise awareness on the importance of ANC attendance. Nurses should provide such information to everybody who goes to the clinic*

so that they are aware of this. Nurses should give information about ANC almost every day in the clinics and encourage people to go for HIV testing whether male or female". "Women should be encouraged to go for HIV testing so that they know their status".

The service providers should provide such information to help the women to have better understanding and be motivated to go back for follow-ups. *"The day she decides to go to the clinic, the midwives must give her information so that she understands and she can come back".*

The current findings showed that there is lack of knowledge and understanding in the community on the importance of attending antenatal and postnatal care services that are available. Findings in Mail et al (2013) confirmed the findings that health workers gave limited information to pregnant women during group health talks and one on one consultation about possible pregnancy complications which is a missed opportunity. The health promotion principles further affirm the findings by showing the need to create a supporting environment for health education for newlyweds and adolescents. They are susceptible to take new ideas and they can have a positive influence on the leaders of the community (Gerein et al., 2002:178).

Titaley et al (2010:9; 10) confirmed the need to strengthen the health education programmes that will assist in raising the awareness of the community on the importance of available maternal child and health services. Such intervention programmes should target husbands, parents including other family members other than focusing on women only. Messages on the importance of antenatal care attendance should also target friends and relatives as they also have influence on decision making related to antenatal care attendance (Mail et al., 2013).

Additionally, the community-based participatory programmes should be strengthened to overcome the existing constraints by involving the local community members in health education. In areas where traditional birth attendants are used, they should also be targeted for increasing awareness through health education because they and their cultural practices are trusted. In countries such as Indonesia, the traditional birth

attendance is highly utilized and even more accessible than village midwives (Titaley et al., 2010:9-10).

Gerein, Mayhew and Lubben (2002:179), in their framework for a new approach to antenatal care, suggest that the competence of midwives should be improved by including community participation and collaboration in their training as it is currently not included. This will improve their competency in the area including group education, counselling, traditional practices and gender approaches.

- **Using various methods of media to educate and disseminate information to the community.**

To expand and intensify the health education on the importance of antenatal care, the participants suggested various forms of media and methods that could be used to reach out to the community. Arrangements could be made to get slots in the local radio stations to educate the community on the importance of antenatal care. Some of their comments were: *"The problem of ignorance can be addressed by having the clinic to run campaigns that will make the community aware of the importance of ANC"*.
"A community campaign can be done to encourage pregnant women to attend ANC including any other health promoting issues that can help people". "The local radio stations can also assist. We can request slots where health workers educate the community".

"The use of media that will be able to reach the community at a larger scale could be used to educate the community. This can be planned with the governance structures so that we get slots in the community radio station".
This should not be the sole responsibility of the Department of Health only. *"Can conduct campaigns with the support of different stakeholders."*

Proper planning for such campaigns is also needed. "There is a need to plan for campaigns and come with ways on how to address these problems". "Pamphlets can be distributed with the information and those who cannot read can ask their kids to read for

them". "Slots for health education should be requested in the local radio stations where this can be taught".

In the study conducted by Simkhada et al. (2007:256), the results showed that women's exposure to mass media such as television and radio were a significant predictor of antenatal care utilisation. It was affirmed by Zamawe, Banda and Dube (2015) who find that in Mchinji District, in Malawi, men who listened to maternal health programmes broadcast by Phukisa la Moyo Radio were more involved in maternal health issues than those who did not. The use of mass media was found to be more effective in promoting maternal health issues such as antenatal care and child birth.

Further to that, men who were exposed to multi-media entertainment-education on birth preparedness in Indonesia showed a favourable response by exhibiting new knowledge gains and birth preparedness. It demonstrates that when men are exposed to education, they can learn and make meaningful contributions in maternal health issues (Mullany et al., 2006:167).

In Makwanur district, Nepal, facilitators used picture games to identify problems and develop solutions to the challenges as one of the strategies to facilitate learning and sharing of information in a community-based participatory intervention study which was a successful method of educating and disseminating information to the community. The intervention was successful in reducing the perinatal mortality rate using women's groups (Manandhar et al., 2004:973).

Category 7.2: Strengthening use of existing community based structures

Strengthening use of existing community based structures is the second category of the theme perceptions on community participation and accountability of governance structures. The category focused on one subcategory which is to empower and use existing functional community based structures for health education. These are organized groups of people existing in all communities with common goals. Friedman et al (2006:91) indicate that there are three different kinds of actively created and maintained groups

which exist in the community. These are families, formal and informal groups which fulfil various roles such as support, security and social control. The subcategory is discussed:

- **Empower and use existing functional community based structures for health education**

The participants indicated that in order to reach out to the broader community, there is a need to explore all existing community structures that could be used for health education by the service providers and community leadership to disseminate the information on the importance of antenatal care. Some of their comments were *"Using forums that exist in the community. It would be good to always have somebody from health in every community meeting to make a presentation in such meetings". "They can use any meeting that happens in the community."*

The Home Based Carers who are working with the Department of Health and are currently doing community outreach programmes, should be used to strengthen the health education on the importance of antenatal care attendance in the community. Their comments included that *"Home Based Carers should also be involved as they always do home visits in the community". "The health workers can educate the Home Based Carers who will spread the information to the community as they are always doing house to house visit in the community". "The Caregivers should be used to spread information on the importance of ANC as they always do house to house visits helping other people in the community. They are knowledgeable and trained and they are already doing the work."*

Other readily available resources that are currently doing some work in the community are the Community Development Workers (CDWs). The participants mentioned that *"There are also community care workers who can also help in encouraging pregnant women to attend ANC. We also have CDWs, Community Development workers who can also assist. We attend meetings together with them.* The private sector could also assist with training to enhance the knowledge and skills of the service providers. "*The private sector can assist by getting and training Home-based carers so they can teach the community, in the "imbizos" by municipality, churches, and soccer tournaments, cultural dances etc."*

The church is one of the existing structures that could also be utilised to disseminate the information on the importance of antenatal care attendance as there are men, women and children who should be targeted with an aim that they will take the message back into their homes and the community at large. *"The church can also play a role. The women and men's ministries should be able to take up the responsibility". "We can also work with women in the churches and raise the awareness of the community about the importance of ANC".*

Existing community forums that should be used to disseminate information are community meetings and the funerals where community leadership always addresses the members of the community. *"To address the community about the importance of ANC in different structures as leadership and also use the church as platform including at funerals". "The message on the importance of attending ANC should be communicated to the community. In community meetings let it be announced and addressed in a large scale, give reminders and give the importance of ANC appointments."*

The opportunity could be used to disseminate the information during the meeting or when making community announcements at the end of the programme. *"So if there are issues that need to be taken to the community, it is easy to do it in those meetings. They can be used to disseminate information to the community. The leaders can convey messages in community meetings on the importance of ANC". "The nurses can be invited to come and give information as long as it does not disrupt the number of staff remaining at the clinic."*

Additional to that is the existence of the social groups commonly known as "societies" which meet on regular basis for social purposes of which mostly are constituted of women. *"There are so many societies out there with groups of women where they can teach each other that it is important to attend ANC when you are pregnant".* Such groups should be targeted and educated on the importance of attending antenatal care and also help to disseminate the information to the broader community.

In the process of developing an innovative model for HIV prevention, Bulterys, (2002:224) identified a need to use the traditional caregivers in the community's preventative health education as they were readily available human resources covering wider areas where they were already practicing and easy to mobilize for the delivery of services in the

community. This is supported by Okuga, Kemigisa, Namutamba, Namazzi, & Waiswa (2015) who indicated that Community health workers (CHW) in eastern Uganda CHW were reported to be identifying pregnant women using their social networks. They were also targeting men and other family members when conducting health education. They were actively participating in improving maternal and newborn care

In the social context, the voices of women are not heard in the community where decisions are made about health. They are also not involved in planning or given an opportunity to influence management of local health services. It is important for antenatal programmes to target women because they play an important role in reproductive health (Gerein et al., 2002:176). They can provide support for pregnant women in varied ways such as developing an affordable functional transport system that is affordable, safe and reliable, establishing a credit fund for emergency, blood donation system and constructing maternity homes (Gerein et al., 2002:173).

An intervention study that was conducted in Makwanur District, Nepal, where women's groups were formed, which included existing community health volunteers who were also women, is a good example of successful community participation for women. The women were supervised by a facilitator who was a local resident, and were recruited through the process of involving the community leadership. Joint planning was encouraged to enhance community participation. The intervention managed to reduce the perinatal mortality rate from 117 to 44 per live births over three years. Community participation is used to build a link between primary services and the users for improving the quality of the services (Manandhar et al., 2004:970).

Changes made were in practices for home care and health care seeking behaviour for both neonates and their mothers. The approach to the public-health intervention was acceptable, cost effective, sustainable and scalable (Manandhar et al., 2004:976-977).

Gerein et al (2002:177) suggest that all pregnant women should be taught how to manage obstetric emergencies such as vaginal bleeding in pregnancy and premature rapture of membranes, conduct clean home deliveries and manage complications that may arise and referrals as needed. This is the information that women can attain to educate each

other to enable them to help themselves, their families and some other members of the communities.

In their study, Titaley et al (2010:9; 10) found that the community lacked knowledge and understanding on the importance of antenatal and postnatal care services that were available. It confirmed the need to strengthen the health education programmes that will assist in raising the awareness of the community on the importance of available maternal child and health services. The programmes should target husbands, parents including other family members other than focusing on women. Traditional birth attendants were considered to be essential and were highly utilized in some of the communities in the West Java Province and they played a strategic role in pregnancy and post-delivery.

There is a need to strengthen community-based participatory programmes to overcome the existing constraints by involving the local community members in health education. In areas where traditional birth attendants are used, they should also be targeted for increasing awareness through health education because they are trusted and know their cultural practices. In countries such as Indonesia, they are highly utilized and are even more accessible than village midwives (Titaley et al., 2010:9-10).

When developing an innovative model for prevention of perinatal transmission of HIV, Bulterys et al (2002:222-223) identified that if traditional birth attendants can be trained on HIV prevention, counselling and testing, they can play a big role on the intervention in the rural areas. All they would need is supervision and support. The advantage of using them was because they are already trusted, speak the local language, reside in the area, are already functional and are providing preventive health services in the community for pregnant women and new-borns. They also share the same cultural beliefs and practices. Similarly, in India, the village workers were used to assess signs of neonatal sepsis and provide supportive neonatal care which shows the potential of what village workers and traditional birth attendants can do when trained (Bulterys et al., 2002:233)

In Uganda, Village health teams (VHT) who were front line community workers were used for community sensitization and mobilizing male partners to be involved in antenatal care. They educate the community and track women who missed their antenatal care visits and encourage them to deliver in health facilities. They acted as a link between the Ministry

of Health and the community whilst the health workers acted as their supervisors. From the interventions, the uptake of HIV counselling and testing among pregnant women in their first antenatal care visit also managed to increase. Antenatal care attendance and skilled attended deliveries also increased (Ediau et al., 2013).

3.3.2.2 Theme 8: Identified needs

The eighth theme is identified needs. Out of the theme emerged two categories strengthening health education in antenatal care and strengthening men's support in pregnancy. The categories focused on three subcategories which are community to accommodate science in their culture by learning to trust modern science, governance structures to take a leading role in community education on the importance of antenatal care, and men need to learn to support their partners in pregnancy.

Table 3.14 shows the theme, categories and the subcategories which emerged from the theme identified needs.

Table 3.14: Theme 8 - Identified needs.

THEME	CATEGORIES	SUBCATEGORIES
8. Identified needs	8.1. Strengthening health education in antenatal care.	8.1.1. Community to accommodate science in their culture by learning to trust modern science
		8.1.2. Governance structures to take a leading role in community education on the importance of antenatal care
	8.2. Strengthen men's support in pregnancy	8.2.1. Men need to learn to support their partners in pregnancy

Category 8.1: Strengthening health education in antenatal care

Strengthening health education in antenatal care is the first category that emerged from the theme Identified needs. The category focused on the subcategories; community to accommodate science in their culture by learning to trust modern science, governance structures to take a leading role in community education on the importance of antenatal care which is discussed.

- **Community to accommodate science in their culture by learning to trust modern science**

The participants mentioned that *"There are people who still trust in traditional medicine "muti" and continue to stick to that. People should learn to trust the scientific measures that are there these days rather than using the traditional "muti"."* This refers to the fact that as much as culture plays an important role in the lives of the community members, there is a need to accommodate the existing scientific advancement in medicine in order to benefit the pregnant women. The community leaders should assist with educating the community to dispel the harmful cultural beliefs. "*Such topic should also be tackled in "ibandla" where traditional leaders and traditional healers meet to address cultural issues because times have changed, and there are so many myths that people stick to and are not helpful".*

The members of the community should be helped by the service providers to understand the importance of attending antenatal care regularly as stipulated in their antenatal cards, for the benefit of both the mother and the unborn baby.

According to Peu (2008:11), culture is defined as a way of living. It is a unique way of how people think, behave and feel which guides the way society and ethnic groups solve their problems. In Nepal where husbands were involved in supporting their wives in child birth, it helped them to be less hesitant about cultural issues and helped in addressing them in a more constructive way. In turn, service providers should also learn to accommodate the culture of the people they are serving (Sapkota, Kobayashi & Takase, 2010:46). Ediau et al (2013) assert that in Uganda, the engagement of Village health teams (VHT) in community sensitization and mobilization of male partners to be involved in antenatal care, helped to address cultural beliefs that were barriers which affected antenatal care attendance.

Health care workers need to acknowledge the uniqueness of different people in the society, accommodate and tolerate them with their different cultures. They have to understand that culture changes over time, but the deeply rooted beliefs and values do not change more readily. The extent to which individuals adhere to their beliefs, values and behaviour associated with culture is also different. The health workers should be

sensitive to the culture of each particular family which includes how they express themselves. It is their responsibility to observe the norms and traditions of the clients they serve (Peu, 2008:11). The guidelines for good practice in the health care professions stipulate that the practitioners should always honour the rights of the patients so that they are able to live in accordance and respect their own beliefs, values and preferences. Their personal, religious and cultural convictions should also be tolerated even if they are different from theirs (HPCSA, 2008:2).

- **Governance structures to take a leading role in community education on the importance of antenatal care**

One participant indicated that as members of the governance structures, they are the people who should assume a leading role in ensuring that the community is educated on the importance of attending antenatal care. *"I think as members of the governance structures we should take the responsibility to educate them on the importance of attending ANC. We should work hand and hand with the community leadership".* This should be done in collaboration with the leadership that is there in the community. *"Community leaders should reach out to the community on health issues and encourage pregnant women to attend ANC. They should be the one giving the community the necessary information." "They were supposed to so do with health issues to get more votes because we would see their effort towards the community."* This includes councillors from the local government.

If the community is involved in health activities and management of health services, their sense of responsibility for their health services can be empowered and they can play an active role rather than being passive. Community members should be in a position to realise the decisions that led to positive outcomes that were taken in their cooperation (Gorgen, Kirsch-woik and Schmidt-Ehry, 2004:212).

It is important to develop the rules that govern the participation in the health services and the demands to ensure accountability of the health service providers. In Tanzania, there are "health committees" which are structures that are comprised of elected councillors and are nominated by the community. They are established at district level and are responsible for health and take part in priority setting (Gorgen et al., 2004:213).

Amongst other responsibilities of the health committees in Tanzania, they are responsible for the planning and arrangement of health service activities and looking into the quality of care provided. They also discuss staff complaints and the problems of discipline. Similar structures at a district and in hospital level were set to be established as administrative advisory councils to ensure effective co-administration. Another innovative means of community involvement used in the rural areas of Tanzania is the use of development theatre where entertainment has been linked with topical issues to tackle topical problems (Gorgen et al., 2004:216).

Category 8.2: Strengthen men's support in pregnancy

Supportive men or partners in pregnancy are the second category that emerged from the theme Identified needs. The category focused on one subcategory which men needed to learn supporting their partners in pregnancy and it is discussed.

- **Men need to learn to support their partners in pregnancy**

The participants mentioned that as part of strengthening health education in the community, men should be taught how to support their partners during pregnancy and through delivery. *"Sometimes there is no support from the partner and if he just stands up and takes the 1st step with her it would be easier for her to go to the clinic."* "*Start to involve men as well educate them on how they should support their pregnant partners by doing door to door campaigns and visiting the churches."*

Their knowledge and skills on being good supportive structures should be strengthened and they should be able to make peace with their partners in cases where there are misunderstandings. *"For those who are always fighting they need to discuss and iron out their differences. There has to be love and peace in a family. At times they need a mediator if they fail to resolve their issues or even go for counselling."*

If men understand why it is important for pregnant women to attend antenatal care, it would be easier for the women to attend antenatal care. Men should be used to educate other men so that they speak in a language that they all understand. One participant said: "*Some groups should focus on men and go house to house. Men to men because we cannot talk to a pregnant woman but we should help the men to understand the*

importance of ANC who will in turn encourage his pregnant woman to go to antenatal care services".

In a study conducted by Titaley et al (2010:9-10) the findings showed that the community lacked knowledge and understanding on the importance of antenatal and postnatal care services that were available. It confirmed the need to strengthen the health education programmes that will assist in raising the awareness of the community on the importance of available maternal child and health services. The programmes should target husbands, parents including other family members other than focusing on women.

Mullany, Becker and Hindin (2006:166) indicate that it is critical to involve the male partners in reproductive health interventions as husbands are the heads of the households. They determine the women's ability to implement the lessons learnt in antenatal care and in seeking health care.

In a study that was conducted in the rural Guatemala where men were involved on maternal health issues, the findings showed their active participation in pregnancy and child birth. They were giving women advice on visiting antenatal care and they were also rubbing women's backs during labour (Carter, 2002:448). However, Sapkota, Kobayashi and Takase (2010:50) in their study, exploring the experiences of the husbands in supporting their wives in child birth, identified that there is a need to start involving husbands from the beginning of pregnancy as they felt overwhelmed by being involved late at birth.

Additional to that, the fact that women's voices about health are not heard in the social context is another reason for wanting to involve men in reproductive health services. This will open an opportunity for women to be involved in planning and management of local health services as they may need permission from their husbands to be involved (Gerein, Mayhew & Lubben, 2002:176). To enable men and family to play their role in community involvement, antenatal care personnel have to seek ways to inform, involve and mobilize families of pregnant women and communities (Gerein et al., 2002:177).

In countries such as Tanzania, men are the gatekeepers of women's reproductive health; they are critical partners in improving maternal health and reduction of mortality. They need to be involved in the maternal care of their partners. Male involvement in antenatal

care and other maternal health issues can be done by raising their awareness and empowering them with knowledge of antenatal care services (Ediau et al., 2013). Although there could be barriers to male involvement related to structural and cultural issues, they can be mitigated by community sensitization and improving client-friendliness in the clinics.

3.3.3 Perceptions of health workers about community participation in supporting pregnant women to access antenatal care

The third objective of the study was: **To explore and describe the perceptions of health workers about community participation in supporting pregnant women to access antenatal care** is a summary of the identified theme, category and subcategories that emerged from the analysis in Table 3.15.

Table 3.15: Summary of the theme, category and subcategories of the perceptions of health workers about community participation in supporting pregnant women to access antenatal care.

THEME	CATEGORIES	SUBCATEGORIES
9. Perceptions on community participation in antenatal care	9.1. Strengthening health education efforts on antenatal services	9.1.1. Collaborative involvement with community leaders in promoting health education on antenatal care attendance in the community
		9.1.2. Empower and use existing community based structures for health education (HBC, church, social clubs)
		9.1.3. Utilise media to educate the community on antenatal care

Table 3.15 shows the identified theme, category and subcategories to describe the perceptions of health workers on community participation in supporting pregnant women to access antenatal care.

3.3.3.1 Theme 9: Perceptions on community participation in antenatal care

The ninth theme identified was perceptions on community participation in antenatal care under governance structures and community leaders. Out of the theme emerged one category which is strengthening health education efforts on antenatal care services. The category focused on four subcategories which are collaborative involvement with community leaders in promoting health education on antenatal care attendance in the community, empowering and using existing community based structures for health education (HBC, church, social clubs) and utilising the media to educate the community on antenatal care. Table 3.16 shows the theme, category and subcategories which emerged from the theme; perceptions on community participation in antenatal care.

Table 3.16: Theme, category and subcategories which emerged from the theme, perceptions on community participation in antenatal care.

THEME	CATEGORIES	SUBCATEGORIES
9. Perceptions on community participation in antenatal care	9.1. Strengthening health education efforts on antenatal care services	9.1.1. Collaborative involvement with community leaders in promoting health education on antenatal care attendance in the community
		9.1.2. Empower and use existing community based structures for health education (HBC, church, social clubs)
		9.1.3. Utilize media to educate the community on antenatal care

Category 9.1: Strengthening health education efforts on antenatal care services

Strengthening health education efforts on antenatal care is the first category that emerged from the theme perceptions on community participation in antenatal care. The category focused on collaborative involvement with community leaders in promoting health education on antenatal care attendance in the community, empowering and using existing community based structures for health education (HBC, church, social clubs) and utilising media to educate the community on antenatal care, which are discussed.

- **Collaborative involvement with community leaders in promoting health education on antenatal care attendance in the community**

The participants indicated that there is a need for the community leaders to be part of the community education on antenatal care. The governance structures and the health workers should work together to strengthen community participation in promoting antenatal care education in the community. They indicated that there is need for health workers to educate the community and the community leaders on the importance of attending antenatal care who will in turn educate community members. Some of their comments were: *"Community leaders, clinic committees should also be involved in making people aware about the importance of ANC and the dangers of taking drugs".*

"Awareness campaigns can be done. Nurses should talk to the community leaders and ask to be included in their meetings to share that information can be given at a larger scale".

"The community leaders should also educate the community on the importance of ANC as they have regular meetings with the community. One can see that people may not be educated but they have information which was achieved through the community leaders in their meetings, as the community has accepted them. Again, if health workers are given a chance to share information in those forums".

One of the participants further indicated that through the reengineering of Primary Health Care (PHC), the DOH is strengthening community participation and involvement through a ward based PHC outreach programme that is engaging the community into a dialogue to understand why pregnant women are not attending antenatal care appropriately. One participant said: "*There is nothing other than community involvement now there are people who have been hired to do community dialogues. And is hoped that the community will be engaged and get an understanding of why women are not attending ANC".*

The participants pointed out that as health workers, they should also visit women in their homes to teach them on the importance of attending antenatal care to encourage them to use facilities at that level. They said: "*Midwives should go to the community and teach them on the importance of attending ANC. There should be a sister who goes out in a car to go and teach people in the community and make referrals to the facility."*

Family members, especially the elders, should also be given the information so that they are able to impart the information to other family members, friends and neighbours including the young people. They said: "*Members of the families should encourage each other including their neighbours to attend ANC. We should teach each other in our community groups like "societies".*

"We need to educate the community on encouraging family members who are pregnant to go to the clinic. Ask parents to encourage their pregnant children to go for ANC"
"If we had elders who are women in the community, who are willing to support any pregnant woman, even if they do not belong to their families."
"Older people should teach younger women the importance of ANC. This should be taught in churches, women's meetings, societies etc. Grandparents and mothers should also teach their girl children that if they have missed their periods they might be pregnant and should attend ANC".

When responding to local needs of individuals, families and the entire population, effective participation and inter-sectoral collaboration still remains a challenge (Rohde et al., 2008:952) although the underlying principles of community participation are clearly outlined in the National Health Act (61 of 2003). Ngubo and Machedi (2006:7) further say that communities will be involved in planning and delivery of health services through meaningful community participation, but it is yet to be realised.

There is also a need to collaborate with other sectors, agencies and other disciplines within the Department of Health as health alone cannot meet the needs of the communities. Ngubo and Machedi (2006:27) indicate that through the PHC approach, the community is able to take responsibility of their own health. Community participation and inter-sectoral collaboration play an important role in promoting health for the individuals, families and the communities (Ngubo & Machedi, 2006:29). Transparent policy decisions and equitable allocation of resources which recognizes community needs and priorities can be used to foster community participation and empowerment (Dookie & Singh, 2012).

It sounds logical for the health workers to expect members of the governance structures to facilitate and lead the process of community participation and involvement on antenatal care education because they were nominated by the communities they live in out of trust

to represent them. They also accepted the nominations because they have the interest of their communities at heart and will represent them well. They also have the power to call community meetings to address issues that are of prime importance additional to their standing meetings with them. They are, therefore, in a good position to mobilize the community in promoting antenatal care attendance.

There is existing evidence which shows that one of the effective methods to promote community participation and empowerment is community mobilization. The following are some of the research studies which showed that the use and the gains of community mobilization in educating communities on health issues are effective and can yield positive results. In a cluster controlled trial (cRTCT) conducted in Ethiopia, the findings showed a 40 % reduction of under 5 mortalities by mobilizing women's groups to recognise and treat malaria at household level. Another cluster controlled trial in Nepal, Makwanpur District showed a 30 % reduction in neonatal mortality and maternal deaths through community mobilization (Rosato et al., 2008:964).

It is also documented that mobilized communities can reduce morbidity and mortality in their community by developing strategies that are highly innovative, practical and culturally sensitive if they are given a chance with adequate support and resources. For successful community mobilization, the social norms, the local cultural context on health, community participation, use of health services, gender roles, decision making processes at household level need to be understood and taken into consideration. The process facilitators should be credible to the community, be culturally sensitive and should understand the local language. These are key steps that need to be followed when developing such programmes (Rosato et al., 2008:964).

The community should be part of problem identification, priority setting and development of the strategies for community mobilization (Rosato et al. 2008:969). For such programmes to be successful; they need to have operational guidelines with clear roles and responsibilities, adequate budget and clear communication systems. There should be clear parameters which are set for implementation and how disputes will be dealt with should they arise (Rosato et al., 2008:969).

- **Empower and use existing community based structures for health education (HBC, church, social clubs)**

The participants indicated that there is a need for the community to participate in educating the community on antenatal care. They see the need for the governance structures as one of the existing structures that can lead the process of community involvement because they are already working with the community and have structured meetings. In order to reach out to the broader community, there is a need to explore all existing community structures that could be used for health education by the service providers and community leaders to disseminate the information on the importance of antenatal care. Some of their comments were: *"They have powers to call meetings and would be able to give out this information. Through the governance structure there is a health worker in all the "imbizos" and that makes it easier and ensures that the information we want to send to the community is spread; it is used as a platform to disseminate information."*

"The governance structure can mobilize the community and call meetings where health workers can come and teach them. Facilities use governance structures to help in addressing the complaints by the community e.g. delay when an ambulance is called. They represent the community in the facility." "The nurses can be invited to come and give information as long as it does not disrupt the number of staff remaining at the clinic."

The Home-based carers could also be used as they are already working with the community at household level, providing care to those who are in need. They can work in collaboration with the clinic committees to expand health education on the importance of attending antenatal care from household level to community "imbizos" with the Department of Health. *"The clinic committees and health caregivers should educate the community at "Imbizos"." "There people who are out working there in the community like NGOs and Home based carers, they can help when doing the door to door visit and educate the community on the importance of attending ANC".*
"The HBCs should also be trained on the importance of attending ANC so they can teach the community". "The Department of Health (midwives) should educate the caregivers

(home-based) who go door to door to give out the information to the community. "Imbizos" should be arranged to educate the community at a larger scale than door to door".

The church can also be used as a platform for disseminating information on the importance of antenatal care to reach a lot of people at the same time. Church members need to be empowered with information to enable them to impart the information to others. Individual members will then spread the information to their families and to other community members.

"To educate the churches so that they spread the message at home, educate parents so that they are able to detect if a girl is pregnant and advise her to go for ANC. The churches need to be taught on the importance of ANC so that they can understand the need to attend ANC and not advice people to pray only".
"Information should be given in churches during the women's meetings and church services"
"This should be taught everywhere, in the churches so that women understand it. Pastors should include it in their services because our women die of lack of knowledge"
"The community will spread the message everywhere in the community e.g. in churches, stokvels and societies where people meet".

South Africa has been implementing Primary Health Care since 1996; however, it is still faced with challenges such as effective participation and inter-sectoral collaboration when responding to local needs of individuals, families and the entire population. In 2008, a study was conducted to assess the progress made in countries that implemented Primary Health Care (PHC) after the 30 years of the Alma Ata Declaration. The findings showed that South Africa still has high rates of HIV epidemic, TB multi drug resistance and high treatment default rate. This is a sign of how the country is still struggling with the PHC system and faced with challenges of making health services available to the communities. However, the Community health workers (CHWs) played an important role in providing HIV counselling, antiretroviral drugs and home based care services to help in addressing the identified challenges (DoH, 2014:17; Rohde, 2008:950).

There are other countries such as Malawi and Nepal where mobilized women's groups continue to play an important role in effectively increasing the capacity of identifying root causes of maternal and neonatal health problems (Rosato et al., 2008:968).

In the Projahnmo cluster controlled trial where community health workers were trained and used, their effectiveness was assessed and the findings showed a 34 % reduction in neonatal rate (Rosato et al., 2008:964). There is evidence that shows that in countries where the midwives who provide community-based midwifery services are a limited resource and cannot deliver a full range of health care services. They use community Health Workers (CHWs), traditional birth attendants, family members and neighbours to provide support during delivery. When trained, CHWs played an important role in strengthening maternal and new born services as outreach services in the continuity of care. They were used for record keeping; increase referrals to health facilities, promoting family planning and encouraging facility delivery, encouraging women to attend antenatal care (UNFPA, 2011:9).

There is evidence that CHWs have contributed a lot in addressing illness and infant deaths. In Asia and Latin America, the traditional birth attendants (TBAs) were trained to improve the knowledge and the attitude of women's survival where there were scarce professional midwives. TBAs can play a role in supporting pregnant women because they are respected and have an influence in the communities they live in. Where TBAs have clear roles and responsibilities and have a positive relationship with midwives, there can be good results (UNFPA, 2011:10)

The study conducted in Mukono District in Uganda showed that the community health service volunteers provided health education and referred pregnant women to formal clinics. They were efficient in distributing intermittent preventive treatment against malaria during pregnancy (IPTp) (Mubyadzi et al., 2010).

In order to address the challenges, South Africa is using the Primary Health Care (PHC) reengineering which is a strategy aimed at strengthening district-based PHC services and improving accessibility of health services to local communities (Rohde et al., 2008:952). Additional to that is the strengthening of the District Management Teams (DMTs) who are

responsible and accountable for managing the districts and for the health of the population in their catchment area. Ngubo and Machedi (2006:14) also affirmed by indicating that two of the key principles of the DHS is local accountability of health providers and the need for community participation. The PHC approach requires that the health service be accountable to the communities. This means that communities should be offered health services which meet their needs. They should be actively involved, have a say in which services to receive and how the services should be offered.

The re-engineering of PHC has been taking place since 2009. It has included extending the health care services to the community level and building on existing services to ensure the strengthening of MNCWH and Nutrition interventions at community and hospital levels (DoH, 2012). The community component of PHC reengineering is in the process of being implemented in pilot districts in all provinces in the country. It focuses on three streams of the current PHC system which are District Clinical Specialist Teams (DCSTs), School Health services and ward-based PHC outreach teams (WBOTs) in the geographical catchment area which is an electoral ward. The DCSTs is aimed at promoting the wellbeing of the population in the district by strengthening clinical governance of Maternal and Child Health services in health institutions and the community within the district. The school health services focus on revitalizing and strengthening the School Health Policy of 2003 in collaboration with the Department of Basic Health Education and Social Development, by providing a selected range of basic health services in schools. This is a good entry point for expanding health education in schools in collaboration with school health services and targeting school children.

The WBOTs are community-based and act as a link between the community and the health facilities, increasing access to health care, strengthening health care in the community and household level and improving health outcomes. In each ward, there are several outreach teams comprising of about five to six community health workers (CHWs) responsible for about 270 households (rural and informal settlements) led by a professional nurse (DoH, 2014:19). The CHW are also responsible for identifying community and household needs, and facilitate access to health services in the area. They are also involved in the prevention of illnesses, health promotion and work closely

with Health Promoters and Environmental Health Officers. They also advocate for improvement of health services in the community and do health promotion (DoH, 2014:25;38). This new approach is well aligned to the proposal made by the participants of building the capacity of Home Based Carers (HBCs) and involving them in expanding health education on the importance of antenatal care attendance because they are already working in the community and visiting households.

The CHW are the former HBCs who are appointed to work in the outreach teams and have been trained and their competencies were assessed and evaluated on maternal, child and woman's health, HIV and TB, chronic, non-communicable diseases and violence and injury (DOH, 2014:35). They are used as great resources in promoting antenatal care attendance by identifying pregnant women in households and referring them to the facilities. They also ensure that pregnant women go back to the facilities for follow up and care which is already happening in the different sites.

In Ehlanzeni District, Mpumalanga, the District Clinical Specialist Team (DCST) in collaboration with other sectors is already in the process of mobilising the community and engaging them in community dialogue. The aim of the dialogue is to elicit the reasons for pregnant women not to attend antenatal care as they should. It will also identify the challenges to enable them to address them from the community perspective. All these interventions aim at improving the health of the mother and baby.

- **Utilize media to educate the community on antenatal care**

The participants acknowledged that the health education on the importance of antenatal care utilisation conducted in health facilities was not adequate to promote pregnant women to attend antenatal care. Health education effort on antenatal care services needs to be strengthened. The participants suggested that various forms of media be used to educate the community on the importance of antenatal care. Arrangements could be made to get slots in the local Radio stations to educate the community on the importance of antenatal care. Some of their comments were *"If we can have access to media where they can be taught about the importance of ANC, it can be helpful"*

"If one of the staff can go to the media like Bushbuckridge or Ligwalagwala radio stations and have a 30 minutes talk on health promotion in general to educate the community".

"Slots for health education should be requested in the local Radio stations where this can be taught".

The governance structures can assist with making arrangements to get slots at the local radio stations and it should be done using local languages for the message to be understood. The benefit for using mass media will be to reach more target audience at the same time. *"The use of media that will be able to reach the community at a larger scale could be used to educate the community. This can be planned with the governance structures so that we get slots in the community radio station".*
"I have already said that pregnant women should be taught the importance of attending ANC in simple and language that is easy to understand starting from their first visit and this should also be taught through media (radio) and in churches".

In Mali, the provision of information on the importance of antenatal care was not adequately given during consultations. Consultations were also done for a short duration to establish correct diagnosis. To bridge the gap, it was recommended that more information on the continuity of care be given at community level. Information Education and Communication (IEC) campaigns need to be conducted at community level and be expanded to schools to target future pregnant women (Couillet et al., 2007:688).

Another study conducted in Cali, Columbia, Jaramillo (2001:68-69) found that passive case finding done in public health care institutions, were insufficient and not effective in reaching out the set TB diagnostic targets. He recommended the use of media in community education on health issues to expand their health education efforts. The findings support the current findings showing the need to expand antenatal education using available mass media because the current strategy of facility based education for pregnant women is not yielding positive results. Following an intervention where media based health education was used in Cali, evidence showed a 64 % increase of direct smears with 52 % of new TB cases diagnosed. The provision of targeted information on TB through the use of mass media led to people demanding direct smears and increased case findings (Jaramillo, 2001:72-73).

O'Hara, Bauman and Phongsavan (2012) also found that the use of television adverts as mass media communication increased the usage of Get Healthy Information and

Coaching Service (GHS). It was effective in increasing awareness, knowledge and beliefs regarding GHS. This was complemented by other marketing activities such as printed materials like pamphlets, magazines and radio targeting the disadvantaged areas to recruit vulnerable communities.

These findings were affirmed by Wakefield, Loken and Hornik (2010:1261) whose findings showed that mass media can produce positive changes in health related behaviour in a large population. Due to the success community mobilization had in countries such as Bangladesh, China, Cuba, Sri Lanka and Tanzania, community mobilization interventions were massively scaled up successfully by using partnerships between government and the non-governmental organizations (NGOs) using media such as television, radio, manuals and training packages (Rosato et al., 2008:969).

However, there are challenges that could be experienced in the use of mass media for health behaviour change. The message may not meet the expectations of the target group; the media environment could be cluttered, the materials used could have been inadequately poorly researched or inappropriate; the message may not be persuasive to the audience; the campaigns might be addressing the behaviour that the audience targeted does not have resources to change (Wakefield et al., 2010:1261).

It therefore becomes crucial to plan the campaigns carefully. The content and the format to be used need to be tested with the targeted audience. There is also a need for the media environment not to be fractured and cluttered in order to achieve adequate exposure of the planned media messages (Wakefield et al., 2010:1268). Campaign messages aimed at vulnerable communities should be well integrated and the mechanisms used should be culture specific and culture sensitive whilst using the local language (O'Hara et al., 2012).

Additional to that, the products and services being marketed should be available to meet the demands of the people. There should also be community based programmes and policies which support the change towards expected behaviour. Funding should also be available for more exposure to media messages and sustainability (Wakefield et al., 2010:1261).

3.3.4 Perceptions of local health workers about the accountability of local governance structures for antenatal care

The fourth objective of the study: **To explore and describe the perceptions of local health workers about the accountability of local governance structures for antenatal care.** The discussion on the objective is summarised with the identified theme, category and subcategory that emerged from the analysis in Table 3.17.

3.3.4.1 Theme 10: Community participation through governance structures

The tenth theme identified is community participation through governance structures. Out of the theme emerged one category; perceived roles and responsibilities of governance structures in health which focused on the subcategory, resolving health systems challenges in facilities and accounting to the community.

Table 3.17: Theme, category and the subcategory from the theme community participation through governance structures.

THEME	CATEGORY	SUBCATEGORY
10. Community participation through governance structures	10.1. Perceived roles and responsibilities of governance structures in health	10.1.1. Resolving health systems challenges in facilities and accounting to the community

Category 10.1. Perceived roles and responsibilities of the governance structures in health

Perceived roles and responsibilities of the governance structures is the only category that emerged from the theme involvement of governance structures. The category focused on facilitating the process of resolving health systems challenges in facilities which is discussed.

- **Resolving health system challenges in the facilities and accounting to the community**

The participants indicated that they were aware of the existence of the governance structures in the form of Community health committees (CHC) or clinic committees and

hospital boards in their facilities. They further clarified that the governance structures are not working directly with all the staff members in the facilities which always makes them not to be well conversant with the activities they are involved with. However, they come to the clinic to check how the services are provided by the health workers. They only work closely with senior management within the facilities and conduct meetings regularly. Some of their comments were: *"Partially I know that when they come to the hospital they look at the problems we are encountering."*

"*They always have meetings with the facility senior managers". "The governance structure meets at the clinic regularly".*

Another participant said; "*They have regular meetings but not sure how often they meet. They also come to find out in the clinic how things are going." "They come and check how we are rendering the services. It is the communication channel between the community and clinic".*

Community participation in health occurs through the governance structures that exist in each health facility. They are involved in various ways which are considered to be their roles and responsibilities. The governance structures act as a link and a communication channel between the community and the health facilities. They are responsible for taking information from the facilities to the community and that from the community back to the facilities. Their comments were *"They take information from the community to the clinic and vice versa. They also report any inquiries or challenges experienced by the community to the facility".*

"The clinic committee is the communication channel between the clinic and community"

"What I understand is that the governance structure is the communication channel between the community and the hospital, if the governance structure has knowledge about the problems experienced they resolve them".

They are also involved in addressing the conflict and complaints raised by the community related to the health facilities. Their comments included "*They address problems that arise between the clinic and the community. They deal with the conflict between the nurses and the community. They assist in addressing patients' complaints of long waiting time at the clinics"*

"They deal with the communities' complaints related to the clinic. If the community has experienced problems at the clinic they address them as they deal with the issues in the clinic and the community".

"Their role is to liaise with the community governance structure helps the clinic by giving out information to the community and from the community back to the clinic. They have quarterly meetings and open the suggestion boxes, give a report regarding the feedback on the findings for the institution. It makes it easier for the community and clinic to communicate. They are informed about everything that is happening in the clinic like if there is a new staff they have to know him/her and introduce her".

Additional to that, they are responsible for dealing with compliments and addressing complaints that are raised by the members of the community using the suggestion boxes which is helpful. "*It helps when the clinic has a problem they can tell them and the matter can be dealt with. There is also a suggestion box that they take care of. They open it and deal with the complaints that are raised including the compliments that come from the community".*

They also work closely with other departments including community leaders in conducting outreach programmes as indicated in the following comment; *"The governance structures are working with other departments and stake holders like the chief," induna" to conduct outreach programmes in the community".*

Although the participants indicated that they were not well conversant with the activities of the governance structures, they were able to highlight some of the activities they are involved with. The activities ranged from acting as a link between the community and the health facilities, resolving conflicts that arise in the facilities, addressing complaints that are raised through the suggestion boxes that are opened regularly and act as a liaison with other stakeholders on outreach programmes for health issues.

Participants confirmed the activities of the governance structures by indicating their positive achievements which were noted in different facilities. In one facility where shortage of water was a problem, the governance structures liaised with the local councillors who helped with resolving the challenge which was stated as follows; *"They*

helped us to address the lack of water problems in the clinic when made it difficult for us to work. They raised the issue to the Councillor who helped to address it."

In a hospital where there were overgrown trees which compromised the safety and security of the doctors especially at night, the hospital board facilitated the process of contracting tree felling services to cut and trim the overgrown trees to make the environment safe. The participant said; *"I also know that from their resolutions taken at some point there was a contract that came to the hospital and did tree felling because the trees had overgrown and the Doctors felt that they were no longer safe".*

In another facility, the governance structures advocated for installation of a security fence which is already installed and are waiting for outdoor lighting. This is what was said; *"Now we have security fence because they put their feet down and fought that we get the fence. Now we are waiting for apollo light so that we can have adequate lighting in the facility. When there are "imbizos" they take the information that we want the community to know out there and bring back the information that the community wants us to know. At times they invite a nurse to those meetings for her to go and address the community on health issues or to just go and listen what the community is saying".*

The District Health System (DHS) is a vehicle for delivering Primary Health Care (PHC) through decentralisation of health services to ensure that the health system responds to the needs of the community. Community participation is an essential element for delivering PHC services through which the community is encouraged to participate in determining their health needs. It is a strategy through which the community members understand their problems and seek ways to address them as a collective (Boulle, 2007:16).

Community participation occurs when the health governance structures are formed when the members of the society organise themselves with an aim of protecting and promoting the health of its population in the form of hospital board, community Health centre committees or clinic committees which are accountable to the community (Ngulube et al., 2004:24).

The service providers are also represented in the CHCs. The current findings show that senior managers represent the facility staff in the clinic committees of Bushbuckridge sub-

district, which is the legal requirement and an improvement towards compliance to the National Health Act, 2003. An earlier study conducted by Padarath and Friedman (2008:39) shows that nationally, the staff is represented by ordinary staff members.

The participants shared their understanding of the roles and responsibilities of the governance structures. They are involved in conflict resolution between the community and the facilities including addressing other issues that emerge from the suggestion boxes. They also advocate for the needs of the community such as need for additional staff in the facilities, ensuring safety and security and resolving water shortages in the facilities.

Based on the understanding of the roles and the responsibilities of the governance structures, the health workers see them as functional based on their achievements which would not have been done without them. Their ability to resolve the challenges, shows some level of being functional in the sub-district. The members of the governance structures are also in direct contact with the community through meetings with existing community structures such as “imbizos”. This is where they engage in some discussions with other community leaders to identify community challenges and take it to the facilities and back. The meetings are also a platform to provide feedback on the issues resolved.

The health workers view the engagement with communities as a way which the governance structures account to the community, although it is an informal process of accountability. The lack of formal accountability of the governance structures could be attributed to the lack of provincial legislation in Mpumalanga province, which prescribes the functions of the committees and how they should be accountable to their constituencies (Boulle, 2007:112; DOH, 2004:69; Berger et al., 2013:69). This creates gaps in terms of understanding how to supply the services; lack of resources to deliver the services; means to ensure that the service is delivered; lack of systems to monitor and evaluate performance and enforcement of sanctions or rewards for performance (WHO, 2010). It is based on such reasons that committees are not yet established and function in a manner they were intended to, which is a challenge that is noted in most provinces nationally (Boulle, 2007:112; Berger et al., 2013:69). It requires representation that is genuinely democratic with clear selection criteria, which should ensure that all

stakeholders or sectors of society are represented, especially those who are disadvantaged (Boulle, 2007:112).

Ensuring effective community participation is one the major challenges facing Primary Health Care. Dookie and Singh (2012:1;3) recommend that the decentralisation process of district health services be strengthened, and community participation and engagement in quality assurance be fostered. Based on the challenges, the National Department of Health is in the process of finalising the development of "District Health policy framework and strategy for 2014 to 2019 to strengthen the District Health System" and an implementation plan of which strengthening governance, community participation and ownership are part of the top agenda. This will assist in strengthening the current provision of Primary Health Care services.

3.3.5 Description of the functionality and accountability of governance structures in health within local communities

The fifth objective of the study: To **explore and describe the functionality and accountability of governance structures in health within local communities** is summarised with the identified theme, category and subcategory which emerged from the analysis in Table 3.18.

3.3.5.1 Theme 11: The functionality and accountability of governance structures in health within local communities

The eleventh identified theme is the functionality and accountability of governance structures in health within local communities. Out of it emerged one category; perceived roles and responsibilities of the governance structures. The category focused on one subcategory which is resolving health system challenges experienced by the facilities and positive achievements of the governance structures.

Table 3.18 shows the theme, category and subcategory which emerged from the theme; the functionality and accountability of governance structures in health within local communities.

Table 3.18 Theme 11: The functionality and accountability of governance structures in health within local communities

THEME	CATEGORIES	SUBCATEGORIES
11. The functionality and accountability of governance structures in health within local communities	11.1. Perceived roles and responsibilities of the governance structures	11.1.1. Resolving health system challenges experienced by the facilities and their positive achievements

Category 11.1. Perceived roles and responsibilities of the governance structures

Perceived roles and responsibilities of the governance structures is the only category that emerged from the theme; the functionality and accountability of governance structures in health within local communities. This refers to the roles and responsibilities of the governance structures. The purpose of forming governance structures in the Primary Health Care facilities is to provide a mechanism for the people who live in the catchment area of the facility to collaborate with the government health services in order to improve their own health (Friedman et al., 2006:52). The category focused on one subcategory which is resolving health system challenges experienced by the facilities and their positive achievements which are discussed.

- **Resolving health system challenges experienced by the facilities and the positive achievements of the governance structures**

When asked about their current involvement on antenatal care issues, the participants who are the members of the governance structures, admittedly acknowledged that although they have been involved in various forms of health education in the community, antenatal care has never been an area they had focused on. However, they are beginning to realise that as governance structures and community leaders, they have a role that they can play based on the discussion they had with the researcher. Their involvement in the interviews has given them an insight into the need to get involved in educating the community on the importance of antenatal care. The following were some of their comments: "*At the moment there is nothing but I can see that we have to do something as we speak*"

"Now that we are having this discussion, I can see that we have a role to play. We can also work with women in the churches and raise the awareness of the community about the importance of ANC."

The participants further indicated that they now realise that they should take the responsibility of educating the members of the community on the importance of antenatal care attendance as members of governance structure by using the existing community meetings to disseminate the information. They should take a leading role in community education on the importance of ANC. Some of their comments were; "*Last week we had our community meeting, if you came before the meeting, we would already include sending out the message that pregnant women should attend ANC". " I think as members of the governance structures we should take the responsibility to educate them on the importance of attending ANC. We should work hand and hand with the community leadership".*

The participants indicated that the clinic committees conduct regular meetings to address the challenges experienced in the health facilities. The current findings on their roles and responsibilities are similar to what was discussed in subcategory 10.1.1. which showed that governance structures were resolving some challenges experienced in the facilities. They are accounting to the community through providing feedback in community meetings, although it is not formalized. They see themselves as a communication channel between the clinics and the community. *Sometimes we resolve issues like shortage of drugs and delay when an ambulance is called in a case of emergency due to ambulance shortage". "The governance structure can assist with addressing problems like shortage of drugs, lack of equipment through the political structures".*

In one of the community health centres, the problem of shortage of drugs, lack of equipment, and late response of ambulances in emergencies were resolved. In another catchment area, the community was successfully informed that the newly opened community health centre could not operate for 24 hours as initially planned because of shortage of staff. However, this was resolved by motivating for additional staff through the office of the MEC for health and it is now providing services 24-hours a day. *"Assisted in*

motivating to the MEC with senior management to get equipment and ensure that there are drugs in the clinic which was a problem".

"When the clinic was opened, it was planned to be opened for 24 hours and the community had to be informed that it was not possible because of the challenges like shortage of staff. That could not be achieved by the clinic staff only we had to work through the MEC's office who delegated the HOD to work with us. We had to present to him with the list of things that need to be corrected. Then more staff was employed, equipment and furniture was bought and other problems addressed and the clinic now functions 24 hours. If we were not there this could not have been achieved".

Resolving long waiting times was another achievement in one of the facilities; *"About the long waiting time, patients should be given appointments so that people only come when they have appointments and they will be evenly distributed to avoid that they come at the same time and be over crowded".*
"Yes, it was suggested and implemented although it is not yet very effective but the nurses are finding it to be helping them because they no longer have those very long queues for pregnant women".

Water shortage was also resolved in another facility; *"The clinic had a problem with shortage of water which made it difficult for them to work, we then talked to Department of Water Affairs and the problem is now sorted. That is what we are trying to do and help with here at the clinic".*

The challenges get resolved as the governance structures meet regularly with the clinic management to identify existing challenges and resolve them with the assistance of the senior leadership within the Department of Health. *"We, as members of the clinic committee meet regularly to address the challenges that the facility is experiencing. We talk to the clinic management to identify the challenges that they have. We then write letters to the leadership of the department and they help us to address the problems."*

They also assist in resolving the complaints which are lodged by the patients on issues that they are not happy with when they visit the facilities such as negative staff attitude and the way the clinic operates. *"There is also a suggestion box that is used to get views of the patients on how they feel about the service. The box is opened by the committee*

every time there is a meeting. Things that are raised are addressed to improve the services that are rendered at the clinic.

Other achievements indicated were maintenance of the buildings, well-kept surroundings, involvement in community outreach programmes and participating in surveys to identify root causes of challenges experienced. Their comments were *"Another thing that we did was to motivate for renovation of the clinic as things like tiles were worn out. That was agreed and the clinic was renovated. We also have trees that are overgrown in the yard, we have negotiated with department of Agriculture and they are busy trimming the trees so that the facility looks neat".*

"Sometimes when I was a member of the clinic committee, we had nurses who complained that many patients were leaving their clinics and came to this one and they had many patients. A survey was done which showed that it was more convenient for them to use the clinic because when they come, they are also able to go to the shopping centre and do other things like going to the bank, buy food etc. in a single trip. This made things to be easier, cost effective and convenient for them".

Despite the achievements noted by participants, it indicates that there are areas which still need to be improved within the health facilities. There is a need to work with the Department of Health in increasing accessibility of health services to ensure that pregnant women are able to access antenatal care services especially in the remote areas. Their comments were *"The Department of Health should take ANC services to the community by mobile clinics or create a visiting point at the community as the facilities that are far from the people. The services should always be there but not on specific days because people also need help in the middle of the night and there are no services".*

They have to ensure that drugs are always available and the community health centres are all equipped as referral centres but not function as clinics; *"If it is lack of drugs, the department should make sure that there are drugs available. If drugs are finished, they should give them the return dates where drugs will be available. These are some of the issues we come across as the health committee of that clinic". "The health centres should be well equipped with everything that is needed so that they have no referrals to the hospitals".*

They also acknowledged that there are challenges related to negative attitudes of the staff in some facilities. Staff need to be held accountable for their conduct when delivering the service in the community. *"Regarding the attitude of nurses, they have code of conduct so they should follow them the way they were taught". "Let the supervisors and management in the Department of Health teaches their staff members on how to treat pregnant women well with respect". "The nurses must treat them with respect and not be rude because it would lead to the expectant mother not to come."*

According to the current findings, the members of the governance structures in Bushbuckridge sub-District see a need to take it upon themselves and lead health education on the importance of attending antenatal care in the community as they are also responsible for resolving the challenges experienced by the facilities. The challenges resolved in some of the facilities are shortage of drugs; lack of equipment; shortage of water; long waiting times; clinic renovation; resolving patient's complaints and being involved in community outreach programmes.

The governance structures are always in touch with the community through regular community meetings and "imbizos" (gathering called by traditional leader). They are well conversant with the challenges communities are experiencing. They advocate for and facilitate processes for better health services for the communities they serve. The above findings confirm that governance structures use existing community structures for reporting and providing feedback as mentioned by the health workers. It is also consistent with findings in Padarath and Friedman (2008:37) which showed that nationally, 60 % of the committees use existing community meetings to communicate with the community they are representing. In Mpumalanga, 80 % of the clinic committees use community meetings to provide feedback to their catchment population. The liaison with the community and provision of feedback through the existing community structures can be considered as a mechanism used for communication and accounting to communities, although it is not formalised.

In 2008, the Mpumalanga Province was rated the lowest nationally with only 31 % of the facilities having functional clinic committees, of which only 58 % were having constitutions. The highest rate of functional clinic committees was in the Free State (78

%) and the Eastern Cape (73 %) provinces which could be attributed to their political support after the National Health Act was promulgated in 2003 (Padarath & Friedman, 2008:31, 34). The Eastern Cape Department of Health further developed a policy framework to guide the establishment and functioning of the clinic committees in the Province whilst the Free State Department of Health used the Provincial Health Bill of 2007 to outline its policy commitment to establishing governance structures (Padarath & Friedman, 2008:32). “During the financial year 2013/14, 90 % of the facilities in Mpumalanga had functional clinic committees whose term of office ended in 2015/16 financial year with Bushbuckridge sub-District having 97 % of clinic committees being functional. The functionality of the governance structures had increased provincially from 31 % in 2008 to 90 % in 2013/14, which is a significant improvement towards compliance to the national policy” (DoH, 2013:12-13).

The current findings show that the clinic committees in Bushbuckridge sub-District are functioning well based on the achievements of the governance structures. However, the functionality is only based on resolving the identified challenges which are mostly once off. They are also accountable to the local communities through community meetings although the process of reporting back to the community is not formalized. There is also no formal mechanism for the clinic committees to communicate with their constituencies. This includes communication between the clinic committees, hospital boards and district health council or other lateral governance structures. A formal mechanism is still needed to provide guidance to the way governance structures should function to enhance their efficiency and operations.

A provincial policy to clarify the roles and responsibilities and governance standardization on how to establish the committees remains a need (Boulle, 2007:8; DoH, 2004:69; Padarath & Friedman, 2008:47). Boulle (2007:8); in her study conducted in Nelson Mandela Bay Municipality affirmed that although it is clearly stipulated in the National Health Act how the formal structure should facilitate community participation in health, the community health committees were not functioning as they were intended to. Additional to that, there were no guidelines which focus on directing and operationalization of the community health committees despite the information contained in the Eastern Cape

Provincial Health Act (10 of 2004) and the White paper on transformation of health services in South Africa (1997); which limit effective functioning of the governance structures.

To date, the policy is not accurately translated into practice as the governance structures are not well constituted and is mostly comprised of volunteers. This is attributed to the lack of institutional arrangements, poor coordination and support, lack of operational guidelines and lack of resources for effective functioning of the governance structures (Padarath & Friedman, 2008:41).

The improved emergency medical transportation for patients and the constant supply of medication in the Eastern Cape and the successfully negotiated land for building nurses home in Kwa-Zulu Natal are some of the examples of the positive outcomes of community participation in some parts of South Africa. However, all the activities are seen as once off and are not linked to the broader Primary Health Care frame work such as water, sanitation, advocacy and income generating activities which are broader socio-economic determinants of health (Padarath & Friedman, 2008:41).

Similarly, the achievements shown in the current findings remain as once off activities as they are facility based which leaves a gap in resolving health systems challenges. The involvement of governance structures in planning and health service provision remains a need to be realised (Padarath & Friedman, 2008:48). The lack of the provincial legislation has created some gaps such as lack of understanding on how the services should be supplied; lack of resources to deliver the services; means to ensure that the services are delivered; lack of systems to monitor and evaluate performance and enforcement of sanctions or rewards for performance (WHO, 2010). It is based on these facts that committees are not yet established and functioning in a manner in which they were intended to, which is a challenge in most provinces nationally (Boulle, 2007:112; Berger et al., 2013:69). Additionally, in some communities, people lack interest in serving in the committees, failure of some members to attend meetings, lack of stipend for the members of the governance structures and that some committees still in the process of being formed, are some of the reasons inhibiting their functionality (Padarath & Friedman, 2008:31).

In Mpumalanga, the findings showed that most members of the governance structures are nominated by the community and the local councillor membership representation in the committee was 65 % which is in accordance to the legislation. They have challenges related to how clinic committees are constituted. Failure to appoint clinic committees in a transparent and uniform manner; the composition of the governance structures with weak representation of the local councillors, makes the membership to go against the legislation and impact negatively on the effective functionality of the governance structures (Padarath & Friedman, 2008:37). This result in limited interaction between the district and the municipal processes to articulate the needs and the concerns of the community at a higher level of decision making; lack of mechanism in place to regularly access input from the communities they are representing; lack of monitoring and evaluation system for the functioning of the governance structures in place (Padarath & Friedman 2008:47, 51); and translating the policy into practice (Boulle, 2007:8).

In order to promote community participation, the focus should be directed to the context in which the involvement takes place rather than on how to make the community participate. For health development structures to be successful, they should be correctly constituted and trained to enhance their capacity for effective functioning. There should be political commitment, local institutional support with adequate resources allocated to cater and sustain the functioning of the governance structures (Padarath & Friedman 2008: 17-18). Gibbs and Campbell (2013:31-32) further suggest development of a framework of incentives to strengthen community participation to meet the set objectives which could result in effective delivery of Primary Health Care public sector employees also need to be trained in community participation for them to effectively facilitate the process.

Community participation should be seen as a basic right, which encourages a sense of responsibility and develop political awareness. It is an essential element that can lead to responsive health services which are appropriate and respond to the needs and perceptions of the local communities. Some of the benefits of community participation are to encourage health care workers and the community to work together as partners in addressing the needs at a local level, including other service delivery requirements. Engaging communities can improve treatment outcomes and enhance local response.

3.4 DISCUSSION OF FIELD NOTES

Field notes are the notes taken during field work which reflect the researcher's unstructured observations and the interpretation of the observations made (Polit & Beck, 2012: 728). Field notes were taken during the focus group discussions and in - depth individual interviews with pregnant women, community leaders, members of the governance structures and the midwives who met at different venues on the pre - arranged dates and times. These include empirical observation and interpretations.

3.4.1 Observational and theoretical notes

Observational notes refer to the notes taken by the observer which provide an in-depth description of the events and conversation which transpired in a natural setting (Polit & Beck, 2012:316). Theoretical notes are the researcher's notes which provide the details of observed events and behavior in field studies (Polit & Beck, 2012:744). These are clarified in the discussion. Table 3.19 sets out the observational and theoretical notes which will be followed by the personal notes.

Table 3.19: Observational and theoretical notes

No	OBSERVATIONAL NOTES	THEORETICAL NOTES (Researcher's interpretation of observations)
1.	The facilities were generally clean and the yards well kempt. The rooms provided for interviews were clean and private	It gives the impression that the health services are always provided in a very clean environment
2.	Staff in facilities were welcoming and supportive to the needs of the researcher	Although health workers experience challenges in their work place, they still carry a positive attitude and are happy to serve their clients and always willing to assist.
3.	The conduciveness of the room provided for interviews varied from facility to facility. In some of the facilities, quiet private rooms were provided for the interviews while in some facilities the venue had to be changed once or twice.	It shows the frustrations that health workers experience on daily basis. There is lack of adequate space for providing services in the facilities. Health workers are always improvising when rendering services as the range of services to be provided is always increased without consideration of the current infrastructure and the availability of staff which remains the same

No	OBSERVATIONAL NOTES	THEORETICAL NOTES (Researcher's interpretation of observations)
4.	Participants were conscious about time	Participants were on time which displayed being considerate and their understanding that sticking to time was important especially because there were always other participants who would still be waiting to be interviewed.
5.	Participants came from different socio-cultural background and ethnic groups and spoke different languages.	This was an advantage because the information shared represented diverse socio-cultural background and beliefs which enriched the data that was collected
6.	At the beginning of the focus group discussions, some participants looked anxious and not free to talk openly, share their experiences in the presence of the other members of the group and the researcher despite being reassured by the researcher	It displayed signs of uncertainty of the participants about the questions to be asked, if they will be able to answer them. Also showed lack confidence, low self-esteem which may have been from comparing themselves with others amongst themselves. Being in a strange environment could be contributory to the behaviour as the interviews were done in the health facility which is a strange environment for them
7.	At times the participants would mumble some words to themselves or talk to other participants instead of talking aloud to the group	The behaviour showed that some of the participants were still shy and lacked confidence to share the information especially the sensitive and painful experience. However, they were noted by the researcher who always gave them an opportunity to openly share what they were saying
8.	Responding with a lowered voice at some point during an interview	It is a sign of re-living the painful or unpleasant experience yet still had the confidence to share it
9.	Noted non-verbal cues such as facial expression of participants and asked them if they were thinking about the issues under discussion	It is important to observe nonverbal cues because when followed up participants end up sharing information they were hesitating or afraid of sharing.
10	Some participants were dominating others during discussions	It is important for the facilitator to be in control of such behaviour to enable all participants to get an opportunity to contribute into the discussions Dominant participants may reduce the involvement of other participants
11.	With individual interviews, all the participants were open and energetic without showing any signs of anxiety	They were comfortable to talk to the researcher because they are used to working with health workers, other stakeholders and members of the

No	OBSERVATIONAL NOTES	THEORETICAL NOTES (Researcher's interpretation of observations)
		community at large. It was an opportunity to show off the work they are doing with health facilities. They had confidence and were passionate with their work
12.	As time went on, some participants were spontaneous in sharing the information and their experiences while some were reserved and were always probed to get responses	It shows how different people are and their level of confidence. Those who are educated are more confident than those who are not. The environment was good and conducive for interviews
13.	Although some of the participants were not seen yet for their antenatal care before they were interviewed, the staff ensured that the participants were seen immediately after the interviews	It was a sign of willingness and commitment to support the researcher for the interviews to be successful
14	Shared information was mostly personal experience or that of someone close to them	The created environment was conducive for the participants and enabled them to share their experiences although some of it could be considered as confidential
15.	Willingness to provide information	As the interviews continued, participants started getting comfortable with the situation and openly shared information including personal experiences without fear
16.	Showing emotions when sharing painful experiences by talking slowly with a low voice	The researcher and the other participants made the environment to be comfortable and conducive for them to express themselves
17.	The environment was conducive for the participants to freely express themselves	Participants talked with a passion, this shows that they have the community needs at heart and the change they want to see
18.	For the participants who were interviewed in their own homes, the environment was clean	The participants live in clean homes and they are also clean people
19.	Distractions experienced in some of the individual interviews conducted at home were by children seeking attention	Commitment of the participants to be interviewed despite the available challenges they faced
20.	It was hot, improvising for a comfortable place for the interview	Two participants concentrated on the interviews despite the fact that they were conducted under trees which could have destructed the interviews. The tree was located along the road and moving cars and people passing by on the road

No	OBSERVATIONAL NOTES	THEORETICAL NOTES (Researcher's interpretation of observations)
21	A participant who shared how they provide the services to pregnant women and how she advocated for the rights of pregnant women in her unit	A proud health worker who has pregnant women's interests and passions at heart
22.	A depressed participant at District office for having to conduct an interview while sitting on top of a small wall on the pavement in the absence of office space	The frustrations that health workers go through to get work done due to lack of offices. However, the interview went very well without the destructions of people and cars passing by because of her commitment

3.4.2 Personal notes

Personal notes refer to all thoughts, feelings, experiences and reflections that the researcher went through and experienced during data collection (Polit & Beck, 2012:744). The feelings and reactions experienced were noted and recorded. The first day of data collection was the most challenging to the researcher because she experienced some feeling of uncertainty and anxiety. This was related to whether the interviews would go according to the plan and whether there would be challenges experienced and how the challenges would be addressed.

The anxiety was allayed when on arrival at the health facility, which was used as the venue; she found friendly and welcoming staff. She was reassured and told that everything was set and indeed everything went well and according to plan. The same experience was felt every time the researcher moved to the next venue where interviews were held and were dealt with accordingly.

3.5 CONCLUSION

The empirical research data was presented and analysed in this chapter following the principles of qualitative data analysis. The process of literature control included comparison of the data with relevant local, regional and international studies as well as national policies (Department of Health) and international standards (World Health Organization). This provides a basis for the next phase of the research, as described in chapter 4.

Tables 3.1. to 3.19 in this chapter were used to present the analysed data which culminated to various themes, categories and subcategories providing a description of how community participation and involvement can promote pregnant women's access to basic antenatal care whilst strengthening the local accountability of the governance structures and community leadership to the local health system in Bushbuckridge sub-District.

The identified limitations of the study will be presented in chapter 6. The results of the empirical study indicate the need for community involvement and participation in antenatal care for pregnant women in Bushbuckridge sub-District, Mpumalanga Province.

The process of developing guidelines for community involvement and participation and intra and inter-sectoral collaboration for instituting such intervention programmes formed the second phase of the research study. The conceptual framework of the results for the development of the guidelines and the model applied in the study, will be described and discussed in detail and presented in chapter 4.

CHAPTER 4

DISCUSSION OF EMPIRICAL FINDINGS OF THE RESEARCH WITH REFERENCE TO THE COMPREHENSIVE COMMUNITY AND HOME-BASED HEALTH CARE (CCHBHC) MODEL

4.1 INTRODUCTION

The previous chapter presented the empirical research results and the literature control of the findings, which provided a basis for the discussion in chapter 4. In chapter 3, the results were presented as the description of perceptions and experiences of barriers and needs of pregnant women on antenatal care in Bushbuckridge sub-District, Mpumalanga Province. A description of participants' perceptions on how community participation and involvement can promote pregnant women's uptake of basic antenatal care was followed. In this chapter, the results of the empirical study will be matched with the core elements and the components of the Comprehensive Community and Home-based Health Care (CCHBHC) model. The formulation of guidelines will be guided by the CCHBHC model.

This chapter provides an overview of the CCHBHC model, the reasons for choosing the model, the comments and critiques of the CCHBHC model, the application of the CCHBHC model and the developed draft guidelines.

4.2 DESCRIPTION OF THE COMPREHENSIVE COMMUNITY AND HOME-BASED HEALTH CARE (CCHBHC) MODEL

4.2.1 Overview of the CCHBHC model

Comprehensive Community and Home-Based Health Care (CCHBHC) is defined as "an integrated system of care designed to meet the health needs of individuals, families and the communities in their local setting" (WHO, 2004:3; Peu, Tshabalala, Hlahane, Human, Jooste, Madumo et al., 2008:77). It is the care which could be in the form of physical,

psychosocial, palliative including spiritual activities given to people who are sick in their own homes (WHO, 2002:6). In Malawi, it is defined as the care provided to patients who are suffering from diseases such as HIV and AIDS, TB, cancer, stroke and are considered to be chronically or terminally ill (Pindani, 2008:5).

Walker and Avant (2005:28) define a model as “any device used to represent something other than itself; a graphic representation of a theory”. The CCHBHC model was developed to improve access to health care and quality community health services which are not well established, and to strengthen the comprehensive health care services that are provided in the community and at home (WHO, 2004:2). The model identifies community and the families as the central focus of care and the source of support (Ncama, 2005:33; Pindani, 2008:6). The model recommends that individual clients and their families work together with the multidisciplinary team in the provision of care (Peu et.al., 2008:76-77). In the context of the current study, the participants view pregnant women as the centre of focus and identify the community, families, and individuals as sources of support that would encourage women to attend antenatal care.

The CCHBHC model was established for various reasons in different countries. In Tanzania, it was established in 1986 due to the increasing burden of AIDS patients and the limited beds in the hospital (Pindani, 2008:19). Caring for the patients at home became the most feasible option. In South Africa, it was initiated in the mid-1990s to provide the continuum of care for the HIV and AIDS patients (Pindani, 2008:19). In Malawi, it was started in 2001 due to the growing demand of care for HIV and AIDS patients. The community was mobilized to provide the care at home (Pindani, 2008:5).

In Uganda, it was started in 2001 when more children were infected with HIV. There was a need for care and support in the homes to support those infected and the affected families (Pindani, 2008:18). In relation to the current findings, the CCHBHC is initiated to expand health education on the importance of attending basic antenatal care among pregnant women in the community and household level to increase the uptake of basic antenatal care. This could be done through community involvement and participation, and inter-sectoral collaboration.

The CCHBHC model has seven essential elements which need to be taken into consideration when developing and implementing the developed guidelines. These elements are provision of care; continuum of care; education; supplies and equipment; staffing; financing and sustainability; and monitoring and evaluation (WHO, 2002:7;12; Wringe, 2010:355; Pindani, 2008:5). These elements inform the development of an effective framework which is applicable at a local level, informs community action on establishing, maintaining and scaling up of the CCHBHC programmes in the community (WHO, 2002:27;31; Wringe, 2010:355, 2005:4-5; Pindani, 2008:5).

Russell and Schneider (2000:329), when reviewing the projects that help people who are infected and affected with HIV and AIDS in South Africa, identified five general models of community home based care models. The models are funding, technical assistance and support, advocacy and community mobilization, drop in centres or support groups, home visiting programmes and comprehensive home-based care. The first three models were identified as not offering home based care per se, but could be incorporated into the home based care models to support and enhance the activities of home based care for the provision of continuum of care.

In relation to that, Peu et al (2008, 77-81) indicate that comprehensive home/community based-model, residential housing home/ community-based model; informal home community-based model, hospice home care model, individual practitioner model, full team model and specialized/ geographic model were the different models that have emerged over the years. The last three models are not common and usually operate on a small scale due to lack of funding. Based on the above, it can be seen that the CCHBHC model was initiated for various reasons in different countries and is implemented differently depending on the needs of the disadvantaged and the vulnerable. Implementation of the model is also based on the context of the area where it is implemented. It is used as a guide, and used differently depending on the availability of resources. It is also used based on the needs of the community and it is context specific.

4.2.2 The goal and objectives

The goal of CCHBHC model is to enhance better access of effective and efficient health care that is affordable, accessible, and equitable in the community and at home. When implementing the CCHBHC model, the community members are motivated and supported to proactively promote healthy lifestyles and prevent illness through resisting threats to their health (WHO, 2004:4). The model suggests the following: reaching out to and meeting the health needs of the vulnerable and underprivileged as identified in the community assessment; promotion of healthy lifestyle and prevention of illnesses; that the consequences of illness are managed by meeting the needs of those requiring care; the contributions of the informal caregivers are supported and acknowledged by building their capacity to provide hands-on care and providing them with the necessary resources; emphasizing on shifting the care to the beneficiaries and facilitate action for health and wellbeing by strengthening partnership, networking, intra and inter-sectoral collaboration with other sectors (WHO, 2004:4-5; Peu et al.,2008:77-78). The CCHBHC services provided are an extension of the health services from the health facilities to home which is of good quality, therefore assisting the patients and their families to improve their quality of life Tanzania Commission for AIDS (TACAIDS, 2015).

The current findings show that there is a lack of knowledge on the importance of attending antenatal care among pregnant women, family members and partners of pregnant women and the governance structures. The pregnant women do not attend antenatal care as they should. There are cultural beliefs which also affect and impact negatively on health seeking behaviour of pregnant women. To address the identified challenges, the participants proposed that health education be intensified by expanding it from the health facilities to the community in areas such as schools, churches, social clubs and homes to reach out to pregnant women, their families and all the community members; the health personnel need to work together with the community in enforcing community involvement and participation to enable joint identification of health problems that affect the community and seek solutions together; and maximize the use of available human and material resources to intensify and expand health education, focusing more on the importance of attending antenatal care by vulnerable and underprivileged pregnant women.

The participants further suggested that service providers and community leaders explore and maximize inclusion of all existing community structures that could be used for health education and disseminating information on the importance of antenatal care. This could facilitate change of behaviour in individuals, family and the community members if their values, beliefs and influencing behavioural change are targeted. The community's self-reliance and self-care which could lead to positive health seeking behaviour could be enhanced.

The current findings further show that the participants suggest that health personnel are to take the responsibility of providing training and support to the community and the non-formal caregivers to enable them to provide health services at any setting that will meet the community's needs. The health professionals could educate governance structures, community leaders, Home-based carers, teachers, children in schools and the community on the importance of antenatal care. These community resource persons could in turn teach other community members to disseminate the information. Similarly, the educated individuals and families could educate other members of their families on the importance of antenatal care attendance and act as a form of support and encouragement to pregnant women at household level. Health education could be done using different forms of media available locally such as local Radio stations and pamphlets. The health education programmes would assist in raising the awareness of the community on the importance of available maternal child and health services (Titaley, Dibley & Roberts, 2010:9-10).

Ncama (2005) asserts that the care is aimed at maximizing the patient's health, functioning, quality of life and dignified death. The community care givers provide the services that are normally provided by a trained community nurse when conducting home visits (Aantjes, Quinlan & Bunders, 2014). The role played by the community informal caregivers is affirmed in the Caregivers Action Network (CAN) report. They were involved in the prevention and promotion of health activities such as prevention of HIV, mitigation of stigma, TB surveillance, connecting clients to treatment sites, adherence to treatment, uptake to HIV treatment, which affirm their important role (van Pletzen & MacGregor, 2013:8**).**

It emerged in the current findings that there are Home-based carers (HBCs) and the Community Development Workers (CDWs) who are already working in the community of Bushbuckridge and could be utilised to expand health education in the community and not focus on maternal health issues only. They could be used to strengthen the health education on the importance of antenatal care attendance in the community because they are the existing resources that are already functional in the community and at household level.

The participants proposed that after the formal service providers built their capacity on maternal health, their roles and responsibilities should be reviewed and they should be provided with the necessary tools and support. This could enable them to provide a comprehensive health care service within the continuum of care for those who are in need and are vulnerable.

4.2.3 Essential elements of CCHBHC

The seven essential elements of the CCHBHC are provision of care; continuum of care; education; supplies and equipment; staffing; financing and sustainability; and monitoring and evaluation (WHO, 2002:7;12; Pindani, 2008:5). They are discussed in the next few pages. Each element can be divided into sub-categories which can also stand on their own and contribute towards the holistic model. The elements are considered to be ideal as they may not all be implemented at once or they can be implemented selectively depending on the availability of the resources and the context as it is context specific (WHO, 2002:7). This is supported by Peu et al (2008:77-81), who pointed out the different models which emerged over the years such as comprehensive home/community based-model, residential housing home/ community-based model; informal home community-based model where the elements were used selectively. Further to that, in their book titled "Home /Community based care", they viewed some of the essential elements as objectives and some as principles (Peu et al., 2008:77-78).

The discussion in section 4.2.1 on the various reasons for establishing the CCHBHC model in different countries also shows how the elements could be context specific. The varied reasons include the increasing burden of AIDS patients and the limited beds in the

hospital, more children who were infected with HIV and the growing demand of care for HIV and AIDS patients (Pindani, 2008:5;18-19). The discussion above shows that HCBHC model can be used differently depending on the availability of resources, needs of the community and is context specific. The elements and their relevance to the current study are briefly outlined below.

Provision of care as one of the elements focuses on the care that should be provided to the client and the care givers such as basic physical care, palliative care, psychosocial and spiritual care and care of the carers depending on the needs of the local priorities (WHO, 2002:35-45; WHO, 2004:12-13; Peu et al., 2008:77-78). Provision of care includes reaching out to meet the needs of those who are underprivileged and vulnerable including pregnant women, the disabled, chronically ill, people living with HIV, the elderly and the terminally ill (Peu et al., 2008:77; Wringe, 2010:353). A study conducted in Swaziland by Root and Whiteside (2013:4-5) shows that the care givers in Shiselweni Home Based Care encouraged people living with HIV to take their treatment, educated them on counselling on the side effects of treatment and the importance of returning to the clinic for follow-ups. The care givers acted as disclosure-brokers between the clients and their families by creating a setting that is safe for disclosure in the households. The care they provide is integrated with religion which includes praying with and preaching to their clients. The care provided is viewed as pivotal to individuals living with HIV and AIDS.

In a study conducted by Pindani (2008:5), the findings showed that at times, caregivers experience physical and emotional challenges as they care for their clients and get burn-out. The caregivers also need psycho-social support and information to continue supporting and meeting the needs of their clients.

In the context of the current study, the focus is on expanding health education and health promotion activities in the community that will promote pregnant women to attend antenatal care services. The participants acknowledged that the current health education is inadequate as it is provided in the facilities only. In their view, the use of available human resources and material resources need to be maximized to intensify and expand health education and health promotion focusing on the importance of antenatal care

attendance. They further indicated that information provided could help women to better understand and be motivated to attend antenatal care and return for follow-up visits.

The continuum of care element focuses on ensuring that the services are of good quality of care. This involves organized structures and processes to ensure delivery of holistic, integrated and continuous care in accordance with the set standards. There is also a referral system from the facilities to the community and households and back (WHO, 2002:46; WHO, 2004:12; Peu et al., 2008:78). Peu et.al (2008:77) assert and emphasize the importance of using the multidisciplinary team to provide the continuum of care and referral to meet the needs of each client. According to the view of the participants in the current study, the purpose of pooling together all the different stakeholders (human resources) with different skills and operating at different levels is to ensure that the range of services needed by pregnant women are provided. The Department of Health alone cannot meet the needs of the community. Collaborating with other stakeholders enhances pooling of resources together which complement each other in the provision of continuum of care. This increases a chance of providing comprehensive care to the beneficiaries (Pindani, 2008:39).

The current findings further indicated that the service providers could use the existing community structures such as governance structures and community leadership to expand health education and disseminate information on the importance of antenatal care in the broader community and in households. Additionally, there are also Home-based carers (HBCs) from the local community based organizations (CBOs) who already have informal relationship with the Department of Health. They are already linked to the local primary health care facilities. They are currently doing community outreach programmes providing home based care services at household level although their focus is not on maternal health issues. It is based on their current work that participants see them as best suitable to be used in strengthening health education on the importance of antenatal care attendance in the community. They are human resources that already exist and function in the local area.

Participants suggested that the formal service providers could build their capacity, clarify their additional roles and responsibilities, provide them with the necessary tools to carry

out the tasks, and provide them with the necessary support. This could assist in providing comprehensive health care services within the continuum of care for those who are in need and are vulnerable. Other additional human resources that could be used are the Community Development Workers (CDWs) who also work in the same community. Community structures such as community forums, schools, churches, social groups could also be used as platforms to expand health education on the importance of antenatal care attendance targeting men, women and children who could further disseminate the information in the community and at home. The private sector could also be approached to request assistance with training to enhance the knowledge and skills of the informal caregivers.

The element on education focuses on the identification of the learning needs and training of the clients, formal and non-formal care providers. It includes the structure of the training, the strategies to be used and how the training will be managed (WHO, 2002:54; WHO, 2004:14). Peu et al (2008:77) assert by indicating that the contribution of informal care givers needs to be acknowledged by equipping them with knowledge and skills for provision of care at home including resources and emotional support. This acts as support and acknowledgment of the contributions that informal caregivers are making.

As indicated by the participants in the current study, the capacity of the identified community resource persons who are formal and non-formal care providers, governance structures, community leaders including families and individuals need to be empowered. The formal health care providers could be trained on issues such as inter-sectoral collaboration and partnerships, and provision of community based care health services. The training could include skills and competencies on supervision and coordination to enhance programme management. They in turn could train the non-formal providers on the importance of antenatal care attendance who would in turn educate the clients and their families.

The element on supplies and equipment focuses on how the supplies and equipment should be used, kept and distributed (WHO, 2002:58). This refers to the supplies that are used for the clients such as medicine, food and other resources e.g. stationery given to caregivers to assist them in doing their work e.g. referrals to the next level of care (Wringe

et al., 2010: 355-356). The most effective programmes in home based care are those which have adequate resources and are trained, supported and are remunerated (Wringe et al., 2010:352).

The element on supplies and equipment is not applicable in the context of the current study as the focus is on development of preliminary guidelines for health education and health promotion. It could be applicable when the developed guidelines are used to implement a health education and health promotion programme. It is at this point where health education and health promotion materials could be developed to disseminate the information. A supply of information, education and communication material could be required.

Staffing focuses on determining the human resources needed and clarify issues such as supervision, coordination of the programme, skills and competencies needed and clarifying roles and responsibilities of the different stakeholders (WHO, 2002:60; WHO, 2004:14). According to Peu et al (2008:77), the staff needed could be a multidisciplinary team whom are determined by the needs of the client such as the psychosocial circumstances and illness. In the context of the current study, the participants proposed that the formal health care providers should involve the existing non-formal human resources such as Home-based carers, community development workers and community leadership who are available in the local area to expand health education and health promotion activities from the facilities to the community. The formal health care providers could train the non-formal caregivers and provide the necessary support and supervision together with the governance structures.

In Uganda, the Village Health Teams (VHT) were used as additional human resources to sensitize and mobilize male partners in the community to be involved in antenatal care where they acted as a link between the Ministry of Health and the community whilst the health workers acted as their supervisors. They educated the community and tracked women who missed their antenatal care visits and encouraged them to deliver in health facilities. The interventions increased the uptake of HIV counselling and testing among pregnant women in their first antenatal care visit, increased antenatal care attendance and skilled attended deliveries (Ediau et al., 2013).

Financing and sustainability focuses on funding and sustaining the programme on how the programme could be determined by the existing policy of the country. It also involves mobilization of additional resources, costing of the activities and financial control and management (WHO, 2002:19; WHO, 2004:14; Peu et al., 2008:78). Based on the view of the participants in the current study, the programme could be implemented in the local area by using all the available and existing formal and informal human resources who are already funded to avoid incurring additional costs.

To enhance sustainability, the programme could be linked with the WBOT when it is implemented in the Bushbuckridge sub-District. The Department of Health in South Africa is currently expanding the implementation of Ward Based Outreach Teams (WBOTs) in all the provinces following testing it on small scales. The WBOTs encompass all activities in the community, households and educational institutions, and referral networks with community-based providers such as government departments, other sectors, community-based organizations and Non-Governmental Organization providing community based services and working in the local community (DoH, 2011:14).

The view of participants in the study was that it could be beneficial to use the existing Home-based carers (HBCs) as it may complement the current human resources for expanding health education on the importance of antenatal care attendance from health facilities to the community and household level. When the implementation of the WBOTs starts in the local area, the existing link between the formal and informal care givers could be strengthened. The results of the current study could be easily integrated with the implementation of the WBOT in the district. Training on mobilization of financial resources could be one area where capacity of all stakeholders is built depending on the learning needs identified.

Monitoring and evaluation focuses on tracking implementation of the programme's planned activities. This is to ensure that activities are carried out as planned and identify divergence. Should a deviation be identified, corrective measures will be taken on time. It also includes developing a feedback loop to elicit lessons learned and utilise them. Evaluation is conducted at the end of the programme to assess the impact of the achieved activities (WHO 2002:15; Peu et al., 2008:78). Monitoring is the ongoing process of

tracking daily activities and the deliverables of a project or programme to check if the expected deliverables or results are achieved. It is done through data collection and reviewing the data to inform the decision makers of the progress made to make positive decisions. Evaluation is the systematic collection and objective analysis of available evidence to assess the performance of a project or programme; whether or not it had an impact (City of Johannesburg, 2012:8). There is no data from the current study that can be aligned with this principle, but the principle could be used to inform the validation of the developed guidelines.

The different models of CCHBHC that have emerged over the years as indicated in the overview of the CCHBHC in 4.2.1support the notion that the principles are ideal and not all of them can be utilised. In the context of the current study, the model could be used to develop health education and health promotion activities that will meet the needs of pregnant women who are vulnerable and underprivileged in Bushbuckridge sub-District. Based on the discussion, it is clear that not all the principles are applicable to the current study. This affirms that the elements are ideal and may not all be implemented at once, or can be implemented selectively depending on the availability of the resources and the context.

4.2.4 The principles of CCHBHC

There are principles which the model should reflect when implemented which are quality, partnership, equity, effectiveness and efficiency which will be briefly explained. These are used to guide the process of making decisions and developing the strategies used for implementing the model.

Quality refers to ensuring that holistic, integrated and continuous care is delivered through well-organized structures, processes and according to agreed standards (WHO, 2004:3; Peu et al., 2008:78). According to Pindani (2008:31), quality is when the material inputs and skills of the care taker are optimized to produce maximum health.

In the current study, participants indicated that in order to have a positive impact in health through improving antenatal care attendance by pregnant women, there should be increased community involvement and participation, and intra and inter-sectoral

collaboration by different stake holders. In their view, when the human resources with different skill mix in the local area and are pooled together, they will complement each other in the provision of continuum of care. This will enhance the provision of holistic, integrated and continuous care that is of good quality.

Kulkarani et al (2008:102) found that women who received good quality of care had a significantly higher utilization of antenatal care which emphasizes the importance of providing good quality of antenatal care. According to the Department of Health (2013:23), there is research evidence showing that the status of nursing is declining and there is deterioration of the image and the status of the nursing profession. The nurses resent the community's views about the complaint of their bad attitude. However, they recognize their unsatisfactory ethical behaviour and admit that it needs to be corrected. Nigenda et al (2003:7) also had similar findings in Saudi Arabia that pregnant women attending antenatal care were frequently experiencing bureaucratic attitude by the staff which had a negative impact on the quality of services provided.

The current study reveals that health workers have a negative attitude towards older pregnant women including those with high parity and tend to ill-treat and embarrass them during their antenatal visits, deterring them from attending antenatal care as they should. Additionally, pregnant women are afraid of the mandatory HIV testing they are subjected to when they visit antenatal care in case the results turn positive because they will be discriminated against by the service providers.

Simkhada et al (2007:256) find that women feared to test for HIV and get positive results which are recorded in their antenatal cards. In Uganda, nurses reacted by refusing to take care of patients with HIV and had minimal contact with them. They experienced rejection with inappropriate isolation (Walusimbi & Okonsky, 2004:92). A similar situation was experienced in the Eastern Cape, South Africa, where nurses discriminated against HIV positive patients and did not want to touch them (Human Rights Watch, 2011:26).

Partnership entails that all stakeholders (client, family, formal and informal care providers, inter-sectoral partners) are empowered and actively participate in decision-making by creating opportunities and methods for them to be involved in a transparent manner

(WHO, 2004:3). In the current study, the participants suggested that the Department of Health strengthens the partnership with governance structures, community leaders and collaborate with other departments and stakeholders. They could jointly identify problems, plan, implement, monitor and evaluate the programme in order to have an effective health education and health promotion activities for pregnant women in the community and at home. Some of the participants who are members of the governance structures indicated that they were involved in various forms of health education in the community but never focused on antenatal care. Following their engagement with the researcher, they realised that together with community leaders, they have a role to play in expanding health education to the community. They need to take a lead in facilitating the process of community involvement and participation.

Friedman et al (2006:51) assert the need for inter-sectoral collaboration where different departments and stakeholders participate in service delivery at different levels including planning, decision-making on implementation and management of planned projects. It can be done in a way that the community representatives are empowered for the purpose of sustainability. He further indicates that, although the development of policy on collaboration with the community is complex, forming partnerships at various levels of government services, NGOs, community, men, and women's organization remains important. To achieve this, common objectives and strategies should be set.

Community participation and collaboration could also be included in the training of midwives to improve their competency in dealing with issues such as group education, traditional practices and gender approaches (Mail, Menaca, Were, Afrah, Chatio, Manda-Taylor, et al., 2013). Families play an important part role in supporting pregnant women and they are part of the wider society. In India, men were targeted after noting that they lacked understanding about the risks of child birth and the consequences thereof. Male outreach workers were used to reach husbands of pregnant women who were given reminder cards on antenatal care attendance to take home to their wives that increased the antenatal care uptake (Manandhar, Osrin, Shrestha, Mesko, Morrison, Tumbahangpe, et al., 2004:970).

Titaley et al (2010:9-10) confirmed the need to strengthen the health education programmes that raise awareness of the community on the importance of available maternal child and health services. The interventions should target husbands, parents including other family members other than focusing on women only. Messages on the importance of antenatal care attendance should also target friends and relatives as they also have an influence on decision making related to antenatal care attendance (Mail et al., 2013).

Equity ensures that the vulnerable and disadvantaged group receive equitable access to all the health care services and resources required (WHO, 2004:5; DoH, undated:3). The use of primary care teams in Brazil assisted the country with closing the gap between the rich and the poor by improving equity in health. This resulted in significant infant mortality reduction and the immunization coverage increased. Additional to that was the increase in the uptake of antenatal care, mental health and screening of diseases (Johnson, Noyes, Haines, Thomas, Stockport, Ribas & Harris, 2013). The Alma-Ata Declaration of 1978 also indicated that the importance of the community being involved in shaping their health services is to ensure that the services are shaped according to the needs and the living conditions of the target population. The health services provided should be able to address and meet the community's needs (Gorgen, Kirsch-woik & Schmidt-Ehry, 2004:212).

The current findings show that although pregnant women find attending antenatal care beneficial, there are existing barriers limiting them from attending antenatal care services. The barriers are inaccessibility of the antenatal care at service points, poor quality of care provided, mandatory HIV testing for pregnant women, socio-demographic factors and cultural beliefs and practices which will further be discussed to provide the context in which antenatal care occurs in the sub-District.

The participants further mentioned that it is difficult for the pregnant women in the area to access antenatal care services because of the sparsely geographical location of health facilities in this rural area which is exacerbated by poverty. The facilities are of poor infrastructure and the women lack financial resources to pay for public transport to reach the clinics or return back for follow-up after their initial visit. These circumstances make

health education to be limited to physical primary health care facilities contributing towards low uptake of antenatal care services because the information reaches those who access facilities only. This further makes the pregnant women to remain vulnerable and disadvantaged in their poorly and under-resourced areas.

The above findings are supported by Myer and Harrison (2003:271) who find that the lack of physical access to most primary health care facilities in the rural areas of South Africa poses a serious challenge to the access of antenatal care despite the availability of mobile services. Kulkarni and Nimbalkar (2008:99) also found that a long distance travel to the clinic led to poor utilization of antenatal care services. The skewed distribution of health care services in the South African rural and urban areas deters women from accessing antenatal care services (Phillips, 2002:70). The availability of money to travel to the clinic and the times at which the services are offered are important factors that influence antenatal care attendance (Tlebere, Jackson, Loveday, Matizirofa, Mbombo, Doherty, et al., 2007:346). Similarly, in Kham District, Xiengkhouang Province, Laos, seventy percent of pregnant women were not attending antenatal care because they lived far from the clinic and had limited transport to get to the clinic (Ye, Yoshida, Harun-Or-Rashid & Sakamoto, 2010:31).

Cham et al (2005) found that another limiting factor for pregnant women to attend antenatal care in the rural Gambia was the provision of antenatal care services on specific days during the week which gave them an impression that maternal health services were only available on those specified days.

The functionality and accountability of governance structures in health within communities need to be strengthened through community participation and involvement, and inter-sectoral collaboration to meet the local needs. This could ensure that the identified challenges are addressed to improve the quality of health services provided. It could also enhance efficient, effective and equitable distribution of health services to meet the needs of the targeted population. Nurses should also take the services to the women who are not willing to attend antenatal care (Lincetto et al., 2006:54).

Efficiency and effectiveness are the most important principles. Efficiency principle focuses on ensuring that there is a range and mix of the available human, financial, physical, technical resources that are optimally used to deliver evidence based practice. Effectiveness principle focuses on ensuring that the services provided yield the anticipated results (WHO, 2004:3).

In order to have the range of skills mix, collaboration and partnerships could be formed with other government sectors, non-governmental organizations and other relevant agencies (Friedman, 2006:70-71). For quality services to be provided, there needs to be a pool of additional professionals to render the comprehensive, holistic services and decentralized health services. The skills mix in the Brazilian primary care teams is comprised of the community health workers, auxiliary nurses, nurses and the doctors (Johnson et al., 2013). Through inter-sectoral collaboration, community involvement and participation all stakeholders could be involved in the process of identifying the needs, the processes, planning, implementation and monitoring and evaluation of the identified projects (Friedman, 2006:70-71).

Additionally, financial and human resources could be mobilized and financial management skills built to sustain the interventions. This could include setting up mechanisms for financial controls to ensure that there is equity, effectiveness and efficiency. Tools to be used could be designed and developed to provide holistic, integrated and continuous care. The use of information management could be strengthened for monitoring and evaluation of the projects. All this will facilitate meeting the objectives of the CCHBHC (Friedman, 2006:70-71). Health care providers will be empowered to increase awareness and enable the community to demand quality health services.

Community participation is an essential element that can lead to responsive health services which are appropriate and respond to the needs and perceptions of the local communities. Some of the benefits of community participation are to encourage health care workers and the community to work together as partners in addressing the needs at a local level, including other service delivery requirements. Engaging communities can improve treatment outcomes and enhance local response (Friedman, 2006:98). Gibbs

and Campbell (2013:31-32) suggest development of a framework of incentives to strengthen community participation to meet the set objectives which could result in effective delivery of Primary Health Care. To increase efficiency in health care service delivery, they further indicate a need for the public sector employees to be trained in community involvement and participation for them to effectively facilitate the process. The Department of Health is in the process of developing a Health Governance Resource Manual that will guide the strengthening of the capacity of governance structures in the country to enhance efficiency and effectiveness.

The two principles are not directly aligned to the current findings, however, the participants' suggestions of promoting collaboration and partnership within the different stakeholders with different skills range is an attempt towards having a programme that will be efficient and effective.

4.2.5 Strategies for CCHBHC

There are strategies that are used to achieve the goals and the objectives of the CCHBHC model which reflect the principles underpinning the model. In the context of the current study, the two relevant strategies are stakeholder involvement and mobilization of resources. All the relevant stakeholders need to be involved to mobilize their commitment and support (WHO, 2004:6). These different stakeholders would be bringing their different expertise in the care of the clients (Peu et al., 2008:78). Additionally, mobilizing of the resources is needed and should be managed well. The use of available resources such as human and financial resources are to be optimized and building on the current system to increase efficiency (WHO, 2004:6; Peu et al., 2008:78).

When applying the principles to make decisions and formulate the guidelines, there will be inputs that will be required and processes to be followed which will result in the output. These concepts will be briefly explained and the current findings will be cited as examples where applicable.

Input refers to the identified resources that are needed to implement the programme which are the systems, human resources, financial resources, material resources and the management of the resources. It includes the resources that are used to do some work

such as personnel, equipment and finance (WHO, 2004:9; National Treasury, 2007:6). In the current study, participants indicated that the individuals, families, members of the community, school teachers, governance structures and community leaders could act as additional human resources if they are trained. They could be used to expand health education on the importance of pregnant women attending basic antenatal care from facility to the community and household level. Additional to that, they proposed that existing community resources and structures such as Home-based carers, the Extension Development Workers including other relevant partners could be utilised to expand health education in the community. By using these community resource persons, a link between the health systems and the community will be strengthened, thus facilitating reorientation of the health system to provide community based health services.

Process is the method used when undertaking the programme in order to meet the set objectives. It is also referred to as all the activities or actions undertaken when using the range of inputs to achieve the desired result or output (WHO, 2004:9; National Treasury, 2007:6).

In relation to the current findings, the participants propose that health care providers need to be reoriented in rendering health services that are beyond the facilities to health services provided in the community and at home. Additional to that, they see a need for the Department of Health to collaborate and work in partnership with other stakeholders on relevant issues such as management of related projects and use of available human and financial resources, mobilization of funds and the use of information. The participants further indicated that formal health care providers could empower and support the non-formal caregivers on the provision of health education in the community and household level. These are the processes that could be followed to equip the human resources to be able to meaningfully contribute in health education and health promotion.

Output is the measure of what is produced after implementing the activities i.e. the immediate results achieved following the activities. It is the final products that are delivered after using the inputs and the planned processes were followed (WHO, 2004:9; National Treasury, 2007:6). In the current results, the participants anticipate that if the inputs and the processes are implemented, the output could be the services that are

extended to the community and household level. There could be increased awareness on the importance of attending antenatal care by individuals, families and members of the community after being reached through health education. There could also be increased community participation and involvement; intra and inter-sectoral collaboration by different stake holders; strengthened capacity of all stakeholders involved which include service providers, partners and community members.

In the context of the current study, the strategy on involving stakeholders to ensure political commitment and support through empowerment and, community participation and partnership is applicable. Additionally, is the strategy for mobilizing and managing resources yet focusing on human resources.

4.2.6 The components and the core elements of the CCHBHC model

The CCHBHC model is underpinned by the following components: forming partnership, involvement of other stakeholders and the local context, linking formal and non-formal caregivers, empowering individuals, the family and community for self-care and self-reliance and providing a bridge between the individual, family, the community and the health care system (WHO, 2004:1). The core elements of the model include three levels of prevention which are primary, secondary and tertiary of diseases as depicted in figure 4.1. Primary prevention is when the diseases or health problems are prevented before they arise through health education and health promotion activities. Secondary prevention is early detection of diseases before the symptoms are visible. The treatment or intervention is done to slow or stop the progress of the diseases. It includes referral where it is necessary (WHO, 2004:10-11; Peu et al., 2008:77; 79; uOttawa, 2015). Tertiary prevention is stopping the progress of the disease that has started. This is done to prevent or reduce complications. Rehabilitation is done to prevent complications (WHO, 2004:10-11; uOttawa, 2015). These levels of prevention can be provided in any setting in the community such as primary health care (PHC) facilities, schools, and churches including at a home setting or household level.

The components act as the basis and support structure for implementing the CCHBHC model. In the current study, the researcher views these components as enabling factors to facilitate the health education and health promotion activities which could be

undertaken for disease prevention and health promotion. No aspects of the CCHBHC model or the whole model can be successfully implemented without these components. This is supported by the policy decision taken by the South African government in 2010 of wanting to formally employ CHWs as part of WBOTs under the supervision of professional nurses, thus linking them with formal health facilities in the electoral wards which is already implemented already implemented in Kwa-Zulu Natal Province (CAN, 2013:6).

In Zambia, PHC facilities have managed to provide a comprehensive package of health promotion, prevention, treatment and monitoring of HIV and AIDS programmes through community home based care (Aantjes, Quinlan& Bunders, 2015). Implementing the core elements of the CCHBHC could result in prevention of diseases, promotion of screening and health assessment, prevention of complications where diseases have occurred, and rehabilitative services where necessary among pregnant women.

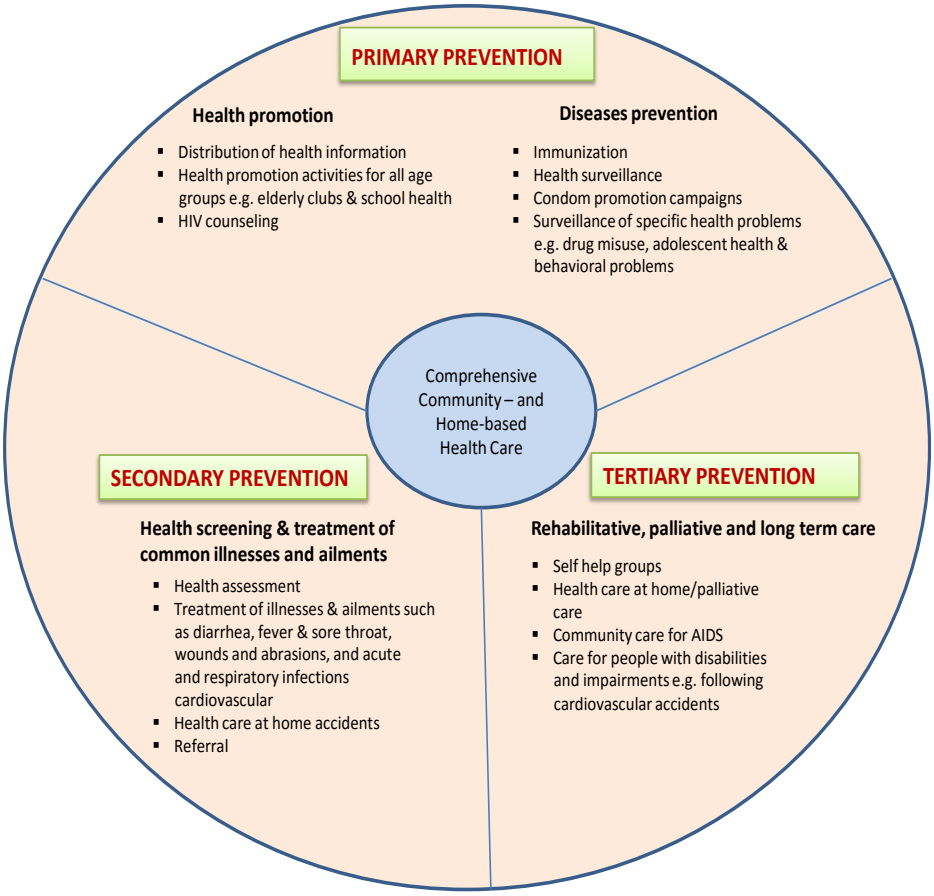


Figure 4.1: The core elements of the CCHBHC Model (Source: WHO, 2004:11)

In South Africa, the Community health workers who are part of the WBOTs are also responsible for prevention of illnesses, promoting health and wellness, and providing psycho-social support to individuals, families and the community (DoH, 2011:6). This is aligned with what the participants indicated in the current study that all existing community structures could be used for health education to be explored for disseminating health education and health promotion. Additionally, there are Home-based carers and the Community Development Workers who are readily available and are already doing some work in the community.

The CCHBHC model puts a particular emphasis on and recognizes that the patients or clients are at the centre of the care whilst the individuals, families, groups, communities

contribute in achieving, maintaining their health and managing illness throughout their existence (WHO, 2004:2). The active service providers are the family members, extended families, other community members and the trained volunteers within the community networks who also contribute in service provision (Peu, et al., 2008:78-79). In relation to the current findings, the family members provide emotional, psychological and social support to pregnant women. They remind them to return to the clinic for check-up visits. Some pregnant women are accompanied to the clinic by their partners or husbands. Some family members remind the pregnant women to take their treatment when they are at home to ensure that they do not forget.

The model suggests bridging of the gap between the community and the health care system by empowering the individual, family and community for self-care and self-reliance (WHO, 2004:3). Schneider et al (2008:185) assert by indicating that the use of Community health workers in the CCHBHC model has empowered them to the extent that they became a bridge between the patients, communities and the health system by acting as a voice for the people living with HIV. This includes strengthening their capacity and expertise on health issues and institutionalizing the concept of volunteerism. In relation to the current findings, the Home Based Carers are currently working closely with the Department of Health and are involved in community outreach programmes. The participants proposed that the carers be used to strengthen health education on the importance of antenatal care attendance as they are always doing house to house visits. The carers are already helping other people in the same community on the provision of home based care in the community and in homes. This is supported by Aantjes et al (2014) who found that the contribution of the community care providers who are carers in Malawi is acknowledged as a mechanism for alleviating the workload of the staff in Primary Health Care facilities.

The model proposes that the services form part of the existing Primary Health Care services and be integrated with other related health programmes and be well coordinated. The care provided meets the health needs of the individuals, families and communities in their local settings. The core elements of the CCHBHC which are primary, secondary and tertiary prevention guide the formulation of the preliminary guidelines. It also

encompasses promotive, rehabilitative and palliative care services (WHO, 2004:3, Peu et al., 2008:79). In relation to the current findings, this could be done through health education and health promotion activities. These will result in prevention of diseases, promotion of screening and health assessment, prevention of complications where diseases have occurred and providing rehabilitative services where necessary among pregnant women.

The components underpinning the CCHBHC model which are forming partnership; involvement of other stakeholders and the local context; linking formal and non-formal caregivers; empowering individuals, the family, and community for self-care and self-reliance and providing a bridge between the individual, family, the community and the health care system are used as the basis and enabling factors to facilitate the health promotion activities which could be undertaken. These components are similar to what emerged in the current findings as the enabling factors for implementing the CCHBHC model which are: community participation and involvement; forming partnership; inter-sectoral and intra-sectoral collaboration; involvement of community leaders in health education and health promotion activities; empowering of and use of existing community based structures such as home based carers by formal care givers to expand health education to the community and households.

4.3 THE REASONS FOR CHOOSING THE CCHBHC MODEL

The goal of the model is to ensure accessibility of effective and efficient health care services in the community and at home, which are relevant to the context of the Bushbuckridge sub-District where the study was conducted. The aspects are closely related to the current findings and will be useful to inform the formulation of the guidelines.

4.3.1 Relevance of the principles of the CCHBHC model

Firstly, the CCHBHC is based on the principle of holistic, integrated and continuous care. It acknowledges all the contributions made by different service providers to achieve and maintain the health of individuals, groups and communities on how they manage their illness throughout their lifespan (WHO, 2004:7). Amenyeiwe, Leclerc-Madlala and Gardi (2014:313) assert that implementing programmes that provide integrated comprehensive

packages of prevention, treatment and care at local level is the most effective way of dealing with the current and long term needs of HIV patients.This principle is relevant to the current study context, as it assists in identifying where there may be a gap in the provision of health care services at the community and at a household level which contribute to inaccessibility of health services to the vulnerable and disadvantaged, such as pregnant women in rural areas in Bushbuckridge. It is important to put mechanisms in place to involve, coordinate and collaborate with private health providers and the non-profit organisation in order to provide a continuum of care to individuals, families and the community (Aantjes et al., 2014).

Secondly, the model supports the Primary Health Care approach and provides a framework for systems and processes that can be adapted to meet the needs and priorities of the local communities; strengthen the existing health system in the community and increase accessibility of health services to the needy the most priority essential care services; builds the capacity of available health personnel who provides health services; enables health services to effectively work with individuals, families, groups and communities in providing quality health care services (WHO, 2004:7). The Western Cape Department of Health has adopted and is implementing Community Based Health Services which is integrated into PHC. It is a model where Community Health workers are led and supported by a nurse. These community services are linked to the facilities to ensure that the work that is done is also linked to the service delivery targets. This is similar to the DoH WBOT which is currently being expanded to all provinces. This is aimed at bringing the services closer to the people who are in need, by using non-formal caregivers supported by the formal health care providers.

The principle is supported by the findings on the evaluation of the Community Response to HIV and AIDS conducted in 8 countries by the World Bank, DFID and the UK Consortium on AIDS and International Development (2012). It shows evidence that community based health services can yield positive results that are beneficial to the individuals, families and the community amongst other things, resulting in improved HIV prevention knowledge and behaviour, and increase the use of prevention, care and support services on substantial mobilization of community resources.

As part of primary health care, it provides a framework of reference through which systems and processes can be adapted and strengthened to extend the delivery of community based health services, in the community and household level. This is to meet the needs and priorities of the local communities. In comparison with the current study findings, the participants proposed the involvement of the existing community structures, families and individuals in expanding and strengthening health education and health promotion in the community. The activities are to be extended to household level in order to reach the vulnerable and disadvantaged pregnant women.

Thirdly, the model considers the local context and is based on partnerships and links both the formal and the non-formal caregivers. It places the patients or clients at the centre of the care and recognises that individuals, families, groups, communities can contribute in achieving, maintaining their health and manage illness throughout their existence. It also provides the context in which the provision of CCHBHC services occurs through the involvement of the different stakeholders and working in partnerships. The gap between the community and the health care system is bridged by empowering the individual, family and community for self-care and self-reliance (WHO, 2004:7). There should be mechanisms in place to involve and collaborate with private health care providers in providing a continuum of care to individuals, families and the community. Additionally, there is a need to strengthen coordination and collaboration with non-profit organisations to deliver comprehensive health care (Aantjes et al., 2014).

Ngubo and Machedi (2006:29) also indicate a need to collaborate with other sectors, agencies and other disciplines within the Department of Health as health alone cannot meet the needs of the communities. Community participation and inter-sectoral collaboration play an important role in promoting health for the individuals, families and the communities. As indicated by the participants in the current study, the community leaders and governance structures need to work together with the health workers to strengthen community participation and involvement in order to promote antenatal care education in the community.

The involvement of the governance structures in health in the Bushbuckridge sub-District is already acting as a bridge between the community and the health care system.

However, it could be further strengthened by engaging and working together with community leaders, families and individuals when expanding health education in the community. Additionally, in relation to this, the participants indicated the need to enhance collaboration and forming partnership with other government departments and sectors for the purpose of expanding health education on the importance of antenatal care attendance in the community.

4.3.2 The CCHBHC model is context specific

As indicated in the examples of contexts in which the CCHBHC model was effectively implemented, the model is of particular relevance in under-resourced communities where comprehensive health care services for different age groups provided in the community and at home are not well established (WHO, 2004:12-13). It contributes in creating an environment where patients are cared for in a familiar environment whilst allowing them to continue to participate and contribute to family life as members of the family and the community at large (TACAIDS, 2015). The model provides a framework to improve access to health care and quality community health services as well as strengthen the comprehensive health care services that are provided in the community and at home.

The model proposes that services form part of the existing primary health care services and are integrated with other related health programmes and are well coordinated. The care provided meets the health needs of the individuals, families and communities in their local settings. It includes primary, secondary and tertiary prevention (WHO, 2004:3; Peu et al., 2008:77). The model helps in keeping families together with a primary objective of caring for the patient. Costs for caring for the patient away from home are also reduced enabling family members or carers to attend to other tasks whilst caring for the patient (TACAIDS, 2015). As part of Primary Health Care, it provides a framework of reference through which systems and processes can be adapted and strengthened. This would extend the delivery of community based health services, in the community and household level and assist in meeting the needs and priorities of the local communities.

In the context of the current study which focuses on health care in an under-resourced and disadvantaged community, the model is relevant as it can be used to expand and

increase access to health education and health promotion activities on antenatal care to pregnant women, individuals, families and the entire community in Bushbuckridge sub-district. The framework guides the restructuring and redesigning of the health system from facility based health care services to services provided in the community and household level based on the local context. This would enhance strengthening partnership and networking between the community, health care providers and other sectors providers (WHO, 2004:9; Peu et al., 2008:77).

The Department of Health assert by stating that one of the reasons for including community-based care and home based care into the primary health care strategy, is the need for the informal sector (families, community health workers, volunteers, caregivers) to be involved in health promotion activities. Additional to that is creating awareness in the community on prevention of diseases, early identification of diseases, basic care, home assistance, referrals, and rehabilitate them at a community level (DOH, 2001:5; 8). Tanzania is one of the countries where community based health care services are integrated into primary health care and it is the responsibility of the Ministry of Health to remunerate for these services. This is to effectively deliver health services (Aantjes, Quinlan & Bunders, 2014).

In the current study, the participants proposed that the Home-based carers who are currently working in the community be empowered on maternal health issues. This could enable them to assist in expanding their scope of work to health education on the importance of attending antenatal care. They further recommended that the relationship of the non-profit organizations, which employ the carers and the Department of Health, be strengthened by formalizing it.

The model also supports and acknowledges the contributions of the informal caregivers by building their capacity to provide hands-on care and providing them with the necessary resources (WHO, 2004:4-5; Peu et al., 2008:77). These informal care givers are unpaid family members, friends and the caregivers who are volunteers (Ncama, 2005:35). In Tanzania, the family chooses one person to be trained on specific elements of the patient care while the community provides support to the patient and the family in all aspects of care, treatment and support. Transferring skills to the informal caregivers is one of the

minimum packages of home based care. The skills that are transferred are in areas such as basic nursing care, infection control, nutrition, hygiene, positive living and referral networking (TACAIDS, 2015). This is done to meet and manage the changing needs of those who need care due to the consequences of illness.

The sources of training have been from the health facilities, community volunteers, community organizations, Non-Governmental Organizations (NGOs) and Faith-Based Organizations (FBOs) and the private sector. Moreover, the model facilitates community actions for health and wellbeing by establishment and strengthening partnership between the health care providers, the community, government sectors and the non-governmental organizations (WHO, 2004:4-5). The main implementers in Tanzania have been the Community Organizations, Non-Governmental Organizations and Faith Based Organizations through donor support (Ncama, 2005:33; Russell & Scheider, 2000:328; TACAIDS, 2015).

The findings in the current study show that there are Home-based carers in Bushbuckridge sub-District who are from the local community based organizations (CBOs). They have an existing informal relationship with the Department of Health and are linked to the local primary health care facilities. They are currently doing community outreach programmes providing home based care services at household level. They use the clinics as their office base of operation where they meet with the nurses to discuss progress reports and replenish their HBC kits. It is based on the current experience of their work that participants propose to use them to strengthen health education on the importance of antenatal care attendance in the community and households, because they are resource persons who are already functional.

The participants further propose that formal service providers could build their capacity on antenatal care education, clarify their additional roles and responsibilities, provide them with the necessary tools to carry out the tasks, and give them the necessary support. This could be done to provide a comprehensive health care service within the continuum of care to those who are in need and are vulnerable.

4.3.3 Relevance of the core elements and components of the CCHBHC model

The core elements of the CCHBHC model are primary, secondary and tertiary and tertiary prevention and the components underpinning the model are: forming partnership; and the local context; linking formal and non-formal caregivers; empowering individuals, the family, and community for self-care and self-reliance and providing a bridge between the individual, family, the community and the health care system. The components act as the basis and enablers for implementing the CCHBHC model. The detailed alignment of the findings of the study to these components and the core elements is summarised in table 4.1, page 229.

4.3.4 Relevance of the CCHBHC model to guideline development

The South African health care policy framework requires the involvement of local stakeholders. The South African health care policy framework requires the involvement of local stakeholders in health care. According to the Department of Health there is a need to involve informal health care providers such as community health workers, care givers, volunteers, families in health promotion activities. Awareness on prevention of diseases, early identification of diseases, basic care, home assistance, referrals, and rehabilitation at a community level should be created (DOH, 2001:5;8).

Manandhar et al (2004:970) view community participation as the vehicle to improving the quality of primary services which also act as a link between the primary services and its users. Community participation occurs when the community is mobilized and involved to actively participate in resolving the problems that affect them. People interact actively as individuals or groups with social links such as local neighbourhood action with intention, with an inclination of continuous and active decision-making that is accessible for their participants (AMREF, 1995:34; Friedman et al., 2006:50; Rosato, et al., 2008:967). At times, it is informal such that community members interact with service providers as individuals or groups such as women's groups who voluntarily offer their health and welfare services to those in need in their community (Friedman et al., 2006:51). The detailed description of the preliminary guidelines is presented in section 4.5 of this chapter.

4.3.5 Examples of contexts in which the model was successfully applied

When the model was piloted in Bhutan, South-East Asia Region, positive results were noted showing improvement in services such as health education, antenatal care attendance, follow up of chronic cases and home visits for sanitation improved which shows the positive effect of implementing the model. There was also improved outreach, follow-up and referral leading to increased accessibility to better quality health care whilst using the existing resources (WHO, 2004:13). Amenyeiwe et al (2011:317) findings affirms that in a resource-limited setting, home and community based care programmes improve health outcomes and are cost effective. Wouters et al (2012) support the growing evidence which shows that the community based programmes are a good investment to improve coverage in health services needed by the community where there is increasing shortage of health workers.

Using the model assisted in identifying gaps in the provision of health care services contributing to health services' inaccessibility at the community and at home for those who are vulnerable and disadvantaged. The model was also used to bridge the gap in meeting the health needs of the vulnerable and underprivileged by introducing cost effective health care services that supported people in their community and at home by using fewer trained health personnel and family members, while the qualified health personnel provided training, supervision and support (WHO, 2004:2). In Brazil, the model was used to close the gap between the rich and poor resulting in equity in provision of health care services, improving indicators such as infant mortality and antenatal care uptake (Johnson et al., 2013).

In Nigeria where more than 90 % of births took place at home due to little contact with the health system, 1 in 23 women were at risk of maternal deaths due to postpartum haemorrhage. Deliveries are supported by traditional birth attendants and family members who are the community resources persons. In the absence of emergency obstetric care and through the support of other community members, traditional birth attendants were trained by health workers on how to keep, dispense and administer misoprostol tablets to pregnant women to prevent postpartum haemorrhage. In twelve months of implementation, the findings showed that 79 % of women who delivered at

home took misoprostol, which prevented postpartum haemorrhage thus reducing maternal deaths (Ejembi, Norick, Starrs & Thapa, 2013:2).

Similarly, in Nepal, the Female Community Health Volunteers were trained to distribute misoprostol tablets to expectant mothers in their 8th month of pregnancy in the areas with low rates of institutional deliveries. This was done to reduce the number of women dying from postpartum haemorrhage which was causing about a quarter of the maternal deaths in the country. The results showed a significant increase in misoprostol uptake in women who delivered at home. Institutional deliveries also increased due to the health education and community dialogues that were done in the community targeting mostly women's groups, influential mother-in-laws and other family members (Ejembi et al., 2013:2). The training also enabled individuals, families and other community members to care for their sick members at home (Chidubem, 2012:17-18).

The community-based participatory programmes are used to strengthen and overcome the existing human resource constraints by involving the local community members in health education. In countries such as Indonesia, the traditional birth attendants are highly utilised to increase awareness through health education because they are trusted for their cultural practices and even more accessible than village midwives (Titaley et al., 2010:9-10). In Tanzania, following training, the community provides support to the chronically ill in the aspects of care, treatment and support. The health care providers in facilities train, supervise and monitor home based care providers including the volunteers and community resource persons in their catchment areas (TACAIDS, 2015).

According to Wringe, Cataldo, Stevenson and Fakoya (2010:354), findings show that community home based care has assisted in reducing the burden clinic based services by shifting tasks from health facilities to the patient’s homes using non-formal care givers which were more sustainable than clinic based services in the context of HIV and AIDS. It was also found that providing services at household level overcame barriers such as economic and opportunity costs in accessing HIV and AIDS related services. Ncama (2005:33) asserts that in southern Africa, the model was used in response to the increasing number of deaths and AIDS related illnesses which overburdened the public hospitals beyond their capacity leading to the burden of care being shifted from hospitals

to the communities and the families where care and support was given. Chidubem (2012:10) further supports by indicating that using the CCHBHC model enables individuals, families and other community members to care for their sick members in the community and at home.

The model was also used for identifying the conditions for effective scale up in the context of antiretroviral therapy provision which includes staffing to provide a range of services, strengthening and restructuring of the health systems to provide integrated health services and involvement of the community and family to promote support (Wringe et al., 2010:355). It also enhances and strengthens health promotion and disease prevention at family, household and community level (WHO, 2004:10). In Tanzania, it assisted with making it easier to tap into all available community resources and providing support. It also assisted the community to work together in combating HIV and AIDS and advocating for more services (TACAIDS, 2015). Amenyeiwe et al (2011:315) emphasize the need to formalize the support structures at both facility and community level to construct a comprehensive, outcome-driven and sustainable service delivery system that will benefit health care in general including HIV prevention, treatment, and care in particular.

Despite the reasons that have been indicated above, there are different views, comments or and debates about the use of the CCHBHC model and they are highlighted in 4.4.

4.4 COMMENTS AND DEBATES ABOUT THE MODEL

The CCHBHC model is underpinned by the following components: forming partnership, involvement of other stakeholders, empowering individuals, the family and community for scare and self-reliance, linking formal and non-formal caregivers thus bridging the gap between the individual, family, the community and the health care system (WHO, 2004:1). The core elements of the model are the three levels of prevention which are primary, secondary and tertiary prevention of diseases (WHO, 2004:10-11). However, there are key factors which could impede the effectiveness of the comprehensive home based care which are related to human resources, health systems, funding mechanisms and adaptability to the local context. Additional to that is also the lack of sustainable and

reliable funding strategies for successful implementation of the model (Wringe et al., 2010:352).

It is also acknowledged that the health sector cannot meet the needs of the community alone, thus forming partnerships, community involvement and participation, and involvement of other stakeholders in health is crucial. To integrate and decentralize HIV and AIDS health services in Swaziland, Community home based care (CHBC) was incorporated in the National Strategic Framework for HIV and AIDS (2009-2014) as a core component of the plan. In the rural, impoverished and hard to reach areas, CHBC plays a critical role in the adherence on antiretroviral therapy for people living with AIDS. Additionally, the government is working in collaboration with Shiselweni Home based-care which provides HIV prevention and treatment support services to about 2500 clients in one of the four regions of Swaziland. Implementing the programme has increased ARV adherence, created a safe setting for disclosure and facilitated HIV disclosure, strengthened HIV prevention, encouraged testing, clinic follow-up and counselling (Root & Whiteside, 2013).

Titaley et al (2010:9-10) indicate the need to strengthen health education programmes that will raise awareness of the community on the importance of available Maternal and Child Health services. The interventions should target husbands, parents including other family members, other than focusing on women only. Mail et al (2013) also affirmed by indicating that messages on the importance of antenatal care attendance should also target friends and relatives as they also have influence on decision making related to antenatal care attendance.

Rohde, Cousens, Chopra, Tangcharoensathien, Black, Bhutta et al (2008:952) affirm that responding to the local needs of the individuals, families and the entire population can only be achieved by effective participation and inter-sectoral collaboration which remains a challenge despite the fact that it is legislated in the National Health Act of South Africa as one of the underlying principles on community participation and involvement. A similar view is shared in the WHO report (2004) which indicates that the partnership between the health care providers, the community, government sectors and the non-governmental organizations should be strengthened and community actions for health and wellbeing

should be facilitated (WHO, 2004:4-5) in order to have effectively met the community's needs. The community should be mobilized and sensitized in preparation for their involvement (Wringe et al., 2010:352).

Gibbs and Campbell (2013:31-32) suggest development of a framework of incentives to strengthen community participation which could result in effective delivery of Primary Health Care. They further suggested the training of public sector employees in community participation to enable them to effectively facilitate the process. The South African Department of Health is in the process of developing a Health Governance Resource Manual that will guide strengthening of capacity of governance structures in the country.

Additional to creation and forming partnership, Ncama (2005:35) in her evaluation of the models for community/ home based care for people living with HIV and AIDS in Southern Africa, found that it was crucial to develop the referral networks and have a functional referral system. All the projects that were evaluated had the referral networks and functional referral system developed in order to offer a more comprehensive package of care for their clients despite the fact that it was time consuming.

Wringe et al (2010:357) assert by indicating that the importance of different stakeholders to forge links, collaborate and develop referral systems is acknowledged in the WHO policies and other national HIV frameworks in order to provide comprehensive home based care. Multisectoral collaboration with other health care services and agencies, working in partnership with other multidisciplinary teams, members of the community and networking with various community based organisations are key for implementing successful programmes (Peu et al., 2008:78).

Referral and networking are critical elements in community and for realising the needs of the chronically ill. The referral systems between CCHBHC and other services should be strengthened to ensure continuum of care (TACAIDS, 2015). Peu et al (2008:78) in her chapter "Models for home/community-based care", emphasizes the need to build a network of professionals to render the comprehensive services and decentralized health services in the community which can be achieved by networking with locally identified stakeholders.

Promoting and sustaining major groupings and agencies to support caregivers and patients remained a major problem facing the community home based care programme. This is because there is lack of guidance on how to promote and sustain the partnership needing urgent systematic research to establish effective partnership styles and strategies that will endorse partnerships between poor communities and the more influential groupings and agencies (Campbell, 2004:5). For the purpose of sustainability and providing quality community/ home based care services, the Department of Health (2001:5) found it beneficial to involve volunteers, support non-formal caregivers and build their capacity to render services in the community and in the homes.

The Department of Health has since 2012 adopted and started implementing the Ward Based Outreach Teams (WBOTs) through the PHC reengineering, delivered home and community health service which are linked to primary health care facilities as they have been found to be critical for good health outcomes (DoH, 2011:5). As of September 2015, there were 1885 WBOTS nationally that were functional; registered and reporting to the District Health Information System (DHIS) (DHIS, 2015). This is done to meet and manage the changing needs of those who need care due to the consequences of illnesses. Schneider et al (2008:186) in their study on community health workers and the response to HIV and AIDS in South Africa: “tensions and prospects”, argue that although CHW is implemented in the Free State Province and South Africa is playing an important role in meeting emerging needs in public health such as in HIV and AIDS, TB and add value, community health workers still lack recognition, stability in their work and in the relationship they have with professionals.

The lack of appropriate recognition of Home-based carers is further affirmed in the NACOSA Position paper (2013) stating that although the government is implementing re-engineering PHC using the Home-based carers at the forefront to create a more efficient and cost-effective health system in South Africa, they are not yet appropriately recognised and their future is not clear. It is recommended that mid-level categories be created through which experienced and skilled CHWs can progress within the health sector to avoid high degrees of turnover (Schneider et al., 2008:186). Wringe et al (2010:352) recommend that there be recognition of human resources and that they be remunerated

and provided with formal employment. In Kenya, a need to involve gatekeepers of information in the community such as community leaders and village health committees through rigorous health education was identified, to facilitate acceptance of home based care in the community (Olenja, 1999:198). Health professionals need to be trained on how to engage with Community Health Workers (CHW) in a better way (Schneider, Hlophe & van Rensburg, 2008:186).

The Community Health Workers (CHWs) who are part of the WBOT are well trained, supported and supervised by trained professional nurses. Their roles and responsibilities are clear wherein amongst others is to prevent ill health and promoting health. The future plan is to have the CHW directly appointed and managed by the Department of Health other than Non-Governmental Organizations which is already achieved by the KwaZulu Natal province (DoH, 2011:3-6).

According to the comments, one of the reasons for including community based care and home based care into the Primary Health Care strategy is the need for the informal sector (families, Community Health Workers, volunteers, caregivers) to be involved in health promotion activities. Additional to that is the creation of awareness in the community on prevention of diseases, early identification of diseases, basic care, home assistance, referrals and rehabilitating them at a community level (DoH, 2001:5; 8). It also ensures that there is adequate clinical support that is provided to the clients, providers have adequate supplies to provide care and that the home based care provided is monitored by the PHC nurses for quality service delivery (Aantjes et al., 2014).

The challenge is recruiting and maintaining volunteers due to the problem of a stipend (Russell & Schneider, 2000:332). It was also found that some people consider volunteerism as some form of abuse to the volunteers who work for free and or get very little incentives when they are also poor and need an income (Aantjes et al., 2014). There is lack of internal capacity to implement the ideas and the lack of resources. The lack of knowledge to account for or maintain the documentation or strategize around funding is apparent in some of the Non-profit Organizations (NPOs) (Russell & Schneider, 2000:332). Malan (2014) reported in the Mail and Guardian that there is still lack of uniformity on how provinces deal with the CHWs in the WBOTs in terms of their

employment and the conditions of employment within the Department of Health. This is despite the indication in the Provincial guidelines for the implementation of the three streams of PHC re-engineering that by 2013, the CHW will be employed by the DoH. It is attributed to the lack of a WBOT policy which is still not finalized and the unfunded mandate of the South Africa's CHW strategy.

It was also found that caregivers who were exposed to training opportunities had sustained motivation and were able to respond to their clients appropriately showing the importance of training non-formal care givers. It is essential that they receive ongoing training and support for them to remain credible and legitimate in their communities (Wringe et al., 2010:356). In a study conducted in Botswana, the quality of care was poor, resulting in alarming high numbers of People Living with AIDS (PLWHAs) being readmitted with complications. This raises a question of the level of knowledge on the spread of HIV and health promotion (Ncama, 2005:18).

Other challenges experienced in delivering comprehensive services were hindered by the weak linkages with other partners providing a range of HIV services such as care, support, treatment and prevention including creation of a well-functioning referral system with the HIV service providers. The lack of sustainable and consistent funding strategies and the top-down donor policies pose a serious threat on the sustainability of the programme (Wringe et al., 2009:1).

The most effective programmes are those that are integrated into the existing health systems. Additionally, is the remuneration of the workers wherein there is ongoing training and support. The local communities need to be involved from the onset of the programme including planning, implementation and monitoring and evaluation (Wringe et al., 2010:352). Ncama (2005:37) emphasizes the importance of recognizing the basic needs and offering community/ home based care services in the context of the Primary Health Care model. This should include a high level of community involvement and the use of available community resources in a greater manner. Community sensitization and mobilization activities are a strategy to overcome the community's lack of ownership (Wringe et al., 2010:359). In addition to that is the development of realistic policies that promote staff retention and integration of the programme within District Health Services.

Another long term threat is the donor policies which are top down leading to lack of sustainable and consistent funding. Policy makers need to consider addressing the human resources issues to promote staff retention and service integration within the District Health System (Wringe et al., 2010:352). Schneider et al (2008:180) also emphasize the need for the right conditions such as political support, appropriate training strong supervision and support, remuneration and incentive systems.

The Brazilian Government has successfully implemented the Family Health Strategy since 1998 where CHW are permanently integrated into the Primary Health Care teams (Johnson et al., 2013). They are successful in reducing infant mortality significantly, increased uptake of breast feeding, antenatal care and increasing immunization coverage. Additional to that is the improvement in health equity and closing the gap between the rich and the poor (Johnson et al., 2013).

In Swaziland, using the community home based care model facilitated HIV disclosure and enhanced antiretroviral therapy adherence and strengthened HIV prevention through integrated health services. It has become an integral part of the health services' infrastructure to alleviate the burden of care in the facilities which is explicitly stated in the 2009-2014 strategic framework (Root & Whiteside, 2013).

The studies conducted in eight countries on the evaluation of the Community Response to HIV and AIDS has shown evidence that community based health services can yield positive results that are beneficial to the individuals, families and the community in the context of HIV and AIDS. The results showed a substantial mobilization of community resources and improved HIV prevention knowledge and behaviour. It further showed an increase in the use of prevention, care and support services (World Bank, DFID & UK Consortium on AIDS and International Development, 2012).

The above discussion has highlighted the factors that need to be taken into consideration by the researcher when applying the CCHBHC model in the process of developing guidelines to promote community participation and local accountability for pregnant women’s access to basic antenatal care in Mpumalanga Province, South Africa. The

application of the model is summarised in 4.5 where the themes of the study are integrated with the components and core elements of the CCHBHC model.

4.5 SUMMARY ON THE APPLICATION OF THE CCHBHC MODEL

After dissecting and debating all the areas of CCHBHC in relation to the findings of this study, it is evident that the 11 identified themes that were described in chapter 3 linked with the components and core elements of the CCHBHC model. Table 4.1 illustrates and summarizes the 11 identified themes which are related to the components and the core elements of the CCHBHC model as discussed above. The formulated preliminary guidelines are also indicated.

Table 4.1: Summary on the application of the CCBHCB Model

SET AND NO OF THEMES	CONTENT OF THEMES	LEVEL OF PREVENTION	PRELIMINARY GUIDELINE
PRIMARY PREVENTION			
Set: A 1. 2. 3. 4. 6. 8.	Perceptions of antenatal care attendance. Perceived barriers to antenatal care access. Perceived culture, beliefs and myths. Perceived limiting socio-demographic factors. Supportive needs during pregnancy. Identified needs.	**1. Health Promotion** - Disseminate information on importance & benefits of antenatal care attendance. - Assess home environment & advice accordingly/ Management of home environment to promote health. - Conduct HIV counselling. **Disease prevention** - Provision of health education relating to prevention of diseases, illnesses, injuries and other health risks. - Health education on the importance of immunization in pregnancy. - Promotion of condom use and prevention of mother to child transmission (PMTCT).	1.Create a conducive environment for rendering antenatal care services in local facilities for providing health education by service providers. 2.Create a conducive environment at home to enable pregnant women to attend antenatal care. 3.Expanding health education on the importance of antenatal care services to the community and homes using health promotion principles. 4.Create a system for interacting/communicating/ engaging with the community on health promotion activities through community participation and involvement.
SECONDARY PREVENTION			
Set: B		**Health screening & treatment of common illnesses/ ailments**	

5. 7. 9. 11.	Experiences of health care system barriers. Perceptions on the role of community participation, and accountability of governance structures. Perceptions on community participation in antenatal care. The functionality and accountability of governance structures in health within local communities.	- Health assessment and diseases screening to identify possible illnesses - Treatment of identified illnesses during assessment & screening - Health care provided at home based on identified illnesses - Referral to the clinic for further management	5.Community mobilization- Facilitate conducting of community assessment/ diagnosis to identify health problems/needs and prioritize them to inform health education & health promotion activities 6.Identifying learning needs for different stakeholders and planning for intervention informs their capacity building. 7.Strengthening the capacity of all stakeholders including service providers to improve the quality of ANC services to participate in promoting ANC and support pregnant women.
TERTIARY PREVENTION			
Set: C 7. 9. 10.	Perceptions on the role of community participation, and accountability of governance structures. Perceptions on community participation in antenatal care. Community participation through governance structures.	**<u>Rehabilitative, palliative and long-term care</u>** - Initiate support groups for those infected and affected by HIV and AIDS/Chronic illnesses - Home based/palliative care - Care of people with disabilities	8.Facilitate pooling of available formal and informal human resources together for improving health education and promotion of ANC attendance by using existing community structures and networks.
COMPONENTS OF CCHBHC			

Set: D 7. 9. 10.	Perceptions on the role of community participation, and accountability of governance structures. Perceptions on community participation in antenatal care. Community participation through governance structures.	**<u>Enabling factors to facilitate health education and health promotion activities</u>** - Linking formal and non-formal caregivers. - Empowering individuals, the family, and community for self-care and self-reliance. - Providing a bridge between the individual, family, the community and the health care system.	6.Strengthening the capacity of all stakeholders including service providers to improve the quality of ANC services to participate in promoting ANC and support pregnant women. 7.Facilitate pooling of available formal and informal human resources together for improving health education and promotion of ANC attendance by using existing community structures and networks.
COMPONENTS OF CCHBHC			
Set: E 7. 9. 11.	Perceptions on the role of community participation, and accountability of governance structures Perceptions on community participation in antenatal care. The functionality and accountability of governance structures in health within local communities.	**<u>Enabling factors to facilitate health education and health promotion activities</u>** - Forming partnership and local context (community participation and involvement of other stakeholders. - Providing a bridge between the individual, family, the community and the health care system.	5.Community mobilization - Facilitate conducting of community assessment/ diagnosis to identify health problems/needs and prioritize them to inform health education & health promotion activities 8. Facilitate pooling of available formal and informal human resources together for improving health education and promotion of ANC attendance by using existing

			community structures and networks.
COMPONENTS OF CCHBHC			
Set: F 9. 10. 11.	Perceptions on community participation in antenatal care. Community participation through governance structures. The functionality and accountability of governance structures in health within local communities.	**<u>Enabling factors to facilitate health education and health promotion activities</u>** - Forming partnership and local context (community participation and involvement of other stakeholders. - Empowering individuals, the family, and community for self-care and self-reliance.	3. Create a system for interacting/communicating/ engaging with the community on health promotion activities through community participation and involvement.

The themes in table 4.1 are grouped into six sets of themes. Set A to D is according to the levels of prevention such as primary, secondary and tertiary prevention while set four to six are the enabling factors which facilitate health education and health promotion activities under the components of the CCHBHC model.

Set A has six themes (1, 2, 3, 4, 6, 8) as displayed in table 4.1 which were corroborated with primary prevention regarding health promotion and disease prevention. These six themes focus on aspects that may affect health education and health promotion uptake in the community and households. The pregnant women's perception of antenatal care attendance, the barriers to antenatal care access, their culture, beliefs and myths, limiting socio-demographic factors, supportive needs during pregnancy and the identified enabling factors may influence their health status negatively if they are not well addressed. It is anticipated that addressing the challenges related to these themes could enhance the antenatal care uptake by pregnant women in Bushbuckridge sub-District following health education and health promotion activities in the community and at home.

The consolidation of the six themes assisted the researcher to come up with the preliminary guidelines specified in table 4.1. under primary prevention.

Set B has four themes (5, 7, 9, 11) as displayed in table 4.1 which were corroborated with secondary prevention regarding health screening and treatment of possible common illness or ailments. The themes focus on health screening to identify possible illnesses and treating them on time to prevent complications. The experiences of pregnant women on the barriers in the health care system could continue to limit pregnant women from attending antenatal care if they are not addressed. Additionally, the perceptions on the role of community participation in antenatal care, accountability of governance structures, the functionality and accountability of governance structures in health within local communities need to be clarified and strengthened as proposed by the participants. This could be done through capacity building of the community members, community leaders, governance structures and other non-formal care providers. Since the governance structures find their mandate from the community, they will be strengthened to be more effective and efficient on their role, including promoting pregnant women to attend antenatal care. Failure to address the challenges related to these themes could continue to limit pregnant women from attending antenatal care as health education and health promotion will not be supported by the members of the community and the governance structures. The consolidation of the four themes assisted the researcher to come up with the preliminary guidelines specified in table 4.1. under secondary prevention.

Set C has three themes (7, 9, 10) as displayed in table 4.1 which were corroborated with tertiary prevention regarding perceptions on the role of community participation, and accountability of governance structures, community participation in antenatal care and community participation through governance structures. Failure to address the challenges related to these themes could reduce the chance to have the community involved, participate and be accountable in expanding health education and health promotion to the community and households which could affect pregnant women who are vulnerable and disadvantaged. Their chance to receive health education which promotes antenatal care attendance could be reduced. The consolidation of the three themes

assisted the researcher to come up with the preliminary guidelines specified in table 4.1 on tertiary prevention.

Set D has three themes (7, 9, 10) as displayed in table 4.1 which are similar to those corroborated with tertiary prevention. They are perceptions on the role of community participation, and accountability of governance structures, community participation in antenatal care and community participation through governance structures. The themes were corroborated with the components of the CCHBHC model focusing on the enabling factors that could facilitate health education and health promotion through empowerment, linking formal and non-formal caregivers, empowering the community for self-care and self-reliance and bridging the gap between the community and the health care system. If the challenges related to these themes are not well addressed, the link between the formal and the non-formal caregivers will not be strengthened; the community may not participate in managing their own health. Health education could continue to be provided in fixed health facilities only and not reaching the vulnerable and disadvantaged pregnant women in the community and households. The rate of poor antenatal care uptake may not be improved. The consolidation of the three themes assisted the researcher to come up with preliminary guidelines specified in table 4.1 on the components of the CCHBHC model focusing on the enabling factors that facilitate health education and health promotion.

Set E has three themes (7, 9, 11) as displayed in table 4.1 which were corroborated with the components of the CCHBHC model. The themes focus on enabling factors to facilitate health education and health promotion through forming partnerships and bridging the gap between the members of the community and the healthcare system. If the challenges related to these themes are not addressed, there will be no collaboration of the Department of Health with other sectors and relevant partners. Pooling available human resources in the local area to expand health education and health promotion activities to reach disadvantaged pregnant women in the community and in their homes, may not be possible. The health services may fail to effect community involvement and participation in health. The consolidation of the three themes assisted the researcher to come up with

the preliminary guidelines specified in table 4.1 on the components of the CCHBHC model focusing on the enabling factors that facilitate health education and health promotion.

Set F has three themes (9, 10, 11) as displayed in table 4.1 which were corroborated with the components of the CCHBHC model focusing on enabling factors to facilitate health education and health promotion through forming partnerships and community empowerment for self-care and self-reliance. The themes are perceptions on community participation in antenatal care, community participation through governance structures and the functionality and accountability of governance structures in health within local communities. Failure to address the challenges related to these challenges may result in the community not being engaged to working in partnership with the health system to expand health education and health promotion activities to the vulnerable and disadvantaged pregnant women in the Bushbuckridge sub-District. The problem of poor antenatal care attendance among pregnant women may remain unresolved. The consolidation of the three themes assisted the researcher to come up with the preliminary guidelines specified in table 4.1 on the components of the CCHBHC model, focusing on the enabling factors that facilitate health education and health promotion.

4.6 SUMMARY

The discussion in this chapter illustrates how the current research findings were matched with the CCHBHC model in the context of the relevant literature. This process serves as the basis for, and provides guidance towards formulation and development of the guidelines to promote community participation and local accountability for basic antenatal care in Mpumalanga province. Table 4.1 provides an illustration and a summary on how the 11 identified themes fit into the components and the core elements of the CCHBHC model. The preliminary guidelines resulted from integrating the components and core elements of the CCHBHC model. These preliminary guidelines form the basis for the development of guidelines in chapter 5.

CHAPTER 5

DEVELOPMENT OF GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION IN AND LOCAL ACCOUNTABILITY FOR PREGNANT WOMEN'S ACCESS TO BASIC ANTENATAL CARE IN THE MPUMALANGA PROVINCE, SOUTH AFRICA

5.1 INTRODUCTION

In chapter 3 of this study, the perceptions, experiences, needs, reasons for pregnant women not attending antenatal care and the functionality and the accountability of the governance structures for basic antenatal care were explored. This resulted in the formulation of 11 identified themes. In chapter 4, the discussion of the research findings illustrated how the 11 identified themes were integrated with the components and core elements of Comprehensive Community and Home-based Health Care (CCHBHC) model in the context of the relevant literature. The process served as the basis and provided guidance towards formulation and development of guidelines which could promote community participation and local accountability for basic antenatal care in Mpumalanga Province. The researcher integrated the findings of the current study with the CCHBHC model. The process resulted in a modified conceptual framework of the CCHBHC model which is briefly discussed in 5.2 and illustrated in figure 5.1. The components and core elements of the CCHBHC model guided the development of the guidelines which will be discussed in detail in 5.6.

5.2 BRIEF DESCRIPTION OF THE MODIFIED CCHBHC MODEL

The eleven themes that were identified were perceptions of antenatal care attendance, perceived barriers to accessing antenatal care, perceived culture, beliefs and myths, perceived limiting socio-demographic factors, experiences of health care system barriers,

supportive needs during pregnancy, perceptions on community participation, and accountability of governance structures, identified needs, perceptions on community participation in antenatal care, community participation through governance structures and the functionality and accountability of governance structures in health within local communities.

Out of the 11 identified themes, the pregnant women's perception of antenatal care attendance, the barriers to antenatal care access, their culture, beliefs and myths, limiting socio-demographic factors, supportive needs during pregnancy and the identified needs were the six themes (1,2,3,4,6,8), which were integrated with primary prevention of the CCHBHC model. It is at this level where health promotion and disease prevention interventions could be conducted to address the challenges that are related to the identified six themes. This could be done by dissemination of information on importance and benefits of basic antenatal care; assessing the home environment and advice accordingly; manage home environment to promote health; conduct HIV counselling; providing health education on prevention of diseases, illnesses, injuries and other health risks; health education on the importance of immunization in pregnancy and promotion of condom use and prevention of mother to child transmission (PMTCT). It is anticipated that addressing these challenges could encourage and promote antenatal care attendance by pregnant women.

The experiences of health care system barriers, perceptions on the role of community participation, and accountability of governance structures, perceptions on community participation in antenatal care, the functionality and accountability of governance structures in health within local communities were the four themes (5, 7, 9, 11) identified which were integrated with secondary prevention of the CCHBHC model. It is during antenatal care where health screening and treatment of common illnesses and ailments is done. This could be done through health assessment and disease screening to identify possible illnesses; treatment of identified illnesses during assessment and screening; health care could be provided at home based on identified illnesses and referred to the clinic for further management based on identified needs. Failure to address the challenges that are related to the four identified themes could continue to limit pregnant

women from attending antenatal care as the facilities cannot be accessed to promote health screening and treatment of identified ailments and early referral from clinics for further management.

The perceptions on the role of community participation, and accountability of governance structures, perceptions on community participation in antenatal care and community participation through governance structures were the three themes (7, 9, 10) that were identified and integrated into tertiary prevention of the CCHBHC model. It is in rehabilitative, palliative and long term care programmes where support groups for those infected and affected by HIV and AIDS and chronic illnesses could be initiated. Additionally, home-based palliative care, community care for HIV and AIDS and care for people with disabilities could be initiated through the involvement and participation of the community. The pooling of available human resources in the local area could assist in expanding health education and health promotion activities to reach disadvantaged pregnant women in the community and in their homes. Failure to address the challenges related to the three identified themes could make the members of the community miss the opportunity to be involved in maternal health issues.

The perceptions on the role of community participation, and accountability of governance structures, perceptions on community participation in antenatal care, community participation through governance structures, the functionality and accountability of governance structures in health within local communities were the four (7,9,10,11) identified themes to integrate with the components of the CCHBHC. The themes were corroborated with the components of the CCHBHC model focusing on enabling factors which could facilitate health education and health promotion activities in the families and the community to promote antenatal care attendance by pregnant women. This could be done through forming partnerships, bridging the gap between the members of the community and the healthcare system and community empowerment for self-care and self-reliance.

If these challenges are not addressed, the Department of Health will not be able to collaborate with the community, other sectors and the relevant partners. Pooling available human resources in the local area to expand health education and health promotion

activities to reach disadvantaged pregnant women in the community and in their homes may not be possible. Their chances to access antenatal care services could be reduced.

The local context should also be taken into consideration when applying the enabling factors of the CCHBHC model. The enabling factors form the central part of the three levels of prevention as they create an enabling environment for health education and health promotion activities that should occur in the community and at household level.

Figure 5.1 illustrates the modified conceptual framework that was used to integrate the findings of the current study with the CCHBHC model and guided the development of the guidelines.

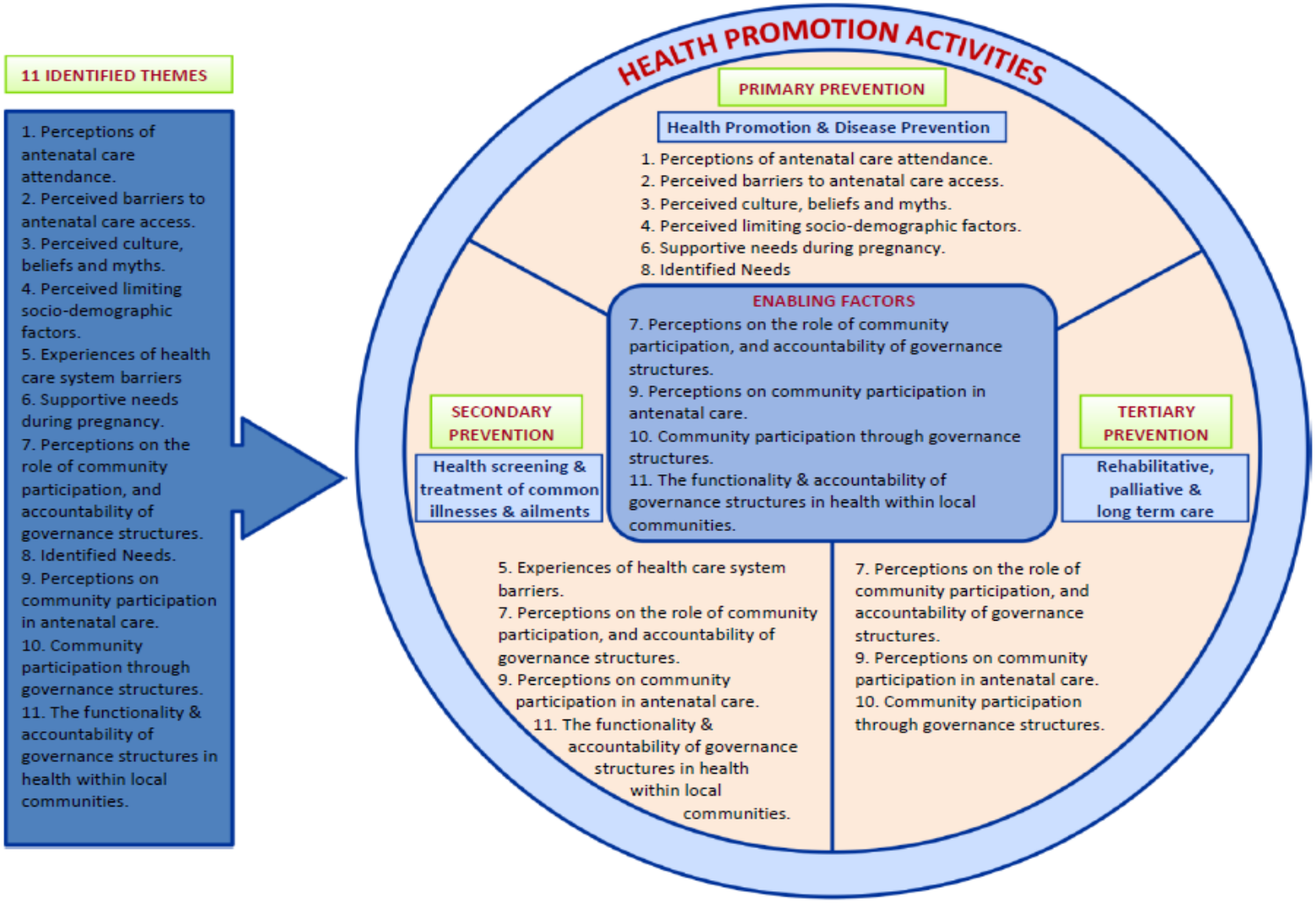


Figure 5.1: Mthethwa's modified Comprehensive Community and Home-based Health Care (CCHBHC) Conceptual Framework

In the next section, the development and benefits of guidelines will be discussed.

5.3 DEVELOPMENT AND BENEFITS OF GUIDELINES

According to the WHO (2012), guidelines refer to any document that contains recommendations on health interventions which could be public health, clinical or policy (WHO, 2012:1). The information could be about what health care providers, policy makers or patients should do in terms of interventions that impact on health and or implications on how resources are used (WHO, 2012:1).

According to Woolf, Schunemann, Eccles, Grimshow and Shekelle (2012), guidelines assist health care practitioners and patients to make decisions from a foundation of improving health care. Guidelines are the standards which are set to guide the appropriate behaviour in health care according to the WHO, public health and health policy (Schunemann, Fretheim & Oxman, 2006; Ministry of Health, 2011:4). They are propositions which are developed to assist in making decisions on the care that is appropriate in a specified clinical setting. These systematic propositions are developed and are applicable to prevention, diagnostic procedures, treatment or follow-up of policies (Fevers et al., 2010: e342). The current guidelines under development could act as standard procedures for promoting antenatal care attendance among pregnant women in South Africa's rural areas.

They outline the care that is expected in a patient (Turner et al., 2008). They are also viewed as the basis for improving health care (Woolf et al., 2012). In the current study, the guidelines will act as a set of standards to be used for operationalizing the involvement of the community on health issues which includes promoting antenatal care attendance amongst pregnant women for better health outcomes. When implemented, the nurses could promote and support increased uptake of antenatal car in the primary health care facilities.

Guidelines are often used to answer questions on how a particular clinical situation or disease can be managed and they are evidence-based. It is important to involve the users

when developing guidelines to ensure that the content reflects their needs and concerns (Turner et al., 2008). In the current study, the intention of developing the guidelines was to involve the community in promoting antenatal care attendance among pregnant women in the Bushbuckridge sub-District to address the low antenatal uptake which increases the maternal morbidity and mortality in the area. The nurses, as potential users of the guidelines, were also participants when the empirical data was generated in the current study. This is aligned with the guideline development manuals which indicate that patient's preferences, the user's experience and their values should be taken into consideration when developing guidelines (National Health and Medical Research Council (NHMRC), 1999:1; WHO, 2012:35).

Guidelines are tools designed to improve the quality of health care and when used effectively, they can improve health outcomes (NHMRC), 1999:1; DoH 2014:16). For an example, one of the objectives of consolidated National prevention of mother-to-child transmission of HIV (PMTCT) guidelines was for timely diagnosis for HIV in children, adolescents and adults for the purpose of initiating them on Antiretroviral drugs (ARVs), to achieve the best health outcomes in a cost effective manner (DoH, 2014:16). Effectively developed guidelines could be cost effective in using the available resources (WHO, 2012:1,9,17). In the context of the current study, the guidelines were developed to guide the process of community involvement and participation in health education and promotion on the importance of antenatal care attendance to reduce maternal morbidity and mortality amongst pregnant women.

The participants, who were pregnant women, members of the governance structures, community leaders and nurses proposed that the community, families and individuals be involved and participate in expanding health education on the importance of antenatal care attendance from the facilities to the community which could increase antenatal uptake in the Bushbuckridge area. This is supported by the South African guidelines for maternity care, in which community participation is included as part of the national strategy for maternity care indicating the need to build the capacity of the community, families and women to actively contribute in maternal and child health, including family health (DoH, 2007:10; DoH, 2015:150).

Guidelines can assist patients to influence public health policy by creating the health problems that are under recognized, preventive interventions and clinical services get to attention (Woolf et al.,1999:527). By conducting the study in the Bushbuckridge area, the community members, their leadership and the governance structures became aware that there was poor or inadequate antenatal care uptake in the area which needs interventions, follow up and needs to be addressed as proposed by the participants. They were willing to be involved in expanding health education and health promotion activities in the community and at household levels, which is their contribution in influencing the health policy.

Guidelines improve the quality of care by using interventions that have maximum chance to benefit patient care (NHMRC, 1999:1). For an example, in Zambia, the nutrition guidelines for care and support for people living with HIV and AIDS were developed to provide standardized management of HIV-related malnutrition by health professionals (Ministry of Health, 2011:4). The guidelines support the activities for quality improvement if the necessary tools for quality assessment are designed and applied (Woolf et al., 1999:528). In relation to the current study, if implemented, the guidelines could enhance the promotion of a conducive environment and patients' satisfaction in health facilities where antenatal care services are provided by health care providers.

Guidelines act as the standards which are set to guide the appropriate practice and decision-making in health care according to the World Health Organization (WHO), public health and health policy (Ministry of Health, 2011:4). Guidelines are used to make-decisions in health care such as providing guidance in decision-making for health care professionals. Example of such guidelines in South Africa are the National HIV Counselling and Testing Policy Guidelines which provide guidance to HCT providers to ensure provision of standardized services which are universal and of high quality (DoH, 2015). In the context of the current study, the guidelines could give direction and provide clarity to the health service providers who will work in collaboration with the clinic committees to expand health education from the facilities to the community and household level on the importance of pregnant women attending basic antenatal care in primary Health Care facilities, which is health promotion actions.

Guidelines are regularly used to answer questions on how a particular clinical situation or disease can be managed (Turner et al., 2008). They are designed to improve the quality of health care and when used effectively, they can improve health outcomes (National Health and Medical Research Council (NHMRC), 1999:1; WHO, 2010:28; WHO, 2012:10, 26). In the context of the current study, the guidelines were formulated to guide the process of community involvement and participation in promoting health education on the importance of basic antenatal care attendance among pregnant women in order to reduce maternal morbidity and mortality.

Guidelines assist in standardizing practice variation in policies and practice of care in different countries, regions and health facilities (Fevers et al., 2010: e349). In the context of the current study, the guidelines will be used to standardise how the community could be involved in promoting antenatal care attendance in primary health care facilities.

The aim of guidelines is to use current available evidence-based decisions on patient care in a meticulous, explicit and shrewd manner (Fervers et al., 2010: e341). They are tools used to make decisions and are prescriptive which could result in significant health outcomes. Guidelines could be used to guide the process of health promotion in families (Peu, 2008:194). They are also used to provide guidance on implementation of policies such as implementing the three streams of PHC reengineering in South Africa (Barron & Pillay, 2015). Based on the current study, the guidelines that were developed could be used as tools by the health care service providers, members of governance structures, families, the community and other stakeholders to educate the community on the importance of antenatal care. If implemented, they could promote healthy lifestyles among pregnant women. They form the framework of the care that is expected and direct the practice that is recommended and possible outcomes of care (Turner et al., 2008). The use of the guidelines could motivate pregnant women to attend antenatal care as informed by the midwives thus increasing the antenatal care uptake.

The guidelines are tools which facilitate integration of research results into practice and therapeutic resolutions (Fevers, 2010: e347). In Canada, they were developed for health care practitioners as a strategy for promoting healthy active living in children and adolescents to prevent and reduce obesity (Lipnowski, 2012:10). In the current study, the

involvement of pregnant women, community leaders, members of the governance structures and the health care workers, which was discussed in chapter 3, demonstrates how the consumers and the formal and non-formal service providers were involved. Additionally, the results of the study in Phase 1 generated the current results which were integrated with the CCHBHC model and discussed in the context relevant literature to, inform the process of drafting of the preliminary guidelines. This was to ensure that the draft of the guidelines was informed by evidence-based research to make better decisions.

The greatest benefit for patients using clinical guidelines is improving health outcomes by discouraging interventions which are ineffective and promote those which have been proved to be effective, thus reducing morbidity and mortality (NHMRC, 1998:1; Woolf et al., 1999:527). Guidelines ensure that the care provided to the patients is consistent despite where they are and who offers the care (Woolf et al., 1999:527). They were also used as tools for enforcing standards such as compliance to hand hygiene among health care workers to reduce infections and improve patients' safety. This includes improving and maintaining the quality of care (Pan, Tien, Hung, Lin, Sheng, Wang et al., 2013). In the current study, the guidelines could be used as a framework to assist the formal and non-formal health care providers in engaging in health education and health promotion activities in the community and in the homes, which could result in improving the antenatal care uptake by pregnant women in Bushbuckridge sub-District, if implemented.

Guidelines can be used as tools for educating patients and clients. They could be offered in a lay language in the form of leaflets and be handed to patients to empower them to make informed choices about their health care (Woolf et al., 1999:527). Guidelines such as the benefits of regular walking for health, well-being and the environment assert that guidelines can help individuals to make their health behaviour choices by making decisions to walk regularly for their physical and mental wellbeing because of the benefits they get (C3 Collaborating for Health, 2012:4). Effectively developed guidelines could contribute to healthy behaviour (Peu, 2008:194). In relation to the current study, implementation of the guidelines under development could inform the development of the various educational information, education and communication materials. The materials

could be in local languages to be easily understood by the target groups in the community, to empower family members and the community on the importance of antenatal care attendance.

Guidelines improve the quality of care by using interventions that have maximum chance to benefit patient care (National Health and Medical Research Council (NHMRC), 1999:1). The objective of the guidelines on patient waiting times is to reduce their waiting time by improving service delivery through improving their experience of care in Primary Health Care facilities (DoH, 2014:6). In relation to the current study, the guidelines could also be used to enhance the service delivery platform in the health facility for rendering antenatal care health services by health care providers. Implementing the guidelines could promote adherence to existing national policies such as the Batho Pele principles and the Code of Conduct for Public Service among the service providers, if implemented.

5.4 ATTRIBUTES TO BE USED WHEN APPRAISING DEVELOPED GUIDELINES

There are many different attributes that could be used as criteria to evaluate guidelines. The attributes are validity, reliability, and clarity of the presentation, applicability, completeness or comprehensiveness, effectiveness, flexibility, relevance, acceptability, rigor and editorial independence. The National Health and Medical Research Council (NHMRC) (1999) recommends that the Institute of Medicine Provisional instrument should be used to evaluate guidelines if they conform to the principles (SIGN, 2011:28). In the current study, the criteria of Scottish Intercollegiate Guideline Network (SIGN) was used to evaluate the current guidelines as affirmed by the NHMRC. It is the criteria that were accepted by the US Institute of Medicine in 1990 to assess the guidelines and recommend using validity, reliability, applicability, flexibility and clarity as attributes for good guidelines (SIGN, 2011:27) which are outlined in table 5.2. However, the other viewpoint is that only credibility, transferability and confirmability should be used as criteria for judging the soundness of qualitative research (Venkatesh et al., 2013:28).

The researcher, in the current study, opted to conform to the principles of SIGN and used validity, reliability, applicability, flexibility and clarity as criteria for assessing good

guidelines (SIGN, 2011:27) to evaluate the preliminary guidelines. The attributes used to appraise the developed guidelines are explained in table 5.1.

Table 5.1: Attributes used to appraise the developed guidelines

ATTRIBUTES	EXPLANATION
1. Validity	The strength in the development of the guidelines is that they are evidence based because they are informed by the empirical research results of the current study and the application of the CCHBHC model. Helps to assess where the guidelines improve health outcomes (NHMRC, 1999:14,21,24,45).
2. Reliability	The preliminary guidelines are evidence based as the integrity of the current findings was evaluated using the epistemological standards, strategies and criteria. According to SIGN (2011:2), when applied in similar circumstances, the guidelines should yield similar results (SIGN, 2011:2). The current preliminary guidelines emerged from a process where the 11 identified themes were integrated with the components and core elements of Comprehensive Community and Home-based Health Care (CCHBHC) model in the context of the relevant literature which served as the basis and provided guidance towards formulation and development of the guidelines. Additionally, the preliminary guidelines were appraised by a panel of experts using reliability as one of the criterion for evaluating the guidelines. If the same process is followed in similar circumstances, the results should be the same.
3. Clarity of the presentation	Clarity of the presentation: The guidelines are clear, written in simple language, understandable, without ambiguity and are specific. All the terms are clearly defined and the intention of the guidelines is stated. The process that was followed when developing the guidelines were be clearly stated including how the results of the empirical study were integrated with the Comprehensive Community and Home-based Health Care model. The panel of experts also affirmed the clarity on the presentations of the guidelines during iterations (NHMRC, 1999:25; SIGN, 2011:31-32).

4. Applicability	The guidelines should clearly indicate who the target audience is and be easy to apply. The target audience for the guidelines in the current study is pregnant women and they will be used by nurses in collaboration with the clinic committees. The end users of the guidelines are clearly defined. They were developed for a poor resource setting which is Bushbuckridge sub-District hence the possible cost implications could be minimal should there be any. Possible barriers for implementing the guidelines also need to be identified and discussed. To set criteria for reviewing the guidelines, and monitoring and evaluation (SIGN, 2011:36-39). When the guidelines are implemented, the impact should be measurable. They were exposed to the panel of experts for review and to assess if they are applicable as applicability was one of the criterion to assess the guideline statements during the Delphi rounds.
5. Flexibility	The guidelines should be flexible and adaptable to suit diverse local settings or contexts which are e.g. geographical or cultural based. To take into consideration the benefits of resources, costs and constraints (NHMRC,1999:2,13,19).

Sources: NHMRC, 1999:2, 12-14, 21, 24-26; SIGN, 2011:2,31-32,36-39

5.5 THE METHODOLOGY OF GUIDELINE DEVELOPMENT USING THE DELPHI TECHNIQUE

In this study, the researcher followed the Delphi technique when developing and validating the guidelines as the research design and the methodology used are the population, sampling, data collection tools, data collection process and data analysis. The details of the research design are discussed in chapter 2, section 2.12 on research design and method for guideline development using the Delphi technique.

5.5.1 Research process : The Delphi Technique

The Delphi technique is a method used to gather opinions of a particular phenomenon from a group of experts within their area of expertise without meeting with them physically.

It is an accepted method used widely by the researchers to gather data and seek consensus from a panel of experts (Keeney, Hasson & McKenna, 2006:205**;** Hsu & Sandford, 2007). It was successfully used to seek consensus among experts on what to include when developing a preferred nursing model in a psychiatric set up for the long staying patients, contributing in resolving problems in a health care setting (Keeney et al., 2006:206). In the current study, the technique was used to pool intelligence and convergence of opinions from the responses received to build consensus on the phenomenon under study by further developing a set of preliminary guidelines into final implementation guidelines. This was done through a series of rounds where data collection instruments were used to collect data from a panel of experts as a means and method of building consensus (Hsu & Sandford, 2007).

The tool was used to solve problems in a health care setting. In the current study, the researcher used the technique to gather data from a panel of experts on their opinions and seeking consensus on their opinions about Primary Health Care reengineering and Maternal and Child Health issues. The technique facilitated convergence of the expert opinions and pooled their intelligence from the responses received, thus building consensus on the phenomenon under study.

A data collection instrument was used in a series of three rounds to collect data from the panel of experts on the selected subject and little was known about the subject (Warner, 2014). Similarly, in the current study, the data collection instruments were sent to the panel of experts by the researcher. The communication was through writing and it was disseminated electronically using email in order to reduce the effect of noise which could distort the data and divert focus on the problem. It also deals with individuals' interest, which is affirmed by Hsu and Sandford (2007).

The use of emails facilitated confidentiality and many participants were involved in the study at once, thus managing the process with little resources. This affirmed what Warner (2014) indicated that using the Delphi technique was cost effective when gathering expert opinions who were in different locations. This was similar to the current study and characteristic of the Delphi technique. The participants were not aware who was part of

the panel of experts other than the researcher who had selected them using purposive sampling.

5.5.2 Research methods

The population, sampling, data collection and data analysis are discussed in 5.5.2.1 to 5.5.2.3.

5.5.2.1 Population and sampling

Using purposive sampling enhances credibility (Polit & Beck, 2012:515; Warner, 2014). The researcher selected her population using purposive sampling to enhance credibility. The criteria for selection of the participants who formed a panel of experts were based on the experts' potential to make the contributions that were legitimate. They need to have up to date knowledge, experience and it should be within their clinical field which was affirmed by Hsu, and Sandford (2007) including Powell (2002:379). The experts were willing to revise their original judgments in order to facilitate consensus (Hsu & Sandford, 2007) which was similar to the selected panel of experts.

In the current study, the panel comprised of experts who were well qualified with extensive experience in Primary Health Care reengineering and or Maternal and Child Health. Amongst the panel of experts were Professors and Senior Managers who were Deputy Director Generals, Chief Director and Technical Assistants (Directors) with over 15 years of experience in the targeted subject. They made valid contributions and were willing to revise the original judgements throughout the process so as to facilitate consensus.

There was no fixed number that was required for the panel of experts to participate in the process. Warner (2014), in his study, recommends a panel of experts of between 10-15 participants and was supported by Chilemba, van Wyk and Leech (2014:1193) who used 10 participants in their study. Powell (2002:378) affirmed and indicated that the Delphi process does not require that the panel of experts to be representative as there is no empirical evidence showing that the consensus process could be more reliable and valid if the number of participants were more. However, the researcher selected a panel comprising of 22 experts in the current study. Only 18 of them responded up to the third and last round. The reason for increasing the number was to build additional numbers of

participants who could drop out of the study as the Delphi process involves multiple rounds before consensus is reached. It was inevitable that some participants would drop out. In the current study, one expert dropped out after the second round. The added advantage of having more participants was to have a broader pool of expertise to contribute to the study.

Table 5.2 reflect the descriptive information of the participants' positions, professional qualifications, current employer, professional experience and their involvement in Maternal and Child Health and PHC reengineering.

Table 5.2: Descriptive information of expert participants

NO	PROFESSIONAL QUALIFICATIONS	OCCUPATION	EMPLOYER	INVOLVEMENT IN MCHW & OR PHC REENGINEERING	PROFESSIONAL EXPERIENCE
1	Bachelor of Nursing Sciences Honours in Nursing Sciences Diploma in Primary Health Care BA in Policy studies Masters in Life Skills and Counselling	Technical Assistance: PHC Reengineering	National Department of Health (NDoH): District Health Services	Involved in District Health Services which includes Primary Health Care Re-engineering	23 years
2	Master of Arts in Clinical Psychology Post Graduate Diploma in Health Management	Deputy Director General Outcome Facilitator: Health, Presidency	Office of the President Monitoring and Evaluation Unit	Involved in Primary Re-Engineering and Monitoring and Evaluation of programmes	21 years
3	Bachelor in Dentistry Diploma in Primary Health care	Clinical Manager/ Sub-District Manager	Gauteng Health Department	Involved in District Health Services which includes Primary Health Care Reengineering	37 years
4	Professor, MD, Fellow of the Royal College (FRCOG), Fellow of the College (FCOG-SA)	Director SAMRC/UP Maternal & Infant Health Care Strategies Unit	University of Pretoria Kalafong Provincial Tertiary Hospital	Clinical Head of Obstetrics and Gynaecology Head of Obstetrics & Gynaecology Department	More than 33 years of professional experience

		Clinical Head, Department of Obstetrics and Gynaecology, Head of Obstetrics & Gynaecology Department, Kalafong Provincial Tertiary Hospital Obstetric &Gynae Specialist			
5	Master of Public Health	Senior Health Researcher	Kanimambo Management Solutions	Technical Advisor in Public Health and research	14 years
6	Diploma in Nursing (4-years) Post Graduate Diploma in Public Health Master of Public Health	Senior Technical Advisor	International Labour Organization	Indirectly involved with PHC reengineering Directly involved with Public Health issues	17 years
7	Diploma in General Nursing Diploma in Midwifery Diploma in Primary Health Care Master in Public Administration	District Clinical Specialist: MCHW, Joe, Gqabi District -Eastern Cape	Department of Health: Eastern Cape	Directly involved in Primary Health Care Re-Engineering and MCHW	32 years
8	B Cur in Nursing Honours in B Soc Science Master in Business Administration	Deputy Director General : NHI, Northern Cape	National Department of Health (NDoH):	Senior Manager Directly and indirectly involved in Primary Health Care Re-Engineering.	32 years
9	Diploma in general Nursing Diploma in Midwifery BA Cur in Nursing	Technical Assistant: PHC Reengineering.	National Department of Health (NDoH): District Health Services.	Senior Manager Directly involved in Primary Health Care Re-Engineering	16 years of professional experience
10	Diploma in Nursing (4-years)	Deputy Director: District Health Services	National Department of	Directly involved in PHC reengineering	Over 15 years of professional experience

	Degree in Nursing Education and Administration Master in Health Services Management		Health (NDoH): District Health Services		
11	Diploma in Nursing science Diploma in Midwifery Degree in Nursing Management	Quality Assurance Manager District Coordinator: Ideal Clinic, Joe Gqabi District, Eastern Cape	Department of Health: Eastern Cape	Directly involved in PHC reengineering	10 years
12	BCHD MSc D Med Sc	Professor, Public Health Management Department SHSPS	University of Pretoria	Directly involved with Public Health issues including Primary Health Care Re-Engineering	38 years
13	BSC in Natural Sciences MSc in Audiology Master in Public Health (Community Oriented Primary Health Care)	Technical Assistant: PHC Reengineering-Mpumalanga Province	National Department of Health (NDoH): District Health Services	Directly involved in Primary Health Care Re-Engineering	25 years
14	Clinical medicine Bachelor of Science MBBS (General Practitioner) Diploma in Health Services Management Diploma in Tropical Medicine and Hygiene Master in Public Health	Technical Assistant: PHC Reengineering	National Department of Health (NDoH): Office of the DDG-PHC	Directly involved in Primary Health Care Re-Engineering	34 years
15	B Cur in Nursing Post Graduate Diploma in Nursing Management Diploma in Advanced Health Management	Quality Assurance Manager District Coordinator: Ideal Clinic, Amathole	Department of Health: Eastern Cape	Directly involved in PHC reengineering	15 years

		District, Eastern Cape			
16	Diploma in General Nursing Diploma in Midwifery Diploma in Primary Health Care B Cur in Nursing Education and Administration Master in Public Administration Master in Public Health Master in Nursing Administration	National Coordinator & Manager Quality Assurance and Ideal Clinic. Department of Health	National Department of Health (NDoH): Quality Assurance	Directly involved in Primary Health Care Re-Engineering	23 years
17	B Tech in Management	Chief Director: District Health Services	National Department of Health (NDoH):	Senior Manager directly and indirectly involved in Primary Health Care Re-Engineering	25 years
18	MBBCH in FFPH (UK) Public Health Research Epidemiology	Public Health Physician	The SEED Trust Kwa-Zulu Natal, but with a national orientation	Public Health with experience in Primary Health Care including CHWs, CCGs and training of community committees	More than 25 years

5.5.2.2 Data collection tools

A data collection instrument was developed in which a Likert scale was employed for the purpose of data collection from the panel of selected experts. The objective of employing a Likert scale in the data collection instrument was to enable the experts to evaluate the formulated guideline statements to the set criteria based on its clarity, validity, reliability, applicability and flexibility (Warner, 2014). This was to allow each statement to be rated according to the level of agreement based on the criteria set which ranged from strongly disagree to strongly agree (AGREE, 2009:11). Further to that, the scale was used to measure the level of agreement among the panel of experts using a set of criteria to

evaluate each guideline statement, which was indicative of whether consensus was reached or not. In the current study, the criteria used were clarity, validity, reliability, applicability and flexibility. According to Warner (2014), consensus is reached once two thirds of the group members are in agreement and strongly agreeing with each item.

Space was provided at the end of each guideline for the panel of experts to comment and or rephrase the guideline and their recommended action statements should there be a need. According to Powel (2002:37), pilot testing of the data collection instrument was indicated as optional when using the Delphi technique. The developed data collection instrument was pilot tested to identify if there were any ambiguous statements in the guideline statements which needed to be corrected before it was administered to the panel of experts. Pilot testing of the data collection tool was done by the researcher. Three experts in Maternal and Child Health and or Primary Health Care reengineering were involved but were excluded in the panel of experts who were used for data collection in phase 2 of the study. The process assisted in refining the data collection instrument before it was sent to the panel of experts. This was also done to allow the panel to make their individual contribution into the development of the guidelines. The participants were also provided with a summary of how the draft guidelines were formulated to enable them to understand the process of developing the guidelines.

5.5.2.3 Data collection and data analysis

In this second phase of the study, data was collected through a series of three rounds. The process which was followed for data collection and data analysis for each of the three rounds is discussed.

5.5.2.3.1 Round 1

Data Collection

The first round of the Delphi technique was the generative round. The panel of experts were presented with a data collection instrument in which a Likert scale was employed which allowed the revised statements to be subjected to a criteria used to evaluate each statement based on its clarity, validity, reliability, applicability and flexibility. Each statement was rated by indicating the level of agreement based on the criteria used. The level of agreement ranged from strongly disagree to strongly agree (AGREE, 2009:11). Space was provided at the end of each guideline statement and the panel was requested to make qualitative input into the statements to improve the drafted statements (Warner, 2014). The first round was considered to be the most important stage of the study as it was the time to involve participants as the questions for the evaluation were being framed (Geist, 2009:147).

The data collection instrument was provided with space at the end of each guideline for the panel of experts to comment and rephrase the guideline or action statements based on the need. This was in line with Warner (2014), who viewed the first round of the Delphi as a generation round. Members of the panel were requested to make qualitative inputs to improve the developed guideline statements. Where applicable, participants provided suggestions to re-formulate the guideline statements in the space provided for comments at the end of each section.

Data analysis

The data was analysed in an intelligible and interpretable form to make conclusions from the suggestions. Data received was consolidated, categorised and compared. The guideline statements were revised accordingly, based on the comments received. Where there were no comments was regarded as indicative of a lack of instructions, unclear wording, or just neutral feelings. Should there have been cases of disagreement among experts, the concerns and the comments were to be reviewed to reveal evidence of existence of incongruence (Hsu &Sandford, 2007).

In the current study, there were no disagreements among the experts other than their comments and suggestions which were incorporated into the guidelines before the second round of the Delphi process. This was done in line with Chilemba, van Wyk and Leech (2014:1193-1194) who indicated that the similarities or differences and the frequency of the comments in terms of the criteria used should be noted on the responses received. The researcher summarised the received data and updated the guidelines accordingly in preparation for the second round. This was done in accordance to Powell (2002:379) who indicates that the information should be translated and used to refine the guidelines forming the basis of the subsequent rounds. The findings were quantified according to the rating of the Likert scale provided against the set criteria. This was consolidated and summarized in the initial summary sheet.

5.5.2.3.2 Round 2

Data collection

In the second round of the Delphi technique, the revised guidelines, which were informed by the feedback from the first round and revised, were sent to the panel of experts for the second round of review. The participants were requested to rate each guideline statement again according to the Likert scale as indicated in the data collection instrument which was provided to further refine the preliminary guidelines. The guide and the level of agreement or disagreement was stated. Space was provided below each guideline statement which was used to provide a rationale to the choice of the rating, improve the phrasing of the guideline statements and or comments. This was done to allow further refining of the guideline statements.

Data analysis

On receipt of the data collection instruments for the second iteration, data was analysed, reviewed and judgements taken into consideration. The information was used to further refine the preliminary guidelines. The guideline statements that were developed in the first round of the Delphi process were revised in the data collection instrument, based on the information received from the panel of experts.

There were comments that were received proposing rephrasing and refining the guideline statements. For an example, the first guideline statement in the first round was "Create a conducive environment in local health facilities for rendering antenatal care services and providing health education by service providers". The negative comment which was received from the panel of experts for the statement was that "creating a non-threatening and receptive environment was subject to different interpretations by individuals". It needed to be clearly defined for it to be interpreted in the same way. However, some of the comments were affirming some of the refined guideline statements such as "creating a non-threatening and receptive environment will be the key in diverse cultural groups and various geographical areas".

At this stage, it was expected that consensus could start building among participants which was evident in the current study. The process was in line with Hsu and Sandford (2007) who indicated that in the second round of the Delphi process, the investigators summarize what was provided in the first round. The findings were again quantified according to the rating of the Likert scale provided against the set criteria by the panel of experts. This was summarized and consolidated in a summary sheet.

The panel of experts were again sent a summary sheet as informed by the second iteration with the rated items and the ratings of all the experts. The summary sheet showed the number of those who agreed and disagreed on the statements in round one. More than a third of the experts agreed on the statements which showed building of consensus amongst them. More than a third of the participants agreed on the guidelines that were being refined. All the inputs received in the second round of the Delphi process were incorporated into the data collection instrument which was revised accordingly in preparation for the third iteration.

5.5.2.3.3 Round 3

Data collection

The revised guidelines were sent out again to the panel following the similar process as in round two. A summary sheet showing the number of those who agreed and disagreed on the guideline statements in round two was attached for the participants' perusal. It was indicated earlier that the process can be repeated continuously into many rounds until consensus is reached (Hsu & Sandford, 2007). In the current study, the third round of the Delphi process was the last iteration as anticipated in round 2. More than a third of the participants were already agreeing with the guideline statements at the end of the second round. This showed that there was sufficient evidence of consensus among the participants that was building up.

Data analysis

Similarly, in round three, received data from the participants was analysed following the same process. The findings were quantified according to the rating of the Likert scale provided against the set criteria by the panel of experts. This was summarized and consolidated in a final summary sheet which is attached as Annexure J.

The results of the third round showed that more members of the panel of experts were in agreement with the guideline statements showing consensus amongst them. The process affirmed what was previously indicated by Hsu and Sandford (2007:3) and Warner (2014) that consensus could start building up in the third round. The participants were strongly agreeing on all the items according to the set criteria that were on the Likert scale. With the last round, the panel was made aware that it was their last opportunity to make their final inputs (Hsu & Sandford, 2007). As anticipated, it only took three rounds of the Delphi process to obtain consensus. The analysis of the third round concluded the section on data collection and data analysis using the Delphi process and introduced the scope of the guidelines and the actions to be taken when operationalising the guidelines.

5.6 DEVELOPED GUIDELINES

5.6.1 The name of the guidelines

The developed guidelines are "Guidelines to promote community participation in and local accountability for pregnant women's access to basic antenatal care in the Mpumalanga Province, South Africa". They emerged from the need to involve the community on basic antenatal care and be accountable for health in Bushbuckridge sub-District. In this section, the aim and scope of the guidelines are described. The guidelines were developed through the process of the Delphi technique as described in Chapter 2. The preliminary guidelines were refined by the panel of experts into the final guidelines.

5.6.2 The aim of the guidelines

The aim of the study was to develop implementation guidelines to enhance community participation and local accountability for health by exploring ways to involve the community in basic antenatal care, to reduce maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province.

5.6.3 The Scope of the guideline

To develop guidelines there must be a clear problem that needs to be addressed. It should seek to address patients' needs which should be based on evidence (NHMRC, 1998:21; AGREE, 2009:2; WHO, 2012:8). When developing guidelines, the target users and the recipients of the guidelines should be clearly stated (AGREE, 2009:2; WHO, 2012:8). In this study, the target users of the developed guidelines are the nurses who are working in Primary Health Care facilities. They will collaborate with clinic committees to enhance community participation and local accountability for health. They will explore ways to involve the community in basic antenatal care in the targeted area to reduce maternal mortality and morbidity. The target recipients are pregnant women, family members and community members.

There were eight preliminary guidelines formulated. Two of the guidelines were merged together because they were closely related resulting into seven guidelines which were developed. The rational for each guideline is stated, which is followed by how each guideline will be operationalized. The trustworthiness of the development process, the implementation and review of the guidelines is also discussed.

5.6.4 The developed guidelines

5.6.4.1 Guideline 1

The facility managers in collaboration with the clinic committees support the staff in creating a non-threatening and receptive environment for pregnant women by monitoring adherence to policies such as Batho Pele Principles in the facility to enhance basic antenatal care attendance.

Rationale

It was identified in the current study that some of the perceived barriers to antenatal care access were due to poor nurse-patient relationships. This was caused by some of the pregnant women who experienced discrimination by nurses and they feared visiting the facilities due to fear of harassment and embarrassment. According to the South African Constitution, everyone in the country has a right to access health care services, which include reproductive health care services. They have the right to an effective and caring health care that is free from harm. Health care providers are expected to provide services in a dignified, empathetically and tolerable way whilst displaying a positive viewpoint (Department of Justice & Constitutional Development, 1996:11, Health Professional Council of South Africa (HPCSA), 2008:1-2). It becomes imperative that the environment in which antenatal care services within Primary Health Care facilities are provided is non-threatening and receptive to the service users for easy access to the available health services. The current findings showed that the environment is not conducive but compromised. Failure to access health care services due to inequitable distribution of health services, coverage and quality of services provided is a violation of human rights for pregnant women (Naledi et al., 2011:20).

The service users have the right to access good quality of nursing and health care and should be treated with kindness and dignity. The service users should also be informed and know that they have a right to complain about the services they received if they are not satisfied. Their complaints should be investigated and a full response issued (HPCSA, 2008:2; Department of Public Service and Administration (DPSA), 2013:14). The Batho pele principles also require public servants to treat service users with courtesy and consideration by always being helpful (DPSA, 2013:14). According to the National DoH (2016), Ideal Clinic Realisation and Maintenance dashboard, domain: Patient safety, clinical governance and clinical care requires that patient satisfaction survey to be conducted annually to assess the satisfaction of the users on the services provided in the health care facilities. It is also a way of monitoring if patients are offered an opportunity to complain about or compliment the facility and whether complaints are attended to within the prescribed time.

Each facility is expected to score an overall average score of 60 %. The results are used to improve the quality of services provided. All facilities should adhere to the National policy on Management of complaints, compliments, suggestions (DoH, 2016) which is aligned to the Batho pele principles. It requires that clients raise their complaints on poor service delivery which should be investigated and the facility provide a full response within a specified period. Additionally, is the monitoring of patient waiting time on whether the facility's prescribed waiting times are adhered to, which is also national policy.

All Primary Health Care facilities in South Africa are expected to adhere and comply with these policies in order to meet the standard requirements of Ideal Clinic status in accordance to the Ideal Clinic Realisation and Maintenance programme. All these interventions as enforced by the National DoH, which are an effort to create a conducive environment for rendering Primary Health Care services which should be receptive to the users. They enforce the nurse’s compliance to the policies and guidelines for protecting the service users. They enhance that their human and health rights be respected irrespective of their social status, which addresses the concerns raised by the participants in the current study.

In order to create a non-threatening and receptive environment for pregnant women to enhance antenatal care attendance, the facility managers in collaboration with the clinic committees will monitor availability, implementation and adherence to Batho Pele, waiting time and management of complaints policies and Patient Experience of Care guidelines in the facility by the facility staff and comply with the Code of Conduct for Public Service. These are the policies which contribute towards enhancing a conducive environment in health facilities by re-enforcing good interpersonal relationships between the facility staff and patients, reducing their waiting time and also allowing the patients to seek for redress where they have complaints about how they were treated in the facility. The policies intend to transform the facilities' environment to be more responsive to the needs of the patients and clients by being user friendly.

Actions

Facility managers in partnership with the clinic committee should:

1. Determine availability of the National policies on Batho Pele Principles, Patient waiting time, National guidelines on Patient Experience of Care (PEC) and Standard Operating Procedures on Management of complaints, compliments and suggestions in the facility.
2. Monitor adherence to the National policies on Batho Pele Principles, Patient waiting time, National guidelines on Patient experience of care (PEC) and Standard Operating Procedures on Management of complaints, compliments and suggestions by the staff in the facility.
3. Assess if the Batho Pele Principles and the standard waiting time are posted visibly at the reception and service areas.
4. Assess if the surveys on PEC and patient waiting times are conducted as prescribed.
5. Observe if the results of the PEC are visibly displayed at reception and the waiting times at each service area after conducting the surveys.
6. Assess if the PEC results are used to improve the quality of service provided in the facility.

7. Evaluate if the records show compliance to the National policy to manage complaints, compliments and suggestions.

5.6.4.2 Guideline 2

The facility managers and the clinic committees support the identified stakeholders in educating family members at home on how to encourage and support pregnant women to attend antenatal care services.

Rationale

According to Mail et al (2013), evidence showed that health workers give limited information to pregnant women during group health talks and one on one consultation about possible pregnancy complications which was a missed opportunity. There is a need to strengthen the health education programmes that will assist in raising the awareness of the community on the importance of available maternal child and health services (Titaley et al., 2010:9-10).

In the current study, participants acknowledged that the current health education on the importance of antenatal care attendance was inadequate as it was done in the clinics only and needed to be expanded to the community. The use of available human and material resources in the community could be used to maximize, intensify and expand health education in the community, focusing more on the importance of attending antenatal care. They suggested that the service providers and the governance structures could explore using all existing community structures to disseminate the information on the importance of antenatal care in the community and household level. The identified stakeholders who could be used were Home-based carers (HBCs), Community health workers (CHWs) Ward Based Outreach Teams (WBOTs), Community Development Workers (CDWs) and Health promoters. This is aligned with the White paper on Transformation of Health services in South Africa which emphasizes the importance of giving the community a chance to participate in planning and provision of health services (DoH, 1997).

The required health education has to target family members and other community members. Intervention programmes should target husbands, parents including other

family members than focusing on women only, but not excluding friends and relatives as they also have influence on decision making related to antenatal care attendance (Mail et al., 2013). Similarly, participants in the current study also suggested that the health education should target families, friends, husbands and partners including children in schools. CHWs were used in India for health education interventions where they were effective in educating families and the community and reducing diarrhoea in children by 65 %. The volunteers in Kenya were also effective in promoting healthier behaviour by using the Kenyan scope of CHW activities (Gilmore & McAuliffe, 2013).

The intention of the guideline is to provide the identified stakeholders with guidance and support on the processes to be followed and the strategies to be used when educating family members and the entire community on how to encourage pregnant women to attend antenatal care and how they can be supported.

Actions

In order to encourage and support pregnant women to attend antenatal care services, the facility manager in collaboration with the clinic committee should:

1. Facilitate meeting with the supervisors of the identified stakeholders to discuss how the different teams will work together.
2. Identify the content of the health education to be covered when educating the community on the importance of antenatal care attendance.
3. Develop educational materials to be used for health education and health promotion
4. Define the roles and responsibilities for the team members, the line of communication and reporting among stakeholders.
5. Allocate each team member the number of households to be visited when providing health education.
6. Demonstrate to the identified stakeholders the different approaches to be used to conduct the health education activities that will enhance the support of and encourage pregnant women to attend antenatal care.
7. Request the stakeholders to demonstrate back the learned approaches to verify their ability to conduct health education in the community.

5.6.4.3 Guideline 3

The facility managers and the clinic committees support the identified stakeholders to expand health education from the facilities to the community and homes on the importance of basic antenatal care attendance by pregnant women.

Rationale

The Alma-Ata Declaration of 1978 emphasizes the importance of the community to be involved in shaping their health services to ensure that they address, and meet the needs and the living conditions of the target population. This could be done by community involvement and partnership which enhances communication and understanding between the community and the health service providers which is an equal relationship for all stakeholders (Gorgen, Kirsch-woik & Schmidt-Ehry, 2004:212). The governance structures should be accountable both upward to the higher administration and downward to the local population to provide mutual feedback. They have an obligation of being responsible and answerable for the results of the activities they are engaged with, in a manner that is transparent (WHO, 2010). This is related to the current findings. Related to accountability, the participants who were members of the governance structures indicated that they were accountable to the community as they are selected by them. They also account to the higher authorities within the Department of Health administration and therefore, have taken a leading role in community health education on the importance of antenatal care among pregnant women.

Evidence shows that health facility committees can improve the quality of health, the health care coverage and can have a positive impact on health outcomes (McCoy, Hall & Ridge, 2011:1). This is in accordance with the White paper on Transformation of Health services in South Africa of 1997 which emphasizes the importance of giving the community a chance to participate in planning and provision of health services. Additionally, is ensuring that there are adequate resources to deliver services and ensuring performance at service delivery level. It promotes dialogue and feedback between the health providers and the members of the public and encourages the community to take a greater responsibility for their health promotion and care (DoH,

1997). Participants emphasized the need to have an effective health education intervention, where the governance structures should collaborate with the Department of Health, community leadership including other relevant stakeholders and existing structures so that their voices can be heard. As they were elected by the community, they need to be accountable to them.

The intention of the guideline is for the governance structures to take a leading role in facilitating community involvement and participation of identified stakeholders in expanding health education from the facilities to the community and homes, on the importance of antenatal care attendance by pregnant women. This includes enforcing accountability to the community and the higher authorities within the Department of Health.

In order to facilitate community involvement and participation of the community in expanding health education from the fixed facilities to the community and homes on the importance of antenatal care attendance by pregnant women, the facility managers should work in collaboration with the clinic committees.

Actions

Facility managers in partnership with the clinic committees:

1. Identify the key stakeholders to be involved from the existing structures and community networks in the clinic catchment area.
2. Identify the key stakeholders to be involved in expanding health education to the community from the existing structures and community networks in the clinic catchment area.
3. Conduct a meeting with the identified stakeholders to discuss their involvement in health education and health promotion activities to be done in the community and households on the importance of antenatal care attendance by pregnant women.
4. Encourage cooperation among all stakeholders in order to ensure that health education is expanded to the community.
5. Brainstorm the health education and health promotion activities which will be done in the community and households to promote antenatal care attendance.

5.6.4.4 Guideline 4

The facility managers and the clinic committees engage the community in promoting healthy life styles among pregnant women and promote basic antenatal care attendance through health education.

Rationale

The participants in the current study identified lack of education as contributing to the poor antenatal care attendance in the Bushbuckridge sub-District. The lack of knowledge and ignorance makes pregnant women to be apathetic and leads them into starting antenatal care late to shorten the number of visits before they deliver. They further indicated that the lack of interest and understanding on the importance and benefits of antenatal care resulted in poor attendance of antenatal care. This is related to the experience from Indonesia which showed that women who came from rural households had low educational level and lacked knowledge on the possible complications of pregnancy due to poor exposure to the media. This shows the need for more health education in the rural areas (Titaly et al., 2010:4), which is similar to the situation in the Bushbuckridge area.

In antenatal care, pregnant women get educated and counselled on the changes which occur in their bodies and possible complications which may occur during pregnancy, labour and delivery (Sohaq et al., 2013:17). They get services to improve the health of mother and baby and information on other health issues (Simkhada et al. 2008:245). Through health education, pregnant women learn and get informed on how to make choices on healthy lifestyles that will lead to best possible pregnancy outcomes including care of the new-born baby (Anya et al., 2008). Participants who were also pregnant women indicated that they received valuable and beneficial information when attending the antenatal care clinic. Examples of such information is on determination of the health of mother and the baby, health education and counselling, informed of the progress on the pregnancy, date of birth and delivery mode, preventative care, disease screening and treatment. The National Health Policy on Health Promotion also emphasizes the need for women to attend antenatal care early in pregnancy for benefits such as counselling, HIV

testing, and identification of ill-health and early treatment of identified illnesses (DOH, 2015:10)

The intention of the guideline is to create a platform where members of the community share their experiences with regard to barriers and challenges experienced by pregnant women at home and in health facilities, limiting them from attending antenatal care. This will be done by means of facilitated community dialogues to establish the root causes of poor antenatal care attendance and develop strategies to resolve them. The outcomes will be used to inform the training content of the identified stakeholders.

In order to engage the community in promoting healthy life styles among pregnant women and promoting antenatal care attendance through health education, the facility managers should work.in collaboration with the clinic committees.

Actions

Facility managers in partnership with the clinic committees should:

1. Identify barriers and challenges experienced by pregnant women at home and in health facilities, limiting them from attending antenatal care.
2. Establish the root causes of the barriers and challenges and prioritize them in terms of their importance.
3. Discuss the possible benefits of resolving the identified problems.
4. Develop practical and realistic interventions that could be done to resolve identified challenges and barriers.
5. Group the challenges and barriers together into themes of health education topics and develop key health messages to inform the training of the identified stakeholders.
6. Together develop educational pamphlets with key health messages to be used during expansion of health education to the community.

5.6.4.5 Guideline 5

The facility managers and the clinic committees support identified stakeholders to engage the community in a dialogue to assess their knowledge on the possible health risk factors that could affect pregnant women to inform health education content.

Rationale

According to Sohaq et al (2013:17) it is in antenatal care where pregnant women get educated and counselled on the changes which occur in their bodies including the possible complications which may occur during pregnancy, labour and delivery. However, the participants in the current study indicated that at times some women indicate that they would start antenatal care at seven months when they are closer to the date of delivery so that they can rest as they do not see the importance of attending antenatal care early enough. The lack of interest and understanding on the importance and benefits of antenatal care attendance is mostly due to low educational status in the area.

Attending antenatal care before fourteen weeks allows early detection and treatment of possible complications of pregnancy and during labour and delivery. It is also an opportunity for women to get educated and counselled on the changes that occur physiologically during pregnancy (Sohag et al., 2013:17). It enables health care professionals to identify possible pregnancy risk factors and risks during delivery and make necessary interventions (Titaley et al., 2010:1). It is imperative to engage the community in a dialogue to determine their knowledge and understanding of the possible risk factors that may occur to women during pregnancy, potential complications, what to do at home in case of obstetrical emergency and when to seek medical care.

The intention of the guideline is to ensure that the facility managers and the clinic committees support the identified stakeholders to engage the community in a dialogue to assess their knowledge on the possible health risk factors that could affect pregnant women. This should inform the health education content.

Actions

Facility managers in partnership with the clinic committees should:

1. Conduct community meetings to raise the awareness of the families and the community on the importance of attending antenatal care by pregnant women.
2. Assess their level of understanding through asking them questions on the importance of antenatal care attendance, the possible health risk factors, potential complications, what to do at home in case of obstetrical emergency and when to seek medical care which could cause morbidity and mortality among pregnancy.
3. Identify the possible barriers at household level which could prevent pregnant women from attending antenatal care through brainstorming.
4. Through group processes, propose and list the possible strategies to address the identified possible barriers to inform the training content of the identified stakeholders.
5. Assist the community to identify, from the developed strategies, the roles they could play as family members and community to support pregnant women to ensure that they attend antenatal care.

5.6.4.6 Guideline 6

The facility managers in collaboration with the clinic committees identify the knowledge and skills required by the identified stakeholders in the community to educate families and the community on the importance of antenatal care attendance among pregnant women.

Rationale

Identifying knowledge and skills of the identified stakeholders in order to educate the community and the families on the importance of attending basic antenatal care is imperative in order to equip them accordingly to expand health education to the community and the households. Titaley et al (2010:9-10) affirms the need to strengthen community-based participatory programmes to overcome the existing constraints by involving the local community members in health education. Traditional birth attendants

should also be targeted where they are used, such as in Indonesia to increase awareness through health education as they and their cultural practices are trusted. They are highly utilised and even more accessible than village midwives. In the current study, the participants acknowledged the need to promote antenatal care attendance in the community as pregnant women were not attending as they should. The participants further proposed that the health workers were to educate the community and the community leadership on the importance of attending antenatal care. They indicated that in order to have a positive impact in improving antenatal care attendance by pregnant women, there should be collaboration between the Department of Health, the governance structures and the community leadership including other relevant stakeholders and existing structures so that their voices can be heard.

In Kenya, volunteers from the community managed to deliver messages in the community and households effectively on health prevention and promotion messages which increased the knowledge of the community on maternal and new-born care which encouraged women to deliver under skilled attendance in three different regions by 2-21 % (Adam, Dillmann, Chen, Mbugua, Ndung'u et al., 2014:7). In the current study, the HBCs, CHWs WBOTs, CDWs and Health promoters were identified as the stakeholders who would be involved in educating families and the community on the importance of antenatal care attendance among pregnant women.

The guideline seeks to identify the knowledge and skills required by the identified stakeholders in the community to educate families and the community on the importance of antenatal care attendance among pregnant women.

Actions

The facility managers and the clinic committees should:

1. Conduct skills audit to identify the knowledge and skills required by the stakeholders for educating families and the community on antenatal care attendance and healthy lifestyles among pregnant women.
2. Use the results of the skills audit to identify topics to focus on and the materials to be used to fill in the identified gaps.

3. Develop key messages in the form of pamphlets that are simple, clear, unambiguous and using the local languages and package them according to the topics to be addressed.
4. Specify how the health education material will be disseminated and where they will be delivered to ensure that they are accessible to the community.
5. Identify resources available; human, material, and financial and additional resources required for filling the identified gaps during skills audit.
6. Advocate for and mobilize for additional resources required from implementing partners to support educating families and the community on the importance of antenatal care attendance among pregnant women.
7. Pool together all the available resources to support the required training that will expand health education to the households and the community**.**

5.6.4.7 Guideline 7

The facility managers educate all identified stakeholders on how to promote healthy life styles and the importance of antenatal care attendance among pregnant women.

Rationale

To expand and intensify the health education using community participation, participants in the current study suggested using various forms of media and methods that could be used for health education including proper planning on the outreach for the community and homes. Simkhada et al (2008:256) in their study on factors affecting the utilisation of antenatal care in developing countries: a systematic review of literature, affirmed that women's exposure to mass media such as television and radio was a significant predictor of antenatal care utilisation. In Malawi (Mchinji District), men who were exposed to Phukisa la Moyo Radio and listened to maternal health programmes were more involved in maternal health issues than those who were not. The use of mass media was found to be more effective in promoting maternal health issues such as antenatal care and child birth (Zamawe, Banda & Dube, 2015).

It shows that if the identified stakeholders are properly trained, the appropriate media is used and the health education sessions are well planned, their health education could result in promotion of healthy life styles and increase antenatal care attendance among pregnant women. Following training, the identified stakeholders could provide the appropriate health education to families and the community, provide guidance on promoting a healthy life style and how to support and encourage pregnant women to attend antenatal care health services. The health education should cover, amongst others, the reasons for attending antenatal care, benefits, possible risk factors which may occur during pregnancy, potential pregnancy complications and when to seek medical care.

In order to facilitate. promote healthy life styles and promote the importance of antenatal care attendance among pregnant women, the facility managers should work in collaboration with the clinic committees.

Actions

Facility managers in partnership with the clinic committees should:

1. Educate the identified stakeholders to develop their health education work plan with
   health topics, clear activities with time frames and adhere to the planned schedule.
2. Ensure that the content of health education focuses on promoting healthy life styles such as cleanliness, importance of exercises, healthy eating and health seeking behaviour.
3. Raise community awareness on planned health education activities to be done by the identified stakeholders in the community.
4. Support and work with the stakeholders to conduct campaigns and facility open days which should also include promoting healthy lifestyles and encouragement of pregnant women to attend antenatal care services.
5. Monitor distribution of health education pamphlets in the community and their accessibility to community members.

6. Ensure that identified stakeholders encourage pregnant women on life style modification. Conduct regular review meetings to assess progress made against set targets, challenges experienced and develop strategies to address them.

5.7 TRUSTWORTHINESS IN GUIDELINES DEVELOPMENT

In order to apply strategies of trustworthiness to enhance validity of the process of guideline development, the 11 themes identified in phase1 of the study were integrated with the components and core elements of Comprehensive Community and Home-based Health Care (CCHBHC) model and discussed in the context of the relevant literature in chapter 4. The process demonstrated how the preliminary guidelines were informed by the empirical research results from phase 1. To enhance credibility, purposive sampling was used to select the panel of experts to be participants in the Delphi process to refine the preliminary guidelines. The selection of participants was based on their knowledge and experience on Maternal and Child Health and/ or Primary Health Care reengineering. The descriptive information of the participants was outlined in table 5.2. The qualifications and experience can be verified for audit purposes should a need arise as the source documents and the participants' contact details are available on request. The process followed when formulating the guidelines using the Delphi process is valid and reliable. There is empirical evidence on the methodology employed on the development of the presented guidelines on population sampling, data collection and data synthesis. A detailed discussion was provided in section 5.5.2.1 to 5.5.2.3 in page 251-256.

5.8 GUIDELINES DISSEMINATION AND IMPLEMENTATION

The formulation of a dissemination and implementation strategy should be part of the process for developing guidelines. The proposed strategy for implementing the guidelines and the possible obstacles should be looked into to inform the implementation strategy (NHMRC, 1999:20). The researcher will share the research report with the District Manager in Ehlanzeni District where the Bushbuckridge sub-District is located. The Mpumalanga Provincial office will also get a copy of the research report which is a requirement in accordance with the Mpumalanga Department of Health Research Committee. The proposed strategy is for the District Manager to present the guidelines to

the District Management Team for discussion, adoption as the District guidelines for the Bushbuckridge sub-District and sign it off as the District Manager, if it is adopted. Once adopted, the implementation strategy could be developed and the guidelines could be launched. Different forms of distribution could be used such as in meetings, online publication in the departmental websites, mobile applications as indicated in the WHO Hand book for guideline development (WHO, 2012:52). This could be followed by implementation. It is at the level of implementing the guidelines where monitoring and evaluation strategies will be developed to assess the progress made. The implementation of guidelines will be done during the postdoctoral period.

The findings of the research will also be made known and accessible to the National Department of Health, MNCWH Directorate so that they can be alerted on the issues that have emerged from this study. Additionally, they will be published in the journals relevant to the topic, and presentations will be made at national and international conferences to share the findings.

5.9 REVIEW OF GUIDELINES

It is a requirement that after developing guidelines, the dates and the strategy for review should be stated as they are subject to change (SIGN 2011:16: NHMRC, 1999:50). The WHO (2012:52) Handbook further indicates that the date for review should be issued with the guidelines which should have considered the pace in which the research topic could have changed. This is corroborated by SIGN (2011:16) Handbook which indicates that guidelines should therefore be updated once there is emergence of new evidence rather than stipulating the review period which the researcher would consider to be the best approach. The current guidelines will be revised after three to five years following adoption and implementation. However, despite the recommendations made by SIGN (2011:16) which is a commitment made to all guidelines developed by SIGN, it argues that the stipulated period imposes a workload which may not be practical to achieve. The researcher proposed that the Delphi technique be used for review in order to pool a similar kind of intelligence from the panel of experts as it is cost effective. It will form part of the discussion when the researcher presents the guidelines to the District Manager.

5.10 SUMMARY

In this chapter, the functions of guidelines, the principles of developing guidelines, applicability in the current study and the process of developing the guidelines were discussed. The formulated preliminary guidelines were informed by the empirical research results of phase 1 and the process of the application of the CCHBHC model. The preliminary guidelines were further developed and refined through the process of Delphi technique using a panel of experts and were described and presented in this chapter.

CHAPTER 6

REVIEW AND SUMMARY OF FINDINGS, DESCRIPTION OF THE GUIDELINES, LIMITATIONS, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

In chapter 1, the research topic was introduced. The problem statement, the significance of the study and the theoretical framework were discussed. The methodology of the study for phase 1 and phase 2 was described in chapter 2. In chapter 3 data of the empirical part of the research study was presented, which was confirmed by the relevant literature. Chapter 4 illustrated how the current research findings were matched with the CCHBHC model in the context of the relevant literature. This process served as a basis for, and provided guidance towards the development of the guidelines to promote community participation and local accountability for basic antenatal care in Bushbuckridge sub-District, Mpumalanga Province. In chapter 5, the researcher described the process used to *develop the* guidelines and the developed guidelines. Chapter 6 concludes the entire research study by reviewing and summarising the findings of the research study. The review and summary of findings, limitations, implications, recommendations and conclusion is described.

The aim of the study was to develop implementation guidelines to enhance community participation and local accountability for maternal health by exploring ways to involve the community in basic antenatal care, for the purposes of reducing maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province. The specific objectives were:

Phase 1:

1. To explore and describe factors associated with pregnant women's access to antenatal care services.

2. To explore and describe factors associated with community participation in and accountability of local governance structures for antenatal care services.
3. To explore and describe the perceptions of health workers about community participation in supporting pregnant women to access antenatal care.
4. To explore and describe the perceptions of local health workers about the accountability of local governance structures for antenatal care.
5. To explore and describe the functionality and accountability of governance structures in health within local communities.

Phase 2:

6. To develop guidelines that will promote community participation and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province.

6.2 SUMMARY OF FINDINGS

In chapter 3, qualitative methodology was used for the empirical part of the study and was supported by literature control to achieve objectives one to five of phase 1 of the study which is summarized in 6.2.1. In phase 1 of the study, five focus group interviews were conducted with pregnant women. Eighteen face-to-face in-depth individual interviews were conducted with community leaders, members of local governance structures and the midwives. In phase 2 of the study, the Delphi technique was used to achieve objective six for guideline development which was also supported by literature control which is summarized in 6.2.2. The eleven identified themes are summarized under six objectives under the two phases of the study which are fully described in chapter 3.

6.2.1 Phase 1

Objective 1

To explore and describe the factors associated with pregnant women's access to antenatal care services. The six identified themes were perceptions of antenatal care attendance, perceived barriers to antenatal care access, perceived culture, beliefs and

myths, perceived limiting socio-demographic factors and supportive needs during pregnancy

Theme 1: Perceptions of antenatal care attendance

The participants had knowledge and understanding of the reasons and benefits for pregnant women to attend antenatal care. Determining the health of the mother and baby, health education and counselling, determining the progress of the pregnancy, determining date of birth and delivery mode, preventative care, disease screening and treatment of identified illnesses, were mentioned as some of the reasons and benefits for attending antenatal care.

Theme 2: Perceived barriers to accessing antenatal care

The participants indicated that some of the pregnant women were unable to attend antenatal care as they should because of existing barriers. Examples of such barriers were geographical location where pregnant women lived far away from the clinics, fear of HIV testing associated with stigma, and perceived poor nurse-patient relationships where clients feared discrimination, harassment and embarrassment.

Theme 3: Perceived culture, beliefs and myths

According to the participants, there was a local cultural practice and a belief that pregnant women should keep their pregnancy a secret as it is believed that if other people know it, they might bewitch them and the pregnancy may not reach full term. The fear of witchcraft and cultural resistance limit pregnant women from getting the support they would receive from other people such as family members. The practices resulted to late initiation of antenatal care as women wait until the pregnancy is visible before they go to the clinic.

Theme 4: Perceived limiting socio-demographic factors

Under theme 4, participants indicated that advanced maternal age and high parity acted as barriers for attending antenatal care services in facilities. This category of women was judged by other people, making them feel embarrassed for being pregnant. Some women failed to attend antenatal care services due to family circumstances such ignorance, lack of education, poverty leading to lack of basic necessities such as appropriate clothes to

wear when visiting the facility. Additionally, women who had previous experiences of uncomplicated pregnancies would avoid attending antenatal care frequently because they believed that they would again have uncomplicated deliveries as in the past.

Theme 5: Experiences of health care system barriers

The participants indicated that some barriers experienced within the health care system were health facilities that were far from the villages where money was needed for transport and they could not walk the long distance to access the services. At times, women wait for a long time before they are seen at the clinics. The care provided at the facility is of poor quality due to lack of privacy and confidentiality at service points; this was also viewed as a limitation. Additionally, some patients were ill-treated, disrespected and neglected by nurses which prevented pregnant women from attending antenatal care.

Theme 6: Supportive needs during pregnancy

The participants indicated that some pregnant women lacked support from family members, friends and their partners which was a barrier for accessing antenatal care services. Such examples were lack of provision of financial and basic needs, provision of emotional and psychological support and accompaniment by the partners to the clinic. A need to initiate men's support group to educate other men on the importance of supporting their pregnant partners or family members to enable them to attend antenatal care, was also identified.

The pregnant women participants indicated that service providers were not giving them proper attention during antenatal visits. They were not thoroughly examined nor were their concerns listened to. Further to that was that they find the patient's complaints system was not effective as their complaints were not addressed and needed to either be reviewed or alternative ways for lodging and addressing their complaints needed to be found.

Objective 2

To explore and describe the factors associated with community participation in and accountability of local governance structures for antenatal care services. Perceptions on the role of community participation, and accountability of governance structures and identified needs were the two themes identified.

Theme 7: Perceptions on community participation, and accountability of governance structures

The participants indicated that community participation was important and enabled the government and the community to jointly work together in identifying local health problems and seeking solutions together. To have an effective health education intervention that will promote antenatal care attendance among pregnant women, the governance structures should collaborate with the Department of Health, community leadership, other relevant stakeholders and existing functional community based structures. They further indicated that the governance structures should be accountable to the community in expanding maternal health education to the community as they are selected by them.

Theme 8: Identified needs

The participants indicated that whilst acknowledging the role played by culture, the community needs to accommodate the existing scientific advancement in medicine in order to benefit the pregnant women. Community leaders need to assist by educating the community in dispelling the harmful cultural beliefs and practices preventing women from attending antenatal care. The governance structures should take a leading role in community education on the importance of antenatal care attendance and raising men's awareness on the importance of supporting their partners during pregnancy.

Objective 3

To explore and describe the perceptions of health workers on community participation in supporting pregnant women to access antenatal care. The only theme identified was perceptions on community participation in antenatal care.

Theme 9: Perceptions on community participation in antenatal care

The participants indicated the facility staff and the community leaders need to collaborate in promoting health education on antenatal care attendance in the community. The existing community based structures need to be empowered with the necessary skills to strengthen health education efforts in the community.

Objective 4

To explore and describe the perceptions of local health workers on the accountability of local governance structures for antenatal care. Community participation through governance structures was the only theme identified.

Theme 10: Community participation through governance structures

The participants indicated that they were aware of the existence of the governance structures in the form of clinic committees and hospital boards in their facilities. However, the structures work closely with senior management within the facilities and they meet regularly. They were, therefore, not well conversant with their activities but they know that they assist in resolving some of the health system challenges in the facilities. They are also seen when they come to observe how the staff provide health services.

Objective 5

To explore and describe the functionality and accountability of governance structures in health within local communities. The functionality and accountability of governance structures in health within local communities was the only theme identified and it was the last theme in phase 1.

Theme 11: The functionality and accountability of governance structures in health within local communities

The members of the governance structures and community leaders as participants indicated they had not done health education on antenatal care before. However, they realised that they had a role to play based on their participation in the study. They need to be involved in educating the community on the importance of antenatal care attendance. They further indicated that the clinic committees in Bushbuckridge sub-district were functional based on the achievements shared such as resolving the identified challenges in the facilities. They were accountable to the local communities through community meetings held regularly but the process was not formalized. Formal mechanism for the clinic committees to communicate with their constituencies was non-existent.

6.2.2 Phase 2

Objective 6

To develop guidelines that will promote community participation in and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province. Under this objective, the guidelines promote community participation in and local accountability for pregnant women's access to basic antenatal care, were developed. The process followed in developing the guidelines is summarised in section 6.3 below.

6.3 THE PROCESS OF GUIDELINE DEVELOPMENT

The process of formulating the guidelines was described in detail in chapter 4 and development in 5. The process was informed by the empirical findings which were described in chapter 3. The findings were matched with the core elements and the components of the Comprehensive Community and Home-Based Health Care (CCHBHC) model. The model was used because it was found to be the most appropriate for the study as it is designed to cater for the health needs of individuals, families and communities in their own settings (See chapter 4 and 5).

6.3.1. Methodology for developing guidelines

The research methodology used to develop the guidelines was the Delphi technique and is described in detail in chapter 4 (see sections 4.5) and 5 (see sections and 5.5). The

technique was used to further develop and refine the preliminary guidelines using a group of experts through a series of three rounds as described in chapter 5.

The researcher selected a group of 22 experts to participate in the study. Only 18 out of the 22 responded up to the third round which was the last one. A complete table reflecting the descriptive information of the group of experts who participated in Phase 2 of the Delphi process is provided in chapter 5, table 5.2.

To ensure that good and quality guidelines are developed, five attributes were used to appraise the developed guidelines. The attributes were used as criteria to evaluate the guideline statements: validity, reliability, applicability, flexibility and clarity to appraise the developed guidelines as described in table 5.1 of chapter 5. The attributes formed part of a data collection instrument in which a Likert scale was employed and used as criteria to evaluate the guideline statements (see table 6.1).

6.3.2 The guideline development group

The group that developed the guidelines comprised of well qualified experts with extensive experience in Primary Health Care re-engineering and or Maternal and Child health. Amongst the group of experts, there were Professors and Senior Managers who were Deputy Director Generals, Chief Director and Technical Assistants (Directors) with over 15 years of experience in the targeted subject. They were willing to revise the original judgements throughout the process to facilitate consensus, thus making valid and valuable contributions.

Table 6.1: Criteria and rating scale for evaluating guidelines

RATING SCALE	CRITERIA																			
1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	**Clarity:** The guideline is clear, simple and unambiguous				**Validity:** The guideline will assist the community to promote antenatal care utilization amongst pregnant women				**Reliability:** When applied in similar circumstances, the guideline will yield similar results				**Applicability:** The target population of the guideline is clearly stated				**Flexibility:** The guideline may be adapted to suit diverse contexts, e.g. geographical, or cultural			
GUIDELINE	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
COMMENTS																				

Sources: AGREE, 2009:11; NHMRC,1999:2, 12-14, 21, 24-26; SIGN, 2011:2, 31-32, 36-39; Warner,2014

Table 6.2 shows the final ratings and scores of the developed guidelines. Eighteen participants rated the guidelines. The rating scale that was used to appraise the guidelines was strongly disagree (1), disagree (2), agree (3) and strongly agree**.** The green blocks indicate the scores of the participants whose response were agree and strongly agree. The white blocks are those who either disagreed or strongly disagreed. The results of the third round showed that majority (90 %) of the group of experts were in agreement with the guideline statements showing consensus amongst them. Only one participant (10 %) did not agree with the majority in guideline statement number 6, for which he provided a proposed statement that was accepted.

Table 6.2: Final summary sheet of the rated guidelines rating summary sheet for round 3

ROUND 1	CRITERIA																			
Rating scale 1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	**Clarity**				**Validity**				**Reliability**				**Applicability**				**Flexibility**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Guideline 1			**3**	**15**			**3**	**15**			**3**	**15**			**2**	**16**			**3**	**15**
Guideline 2			**2**	**16**			**2**	**16**			**2**	**16**			**3**	**15**			**3**	**15**
Guideline 3			**4**	**14**			**8**	**10**			**5**	**13**			**4**	**14**			**5**	**13**
Guideline 4			**3**	**15**			**3**	**15**			**4**	**14**			**6**	**12**			**8**	**10**
Guideline 5			**5**	**13**			**6**	**12**			**5**	**13**			**5**	**13**			**3**	**15**
Guideline 6			**6**	**12**		**1**	**2**	**15**			**7**	**11**			**6**	**12**			**4**	**14**
Guideline 7			**3**	**15**			**3**	**15**			**7**	**11**			**5**	**13**			**3**	**15**
SUB - TOTAL (n)			**26**	**100**		**1**	**27**	**98**			**33**	**93**			**31**	**95**			**29**	**97**
TOTAL SCORE (n)			**126**		**1**		**125**				**126**				**126**				**126**	

6.4 DESCRIPTION OF DEVELOPED GUIDELINES

The process which was followed by the researcher when developing the guidelines is summarized in section 6.3 of this chapter. The steps which were followed to develop the guidelines are described in chapters 2, 4, 5 and 6. The description of the guidelines is comprised of the following sections:

- The name of the guidelines
- The aim of the guidelines
- The scope of the guideline
- The developed guidelines
- Trustworthiness in guidelines development
- Guidelines dissemination and implementation
- Guidelines review

6.4.1 Introduction

The section introduces the developed guidelines. The name of the guidelines is: Guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province, South Africa. These guidelines emerged from the need to involve the community on basic antenatal care and for the governance structures to be accountable for maternal health care in Bushbuckridge sub-District. See section 5.6.1 of chapter 5 for details.

6.4.2 The aim of the guidelines

The aim of the study was to develop guidelines to promote community participation and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province.

6.4.3 The Scope of the guidelines

The section describes who the intended users of the developed guidelines are and the target recipients. The development of the guidelines sought to address the poor attendance of antenatal care services by pregnant women in Bushbuckridge sub-District, lack of community involvement in basic antenatal care and lack of existing guidelines for promoting community involvement in antenatal care. The target users of the developed guidelines are the nurses working in Primary Health Care facilities. They will collaborate with clinic committees to promote basic antenatal care attendance to contribute in the reduction of maternal mortality and morbidity. The target recipients are pregnant women, family members and community members. The details are provided in section 5.6.3 of chapter 5.

6.4.4 The developed guidelines

The section provides a description of the guidelines. The rationale and the actions that need to be taken to effect the guidelines are described in section 5.6.4 of chapter 5.

6.4.5 Trustworthiness in guidelines development

The strategies of trustworthiness which were applied to enhance validity of the process of guideline development are described. To enhance credibility, purposive sampling was used to select a group of experts who were participants in the Delphi process to refine the preliminary guidelines. The selection of participants was based on their knowledge and experience on Maternal and Child Health and/ or Primary Health Care reengineering. The descriptive information of the participants is outlined in table 5.2. The process followed when formulating the guidelines using the Delphi process is valid and reliable. There is empirical evidence on the methodology employed on the development of the presented guidelines on population sampling, data collection and data synthesis. The details are in section 5.7 of chapter 5.

6.4.6 Guidelines dissemination and implementation

The section describes how the guidelines could be disseminated and implemented. The guidelines will be presented to the District Manager. The proposal is for the District Manager to present the guidelines to the District Management Team for discussion, adoption as the sub-District guidelines and sign it off as the District Manager if adopted. Once adopted, the implementation strategy could be developed and the guidelines may be launched. Different forms of distribution could be used such as in meetings, online publication in the departmental websites and mobile applications. The details are in section 5.8 of chapter 5**.**

6.4.7 Guidelines review

The section describes how the developed guidelines could be reviewed and updated. The guidelines will be reviewed and revised after three to five years following adoption and implementation by the Bushbuckridge sub-District. The researcher proposed that the Delphi technique be used for review in order to pool a similar kind of intelligence from the group of experts as it is cost effective. It will form part of the discussion when the researcher presents the guidelines to the District Manager. The details are in section 5.9 of chapter 5**.**

6.5 RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

Based on the developed guidelines which aimed at developing implementation guidelines to enhance community participation and local accountability for health by exploring ways to involve the community in basic antenatal care, the following recommendations emerged:

- Facility managers should ensure that health services in Primary Health Care facilities are rendered in an environment that is non-threatening and receptive for pregnant women to easily access all the available health services.
- Facility managers should ensure that health care providers adhere and comply to policies which contribute towards enhancing a conducive environment in health facilities by re-enforcing good interpersonal relationships between the facility staff

and the patients, reduce their waiting time and also allow the patients to seek redress where they have complaints about how they were treated in the facility.

- There should be ongoing education on Patient's Rights in Primary Health Care facilities to raise patients' awareness and conscientise them on their rights to access good quality nursing and health care, whilst treated with kindness and dignity and seeking redress should the need arise.
- The nurses and the governance structures should work together in mobilizing available human resources and existing structures in the community to be involved in health education and health promotion activities that will encourage pregnant women to attend antenatal care services.
- The nurses and the governance structures should develop a plan on how to expand the health education to promote antenatal care attendance by pregnant women from the fixed facilities to the community and homes and implement it.
- The nurses should develop programmes that will assist them to engage the community in promoting healthy life styles among pregnant women and promote antenatal care attendance through health education.
- The nurses and the governance structures should provide guidance and support to the identified stakeholders on the processes to be followed and the strategies to be used when educating family members and the entire community on how to encourage pregnant women and how they can be supported.
- The facility managers and the clinic committees should support the identified stakeholders to engage the community in a dialogue to assess their knowledge on the possible health risk factors that could affect pregnant women to inform the health education content to be planned for the community.
- The facility managers should conduct skills audit to identify the knowledge and skills required by the identified stakeholders in the community to educate families and the community on the importance of antenatal care attendance among pregnant women.

- In order to facilitate and promote a healthy life style and promoting of the importance of antenatal care attendance among pregnant women, the facility managers should work in collaboration with the clinic committees to educate the community and households.
- The Infrastructure Unit within the Department of Health should fast track the construction and revitalisation of planned Primary Health Care facilities in the country to resolve the problem of poor access and inequitable distribution of health services for communities to access health services such as antenatal care.
- The lack of Provincial policies which is aligned to the Health Act number 61 of 2003 inhibit governance structures from being effective in facilitating community participation and involvement in health with formal accountability to their constituencies.

6.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The following are the areas where further research is needed based on the recommendations:

- Develop guidelines for training nurses on how to work with the community leadership, governance structures and the community in addressing health challenges that affect the local communities.
- To assess the impact of the guidelines following implementation of the developed guidelines and their effectiveness if they achieve the intended purpose.
- Monitoring and evaluation on the training of stakeholders and implementation of the developed guidelines.
- Conduct similar studies in other provinces which are affected by high maternal morbidity and mortality, especially those with rural areas as they are disadvantaged, to facilitate improved access to basic antenatal care services.
- Evaluate the effectiveness of the governance structures following implementation of the guidelines in the Bushbuckridge sub-District.

- Similar studies could be conducted in urban areas using the same research methodology and study design to test if the outcomes will yield similar and positive results.

6.7 IMPLICATIONS

The results of the study have the following implications for nursing practice, nursing education, Department of Health and for policy makers which are discussed in 6.7.1 to 6.7.4.

6.7.1 For nursing practice

- Implementation of the developed guidelines could improve health education and health promotion activities in the community if implemented.
- The developed guidelines could inform the development of the various educational information, education and communication materials for promoting antenatal attendance amongst pregnant women.
- The collaboration and the relationship between the community leadership, governance structures, implementing and supporting partners and the facility staff could be strengthened by using the guidelines to enable them to address health problems in the community and the households.
- The developed guidelines could direct and provide guidance to the facility managers and the governance structures working in Primary Health Care facilities to expand health education and implement health promotion activities in the community and the households.
- Additional to that, implementation of the guidelines could assist in improving basic antenatal care uptake in health facilities in the Bushbuckridge sub-District.

6.7.2 For nursing education

- The issue of dealing with cultural issues should be emphasized during training of nurses to ensure that they are dealt with appropriately as there could be some cultural practices that have a positive impact on health as much as those that could have a negative impact.

- The negative attitude of nurses continues to be limiting health service users. The training of nurses should emphasize the importance of good interpersonal relationships and acceptable ethical behaviour when dealing with patients. This should also be addressed in the form of in-service education for all the nurses by introducing obligatory continuing-professional-development.

6.7.3 For the Department of Health

- The Department of Health puts emphasis on prevention and health promotion but facilities remain with inadequate staff to reach out to the communities for health education and health promotion activities due to staff shortage. More staff is required to expand health education to the community and households to have an impact on promoting the importance of antenatal care attendance among pregnant women.
- The Infrastructure Unit within the Department of Health should fast track implementation of the facility revitalisation project which renovates and constructs Primary Health Care facilities to address poor access and inequitable distribution of health services especially in rural communities.
- The guidelines will enhance the compliance of the clinic health committees to the National Health Act (61 of 2003) legislative framework which requires the community to participate on health care issues which strengthens the District Health System.

6.7.4 For policy makers

- The National Department of Health should fast track finalisation of the national guidelines which will direct and assist with functioning of the governance structures in the facilities where they are appointed to enhance functionality and accountability of the governance structures as the progress has been slow.

6.7.5 For the community

The functionality and the accountability of the governance structure in health promotion activities and other health matters could be enhanced. The knowledge of the community,

families and individuals on the importance of antenatal care attendance, encouraging pregnant women to attend antenatal care services and living a healthy lifestyle could be improved.

6.8 LIMITATIONS

The following are the limitations which apply to this study:

When selecting the participants for the study, men who were at the reproductive age were not included. They were supposed to have been included as they form part of the family members who are supposed to support pregnant women and encourage them to attend antenatal care services. Their exclusion was a missed opportunity which should be taken into consideration when conducting similar studies as their involvement is crucial. The study focussed on developing the guidelines only which are yet to be implemented in a clinical setting. It cannot be assumed that the guidelines will achieve their intended purpose unless they are implemented.

The study was conducted in Bushbuckridge sub-District, a rural area in Mpumalanga Province. The findings are context specific to that area and cannot be used on different contexts. At this stage, it is not known whether the results could be similar if the study were to be conducted in an urban area using the same research methodology and study design.

The risk is that after guidelines are presented to the District Manager, it cannot be guaranteed that the District Manager will present them to the District Management Team for discussion, adoption and signing-off. The guidelines may not be prioritised which could delay implementation.

The availability of the guidelines in the facilities does not automatically translate into implementation. Managers in the facilities may not manage to successfully implement the developed guidelines if there is shortage of staff and unavailability of the identified stakeholders due to limited capacity and time.

Some of the staff in facilities may lack knowledge and skills on how to effectively engage with communities and work with the governance structures on health issues which could

delay the process. The governance structures may also stop functioning due to other reasons and fail the process of implementing the guidelines.

6.9 CONTRIBUTION TO THE EXISTING NURSING KNOWLEDGE

The integration of the findings of the study with the CCHBHC model which guided the development of the guidelines, resulted in a modified Comprehensive Community and Home-based Health Care (CCHBHC) conceptual framework. The modified framework is different from the original CCHBHC model because the 11 identified themes from the first phase of the study were integrated with the primary, secondary and tertiary levels of prevention of the CCHBHC model. The local context was taken into consideration when applying the enabling factors of the CCHBHC model. The enabling factors now form the central part of the three levels of prevention as they are to create an enabling environment for health education and health promotion activities that should occur at all these levels in the community and at household level.

The emerged concepts and framework might contribute to the body of knowledge in nursing practice specifically in community health and Primary Health Care to involve the community in health care matters. It would empower them with the knowledge and skills to collaborate with community leadership, governance structures and the community at large to address local health issues in their communities.

The conceptual framework could also be taught in the training of Community Health nursing and Primary Health Care nursing to lay a foundation by providing an explanation, description and provision of guidance in community involvement in health matters. On completion of these courses, the nurses could be empowered to be competent on how to work with the community leadership, governance structures and the community in addressing health challenges that affect the local communities.

The developed guidelines could address the gap which exists within MNCWH programme which shows a need for guidelines to promote community support for basic antenatal care services for the purpose of improving the state of Maternal and Child Health as well as

sexual and reproductive health (DoH, 2012); although the guidelines focus on Bushbuckridge sub-District only.

6.10 SUMMARY AND CONCLUSIONS

The purpose of the study was to develop implementation guidelines to enhance community participation and local accountability for health by exploring ways to involve the community in basic antenatal care with an aim of reducing maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province. The specific objectives which guided the process were in two phases:

- To explore and describe factors associated with pregnant women's access to antenatal care services.
- To explore and describe factors associated with community participation in and accountability of local governance structures for antenatal care services.
- To explore and describe the perceptions of health workers about community participation in supporting pregnant women to access antenatal care;
- To explore and describe the perceptions of local health workers about the accountability of local governance structures for antenatal care.
- To explore and describe the functionality and accountability of governance structures in health within local communities.
- To develop guidelines that will promote community participation in and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province.

Qualitative methodology was used for the empirical part of the study supported by literature control. According to the findings, participants indicated that there were perceived barriers which prevented pregnant women from attending antenatal care in Bushbuckridge sub-District. Examples of the identified barriers are health systems; socio-demographic; cultural beliefs and myths; and pregnant women's unmet needs by families, friends and partners on financial, physical, psycho-social needs.

The governance structures in the area were perceived to be functional and accountable to the community although the accountability to the community was not formalised. The

members of the governance structures and the community leaders identified a need for them to be involved in promoting the importance of antenatal care attendance among pregnant women in the community and households through health promotion activities and be accountable for it. Training to strengthen the knowledge and skills of the stakeholders to be involved was also needed. The facility staff and the community need to collaborate in identifying local health problems affecting their community and seek solutions together.

The findings were grouped into 11 themes. The identified themes were perceptions of antenatal care attendance, perceived barriers to antenatal care access, perceived culture, beliefs and myths, perceived limiting socio-demographic factors, experiences of health care system barriers, supportive needs during pregnancy, perceptions on the role of community participation, and accountability of governance structures, identified needs, perceptions on community participation in antenatal care, community participation through governance structures, the functionality and accountability of governance structures in health within local communities.

The themes were correlated with the components and the core elements of the CCHBHC model in the context of the relevant literature. The process resulted into a modified conceptual framework of the CCHBHC model and served as the basis for, and provided guidance towards formulation and development of the preliminary guidelines by the researcher. The preliminary guidelines were further developed and refined into the final guidelines through the process of Delphi technique, using a group of experts. The step completed the process of guideline development to meet the set objectives.

The results of the study will promote community participation in and local accountability for pregnant women's access to basic antenatal care in Mpumalanga Province. They will contribute in improving and expanding health education and health promotion activities from the health facilities to the community and in the households if implemented. This could increase the antenatal uptake in Primary Health Care facilities which could contribute in the reduction of maternal morbidity and mortality in the sub-District.

REFERENCES

Aantjes, C, Quinlan, T & Bunders, J. 2014. Integration of community home based care programmes within national primary health care revitalisation strategies in Ethiopia, Malawi, South Africa and Zambia: a comparative assessment. *Globalization and Health*, vol. 10, no. 85.

Aantjes, CJ, Quinlan, TKC & Bunders, JFG. 2014. Practicalities and challenges in re-orienting the health system in Zambia for treating chronic conditions. *BioMed Central Health Services Research,* vol. 14, no. 295.

Adam, MB, Dillmann, M, Chen, M-k, Mbugua, S, Ndung'u, J, Mumbi, P, Waweru, E & Meissner, P. 2014. Improving Maternal and Newborn Health: Effectiveness of a Community Health Worker Program in Rural Kenya. *PLoS ONE* vol. 9, no. 8.

Africa Progress Panel Policy Brief. 2010. *Maternal Health: investing in the lifeline of healthy societies and economics*. Geneva: Africa Progress Panel.

African Medical and Research Foundation (AMREF). 1995. *Training guidelines: Primary Health Care and community-based Health care.* Nairobi: Community-Based Health Care Support Unit.

Amanyeiwe, U, Leclerc-Madlala, S & Gardi, H. 2014. Do Community-Based Programs Help to Improve HIV Treatment and Health Outcomes? A Review of the Literature. World Journal of AIDS, vol. 4, pp. 311-320.

Amnesty International, 2014. *Struggles for maternal health: Barriers to antenatal care in South Africa.* Amnesty International Ltd, London. Available at <http://www.amnesty.ca/sites/amnesty/files/south_africa_maternal_health_report_pdf.pdf > [Accessed: 2 February 2017].

Anya, SE, Hydara, A & Jaiteh, LES. 2008. Antenatal care in the Gambia: Missed opportunity for information, education and communication. *BioMed Central*, vol. 8, no. 9.

Appraisal of Guidelines for Research and Evaluation (AGREE) II. 2009. *Appraisal of guidelines for research and evaluation II*, the AGREE Research Trust, Revised September 2013, Available at <http://www.agreetrust.org> [Accessed: 7 April 2016]

Banda, CL. 2013. *'Barriers to utilization of focused antenatal care among pregnant women in Ntchisi District in Malawi,*'. MSc theses. University of Tampere. Malawi.

Banta, D. 2003. *What is the efficacy/ effectiveness of antenatal care and the financial and organizational implications? Health Evidence Network report*, WHO Regional Office for Europe, Copenhagen. Available at <http://www.euro.who.int/Document/E82996.pdf> [Accessed: 17 October 2015].

Barron, P & Pillay, Y. 2015. *Implementation of PHC reengineering in SA*. Pretoria: National Department of Health.

Berger, J, Heywood, M, Krynauw, M, Hassim, A, Honermann, B & Rugege, U. 2013. The National Health Act Guide. 2nd ed., Siber Ink cc, Cape Town.

Berhan, Y & Berhan, A. 2014. Antenatal Care as a Means of Increasing Birth in the Health Facility and Reducing Maternal Mortality: A Systematic Review, *Ethiopian Journal of Health Sciences*, vol. 24 (0 Suppl), pp. 93-104.

Better Health. *Ottawa charter for Health promotion*, Better Health Fact sheet. Available at <wwwbetterhealth.vic.gov.au.1999/2015.2 [Accessed:8 April 2013].

Bharat, S & Mahendra, VS. 2007. Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers. *Reproductive Health Matters*, vol. 15, no. 29, pp. 93-112.

Bogdan, RC & Biklen, SK. 2003. *Qualitative research for education. An introduction to theories and methods*. 4th ed., South America. Pearson: Education Group.

Bolt, V & Bird, K. 2003. *The Intra-household Disadvantages Framework: A Framework for the analysis of Intra-household Difference and Inequality,* CPRC working paper, no.32, Available at <http://www.chronicpoverty.org/pdfs/KBNo32.pdf> [Retrieved: 8 April 2013].

Boulle, TM, 2007. *Developing an Understanding of the factors related to the effective functioning of Community Health Committees in Nelson Mandela Bay Metropolitan Municipality, Eastern Cape Province, South Africa*. Doctoral dissertation. Cape Town: University of the Western Cape.

Botma, Y, Greef, M, Mulaudzi, FM, Wright, SCD. 2010. *Research in Health Sciences,* Cape Town*:* Pearson Education South Africa (PTY) LTD.

Britta, C, Mullany, BC, Becker, S, Hindin, MJ. 2006*. The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial*. Epub*, vol. 22, no. 2, pp. 166-176.*

Bulterys, M, Fowler, MG, Shaffer, N, Tih, PM, Greenberg, AE, Karita, E, Coovadia, H & Kevin M De Cock, KM. 2002*.* Role of traditional birth attendants in preventing perinatal transmission of HIV. *British Medical Journal*, vol. 324, pp. 222-225.

Burns, N & Grove, SK. 2001. *The practice of nursing research: Conduct critique & utilization.* 3rd ed., Philadelphia: Saunders.

C3 Collaborating for Health*.* 2012. *The benefits of regular walking for health, well-being and the environment*, C3 Collaborating for Health. Available at <http://www.c3health.org> [Accessed: 7July 2016].

Campbell, C. 2004. Creating contexts for effective homebased care of people living with HIV/AIDS. *Curationis,* vol. 27, no. 3, pp. 5-14.

Carter, M. 2002. Husbands and maternal health matters in rural Guatemala: Wives' reports on their spouses' involvement in pregnancy and birth*. Social Science and Medicine,* vol. 55, pp. 437-450.

Castellan, MC. 2010*.* Quantitative and qualitative research: A View for clarity, Macrothink Institute. *International Journal of Education*, vol. 2, no. 2.

Cham, M, Sundby, J & Vangen, S. 2005. Maternal mortality in rural Gambia, a qualitative study on access to emergency obstetric care. *Reproductive health*, vol. 2, no. 3.

Chidubem, ME. 2012. *Formats for storytelling by Caregivers for sharing knowledge in Home-based health care*. Master of Technology: Design thesis, Cape Peninsula University of Technology, Cape Town.

Chilemba, W, Van Wyk, NC & Leech, R. 2014. Development of guidelines for the assessment of abuse in women living with HIV/AIDS in Malawi*. African Journal for Physical, Health Education, Recreation and Dance (AJPHERD*), vol. 20, no. 3-2, pp. 1189-1201.

Chopra, M, Daviaud, E, Pattinson, E, Fonn, S, Lawn, JE. 2009. Saving the lives of South African mothers, babies and children: can the health system deliver? *The Lancet*, vol. 374, pp. 835-846.

Chowdhury, MF. 2014. Interpretivism in aiding our understanding of the contemporary social world*. Open Journal for Philosophy*, vol. 4, pp. 432-438.

City of Johannesburg. 2012. *The City of Johannesburg's monitoring and evaluation framework*. Available at <http://www.joburg.org.za/images/stories/2013/June/monitoring%20and%20evaluation%20framework%20-%20annexure%203.pdf> [Accessed: 23 November 2015].

Corley, MC, Minik, P, Elswick, RK & Jacobs, M. 2005. Nurse moral distress and ethical work environment. *Nursing Ethics*, vol. 12, no. 4, pp. 381-390.

Corley, MC, Elswick, RK, Gorman, M. & Clor, T. 2001. Development and evaluation of a moral distress scale. *Journal for Advanced Nursing*, vol. 33, no. 2, pp. 250-256.

Couillet, M, Serhier, Z, Tachfouti, N, Elrhazi, K, Nejjari, C & Perez, F. 2007. The use of antenatal services in health centres of Fes, Morocco. *Journal for Obstetrics and Gynaecology*, vol.27, no. 7, pp.688-694.

Cronje, HS, Cilliers, JBF, Pretorius, MS. 2011. *Clinical obstetrics in South African perspective*. Pretoria: Van Schaik.

Daymon, C & Holloway, I. 2011. *Qualitative research methods in public relations and marketing communications*. 2nd ed., Oron: Routledge.

Deave, T, Johnson, D & Ingram, J. 2008. Transition to parenthood: the needs of parents in pregnancy and early parenthood. *BMC Pregnancy and Childbirth*, vol. 8, no. 30.

Department of Health. 2016. *Annual Performance Plan 2016/17*. Pretoria: Government Printer.

Department of Health. 2016. *Ideal Clinic Dashboard version 16*. Pretoria: Government Printer.

Department of Health. 2015. *National report for mid-term review of the strategic plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa.* Pretoria: Government Printer.

Department of Health. 2015. *Report on ambulances status in provinces*. Pretoria: Government Printer.

Department of Health. 2015. *Guidelines for maternity care in South Africa: A manual for clinics, community health centres and district hospitals.* Pretoria: Government Printer

Department of Health. 2015. *National HIV counselling and testing policy guidelines*. Pretoria: Government Printer.

Department of *Health. 2014. Saving Mothers Annual report and non-pregnancy related infections (NPRI) analysis.* Pretoria: Government Printer.

Department of Health. 2014. Saving *Mothers, Sixth report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Government Printer.

Department of Health. 2014. *Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa: Fact sheet*. Pretoria: Government Printer.

Department of Health. 2014. *National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults*. Pretoria: Government Printer.

Department of Health. 2014. *Ideal Clinic Realisation and Maintenance Lab Report on waiting times.* Operation Phakisa. *Pretoria: Government Printer.*

Department of Health. 2013. *The National Strategic Plan for nurse education, training and practice,* 2012/13 - 2016/17. Pretoria: Government Printer.

Department of Health. 2012. *Contraception & Fertility Planning Policy and Guidelines: Policy framework, service delivery and clinical guidelines.* Pretoria: Government Printer.

Department of Health. 2012. Saving *Mothers, fifth report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Government Printer.

Department of Health. 2012. *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012-2016*. Pretoria: Government Printer.

Department of Health. 2011. *Annual Performance Plan 2011/12-2013/14.* Pretoria: Government Printer*.*

Department of Health. 2010. *Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS*. Pretoria: Government Printer.

Department of Health. 2010*. Negotiated Service Delivery Agreement (NSDA) 2010-2014,* Pretoria: Government Printer.

Department of Health. 2011. *Toolkit, Ward Based PHC Outreach Teams Implementation Toolkit*. Pretoria: Government Printer.

Department of Health. 2010. *National Service Delivery Agreement: A long and healthy life for all South Africans*. Pretoria: Government Printer.

Department of Health. 2008. *Saving Mothers, fourth report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Government Printer.

Department of Health. 2007. *Guidelines for maternity care in South Africa, A manual for clinics, community health centers and district hospitals*. 3rd ed., Pretoria: Government Printer.

Department of Health. 2005. *Saving Mothers, third report on confidential enquiries into maternal deaths in South Africa*. Pretoria: Government Printer.

Department of Health. 2004. *National Health Act, 2003 (No 61 of 2003),* Government Gazette, vol. 2, no. 26595. Pretoria. Government Printer.

Department of Health. 1997. *White Paper on the Transformation of the Health System in South Africa,* Government Gazette, vol. *382,* no. 17910. Pretoria: Government Printer.

Department of Justice and Constitutional Development. 1996. *The Constitution of the Republic of South Africa*. Pretoria: Government Printer.

Department of Public Service and Administration (DPSA). 2013. *Step-by-step guide for the development of effective, realistic and incredible service delivery improvement plans (SDIPs).* Pretoria: Government Printer.

Department of Public Service and Administration (DPSA). 1997. *White Paper of Transforming Public Service Delivery (Batho Pele White Paper) (No. 1459 of 1997).* Pretoria: Government Printer.

De Vos, A. 2002*. Research at grass roots, For the social sciences and human service professions*. Pretoria: Van Schaik.

Doku, D, Neupane, S and Doku PN. 2012. Factors associated with reproductive health care utilization among Ghanaian women. *Bio Med Central International Health and Human Rights,* vol. 12, no. 29.

Dookie, S, & Singh, S. 2012. Primary health services at district level in South Africa: a critique of the Primary Health Care approach*. BioMed Central Family Practice,* vol. 13, no. 67.

Ediau, M, Wanyenze, RK, Machingaidze, S, Otim, G, Olwedo, A, Iriso, R & Tumwesigye, NM. 2013. Trends in antenatal care attendance and health facility delivery following community and health facility systems strengthening interventions in Northern Uganda. BioMed Central Pregnancy and Childbirth, vol. 13, no. 189, pp. 13-189.

Educational Broadcasting Corporation. 2004. *Constructivism as a Paradigm for teaching and learning*. Available at <http://www.thirteen.org/edonline/concept2class/constructivism> [Accessed on 30 March 2017].

Ejembi, CL, Norick, P, Starrs, A & Thapa, K. 2013. New global guidance supports community and lay health workers in post partum hemorrhage prevention. *International Journal of Gynaecology and Obstetrics*, vol. 122, no. 3, pp. 187-9.

Eshleman, JR. 1974. *The family, an introduction*. New York: Allyn & Bacon.

Esterberg, KG. 2002. *Qualitative methods in social research*. USA: McGraw-Hill Inc.

Fevers, B, Carretier, J, Bataillard, A. 2010. Clinical practice guidelines. *Journal of Visceral Surgery*, vol, 147, pp. e34-e349.

Firoz, T, Vidler, M, Makanga, PT, Boene, B, Chiaú, R, Sevene, E, Magee, LA, von Dadelszen, P, Munguambe, PT & the CLIP Working Group.2016. Community perspectives on the determinants of maternal health in rural southern Mozambique: a qualitative study. *Reproductive Health*, vol. 13 (Suppl. 2), no. 112.

Friedman, I, Machedi, S, Ngubo, T & Southgate, K. 2006. *Learning about community development, Community Care worker series.* Lansdowne: Juta Learning.

Geist, RM. 2009. Using the Delphi method to engage stakeholders: A comparison of two studies. *Elsevier*, vol. 33, no. 2010, pp 147-154.

Gerein, N, Mayhew, S & Lubben, M. 2002. Special communication, A framework for a new approach to antenatal care. *International journal of Gynaecology and Obstetrics*, vol. 80, pp. 176-182.

Gibbs, A & Campbell, C. 2013. '*Strengthening community participation in Primary Health Care: experiences from South Africa'* in McGuire, A and Costa-Font, J (eds). The LSE companion to health policy. Edward Elgar, Cheltenham.
Available at <http://www.eprints.lse.ac.uk> [Accessed: 09 January 2015].

Gilmore, B & McAuliffe, E. 2013. Effectiveness of community health workers delivering preventive interventions for Maternal and Child Health in low-and middle-income countries: a systematic review. *BioMed Central Public Health*, vol. 13, pp. 847.

Gorgen, H, Kirsch-woik, T & Schmidt-Ehry, B. 2004. *The District Health System Experiences and prospects in Africa. Manual for Public Health Practitioners*. 2nd ed., Deusche Gesellschaft Fur, Schriftenreine der GTZ.

Gray, DE. 2009. *Doing Research in the Real World.* 2nd ed. Los Angeles: SAGE Publication, Print. Available at <http://www.123library.org/book_details/?id=287> [Accessed: 20 February 2017].

Guba, EG, & Lincoln, YS. 1994. *Competing paradigms in qualitative research.* In Denzin, NK & Lincoln, YS (Eds.), *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Ha, TT, Tac, PV, Duc, DM, TT Duong, DT and Thi, LM. 2015. Factors associated with four or more antenatal care services among pregnant women: a cross-sectional survey in eight South Central Coast provinces of Vietnam. *International Journal of Women's Health,* vol. 7, pp. 699-706.

Hagey, J, Rulisa, S & Pe´rez-Escamilla R. 2014. Barriers and solutions for timely initiation of antenatal care in Kigali, Rwanda: Health facility professionals' perspective. *Midwifery,* vol.30 pp. 96-102.

Health Professions Council of South Africa (HPCSA). 2008. *Guideline for good practice in the health care professions, national patients' rights charter, Booklet 3*. Pretoria: HPCSA.

Health Professions Council of South Africa (HPCSA). 2008. *Guidelines for good practice in the health care professions, General ethical guidelines for the health care professions, Booklet 1*. Pretoria: HPCSA.

Health Professions Council of South Africa (HPCSA). 2008. *Guidelines for good practice in the health care professions, National patients' rights charter, Booklet 3*. Pretoria: HPCSA.

Health Professions Council of South Africa (HPCSA). 2008. *Guidelines for good practice in the health care professions, Confidentiality: Protecting and providing information, Booklet 10.* Pretoria: HPCSA.

Hsu, C *& Sandford, BA. 2007. The Delphi Technique: Making sense of consensus,* Practical assessment*. Research and evaluation,* vol. 12, no. 10.

Human Rights Watch. 2011. *Stop making excuses, Accountability for maternal health care in South Africa*. New York: Human Rights Watch.

Human Rights Watch 2. 2009. *No Healing Here Violence, Discrimination and Barriers to Health for Migrants in South Africa*. New York: Human Rights Watch.

Jackson, JI. 2015. *Nursing paradigms and theories: A primer. Virginia Henderson Global Nursing e-Repository*. Available at <http://www.nursinglibrary.org/vhl/handle/10755/338888> [Accessed: 4 January 2017]

Jamshed, S. 2014*.* Qualitative research method-interviewing and observation. *Journal of Clinical and basic Pharmacy*, vol. 5, no. 4, pp. 87-88.

Jaramillo, J. 2001. The impact of media-based health education on TB diagnosis in Cali, Columbia. *Health and policy planning,* vol. 16, no. 1, pp. 68-73.

Johnson, CD, Noyes, J, Haines, A, Tomas, K, Stockport, C, Ribas, AN & Harris, M. 2013. Learning from Brazilian Community Health Worker Model in North Wales. *Globalization and Health*, vol. 9, no. 25.

Jormsri, P, Kunaviktikul, W, Ketefian, S & Chawowalit, A. 2005. A moral competence in nursing practice, Nursing ethics*. An International Journal for Health Care Professionals,* vol. 12, no 6, pp. 582-594.

Keeney, S, Hasson, F & Mckenna, H. 2006. Consulting the oracle: Ten lessons from using the Delphi technique in nursing research. *Journal of Advanced Nursing,* vol. 53, no. 2, pp. 205-212.

Khoza, S. 2007. *Socio-economic rights in South Africa, A resource book*. Cape Town: Community Law Centre.

Knudsen, LV, Laplante-Lévesque, A, Jones, L, Preminger, JE, Nielsen, C, Lunner, T, Hickson, L, Naylor, G & Kramer, SE. 2012. Conducting qualitative research in audiology: A tutorial*. International Journal for Audiology,* vol. 51, no. 2, pp. 83-92.

Kulkarni, MS & Nimbalkar, MR. 2008. Influence of socio-demographic factors on the use of antenatal care*. Indian Journal of Preventive and Social Medicine*, vol. 39, no. 3 & 4.

Lincetto, O, Mothebesoane-Anoh, S, Gomez, P , Munjanja, S eds. 2006. Antenatal care' in *Opportunities for Africa's Newborns: Practical data, policy and programmatic support for newborn care in Africa.* Cape Town: Partnership for Maternal, Newborn &Child Health.

Lincoln, YS. & Guba, EG. 1994. Constructivist, interpretive approaches to human inquiry.

Lipnowski, S. 2012. Healthy active living, physical activity guidelines for children and adolescents. *Canadian Paediatric Society*, vol. 17, no. 4.

Loh, J. 2013. Inquiry into Issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report*, Vol. 18, no. 65, pp. 1-15.

London, L & Baldwin-Ragaven, L. 2008. Human Rights and health: challenges for training nurses in South Africa. *Pubmed*. vo. 31, no. 1, pp. 5-18.

Lowe, M, Chen, D & Huang S. 2016. Social and cultural factors affecting maternal health in rural Gambia: An exploratory qualitative study*. PLoS ONE*, vol. 11, no 9. Available at <http://dx.doi.org/10.1371/journal.pone.0163653> [Accessed: 13 February 2016].

Mail, CP, Menaca, A, Were, F, Afra, NA, Chatio, S, Manda-Taylor, L, Hamel, MJ, Hodgson, A, Tagbor, H, Kalilani, L Ouma, Peter & Pool, R. 2013. Factors affecting Antenatal care attendance: Results from qualitative studies in Ghana, Kenya and Malawi. *PLOS Collection*, vol. 10, no. 1371.

Malan, M. 2014. *'Community health workers shafted by SA's policy shambles'*, Mail and Guardian 11 September 2014, Available at <http://bhekisisa.org/article/2014-09-11-community-health-workers-shafted-by-sas-policy-shambles>, [Accessed: 14 November 2015].

Mark, R, Werner, M, Afif, O. 2009. *Nursing knowledge: Science practice and philosophy*. Wiley- Blackwell.

Mason, L, Dellicour, S, Kuile, FT, Ouma, P, Phillips-Howard, P, Were, F, Laserson, K & Desai M. 2015. Barriers and facilitators to antenatal and delivery care in western Kenya: a qualitative study. *BMC Pregnancy and Childbirth,* vol. 15, no. 26.

Mason, J. 2002. *Qualitative researching*. Sage Publication, London.

Manandhar, DS, Osrin, D, Shrestha, BP, Mesko, N, Morrison, J, Tumbahangpe, KM, Tamang,S, Thapa, S, Shrestha, JR, Wade, A, Borghi, Standing, H, Manandhar, M ,de L Costello, AM, & members of the MIRA Makwanpur trial team. 2004. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised control trial. *Lancet,* vol. 364, pp. 970-79.

Maxwell, JA. 1998. *Designing a qualitative study*. In L. Bickman & D. J. Rog (Eds.), Handbook of applied social research methods. Thousand Oaks, CA: Sage.

McCoy, DC, Hall, JA & Ridge, M. 2011. *A systematic review of the literature for evidence on health facility committees in low-and middle-income countries*. Oxford University Press in association with The London School of Hygiene and Tropical Medicine, czr077.

McMillan, JH & Schumacher, S. 2010. *Research in Education, Evidence-based inquiry*. Upper Saddle River, New Jersey: Pearson Education, Inc.

Myer, L & Harrison, A. 2003. Why do women seek antenatal care late? Perspectives from rural South Africa, *The Journal for Midwifery & Women's Health*, vol. 48, pp. 268-272.

Ministry of Health. 2011. *Nutrition guidelines for care and support for people living with HIV and AIDS.* Ministry of Health, Republic of Zambia.

Mouton, J. 2011. *How to succeed in your Master's and Doctoral studies, a South* African *guide and resource book.* Van Schaik, Pretoria.

Mpumalanga Department of Health. 2016. *Mpumalanga Department of Health Annual Performance Plan 2016/17* [Acessed: 20 January 2017].

Mpumalanga Department of Health. 2015. *District Health Information Systems: District Health Information Database*, Mpumalanga Department of Health [Acessed: 20 March 2015].

Mpumalanga Department of Health. 2012. *District Health Information System: District Health Information Database*. Mpumalanga Department of Health [Accessed: 20 March 2012].

Mubyadzi, GM, Bloch, P, Magnussen, P, Olsen, OE, Byskov, J, Hansen, KS, Bygbjerg, IC. 2010. Women's experience and views about costs of seeking malaria chemoprevention and other antenatal services: a qualitative study from two districts in rural Tanzania. *Malaria Journal*, vol. 9, no. 54.

Mullany, BC, Becker, S & Hindin, MJ. 2006. The impact of including husbands in antenatal health services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health Education Research,* vol. 22, no. 2, pp. 166-176.

Mullick S, Kunene B & Wanjiru, M. 2004. *Involving men in maternity care: Health service delivery issues. Agenda Special Focus,* vol. 6, no. 124-35.

NACOSA Position Paper. 2013. *Community Care Workers.* Available at <www.fornacosa.org.za> [Accessed: 6 July 2015]

Naledi, T, Barron, P & Schneider, H. 2011. *Primary Health care in South Africa (PHC) since 1994 and implications of the new vision for PHC reengineering*. Durban: South African Health Review, Health Systems Trust.

National Health and Medical Research Council (NHMRC). 1999. *A guide to the development, implementation and evaluation of clinical practice guidelines*. Canberra: NHMRC.

National Treasury. 2007. *Framework for Managing Programme Performance Information.* Formeset Printers, Cape (Pty) Ltd. Available on <www.treasury.gov.za> [Accessed: 24 October 2015]

Ncama, BP. 2005. Models of Community/ Home Based Care for People Living with HIV/AIDS in Southern Africa. *Journal of the Association of Nurses in AIDS care*, vol. 16, no. 3, pp. 33-40.

Nigenda, G, Langer, A, Kuchaisit, C, Romero, M, Rojas, G, Al-Osimy, M, Villar, J, Garcia, J, Al-Mazrou, Y, Ba'aqeel, H, Carroli, G, Farnot, U, eLumbiganon, K, Belizán, J, Bergsjo, P, Bakketeig, L & Lindmark, G. 2003. Womens' opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. *BioMed Central, Public Health*, vol. 3, no. 17.

Ngomane, S, & Mulaudzi, FM. 2010. Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa. *Journal of Midwifery*, vol. *28, no.* 1, pp. 30-38.

Ngubo, T & Machedi, S. 2006. *Learning about Primary Health Care, Community care worker series.* Lansdowne: Juta Learning.

Ngulube, TJ, Mdhluli, L, Gondwe, K & Njobvu, CA. 2004. *Governance, participatory mechanisms and structures in Zambia's health system: An assessment of the impact of Health Centre Committees (HCCs) on equity in health and health care.* Lusaka: Centre for Health, Science & Social Research (CHESSORE).

Ngunyulu, RN. 2012. *A model for incorporating "indigenous" postnatal care practices into the midwifery healthcare system in Mopani District, Limpopo Province, South Africa*. Pretoria: University of Pretoria.

Noble, J & Smith, J. 2015. Issues of validity and reliability in qualitative research Evidence Based Nursing. *British Medical Journal,* vol. 18, no. 2.

Odendal, L. 2011. Mail and Guardian, *Midwives deliver life-saving care*, 26 June 2011. Retrieved from:<http://mg.co.za/article/2011-06-26-midwives-deliver-lifesaving-care, [Accessed: 5 June 2015].

Odimegwu, C, Adewuyi, A, Odebiyi, T, Aina, B, Adesina, Y, Olatubara, O & Eniola, F. 2005. Men's role in emergency obstetric care in Osun State of Nigeria. *African Journal for Reproductive Health,* vol. 9, no. 3, pp. 59-71.

O'Hara, BJ, Bauman, AE & Phongsavan, P. 2012. Using mass-media communications to increase population usage of Australia's Get Healthy Information and Coaching Service. *BioMed Central Health*, vol. 12, no. 762.

Okuga, M, Kemigisa M, Namutamba, S, Namazzi, G and Waiswa, P. 2015. Engaging community health workers in maternal and newborn care in eastern Uganda. *Global Health Action,* vol.8. Available at <http://dx.doi.org/10.3402/gha.v8.23968 [Accessed: 23 July 2017]

Olenja, MJ. 1999. Assessing community attitude towards Home Based Care for the people with AIDS(PWAs) in Kenya. *Journal of Community Health,* Human Science Press, vol 24, no.3.

Onyango, MA, Owoko, S & Oguttu, M. 2010. Factors that influence male involvement in sexual and reproductive health in western Kenya: a qualitative study. *African Journal of Reproductive Health*, pp. 32-42.

Packer, CAA. 2002. *Using human rights to change tradition, Traditional Practices Harmful to Women's Reproductive Health in sub-Saharan Africa*. Antwerpen, Intersentia.

Padarath, A & Friedman, I. 2008. *The status of clinic committees in primary level public health sector facilities in South Africa.* Durban: Health Systems Trust.

Pan, S-C, Tien, K-L, Hung, I-C, Lin, Y-J, Sheng, W-H, Wang, M-J, Chang, S-C, Kunin, CM & Chen, YC. 2013.Compliance of health care workers with hand hygiene practices: independent advantages of overt and covert observers*. PLoS ONE*, vol. 8, no. 1, pp. e53746.

Pell, C, Men˜ aca A, Were F, Afrah NA, Chatio S, Taylor, LM, Hamel, MJ, Hodgson, A, Tagbor, H, Kalilani, L Ouma, P & Pool, R. 2013. Factors affecting antenatal care attendance: Results from qualitative studies in Ghana, Kenya and Malawi. *PLoS ONE,* vol. 8, no. 1, pp. e53747.

Peu, MD. 2008. *Health promotion for families with adolescents orphaned with HIV/AIDS in rural Hammanskraal.* PHD thesis, University of Pretoria, Pretoria

Peu, MD, Tshabalala, AM, Hlahane, MS, Human, SP, Jooste, K, Madumo, MM, Motsomane, F, Nemathaga, LH, Nzimakwe, DS, Oosthuizen, A, Richter, S, Selaledi, B & Xaba, A. 2008. *Home / community based care*. Van Schaik, Pretoria.

Phillips, H. 2002. Use of maternal health care among African women in South Africa. *The South African Journal of Demography*, vol. 8, no. 1, pp. 61-72.

Pindani, M. 2008. *Community Home Based Care for HIV and AIDS patients: A Malawian experience.* PHD thesis. Pretoria: Univeristy of South Africa.

Polit, DF & Beck, CT. 2012. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia: Wolter Kluwer Health, Lippincott Williams and Wilkins.

Population Reference Bureau. 2001. *Maternal & Neonatal Programme Effort Index: A tool for maternal health advocates.* Washington DC: Population Reference Bureau.

Powell, C. 2003. The Delphi technique: myths and realities*. Journal of Advanced Nursing,* Blackwell Publishing Ltd, vol. 41, no. 4, pp. 376-382.

Public Service Commission (PSC). 2002. *Explanatory manual on the code of conduct for the public service, A practical guide to ethical dilemmas in the workplace*. 1st ed. Pretoria: Tirommoho Communications.

Public Services International. 2011. *Quality health care and workers on the move. South Africa National Report.* Public Services International, Ferney Voltaire.

Rohde, J, Cousens, S, Chopra, M, Tangcharoensathien, V, Black, R, Bhutta, Z & Lawn, JE. 2008. Alma-Ata: Rebirth and revision 4, 30 years after Alma-Ata: has primary health care worked in countries? *The Lancet*, Vol. 372, pp. 950-961.

Root, R & Whiteside, A. 2013. A qualitative study of community home based care and antiretroviral adherence in Swaziland. *Journal of the International AIDS Society*, vol.16.

Rosato, M, Laverack, G, Grabman, LH, Nair, N, Mwasambo, C, Azad, C, Morrison, J, Bhutta, Z, Perry, H, Rifkin, S & Costello, A. 2008. Community participation: lessons for the maternal, newborn, and child health. Lancet, *vol. 372 (9642), pp. 962-72*.

Russell, M & Schneider, H. 2000. *'Models of community-based HIV/AIDS and support' [in] A rapid appraisal of community based HIV/AIDS care and support in South Africa.* Durban, South Africa: Health Systems Trust.

Sapkota, S, Kobayashi, T & Takase, M. 2010. Husbands' experience of supporting their wives during child birth in Nepal. *Midwifery Journal*, vol. 28, pp. 45-51.

Schneider, H, Hlophe, H & van Rensburg, D. 2008. Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Oxford University Press in association with The London School of Hygiene and Tropical Medicine, Health Policy and Planning*, vol.23, pp.179 -187.

Scottish Intercollegiate Guidelines Network (SIGN). 2015. *SIGN 50: a guideline developer's handbook*, SIGN publication. 3rd ed., no. 50, Edinburgh. Available at <http://www.sign.ac.uk>, [Accessed: 14 January 2016].

Schwandt, TA. *1994. Constructivist, interpretivist approaches to human inquiry*

Available at <https://johnljerz.com/superduper/tlxdownloadsiteWEBSITEII/id382.html>. [Accessed: 02 January 2017].

Schunemann, HJ, Fretheim, A, & Oxman, A. 200*6.* Improving the use of research evidence in guideline development 1, Guidelines for guidelines. *Health Research Policy and Systems*, vol. 4, no. 13.

Shekelle, P, Woolf, S, Grimshaw, JM, Schünemann, HJ & Eccles, MP. 2012. Developing clinical practice guidelines: reviewing, reporting, and publishing guidelines; updating guidelines; and the emerging issues of enhancing guideline implementability and accounting for comorbid conditions in guideline development*. Implementation Science*, vol. 7, no. 62.

Shirani, F, Henwood, K & Coltart, C. 2009. Men's Experiences of Antenatal Services. *International Journal of Social Research Methodology*, vol. 14, no. 1, pp. 17-30.

Sikolia, D, Biros, D, Mason, M & Weiser, M. 2013. *Trustworthiness of Grounded Theory Methodology Research information system*. Midwest.Association for Information Systems AIS electronic Library (AISeL).

Simkhada, B, Van Teijlingen, *ER*, Porter, M & Simkhada, P. 2007. Factors affecting the utilization of antenatal care in developing countries: systemic review of the literature*. Journal of Advanced Nursing*, vol.61, no.3, pp. 244-260.

Sohaq, A, Memon, S, Bhatti, M & Azeem, MA. 2013. Factors affecting utilization of antenatal care: The opinion of pregnant women. *Pak J Physiol*, vol.9, no.1.

South Africa. *Constitution of South Africa Act 108 of 1996, section 27(1)(a) and 28(1)(c).* Pretoria: Government Printer.

South African Nursing Council (Under the provisions of the Nursing ACT, 2005). 2013. *Code of Ethics for Nursing Practitioners in South Africa. Excellence in Professionalism and Advocacy for Healthcare users.* Pretoria: South African Nursing Council.

Statistic South Africa. 2017. *South African Demographic Health Survey*. Statistics South Africa, Pretoria.

Statistics South Africa. 2012. *South African Statistics, 2012*. Pretoria: StatsSA.

Statistics South Africa. 2011. *Census 2011, Provincial profile*, Mpumalanga, Statistics South Africa, Pretoria.

Tanzania Commission for AIDS (TACAIDS). 2015. *Home Based Care services in Tanzania,* TACAIDS, Available at <http://www.tacAIDS.go.tz/index.php?option=com_content&view=article&id=121&itemid=149>, [Accessed: 09 August 2015].

Titaley, CR, Dibley, MJ & Roberts, CL. 2010. Factors associated with underutilization of antenatal care services in Indonesia: results of Indonesia Demographic and Health survey 2002/2003 and 2007. *BioMed Central Public Health*, vol.10, no. 485.

Titaley, CR, Hunter, CL, Heywood, P & Dibley, MJ. 2010. Why don't some women attend antenatal and postnatal care services? a qualitative study of community member's perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. *BMC Pregnancy and childbirth*, vol.10, no. 61.

Tlebere, P, Jackson, D, Loveday, M, Matizirofa, L, Mbombo, N, Doherty, T, Wigton, A, Treger, L & Chopra, M. 2007. Community-based situational analysis of maternal and neonatal care in South Africa to explore factors that impact on utilization of maternal health services*. Journal of midwifery & women's health***,** vol. 52, no 4.

Tracy, SJ. 2013. *Qualitative Research Methods. Collecting evidence, crafting analysis, communicating impact*. Hoboken, A John Wiley & Sons.

Turan, JM, Miller, S, Bukusi, EA, Sande, J & Cohen, CR. 2008. HIV/AIDS and maternity care in Kenya: how fears and discrimination affect uptake and provision of labour and delivery services. AIDS Care: Psychological and socio-medical aspects of AIDS/HIV, *AIDS and Behavior,* vol. 20, no. 8, pp. 938-945.

Turan, JM, Bukusi, EA, Onono, M, Holzemer, WL, Miller, S & Cohen, CR, 2011, HIV/AIDS Stigma and Refusal of HIV Testing Among Pregnant Women in Rural Kenya: Results from the MAMAS Study. *AIDS and Behavior,* vol. 15, no. 6, pp. 1111-1120.

Turner, T, Misso, M, Harris, C & Green, S. 2008. Development of evidence-based clinical practice guidelines (CPGs): comparing approaches. *Implementation Science*, vol. 3, no. 45.

Tyer-Viola, LA. 2007. Obstetric Nurses' Attitudes and Nursing Care Intentions Regarding Care of HIV-Positive Pregnant Women. *Journal of Obstetrics*. *Gynocologic and Neonatal Nursing (JOGNN),* vol. 36, no. 5, pp. 398-409.

UNDP & UNICEF. 2010. *Millennium Development Goals country report.* New York: UNDP & UNICEF.

UNFPA. 2011. *The State of the world's midwifery: Delivering health, saving lives*. New York: UNFPA.

Van Pletzen E & MacGregor, H. 2013. *Community caregivers: The backbone for accessible care and support multi-country research: South Africa Report.* The Caregivers Network.

Vaughan, R. 2008. *Conceptual Framework, a ppt presentation.* Bourne University Available at <www.bournemouth.ac.za> [Accessed: 20 February 2017].

Venkatesh, V, Brown, SA, Bala, H. 2013. Bridging the qualitative-quantitative divide: guidelines for conducting mixed methods. *Research in information systems MIS,* vol. 37, no. 1, pp. 21-54.

Wakefield, MA, Loken, B, & Hornik. 2010. *Use* of *mass* media campaigns to change health behaviour. *Lancet*, vol. 376, pp. 1261-1271.

Walker, LO. & Avant, KS. 2005: *Strategies for Theory Construction in Nursing*. 4th ed., CT: Appleton & Lange Norwalk.

Walusimbi, M & Okonsy, JG. 2004. Knowledge and attitude of nurses caring for patients with HIV and AIDS in Uganda. *Applied Nursing Research*, vol. 17, no. 2, pp. 92-99.

Warner, LA. 2014. *Using the Delphi technique to achieve consensus: A tool for guiding extension programs*. University of Florida, AEC521: IFAS Extension. Available at http://edis.ifas.ufl.edu/wc183, [Accessed: 20 December 2015].

Williams, C. 2007. Research Methods, *Journal of Business and Economic Research,* vol. 5, no. 3.

World Health Organization (WHO). 2015. *Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.* WHO, Geneva.

World Health Organization (WHO). 2014. *Adolescent pregnancy: WHO Fact sheet,* Geneva: WHO Press. Available at <www.who.int/mediacentre/factsheets/fs364/en/> [Accessed: 03 March 2017].

World Health Organization (WHO). 2014. WHO *handbook for guideline development*. Geneva: WHO Press.

World Health Organization. 2012. *WHO handbook for guideline development*. Geneva: WHO Press.

World Health Organization. 2010. *WHO handbook for guideline development*, Geneva: WHO Press.

World Health Organization. 2010. *Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health*. Geneva: WHO Document Production Services.

World Health Organization. 2010. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies. Geneva:* WHO Press. *Available at*

<http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf>.[Accessed: 12 May 2013].

World Health Organization. 2006. *Health Services Coverage Statistics: Antenatal care coverage (percentage).* Available at <http://www.who.int/healthinfo/statistics/indantenatal/en/>, [Accessed: 12 May 2013].

World Health Organization. 2005. *Conceptual and Institutional framework, The Partnership for Maternal, Newborn & Child Health.* Available at <http://www.who.int/pmnch/about/vision/en/index.html> [Accessed: 14 August 2012].

World Health Organization. 2005. *Conceptual and Institutional framework, The Partnership for Maternal, Newborn & Child Health*, Available at <http://www.who.int/pmnch/about/vision/en/index.html> [Accessed: 14 June 2012].

World Health Organization. 2004. *Model for Comprehensive Community and Home-based Health Care, Report of Regional Consultation, 2-4 December 2013*, WHO South East Asia Regional Office (SEARO) Publication, Bangkok.

World Health Organization. 2004. *Comprehensive Community-and Home-based Health Care Model,* WHO South East Asia Regional Office (SEARO) Publication, no. 40, WHO Regional Office, New Delhi.

World Health Organization. 2002. *WHO Antenatal Care Randomised Trial: Manual for the implementation of the new model*. Geneva: World Health Organization.

World Health Organization. 2001. *Programming for male involvement in reproductive health, Report of the meeting of WHO Regional Advisers in Reproductive* Health WHO/PAHO. Geneva: World Health Organization.

World Health Organization. Media Centre. 2012. *Maternal Mortality.* Available at <http://www.who.int/mediacentre/factsheets/fs348/en/index.html> [Accessed: 24 May 2012].

World Health Organization, UNICEF, UNFPA & the World Bank. 2012. *Trends in maternal mortality: 1990 to 2010*. Geneva: WHO Press.

Wilhelmson, K. 2006. *Impact on economic growth of investing in maternal-newborn health.* Malmo: Lund University.

Williams, C. 2007. *Research Methods*. *Journal of Business & Economic Research*, vol. 5, no. 3.

Woods, M. 2011. "*The interview method is a conversation with a purpose*", Massey University, a ppt. presentation.

Woolf, S, Schünemann, HJ, Eccles, MP, Grimshaw, JM, & Shekelle, P. 2012. Developing clinical practice guidelines: types of evidence and outcomes; values and economics, synthesis, grading, and presentation and deriving recommendations. *Implementation Science*, vol. 7, no. 61.

Woolf, S, Grol, R, Hutchinson, A, Eccles, M, Grimshaw, J. 1999. Potential benefits limitations and harms of clinical guidelines. *British Medical Journal*, vol. 318.

Wouters, E, Van Damme, W, Van Rensburg, D, Masquillier, C & Meulemans, H. 2012. Impact of community-based support services on antiretroviral treatment programme delivery and outcomes in resource-limited countries: a synthetic review. *BioMed Central, Health Services Research,* vol. 12, no. 194.

Wringe, A, Cataldo, F, Stevenson, N & Fakoya, A. 2010. Delivering home based care programmes for HIV: a review of lessons learned and challenges ahead in the era of antiretroviral therapy. Oxford University Press in association with The London School of Hygiene and Tropical medicine. *Health Policy Planning*, vol. 25, pp. 352-362.

Ye, Y, Yoshida, Y, Harun-Or-Rashid, MD & Sakamoto, J. 2010. Factors affecting the utilization of antenatal care services among women in Kham District, Xiengkhouang Province. Lao PDR, Nagoya. Journal of Medical Sciences, vol. 72, pp. 23-33.

Yende, N, Van Rie, A, West, NS, Bassett, J & Schwartz, SR. 2017. Acceptability and preferences among men and women for male involvement in antenatal care. *Journal for Pregnancy, Hindawi Publishing Corporation*, vol. 2017, no. 4758017, pp1-8.

Zamawe, C, Banda M, & Dube. 2015. The effectiveness of mass media campaigns on men's participation in maternal health: a cross sectional study in Malawi. *Reproductive Health, Biomed Central*, vol. 12, no. 31.

LIST OF ANNEXURES A - J

ANNEXURE A: PERMISSION LETTER FROM THE UNIVERSITY OF PRETORIA ETHICS COMMITTEE

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

25/10/2013

Approval Certificate
New Application

Ethics Reference No.: 397/2013

Title: Developing guidelines to promote community participation in and local accountability for basic antenatal care in Mpumalanga Province,South Africa

Dear Ms Evangeline Shivambu

The **New Application** as supported by documents specified in your cover letter for your research received on the 24/09/2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 23/10/2013.

Please note the following about your ethics approval:
- Ethics Approval is valid for 3 years
- Please remember to use your protocol number (**397/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

DR R SOMMERS; MBChB; MMed(Int); MPharmMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee
University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 354 1677 🖷 0866516047 deepeka.behari@up.ac.za http://www.healthethics-up.co.za
✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

ANNEXURE B: PERMISSION LETTER FROM MPUMALANGA DEPARTMENT OF HEALTH

MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa

Private Bag X 11285
Nelspruit, 1200
Tel: 013 766 3429
int: +27 13 766 3429
Fax: 013 766 3458
int: +27 13 766 3458

Department of Health

Litiko Letemphilo | Umnyango WezaMaphilo | Departement van Gesondheid

Enquiries: Themba Mulungo (013) 766 3511

06 November 2013

Ms. Evangeline Shivambu
35 Harmse Street
The Orchards Ext 11
Akasia
0182

Dear Ms. Evangeline Shivambu

APPLICATION FOR RESEARCH & ETHICS APPROVAL: DEVELOPING GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION AND LOCAL ACCOUNTABILITY FOR BASIC ANTENATAL CARE IN MPUMALANGA PROVINCE, SOUTH AFRICA

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MR. MOLEFE MACHABA
RESEARCH AND EPIDEMIOLOGY

07/11/2013
DATE

We care Do you?
Siyanakekela

MPUMALANGA
A Pioneering Spirit

ANNEXURE C: CONSENT FORMS TO PARTICIPATE IN THE STUDY

CONSENT TO PARTICIPATE IN THE STUDY

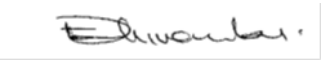
I confirm that I received, I read and I understand the information about the study. I understand that there are no risks for me. I am aware that the results of the study will be analyzed and the report will be published without my name and personal details. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to stop being part of the study and this will not affect the care that I receive at the clinic.

I have received a signed copy of this informed consent agreement.

Participant's name:…….....(Please print)

Participant's signature:.....…… Date.....

Investigator's name: Evangeline Shivambu

Investigator's signature:  **Date:** 24 September 2013

Witness's Name:.....…….....(Please print)

Witness's signature:.....…….. Date.….....

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participant whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that s/he has had time to ask questions and has no objection to participate in the interview. S/he understands that there is no penalty should s/he wish to discontinue with the study and his/her withdrawal will not

affect any access to health services in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name: .....……... (Please print)

Person seeking consent: .....….....(Please print)

Signature: .....…….....Date: .....

Witness's name .....……..….....(Please print)

Signature .....……Date.….....

ANNEXURE D: INTERVIEW GUIDE

MAIN QUESTION

What factors can promote community participation in and local accountability for basic antenatal care and what barriers exist that hamper access to and uptake of basic antenatal care (ANC) services (health services for pregnant women) in Bushbuckridge, Mpumalanga Province?

1. For Pregnant women

- What are the factors that support or create barriers to attending antenatal care services (e.g. personal, family, financial, physical, and psychological)?
    - Why do pregnant women attend ante natal care clinic?
    - Who in your family ensures that you attend antenatal care, how are they involved and what is their role?
    - What could be the barriers that prevent pregnant women from attending antenatal care?
- How can the community be involved to promote antenatal care for pregnant women?
    - In your opinion what could be done to unblock the barriers?

2. For Health Workers

- What are your perceptions, barriers and contributory factors to involve the community to support pregnant women to attend antenatal care?
    - In your opinion, why do think are the reasons for pregnant women not to attend antenatal care as they should?
    - What do you think can be done to address the challenges?
    - What are the challenges you are experiencing in the facility regarding offering antenatal care services?
    - Do you think the community has a role in supporting pregnant women to attend antenatal care, and what role can they play?

- Can you share with me how the governance structure for this facility functions and how that benefits the facility or the services provided?

3. Community Leaders

- What are your perceptions, barriers and contributory factors to involve the community to support pregnant women to attend antenatal care?
    - Why do pregnant women attend antenatal care?
    - What role do you play as community Leaders to ensure that pregnant in your family attend antenatal care and what support do you provide?
    - What do you think are the barriers that prevent pregnant women from attending antenatal care?
- How can the community be involved in promoting antenatal care for pregnant women?

4. For Governance Structures

- What are your views on community involvement to support pregnant women to attend antenatal care?
    - Why do pregnant women attend antenatal care clinic?
    - What role do you play as members of the governance structure to ensure that pregnant in your family attend antenatal care and what support do you provide?
    - What do you think are the barriers that prevent pregnant women from attending antenatal care?
- How can the community be involved to promote antenatal care for pregnant women?
- What are your responsibilities as a Health Committees to promote health in the community?

ANNEXURE E: INVITATION TO PARTICIPATE IN RESEARCH, PHASE 1

35 Harmse Street
The Orchards Ext 11
Akasia
0182
Date

Dear Sir/Madam

Re: Invitation to participate in research study for PhD purposes REF: Student Number – 12217825

My name is Evangeline Mthethwa and I would like to conduct research titled “Developing guidelines to promote community participation and local accountability for pregnant women’s access to basic antenatal care in Mpumalanga Province, South Africa”. The research study is part of the requirement for my doctorate studies. The University of Pretoria Ethics committee and the Provincial Department of Health in Mpumalanga have approved this study.

The aim of the study is to develop implementation guidelines to enhance community participation and local accountability for health by exploring ways for involving the community in basic antenatal care for the reduction of maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province. This will be done in two phases. Specific objectives of the study per phase are:

Specific objectives are:

Phase 1:

- To explore and describe factors associated with pregnant women’s access to antenatal care services.
- To explore and describe factors associated with community participation and accountability local of governance structures for antenatal care services.
- To explore and describe the perceptions of health workers on how to involve the community in supporting pregnant women to access antenatal care.
- To explore and describe the perceptions of health workers on community participation and accountability of local governance structures for antenatal care.

- To explore and describe the functionality and accountability of the governance structures within local communities in health.

Phase 2:

- To develop and describe implementation guidelines for community participation and local accountability for antenatal care services in Bushbuckridge, Mpumalanga Province.

You are invited to participate in the second phase of the study that will be conducted during the period of March to June 2013. Participation is voluntary. You are requested to participate in the study because you have been identified as an expert with experience in the field of Maternal and Child Health including community participation and involvement who will make a meaningful contribution to the development of the said guidelines.

Kindly read the information below, which will enable you to make an informed decision on whether to participate in the study or not.

Procedure

Delphi technique will be used to gather opinions from the panel of experts without having to meet physically. It provides for a consensus-based structured communication process to gather opinions and make decisions. As a member of the panel of expert, you will be expected to respond to a set of open-ended questions over a series of rounds to generate expert opinions on the drafted guidelines until consensus is reached.

Potential risks and benefits

There are no personal risks involved and confidentiality will be maintained. Should discomfort occur, you are free to withdraw from participation. The study will inform development of relevant policies, inform programming and practice and eventually contribute to the reduction of maternal deaths in the community.

Compensation of participants

No compensation will be given to the participants and there is no cost in participating in the study. The participants will incur no costs.

Confidentiality

No names will be used in the study. All the information will be kept confidential and will be disclosed only with your permission

Yours faithfully

Ms E Mthethwa

Principal Researcher

ANNEXURE F: TRANSCRIPT FOR PREGNANT WOMEN (PW), HEALTH WORKERS (HW), MIDWIVES AND ADVANCED MIDWIVES), COMMUNITY LEADERS (CL) AND GOVERNANCE STRUCTURES (GS)

CLASSIFICATION OF DATA SETS: A-G

*Note: Groups of pregnant women are focus group discussions (FGDs) and the rest are individual interviews. The numbers in brackets are the number of interviews done per category. Codes are used for the facilities for them to remain anonymous.

DATA SET A: "AA" COMMUNITY HEALTH CENTRE (CHC)

Group 1: Pregnant women (2)

Group 2: Health Worker (Advanced Midwife) (1)

Group 3: Community Leaders (0)

Group 4: Governance Structure (1)

DATA SET B: "BB" COMMUNITY HEALTH CENTRE (CHC)

Group 1: Pregnant women (2)

Group 2: Health Workers (3)

Group 3: Community Leaders (6)

Group 4: Governance Structure (2)

DATA SET C:"CC" COMMUNITY HEALTH CENTRE (CHC)

Group 1: Pregnant women (1)

Group 2: Health Workers (1)

Group 3: Community Leaders (1)

Group 4: Governance Structure (1)

DATA SET D: "DD" HOSPITAL

Group 2: Health Worker- Advanced Midwife (1)

DATA SET E: "EE" HOSPITAL

Group 2: Health Worker- Advanced Midwife (1)

DATA SET F: "FF" HOSPITAL

Group 2: Health Worker - Midwife (1)

DATA SET G: DISTRICT CLINICAL SPECIALIST TEAM (DCST) - EHLANZENI DISTRICT

Group 2: Health Worker- Advanced Midwife (1)

DATE: 13 15 JANUARY 2014 FDG1

DATA SET A: "AA" CHC [Group 1: Pregnant women (2); Group 2: Health Worker (Advanced Midwife) (1); Group 3: Community Leaders (0); Group 4: Governance Structure (1)]

Group 1: PW (1)

Why are pregnant women not attending ANC?

P1: Some people do not want to be tested for HIV so they do not want to test for the fear of stigma attached.

P2: Some come from disadvantaged families and have no money for transport to go to the clinic. They end up coming to start ANC late. By the time you come the nurses will scold you. They will embarrass you by asking offensive questions in front of other clients.

You are afraid of being offended?

P2: Yes, we are afraid of being offended. You are afraid to be embarrassed. Lack of privacy is also a problem. There is no privacy at the area the nurses are checking vital signs.

You saying you will not feel uncomfortable?

P3: Yes, you will be embarrassed for the whole day. You will not feel comfortable. There will be nothing for that day that you will enjoy. Sometimes it is because you did not go to school and when you get to the clinic others who went to school will talk in English, do you understand. Lack of education is a problem,

P4: Yes, when we come to the clinic we do not bring our certificates of our qualifications from that shows where you are coming from and what you are qualified for. Nurses look at how people are dressed and treat you differently. If you are not well dressed, they will harass you and when you talk back you will not get the necessary care that you need. They will just do "touch ups" so that you can finish and go because you annoy them.

Is there someone who would like to pick up on what she said or add?

P5: I started ANC at a Gynaecologist. And when I came here I find that there are no gynaecologists close by and had to come here. I was scolded and asked why I came late to the clinic? I did not answer them because I needed they help. "Sigh"

P6: She is speaking the truth. The nurses sometimes speak ill of the people and they judge you and the community will comment badly about you especially if you are an older woman.

P1: Judgment by the community, older women are afraid of the community's comments. That they got pregnant whilst they are too old.

P2: Some other people when they see older women coming to ANC, they talk bad things like why does she fall pregnant at that age because she is old. It means she likes" swamasangu" (sex)…small laugh…the people here sometimes talk bad here.

P1: Some people are lazy to walk since they do not have transport. So they may say that they will start ANC at seven months when they are closer to the date of delivery so that they can rest.

P4: Some people are just lazy to work and want start at 7 or 8 months

P2: If you are poor and come to the clinic on the same dress and under wear, the nurses will say that you smell and you are not bathing. So every sister in the clinic will know you, talk badly about you. They will not give you proper examination but they will just fulfil so that you leave. If you have discharges they will say you that you smell. So you rather stay home and go to the hospital for delivery.

P1: So they will say that I'm talking for the nurses. I have not seen anything wrong with the nurses. I think it's them who are lazy to come to the clinic when they are pregnant; they are lying when the say nurses are scolding them. They are just telling them that if you do not come to the clinic, this is what will happen to them.

P2: I am talking from experience; nurses are bosses here because it is their area of work. So she (nurse) just takes it personal. Some lack money for transport. The young girls are afraid to do HIV test and know the truth about their status.

(Requested the pregnant nurse to leave the group because it was hindering progress-people no longer want to contribute)

P5: The woman might have other younger children to take care of or fell pregnant too soon and afraid to be embarrassed.

Are there any home/family circumstances that can make pregnant women not to attend ANC and what kind of circumstances could be that? When are they saying you should start ANC?

P4: As soon as you know that you are pregnant. You have to test at 3months, and again test at 7months. So if you test for the 1st time at seven months it is already late

P2: People are lazy to go to the clinic because in some other places you will wait for too long and sometimes you are seen at 12 midday mean while you came very early at about 6am and go home at about 5pm, so people get bored.

P3: I wanted to say that when you come here early when you are one month pregnant the nurses say that they do not see anything when they examine you.

And when they teach you, what are they saying? When should you start to attend the clinic?

P4: They told us that we should come immediately when we see that we have stooped menstruating. But when we get there they tell us that they do not see anything.

And what do they say after that?

P5: So they give some months to stay at home and tell you when you are supposed to come back. But they do the rest of the other things other than examining the abdomen.

P3: Denial of being pregnant, not accepting the pregnancy. Psychological pressure caused by the family or man. Sometimes it is lack of money in the family.

What kind of psychological pressure are you talking about?

P3: You will not love the baby until after delivery and start bonding with the baby then. Sometimes at home they no longer provide for you and leave you stressed. They will not give you money for transport to go to the clinic. Some cannot afford to buy food when you are at the clinic.

P4: There is no secret in the clinic, there is no confidentiality. Some people believe in witchcraft, people do not say that they are pregnant. There is distrust between neighbours, they believe in witchcraft. They fear that some people will put “muti” (traditional medicine) at the gates that will “tie” them (block them from getting a live baby) which is the reason they hide it for the community

How do your families support you now that you are pregnant or if you do not have any how would have liked your family to support you if all was well?

P6: My husband supports me by. I do not have a problem.

P5: They can buy you clothes, fruits to show that they support and love you. If you have a problem, they must help you to resolve the problem but not leave you without assisting you. Like if you have tested positive, the stress that you are ill, at home they do not care

about me. When you say you are hungry, even if you made them angry, they must give you food to eat

P2: My family and partner support me. Friends provide psychological support and tell me that things will be well. Love is the most important to receive from family and friends to be comfortable e.g. HIV positive mothers should get all the care at home and support like those who tested HIV negative.

P3: Sometimes a baby ends love between the partners. Once you tell a man that you are pregnant he denies the pregnancy and does not want to see you again. Traditional men only want a report back when you come back from the clinic. They do not want to know much.

P6: I need support, love and understanding. If I have pain they cook for me. The father of my baby tells me that I should not worry, soon it will be over. We take walks together.

P5: I feel supported by my mother with food, clothes and money to do my hair. She reassures me by telling me that all will be well she will provide for my baby. My boyfriend buys me fruits.

P2: I get good support from my mother and my boyfriend. He came with me to the clinic and reminds me to go to the clinic. My first born gives a good massage and elevate my feet. My husband brushes my tummy." Laughter" He is happy with my pregnancy. Both partners should attend ANC so that they all know what is happening with the pregnancy

How can we address the barriers that we have talked about? How can we resolve them?

P2: If both partners tested regularly, not only when they are pregnant. They will get used to the testing and not be afraid to test when they are pregnant especially if they both tested before.

P3: My friend is always talked badly about falling pregnant and accused of things at her home and they always have misunderstandings because of that. She is fed-up and does not want the baby anymore because at home there is no peace because of her pregnancy.

P2: You need to avoid what the neighbours are saying and only concentrate on what I want for my family. They will then give up.

P4: No longer have anything to say"

P5: The staff should give proper care to pregnant women and not make feel uncomfortable at the clinic. Even if people have come late they do not have to scold them so that they get angry.

P2: Confidentiality does not exist amongst nurses. Nurses should keep information about people confidential. The community needs to be educated on the importance of ANC.

How can we involve men to be able to be in their partner's pregnancy? Are there cultural issues that you know of that can contribute towards that?

P3: It is easy for him to be involved if you are staying with your partner. If you are not staying with him he may deny the pregnancy to an extent of ending your relationship. He might only come back when the baby is big and walking to give you another pregnancy and run away again. If you are not married it is dangerous. Unless if you had an agreement because his wife is not getting children. You can't even get hold of him telephonically he says he is busy. When you phone…" Subscriber is not available" …" all laughed" … He does not want to talk to you.

Will you also agree that he should experience with you and dump you again?

P3: Men are sweet talkers and that can blind you. Yes, because I want to win the man and overtake his wife at home. Not knowing that I'm creating a burden for myself.

Any addition?

P2: Men are different; the civilized ones will go with you to the Doctor while some just want to get a report back of what transpired at the clinic. It is good to go to ANC together so that both of you know what is happening. Some men want to hear for themselves and also see the baby on TV. But the traditional ones can learn and start doing it if they want to.

How can we involve the community to participate in encouraging pregnant women to attend ANC? How can they be involved? What role can they play?

P4: It is not easy because I cannot tell anyone at one month that I'm pregnant.

Why is it a problem to tell at one month?

P4: As Africans we believe in witchcraft. If we tell at 1month, they will count the months and "tsimba" "tie" (block me from delivering a baby) block me when my time for delivery comes. You have to keep it a secret to save yourself.

How do they "tie" you?

P3: Due to witchcraft, we do not trust each other. Sometime they will bewitch you and do things that you never know. I hid my pregnancy until 7 months. When labour started, I just packed my bag and left with back door because I was afraid of my neighbours. They saw me when I came back.

P5: It is not easy to help the community if people hide their status of being pregnant. If a woman started ANC late, her illness will not have been checked. That kind of a person, it's not easy to help her because she kept it secret so that both of them can be safe. If you know that someone is pregnant, you will advice her to attend ANC.

P2: If they can start Wellness programmes that will educate and encourage pregnant women to attend ANC. Free services like testing for sugar, eye care, high blood etc. can be provided as people like to participate in things that are free. The service providers for health must always visit the community as that can help. If they do not reach out to the community, the community will die.

How do you think is the role of the community leaders like councillors, "indunas" in encouraging pregnant women to attend ANC? What can they contribute to address this problem?

P2: If the Councillor has never experienced a problem in his own family, he will not do it. They only go out for campaigns when they want to be voted for. They were supposed to

so do with health issues to get more votes because we would see their effort towards the community.

P4: Community Leaders should reach out to the community on health issues and encourage pregnant women to attend ANC. They should be the one giving the community the necessary information.

Does the church and the schools have a role?

P2: On Thursdays, at the women's prayer meeting we can teach each other about this although in some churches it is not easy to get in there if you are pregnant and you are not married.

P3: People should not be judged because of that. Some will always preach about you until you do not want to go to church ever again.

Any other response? …..“All shaking heads”…….*If not, I thank you for your time and your contributions and your time. Thank you.*

14 January 2014

Group 1: PW (2) FDG 2

I would like to know from you why you as pregnant women attend ANC?

P1: As a first time parent are interested in knowing how the child is inside and if there is a problem it can be detected and treated. I also get some pills like calcium gluconate and ferrous sulphate that helps me and the baby. So that walk every month to the clinic helps me much. It is important that I should come. Last Sunday I came several times because the baby was not playing well and they checked me and said the baby is well.

Anyone else? Why did you leave home and come to the clinic?..... “All silent, no one wanted to talk” Everybody is going to talk. Next?

P2: “sigh” ….Eish! It's a must to come to the clinic because you want to know if the baby is well or not. You want to know if you are healthy or not. “Quiet”

Talk. Who told you to come to the clinic when you started? Were you pushed by someone or you came alone?

P3: I started ANC late when I was advanced because I feared that the nurses will scold me and tell me that I'm still young although I knew that I was pregnant. I feared to be judged. I was advised by my friend to come to the clinic. When I came I found that everything went well, I was not scolded. I am no longer pushed now I come on my own and

What do you benefit from coming to the clinic?

P4: To know my status, my health, get pills and that the baby is well.

Anyone else? Please talk, anything you can think of, feel free to say anything that you can think of. No one will judge you on what you will say.

P5: To be checked and find out about the stage of my pregnancy and the health of the baby and mother. To know my HIV status and to check if everything is well with me.

P6: So that illnesses are detected early so that I get the help that I need. When finding out that you are pregnant you should start ANC.

P7: I went to the clinic for ANC immediately after I tested my pregnancy and was positive. I was not afraid to be judged like she said sometimes people are judged. It is true that some nurses are aggressive and scold young pregnant mothers for being pregnant at an early age. I went to another clinic where I went several times but could not start ANC because the nurses were scolding me. I changed from one clinic to the next until I got one where I was well received. When I get there, they started educating me about the importance of ANC and checked me. That was already late because I was 6 months pregnant. It is good to attend ANC because they tell you how healthy you and your baby are.

Next one? Why did you come to ANC?

P6: I was afraid to come to the clinic but I came and was told I was pregnant. I went back home and stayed for a month and I'm coming for the first time now. Some are afraid to

test HIV positive as they do know their status and they are afraid to be on treatment and that makes them to be scared of going to the clinic.

P7: At the clinic they educate the young mothers on how the baby is supposed to grow and how many times the baby should be playing per day

P8: At the clinic women are taught why it is important to attend ANC. Their health is checked and told of the status of the baby inside for the safely of the baby

Who provides support to ensure ANC attendance?

P2: I stay with my husband and had to think myself that I have to go to the clinic. My husband supports me financially and asks me when I come back and ask for feedback. He advises me and encourages me that things will be well.

P1: I do not get any support from my family members as they want you to regret every day that you fell pregnant and they are not happy about it. They are still angry that I'm pregnant and always want to see me unhappy. I embraced my pregnancy and I'm happy that I will be a mother because I'm 25 and old enough to take care of my baby. It would be good to get financial support so that I go back to school and study further but my parents are not supportive. At least I just got a job where I will start working soon.

P3: I get support from my two sisters who stay with me. They try to find out what happened at ANC and are interested in my progress. They also support me financially.

P5: I also get support from my family. They ask what we learnt at ANC. Some partners also give advice and guidance and contribute towards the pregnancy. They want to know about the first kicks as they know that if the kicks are there the baby is alive. A concern comes when the baby stops playing and that stresses the mother and baby.

P6: Within the family, the other siblings have their own children and it is hard to provide support or take part in the pregnancy.

P4: My mother supports me by asking what transpired at the clinic and if I have any problems. Some people have very good support from my family until time of delivery they

get engaged and ask all questions regarding what they said at the ANC and follow up on my appointments.

What are the things that make preventing pregnant women from attending ANC?

P1: They fear the attitude of the staff. We are told that we are still young to fall pregnant so we end up not coming for ANC

P3: Nurses ask funny questions that are judgmental to young pregnant women so that makes us to stay away.

P2: Some people think ahead and foresee problems they will encounter when they come to the clinic. They think a lot and afraid of being judged by others about your pregnancy. They are afraid of testing for HIV.

Is HIV testing a problem?

P2: Yes, it is, testing is not that simple but it is important to test when you are pregnant. The results are scary because when you have tested positive it is hard and this make them not come for ANC. It is important to test so that you can be treated and protect the baby. If a person tests positive she thinks that the world has come to an end. There is also stigma attached to it

P5: There is nothing that can stop a woman not to come to ANC, they just do not want to.

P1: Distance also plays a role in women not coming to the ANC for treatments. The mobile clinics should also cater for pregnant women but not focus of child immunization only.

Are mobile clinics currently focusing on child health only?

P1: I don't know; I just hear people saying they went there for immunization. Sometimes the way the nurses touch their tummies is not good, they are hard and rough and it hurts. Nurses need to be gentle when they examine people. At times they judge the young pregnant women about falling pregnant. If they (nurses) have to teach them, they need good approach and timing to ensure that their lessons are heard.

P4: The attitude of nurses chases them away. Personal questions are asked to young women like “were there no condoms when you fell pregnant”? Instead relevant advice should be given and correct timing is needed. They should approach them well and not judge others. Sometimes they will say” Year after year a person is attending ANC appointments” and are told that they are tired of her, she must stop conceiving. Distance is also a problem because some have to walk for a long time to the clinic because there is no clinic nearby.

What can be done to address the barriers that were indicated in our discussion?

P1: Maternal education in the community so that they understand the importance of ANC. The department should get people hired specifically to go out to the community. Doing ANC campaigns. Start to involve men as well educate them on how they should support their pregnant partners by doing door to door campaigns and visiting the churches.

P3: I have no answer

P2: Transport might be a big problem; if there can be regular transport that takes pregnant women to the clinic. The government should provide transport to the people. Clinic staff can go around providing the ANC services at household level.

P4: Those who know about the importance of attending ANC should teach each other in their families as some people are far from the clinics. Nurses can teach people who are here at the clinic so that they go home and encourage their people to go to the clinic. Those with information should give the others who do not have information to get them to come to the clinic.

P2: People should persevere even if they are not treated well at the clinic for the sake of their babies. Some nurses have moods, today they are good but tomorrow they are moody. People should not give up when the nurse’s attitude is not good at times. Women should not to give up that they have to attend ANC. To build more clinics in the community; Not mobile clinics because mobile clinics are not always there when they are needed because they come and go.

P1: The government should add more clinics so that they clinics are not full and they can walk a short distance. Mobiles are not good because they come and go. They have to employ more staff so that the work is easy. The government should give more bursaries for people to train as nurses to avoid waiting for a long time before being seen.

P5: Addressing the staff within the Department of Health so that they have a positive attitude and treat people correctly. Young pregnant women should not take it to heart when scolded by nurses but just see it as one of those days and never give up on them and their attitude towards you.

How can the community be involved in promoting ANC?

P1: Pamphlets should be distributed to the community on the importance of ANC attendance. These should be given to everybody not pregnant women only. Having the knowledge will alert the expecting mother if there is a problem and they will go to the clinics.

Do you think the church has a role on these issues?

P1: In the church I go to, sometimes they bring Doctors to teach us on specific issues related to health. It is possible to involve the church as that send the information out to people in the community. The churches should involve nurses, doctors and other members of the departments who are experts in their field come to the churches and teach the congregation about health issues and empower them with knowledge as it can reduce maternal and infant deaths.

Anyone to add? ….."Shaking heads"

If you no longer have anything to add, I would like to thank you for your time and contributions.

DATE: 15 - 16 JANUARY 2014

DATA SET B: "BB" CHC [Group 1: Pregnant women (2); Group 2: Health Workers (3); Group 3: Community Leaders (6); Group 4: Governance Structure (2)]

Group 1: PW (1) FDG 3

My first question to you is why do you come to ANC? Just answer, anyone can answer.

P1: So that they check if the baby is well and sitting well inside because sometimes you will find that the baby is not in the womb. They check if there are diseases that can affect the baby

P2: To check for any health problems from the mother and baby. If you don't you may find that when you go for delivery your baby is dead. They want us to liver healthy and live babies.

P3: To detect the baby's position whether it is inside or outside the womb.

P4: To check if the baby's heart is beating well.

P5: They give us pills that help to improve the health of the baby and mother. If you do not come to the clinic you will never know these things.

P6: To detect if the baby is playing well and if nothing is happening they can find solutions. They check how far the pregnancy is and determine when the birth is going to be. Having knowledge of what to do when faced with problems e.g. bleeding during pregnancy.

Any addition? Anyone can add

P7: They check the status of the mother and baby and give us pills. They check how far we are with the pregnancy and tell us when we will get the baby.

P2: Yesterday I was bleeding and if I did not come I would not know what to do and how to resolve it.

What are the barriers that prevent pregnant women from coming to ANC?

P1: some do not see it as important. They don't understand this thing of getting pills.

P5: Women always cry about being hungry because they arrived early at the clinic and leave late

P2: Some do not want to test and find out that they are HIV positive. They do not want to know their status because they do not want to think too much.

P3: Some feel that they are ignored by nurses. They come early and end up leaving late. They do not want to be delayed.

Any other thing?

P4: For those who do not want to come because of that, they are not going to get help. They will have problems.

P3: Some just decide not to come because they think that it is not important.

Anyone else? "Silence" what about young mothers, is it easy for them to come?

P5: No it is no easy for them. Young mothers are afraid of being discouraged and asked uncomfortable questions by the nurses. At times they are not decided as to whether they want to keep the pregnancy or not. Sometimes they fear that the nurses will scold them.

P6: Yes, nurses scold people. They ask questions like "why did not you come for family planning"? This makes make them feel uncomfortable.

P7: Older women sometimes do not see the importance of going to the ANC appointments because they think that they know too much about pregnancy.

P2: They think that there is no valid reason to go to the clinic and give birth at home which makes the community to be amazed.

Anything you can think of about family circumstances?

P6: In case there is no money for transport may be. These days there are clinics and mobile clinics everywhere. There is no reason why someone may not go to the clinic.

P4: Even if the clinic is far and there is no money for transport, I can just wake up in the morning and walk for the sake of my health and that of the baby. I cannot stay at home.

P3: I once saw someone who surprised us by giving birth at home. Nobody knew that she was pregnant even the members of her family. They just heard the baby cry and were all shocked. Everything went well she did not have a problem.

How can the barriers mentioned be addressed?

P1: Pregnant women need to be educated about the importance of ANC.

P2: They should be encouraged to go for testing even if they are not pregnant. They must know that testing HIV positive is not the end of the world, there is treatment and life after that.

P6: Women need to ignore the negative attitude of the nurses and focus on the health benefit for the mother and the baby.

P7: You have to educate each other pertaining things of pregnancy and the baby before the baby is born. A child should not only be the mothers but both partners.

Who supports you at home and encourage you to attend ANC? Everybody will talk.

P1: My parents at home ask when I will be going to ANC and when I come back they ask me for feedback. I also get support from friends, and partners who tell and remind me to go to the clinic as per appointment.

P2: I stay with my sisters who tell me that there is pain of labour when the time of delivery comes but it will be over and it shall pass. It passes but it is painful. “Laughing”

P3: My biological mother encourages me and provides financial support. She gives me money for transport to go to the clinic when I do not have it.

P4: I get support from my mother and my partner who give me money to come to the clinic and if I have pain because sometime labour comes early so they give me encouraging words.

P5: I get support from my husband and his parents. They remind me to go to the clinic and to take the pills that I get from the clinic. They also buy me fruits to eat.

P5: They help me by not to carrying heavy things and not do heavy chores at home. When in pain they help me to go to the clinic and give me money for transport. They hired a car to take me to the clinic when I am in pain like yesterday.

P6: I get support from both families from the partner's side and mother's side in all ways including my friends. They tell me not to climb trees and always be asleep because I like sleeping. I like playing with the kids on the road.

P7: I'm supported by my mother. She enquires about the baby and my health. Last week I could not go to ANC because there was no money for transport but this week she gave me money to come.

How do you think the community can be involved in promoting ANC?

P2: Nurses should teach the Home-Based Cares who should do door to door campaigns or even provide ANC services at their homes as they do not go to the clinic so that they get pills that will help her through the pregnancy. It should be must to attend ANC at home because she is afraid to go to the clinic.

P3: I do not see the importance of HBCs to give ANC treatments at home because it is important that expectant mothers themselves go to the clinic. They are not disabled but they just do not want to go there. Home based care should be continued the way it is done by helping those who are in real need. HBCs should go out to teach women on the importance of ANC Need to have campaigns and give information to those that do not go to the clinic so that they are able to go to the clinic on their own.

P5: Educate the community that HIV testing is important and finding out that you are HIV positive is not a death sentence. There should be special people who are trained to educate the community about these issues.

P4: Doing door to door is the most important thing and involving the male figures so that they are able to encourage and support their expecting partners and easily support them. Going to the ANC with the partner also helps so that he is involved in the pregnancy as well.

P6: Parents should also take the responsibility of teaching their pregnant children on the importance of attending ANC. They should make sure that on the day of the clinic they really go and attend but not sit somewhere and forge the old notes on the card and go back home and say they are coming from the clinic…" all laughed".

How do they forge the notes?

They just sit down and copy what was written before and fill the space for that day.

How do you involve your partners?

To keep him updated about everything that happens with the pregnancy. Let him play with the baby.

Is there any other thing you would like to say?

"silent"

If none, I would like to thank you for your participation. It is much appreciated

Group 1: PW (2) FDG4

My first question to you is why do you come to ANC? Just answer, anyone can answer.

P1: During these times that we live in there are many diseases like HIV. If diseases are detected, they will be treated on time and coming to the ANC appointments helps determine one's HIV status so that if positive you can prevent the transmission from mother to child.

P2: If I attend ANC I will know my state of health……"interruption, noise"….and to protect the baby from being stressed and coming to the clinic also gives one the opportunity to get counselled so that our pregnancy can be a successful one.

P3: I want to be healthy and enjoy my pregnancy so that my baby can be safe. There are diseases like HIV, hypertension and if you do not attend ANC you will never know if you have those diseases. They may affect the baby.

P4: I want to know my HIV status. To detect any problem that can affect my baby. At the clinic they are able to counsel you if you have some problems and help you.

P5: To check if I do not have HIV, TB, and asthma and to treat them on time so that the baby is not affected but safe. Nurses also educate us on various things that will help us during our pregnancy. It is for the safety of the baby, being taught on how to take care of the baby.

Who in the family provide support to you now that you are pregnant? Support from the family, partners, friend etc.

P1: My mother supports me and encourages me to go to the clinic.

P2: My mother and my mother-in-law play a very important role because they encourage me to come to the clinic.

P3: My sister advises them that going to the clinic are very important. It is never the end of the world if the father leaves you if they are pregnant, because things might change at any moment. At the moment I'm not staying with my parents but they supported me in the past

P4: I stay with my husband who encourages me and to be on a strict diet so that the baby can grow well. He gives financial support for the woman to go to the clinic anytime if there is a problem or pain. He buys me fruits and vegetables to eat.

P6: My biological mother does everything, whatever the expecting mother want. She buys fruits for me because I do not like pap.

P5: My mother supports me and buys anything I want to eat. She buys me fruit to eat.

Any other addition? …" silence" If there is nothing to add, what are your partners doing? Even if it is a wish if they are not doing anything.

P3: My wish is for partner to be always there for me even after delivery. When we go for birth certificates we should go together.

P2: He should continue to take care of me now and even after delivery to show that he loves his baby

P1: You have to be partners in everything be around the child and the mother as well all the time. After the birth the child should be treated the same way as was treated before.

P4: Some males do not play any part and that hurts the expecting mother

Some women do not go for ANC, what could be the reasons?

P2: Some say they do not want to get tired of going to the clinic many times. They decide to start late so that once they start they are close to their time of delivery.

P3: At times we give wrong people wrong advices to the people who are from outside the country. So some end up thinking that because they do not have SA identity document (ID) they will not get help and have problems from the myths that their child will not get any certificate if they do not have ID's. Some pregnant women cannot walk for a long distance and if they do not have money they fail to go to the clinic

P6: I do not have an answer

P1: Just to add on what she said, I saw some woman who was not attending ANC and ended up delivering at home because she did not have an ID. So there are many women out there e.g. those who come from Mozambique who do not attend ANC for that reason.

P5: Some just fear to come to the clinic for the different reasons mentioned and some it is just laziness. Some have wrong information given by others to the expecting mothers.

How can we address these challenges so that people can attend ANC?

P3: If there could be more mobile clinics that provide ANC services. The services should go to the community so that people do not suffer. These problems can be reduced because some villages do not have clinics. That would also make it easier to pull someone and say" Let's go to the clinic".

P2: At home, we need to encourage each other. We can tell those who do not have IDs that the services are free, for them is to attend.

P1: Just to add on that we should encourage each other

P3: There should be people who are able to advice us and we should be able to teach each other also in the communities where we come from. We should get actively involved and able to ask if pregnant women are attending ANC.

We have already started to discuss my next question of who in the community can play a role in promoting ANC. How the community can be involved?

P3: The Home-base Cares can take responsibility by educating the community during their house to house visits and conduct campaigns to encourage the expecting mothers. I think they are the best people to educate families.

What about the community leaders like members of the civic?

P4: Aaah! Those ones? "Surprised" They cannot help. If you can tell them that so and so stole in such a place, may be they can do something. They are of no help as respect has been lost in this generation. They are not helpful.

What about churches?

P3: The churches can help especially in the women's services. They can teach and encourage each other and can talk about women's issues.

P2: The staff at the clinic can make reminders everywhere they are about the importance of ANC. They can also do it in the clinic on daily basis to everybody who is there.

P6: We have to get ourselves closer to pregnant women and encourage them to go to the clinic. We have to give out information that is learnt and educates others in the community about ANC.

Any last words?

P1: We just want to appreciate the opportunity of learning these things.

P3: We have learnt a lot. We will be able to encourage other pregnant women

I would also like to thank you for your time and your contributions.

GROUP 1: PW (2) FDG 5

Why do pregnant women attend ANC?

P1: We want to be checked for diseases that can affect the baby. To check and know the date of delivery. To check if the baby and the mother's health is good.

P2: To check if the baby is in a good position and if the mother is a sickly person she can get help.

P3: To find out if the mother has illnesses in order to prevent any diseases that can affect the baby. Sometimes you find that you are bleeding while pregnant, the nurses will check you and treat you. They check out blood and if it is low they give us pills that will add more blood in the body

P4: They check if the baby's position good, if the baby is breathing well and there is enough blood in the body.

P5: They test the blood to detect diseases and give us treatment. To check if the mother has enough blood and if not she can be treated or given blood.

Who gives you the support?

P6: All the family members from my side and my husband's side. They ask how I am doing and things are and if I do not have problems. At some point I had threatening miscarriage so they are all concerned about it. Even if I'm far they phone to find out.

All of you are going to talk because the support you get is different.

P7: I am supported by my mother; she does everything for me

P1: I get support from my sister, my sister-in-law and my mother. My husband is not supportive at all. They give me advices, take me to the clinic by car and are always encouraging me that things will be fine.

P2: I'm supported my grandmother, my aunt and my husband. They buy me food that I like including fruits. They advice me to eat properly.

P3: I'm supported by my mother, sister in law. My husband supports me verbally but not financially. They give me advices and money to come to the clinic. My husband says he will support me financially when the baby is born as for now, my parents should take responsibility.

P4: I'm supported by my grandmother. My mother would also ask me if I started to attend ANC. My mother cooks me "morogo" (relish) and my husband always brings something nice to eat from the shopping centre like bananas and apples.

P5: I'm supported by my sister, my mother and my mother in law. My mother gives me advices related to the pregnancy and my sister and my mother in law gives me money for transport to come to the clinic.

P6: My mother shares her experience of pregnancy to encourage me and supported me when I was threatening to miscourage.

What could be the barriers preventing some pregnant women from attending ANC?

P1: Those who do not attend ANC are just Ignorant which is a major problem. They tell themselves that they will start late at 8 months. They need to do blood tests and it will be late by that time. At times you find that your partner is not supporting you and wants an abortion so that makes it a problem because you want to keep the pregnancy. And when you go home he calls you back but fails to accept the pregnancy. It becomes very hard when you are in that situation and you are married, you have to live with stress but it eventually passes.

P 3: Some people do not want to take pills from the clinic because of their beliefs in myths.

P5: Having financial problems at home. If there is lack of support therefore there will not attend. Some are lazy and have to travel the long distance mean while they will still take a lot of time at the clinic.

P2: If you do not have support, you may not want to come for ANC. The long waiting time is also a problem. You have to wait for a long time and get hungry whilst waiting.

P4: The way the staff is treating pregnant women is sometimes bad, if it is bad then they will decide never to come back to the clinic. Always concentrate on what you are there for and ignore being ill-treated badly.

Based on what was said, how can we address the barriers?

P3: Set dates for those who are far and get mobile out to teach them and give them the services needed. This will help those who may not have money to go to the clinic.

P4: Sometimes when you start they want you to come to the clinic and you can make follow up visits at the mobile clinic. The problem with mobile clinics is that they do not palpate you. They just take history which is not good because a lot can be missed. They check BP, test urine then go and collect treatment. That is the reason we are avoiding mobile clinics and come to the fixed clinics because we are not well examined. What they are doing in mobiles is wrong. They do not even listen to the heart of the baby. When they give you pills what are they for because listening to the baby's heart is important? A mobile clinic should have all the necessary services that people need otherwise they are useless.

How do we address the issue of ignorance?

P1: If they don't want, there is nothing you can do. My cousin sister was pregnant but did not share with any one about her pregnancy. She started attending ANC late and delivered a baby who later died. How could you have helped such a person because she is the cause of her problem? To be able to help people to understand the importance of attending ANC, pamphlets can be made and distributed all over so that people can read and know the information.

P4: If there can be a campaign where there are people who go from house to house talking to individuals in privacy so that even those who hide their pregnancy are accommodated. It can be help.

P4: Dealing with the attitude of nurses is not easy. There are suggestion boxes that are there but they are not helpful. It would be better if there was an SMS number where we can send the complaints.

P7: The attitude of the nurses towards the clients must change and they must be able to communicate with each other well. They should talk to them in a good way.

P5: Time management by the nurses is not efficient and they use it irresponsibly. Tea time is extended instead of attending patients. The tea time is not used for tea anymore but it is time for conversations. The staff should not all go together out during lunch and tea time.

P1: We need SMS number and if there was a face book page where you can write back to the department. We need numbers where we can send complaints about the staff because the suggestion box is irrelevant, it doesn't work.

DOH does have a face book page, just use it.

How can the community be involved in promoting ANC?

P3: In the community in the rural areas for example, to give reminders in every meeting that are being held every week remind expectant mothers about going the clinic and even at schools. They can use any meeting that happens in the community. They can also use schools by sending kids home with the message they have to deliver at home.

P4: Having campaigns every month is the best way so that the message can get across. At the end of each month there are so many people at the shopping complex. That opportunity can be used to spread the information.

P3: In churches there should always be some announcements during church services to remind people. Posters should be placed out there in the public with the messages encouraging people to attend ANC.

P1: In schools, teachers must support and give advices and remind the pregnant students to go to the clinic for ANC. Conduct campaigns in school so that pregnant students are not afraid of going to the clinic.

P6: The media can get the messages out to encourage women to attend ANC. Also develop pamphlets with the information and distribute them out in the community. Conduct campaigns to raise awareness and also go door to door providing the information

so they can get the help they need. With this information pregnant women can be able to attend the ANC regularly.

We have come to the end of the interview. Thank you for your time and your participation.

DATE: 20 JANUARY 2014

DATA SET C: "CC" CHC [Group 1: Pregnant women]

GROUP 1: PW (1) FDG 6

Why do you come for ANC?

P1: It is because we want to know our health and the position of the baby inside the womb. They will be able to detect diseases that can affect us and treat us on time.

P2: To know your HIV status and get treatment on time if needs be to prevent mother to child transmission.

P3: I do not have anything to say.

P4: They have already said what I wanted to say.

Any one to add?

P1: To know when you are going to give birth you get to know what to bring with you to the hospital when it is time to give birth. These are things like sanitary pads, baby's clothes and your cosmetics.

P2: To know if you have enough blood in your system to determine if it is going to be enough when you give birth. If not, they will give you pills so that you can have enough blood to avoid the risk of dying.

P5: They educate us on how to behave during pregnancy.

P6: they teach us and encouraged us use protection in case you tested positive when having sex to prevent infecting the child.

P7: We come here to get help and to see the position of the baby inside. To also check if I will deliver in a normal way. They also check if the baby's heart is beating well.

Who provides you with support to ensure that you attend ANC, who encourages you?

P1: I live with my sister and she is the one who encourages me to come for ANC, advice her and tell her the risks of not going to the clinic.

P2: You have to do it yourself; if you do not go you will not get the required care.

P3: My grandmother supports me and my mother is the one who said I should start going to the clinic.

P4: My mother is the one who encouraged me to come to the clinic. She was saying that I should come so that things will be easy for me like checking if I have diseases that can affect the baby.

P5: They tell me that I should always be happy so that the baby is not affected. My mother supports me.

P6: My parents give encouragement because sometimes as a young person you do not even know that you are pregnant.

P7: I'm helped by my sister. It has to be your own personal responsibility to find out on time how the baby is and how the mother is as well.

P4: Sister-in-laws also support with encouraging words and advices. They tell you to save money when you get it so that when you are craving for something you are able to get it yourself.

Some other pregnant women do not attend ANC, what could the barriers preventing them from attending ANC?

P2: They fear of the knowing their HIV status especially testing positive. They do not find it easy.

P1: Some have financial problems. I use two taxis when I come here and if I did not have money it would be difficult to come. The clinic might be far and sometimes there is no money for taxi fare.

P4: Fear of other people that they were not expecting you to be pregnant. It can happen to both young and old.

P3: People feel pressurized because Testing for HIV is mandatory by the department, as there is no choice but forced to test, they feel that they are put under pressure and choose not to go to the clinic.

Do you think the department is not doing any good by forcing people to test?

P3: It is good because they are looking at reducing HIV infection and protecting the baby but it did not look into the individual herself, how she feels about the whole thing.

P5: They are afraid of being tested. Some do not accept the pregnancy and might not even have the support or encouraged to go to the clinic.

P7: The way the clinic staff treats the HIV positive expecting mothers is very harsh, so they run away.

How can the barriers be addressed?

P3: To have transport from the government for expectant mothers so that they are able to go to the clinics as they do not have money.

P4: They should also provide mobile clinics in areas where there are no clinics so that the services are closer to the people.

P2: The young people should prevent falling pregnant by preventing pregnancy.

P1: Parents should sit down with your children that if you have sex, you will fall pregnant, but there are family planning services available that can be used to prevent unwanted pregnancy. They should talk to them so that they are able to make informed choices.

P5: Projects should be started that will work with the department of education and the department of health to educate young people about teenage pregnancy, how to abstain and the availability of prevention methods. They should know that they can prevent pregnancy at some point but not other STI infections and HIV. They should focus on their studies and abstain.

P3: The department of education and the department of health should unite and work together in conducting campaigns on teenage pregnancy and the importance of attending ANC.

P7: Nurses should have time for their clients. The staff should give assistance even in their private capacity when they are off duty. They must not always be in a hurry to address your concerns. Nurses should give information to all clients in a good way but not according to their HIV status and not treat them as animals. Nurses miss a lot of opportunities to advice clients when they are being examined. Sometimes people come to the clinic and go back home with their challenges not being addressed by the health workers especially those who are HIV positive.

P7: A good example is that this morning an announcement was made that the person who was doing CTOP services has surrendered but we should not ask any other thing related to CTOP services. If there is someone who came for that reason what does that mean to her? Where should people go? It would be better if they were saying that such services are no longer available but this is what you should do or where you should go. This is what makes people to end up doing back street abortion because health workers are not helping them.

How can the community be involved in promoting ANC?

P2: Home Base Carers can manage to help and encourage pregnant women to attend ANC when they visit their homes for those who do not attend ANC.

Do you think the church or civic members have a role to play in this? …"Silence".....

P3: The community should be gathered in the form of meetings and teach them on the importance of attending ANC by pregnant women. The parents will then teach their

children at home. The nurses must teach the HBCs on the importance of attending ANC who will go door to door in the community and share the information.

Any last words?..... If there is nothing more I would like to take this opportunity to thank you for your time and contributions.

DATE: 14/01/14

GROUP 3: AM (1)

In your opinion what is it that makes women not attend ANC

R: Women do come for ANC but come late. Some do not like to travel and some do not have taxi fare. Some are ignorant; they do not see the reason why they should come if they do not have a problem. At times they feel that they are kept for too long at the clinic and sometimes will say they decided to go to another clinic. They are scared of the nurses who scold them, they are not well received. Nurses have negative attitude towards them. Some say they were not aware that they are pregnant hence they come to the clinic late.

Any other thing?

R: Having unplanned pregnancy because they do not like the baby. Some women just come late to come and get the SASSA book for the child grant. Some women changes clinics after testing HIV positive because they are in denial and that delays initiation of the treatment. They need to be taught and helped to accept their status. Poverty because there is no money for transport or is working in the farms. Lack of education makes it difficult to understand things, so it is ignorance.

What can be done to address these challenges?

R: Nurses need to improve the nurse-patient relationship. They must improve their attitude. We need to educate the community on encouraging family members who are pregnant to go to the clinic. Ask parents to encourage their pregnant children to go for ANC. If we can have more staff (midwives) patients can be seen on time so that they are able to go home early. If we can have access to media where they can be taught about the importance of ANC, it can be helpful

What are the challenges do you experience in the facility?

R: Late booking at 36 weeks where the woman test HIV positive, it is already late to start her on treatment and the baby is at risk. Seeing patients who get home late is a risk for their lives because they are not safe. This can be addressed by having more midwives so that they are seen on time. Nurses attitude need to improve so that patients are not scared to attend ANC in their nearest clinics. Shortage of staff making patients to go home late.

How many deliveries do you have?

R: We have about one delivery in a while. Sometimes we do not have any delivery in a month. Patients coming late for ANC e.g. at 37weeks and has syphilis, she may deliver before the woman is fully treated. The same applies to those who test HIV positive because it is late to prevent mother to child transmission.

Do you think the community has a role to play in promoting ANC attendance?

R: Yes, they have a role; they need to understand the importance of attending ANC early. Members of the families should encourage each other including their neighbours to attend ANC. We should teach each other in our community groups like “societies”. As a nurse we can have topics that we can teach there. As nurses we should do that in our different areas when we are around the people that we know. If one of the staff can go to the media like Bushbuckridge or Legwalagwala and have a 30 minutes talk on health promotion in general to educate the community.

What about using schools?

R: The governance structures can be used and work with other departments and stake holders like the chief,” induna” to conduct outreach programmes for the community. The church can be used to share information before the service starts while seated. This is because in her church (ZCC) women are not allowed to talk in the congregation, only men are allowed to do.

How does the governance structure work in the facility?

R: They are involved in resolving the problems that the clinic is encountering. They have regular meetings but not sure how often they meet. They also come to find out in the clinic how things are going. If the community has complaints, they help to resolve them and the community knows them very well.

Anything that you know as a benefit to have the governance structure?

R: They are good because they know and understand the community they serve very well.

Anything you would like to say?

R: If nurses can have good nurse-patient relationship so that people are not afraid to use our clinics. If midwives can be given refresher courses every now and then concerning a woman and the baby to keep them updated to reduce maternal deaths.

If there is no any other information, thank you.

GROUP 3: MW (1) FDG 2

My first question to you is why are pregnant women not attending ANC as they should?

R: They are afraid that they will be tested for HIV and fear for testing for being positive. There are also myths that if people know that you pregnant, they will kill the baby. So some people do not want other people to know that they are pregnant because they want to save their babies.

Any other thing? What about family circumstances?

R: Yes, there could be financial reasons like lack of money for transport in the family. You may find that others have a responsibility of taking care of other young children and the elderly at home. They cannot leave them alone and therefore cannot go to the clinic.

From what you said, how can these barriers be addressed?

R: There people who are out working there in the community like NGOs and home based care, they can help when doing the door to door visit and educate the community on the importance of attending ANC. Every day at the clinic there should be a period where pregnant women are taught about the importance of ANC. For those who cannot reach the clinic because they do not have money for transport there could be mobile clinics and can have particular stations in all villages where they can perform the ANC. At the moment the mobile see patients in the car. They need to have proper houses where they can examine women properly because they do not get full examination because there is no privacy.

How do you think that the HBC can do it?

R: The HBCs should also be trained on the importance of attending ANC so they can teach the community. Regarding the issue of fear from testing they should be encouraged to test. There should be no fear on testing for HIV as knowing your status would help in the baby's growth and health. They should be made aware of the importance and benefits for testing like PMTCT.

What do you think the role of men is regarding promoting ANC?

R: Men are heads of families and they should be involved if a woman is pregnant. Although traditionally men are not involved, he should be part of the HIV testing and encouraging the woman to attend ANC. If the men are informed about this early they should actively take part in the pregnancy by taking a first step himself to take his partner to the clinic.

R: If the woman does not disclose that she is pregnant, she may not get the support that she needs because they do not know. It is not a bad idea to inform the members of the family as long as it is not known to the people outside the family. The family and other members of the family should encourage expectant mothers to go to the clinic.

How else should men support their pregnant wives?

R: To support them financially and by thought from the partner is important so that the women cannot be lazy to get another child. Late appointments make the work of the nurses to be hard as they do not have any details on that particular patient, so men should be there to provide the information.

What are the challenges you are experiencing in the facility?

R: Late bookings by pregnant women which makes treatment to be delayed e.g. for PMTCT. Some will be coming late in labour meanwhile they know that they delivered by operation previously and that makes them to complicate because we do not always have ambulanced to transfer them to the hospital. They will give excuses like “I was treated traditionally that I will deliver normal this time” Some come late meanwhile they have diabetes or hypertension which is a problem.

“interruption”

R: We also have a problem of lack of equipment and instruments. We do not have enough midwives and therefore cannot give the post deliveries the care that they need because we have to rush and see other patients. The lack of beds makes it almost impossible to make deliveries. Sheets are also not available; nothing (clothes and blankets) is available for new-borns. We use curtains for sheets. We have no dresses for women or clothes for the baby. There is no kitchen therefore there is no food for the patients who delivered. Food has to be brought by relatives from home, it does not matter how far you are coming from. There is a shortage of staff and there is a lot of work to be done and that makes the service slow and unsatisfactory. We may look more but the sections are many and the services that we provide are many. You find yourself working in many sections being alone. Sometimes you find that you see about one hundred and sixty something chronic patients in a day.

R: We also have problems where we have patients who are not attending ANC in this clinic but come here for delivery. You find that there are gaps of information which is important like blood results. At the end they are not managed well as they were supposed to. We also have overcrowding with ANC patients who leave their closest clinics and come here mean while we are short staffed.

How do you think community can be involved in promoting ANC?

R: Awareness campaigns can be done. Nurses should talk to the community leaders and ask to be included in their meetings to share that information can be given at a larger scale. The clinics should continue teaching every morning. Sometimes pregnant women come late and find that they have already given health education which is a missed opportunity. The use of media that will be able to reach the community at a larger scale could be used to educate the community. This can be planned with the governance structures so that we get slots in the community radio station.

Any other thing that you can think of?

R: We also have Home Base carers who start here at the clinic before they go out to the community. We can teach them on the messages that they should give to the community as we use them in all other health campaigns that we have. All we need to do is to educate them and they will do the work. They should work with the clinic to reach the community at a larger scale.

You said you have a governance structure here at the clinic, what is their role?

R: They have meetings with the senior personnel once a month. They deal with the communities' complaints related to the clinic. If the community has experienced problems at the clinic they address them as they deal with the issues in the clinic and the community. They are the communication channel between the clinic and the community. It helps when the clinic has a problem they can tell them and the matter can be dealt with.

There is also a suggestion box that they take care of. They open it and deal with the complaints that are raised including the compliments that comes from the community.

R: The clinic was old and needed renovation and they assisted to tell the community that they cannot access all the normal services but should use the other facilities until the renovations are completed. They would make such announcements in all community meetings including the funerals.

How helpful is the clinic committee?

R: They helped us to address the lack of water problems in the clinic when made it difficult for us to work. They raised the issue to the Councillor who helped to address it. They help a lot because when we do wrong to the community they intervene and if we have problems with the community they assist. They act as mediators.
Is there any other thing you would like to add?

Any last words?

R: Nothing more.

GROUP 3: STUDENT MW (2)

Why are some pregnant women not attending ANC?

R: I can say it is because of lack of information in understanding why it is important to attend ANC. Some are following the church's rules which forbid them to go the clinic for ANC and even during delivery. They are expected to deliver at the church.

Is it a common practice in this area? Do they have midwives there?

R: No

What about young girls?

R: Young expecting mothers are afraid of going to the clinic because at home they do not see that she is pregnant. They are hiding the pregnancy from family because they fear that that the parents will know that they pregnant.

Are there any family circumstances you can think of or cultural issues?

R: No. I don't think things like distance and lack of money is a problem because there are clinics all over and where they are not, there are mobile clinics. Some do not have a reason not to come for ANC.

How many deliveries do you have per month?

R: I don't know because I'm new here for two weeks only. I have been working at the hospital.

What can be done to address the identified challenges?

R: To educate the churches so that they spread the message and at home, educate parents so that they are able to detect if the child is pregnant and advice them to go for ANC. The churches need to be taught on the importance of ANC so that they can understand the need to attend ANC and not advice people to pray only. The Department of Health (midwives) should educate the Caregivers (Home Based) who go door to door to give out the information to the community. "Imbizos" (gathering called by traditional leader) should be arranged to educate the community at a larger scale that door to door. The" imbizo" is a platform to address the community by the services providers from health.

What challenges are you experiencing in the facility related to rendering ANC services?

R: We have shortage of equipment such as ECG machine to detect any abnormalities. There is also shortage of midwives with a lot of enrolled nurses. We seem to be many but 10 are student midwives.

How can the community be involved in promoting ANC? Does it have a role?

R: Yes, the community has a role because they can ask at a community level if an expectant mother is attending ANC and if not, advice them to go. The clinic committees and health caregivers should educate the community at “Imbizos” . The nurses can be invited to come and give information as long as it does not disrupt the number of staff remaining at the clinic.

How does the governance structure work, what is their role?

R: The clinic committee is the communication channel between the clinic and community and they address problems that arise between the two. They deal with the conflict between the nurses and the community. They assist in address patients’ complaints of long waiting time at the clinics. They always have meetings with the facility senior managers.

Any other thing?

R: No

If you do not have more to say, I would like to thank you for your participation.

GROUP 3: MW (3) FDG 4

What are the barriers preventing pregnant women from attending ANC?

R: They fear to do HIV testing because they do not want to know their HIV status as it is mandatory in pregnant women. Poverty, other people do not work and are not financially

stable and it difficult for them to walk. They just come late and attend a few times before they deliver….."phone ringing"….They only come for the ANC booklet to be able to be admitted into the hospital they use it as a passport to go deliver to the hospital. I had one patient who came from the private Doctor and only come for the card so that when she goes for delivery it is not difficult for them. Gender inequality can also be a problem. Some women still need permission from their husbands to come to the clinic. She can only do things if he says she can do and if he refuses she will not go.

How do you think these barriers can be addressed?

R: To address poverty, job creation so that they can be financially stable and curb poverty. To have more clinics so that people are able to access services nearby. Gender equality, the males should be educated that ANC is important. The care workers can also assist by providing information. The health workers should teach the care workers who in turn will educate the community just like they did with TB, HIV and AIDS education. They will be taught issues related to maternal health and they work under the guidance of health workers.

Any addition?

R: To involve the clinics as well so that they conduct a workshop to the caregivers and they are field workers and can carry the information to the community. To strengthen the education level on HIV and AIDS so that people can be able to act responsibly and go for testing and know their status.

What are the challenges that you are experiencing at the facility?

R: People including pregnant women do not use the clinics in their own areas but flock to only one clinic. As nurses we do not question them but only provide the services as it is their right to make a choice of where to go. At times you find that when you give them a return date for review, they are unable to come due to lack of money for transport.

Any addition?

R: We have a serious problem with lack of equipment. There is no budget leading to shortage of equipment and machines like baby warmers. There is no linen, at the moment we are using curtains as sheet. I remember one day where I delivered a baby and had to ask the father to give me his jacket to wrap the baby. Some patients have to come with their own linen when they come for delivery. At times there is water shortage which makes it difficult to deliver women. There is also staff shortage although it is not that really bad because at times we have three midwives.

How the community can be involved in promoting ANC? Do you think they have a role?

R: The community should give information amongst themselves. Midwives should go to the community and teach them on the importance of attending ANC. There should be a sister who goes out in a car to go and teach people in the community and make referrals to the facility. There is a need for an ANC outreach programme.

Do you think care givers can have a role?

R: Getting the caregivers to give the community information on the importance of ANC. They can do the same thing that they did with TB and HIV and AIDS. Also teach every department and spread the information. Members of the governance structure can also participate if they are given the necessary information. They can educate the community.

You talked about the governance structure, what is the role of governance structure in the clinic?

R: Their role is to liaise with the community governance structure helps the clinic by giving out information to the community and from the community back to the clinic. They have quarterly meetings and open the suggestion boxes, give a report regarding the feedback on the findings for the institution. It makes it easier for the community and clinic to

communicate. They have powers to call meetings and would be able to give out this information. They are informed about everything that is happening in the clinic like if there is a new staff they have to know him/her and introduce her.

We have come to end of the interview. I would like to thank you for your time and your contributions.

DATE: 17 JANUARY 2014

DATA SET D: "DD" HOSPITAL [Advanced Midwife]

GROUP 3: AM (1)

Why pregnant women are not attending ANC as they should?

R: Some will say that they did not know that they were pregnant. One woman I saw yesterday said she went to three clinics where she was told that she was not pregnant. Some will say they went to the clinic and the clinics were close. And when you dig further and talk to them in a friendly way you will find that they are hiding their HIV status. They do not want to disclose especially to their partners and relatives. Some fear that their husband will leave them because they tested positive. Sometimes they are afraid that if they test in the clinic next to them because the clinic staff might know her or related to her. So they prefer to go and test somewhere far away from the clinic.

R: There is also high rate of teenage pregnancy which makes them to come late. When you check their records you find that they wanted to terminate the pregnancy but it was too late. Some say that they are not treated well by the health workers. They say that midwives are harsh; they are not given proper information. Some say the nurses said they are late and cannot find anyone to help them. If booked for the next day they never return.

R: Lack of money for transport could be a contributory factor although it is self-made because of fearing to test in the nearest facility as I said earlier due to lack of confidentiality because that really lacks at times.

What can be done to address these problems?

R: These women should be taught that their status is kept confidential and they are the people who can disclose the information to who they trust. The clinic staff should also try by all means to keep all confidential information confidential. Give health education regularly so that they can be able to understand that those health workers do not have the right to disclose their status without their concern.

R: Teenagers can be accommodated over the weekend and after school but should be at school during the school hours. I was working in a clinic where I was encouraging them not to come during the week. They need to be given a chance to attend ANC. What is best to educate them that they should not be pregnant? They should also come for family planning services after hours and over the weekend. They should be allowed to come to the clinic during the weekend and during the afternoon after school on Fridays. Nurses should give them a chance and accept them as they are and allow them to come when it is convenient for them.

How do you think you can help others to also implement your idea because other young girls can benefit and other facilities can implement it?

R: I think if it can be taken up with the area supervisors so that it is discussed with senior management at the District, it can be helpful

What are the problems you are experiencing in the facility?

R: Shortage of staff and most clients are not attended well because one person cannot be at two places at once. If we have a patient who is in labour and have to be checked every now and then it becomes a problem because there are still other patients who need to be seen. Sometimes you find that there is no electricity or water and have to refer the patient to the nearest hospital. And that woman needs to be accompanied by a midwife meanwhile we are already short staffed. We also have patients who come in with precipitated labour. There are people who sell drugs like cytotec that induce labour because they want money. These drugs are sold to these pregnant women and these people kill our community as they give unsafe abortion and that can make them or causes death for both child and mother. Babies are killed because of taking medication bought from these people. The life of the pregnant women and the baby is not cared for by these

business people. Women lose their babies because of these people. Some are given traditional medicines by the family members, which precipitate labour.

R: Another challenge is the pregnant teenagers do not come to the hospital and problems are identified late. After that the lost their babies and the staff get blamed. Clients come late for their ANC and if they came earlier it would help. The young girls do not report if they have bleeding before delivery. They should be made aware of the dangers of not coming to the hospital on time. The structure of the maternity is not that well structured, there is no admission nor progressing rooms. The ANC patients are far from the maternity ward which makes close monitoring of these patients a problem.

How can these challenges that you have raised be addressed?

R: Women are educated on the dangers of inducing labour and buying those drugs. Health education on the importance of attending ANC should continue to be done.

How are you addressing the challenge of the drugs that are sold in the streets?

R: Senior management of the hospital has been informed about the problem. Visit those business people who sell the induction drugs and give them health education because what they are giving to these pregnant women harms them. Shortage of equipment is also a problem.

Do you think the community can be involved in promoting ANC?

R: The community should receive information maybe in a form of road shows that will tell the community about all the issues that are of concern. Tell the community about the dangers of taking these drugs they are buying in the streets including the traditional medicine. Talk to young girls and children before about teenage pregnancy and make sure they have information. Advice women not to go to those business people who sell drugs to induce labour because it causes huge problems. Community leaders, clinic committees should also be involved in making people aware about the importance of ANC and the dangers of taking drugs. Information should be given in churches during the women's meetings and church services. Everybody should be asked to take the message home.

You were talking about the clinic committees, do you have a Governance structure in your hospital and what is their role?

R: They are there but I'm not sure how they function. What I understand is that the governance structure is the communication channel between the community and the hospital, if the governance structure has knowledge about the problems experienced they resolve them. At the moment there is nothing that has been done that I know of as I do not have a lot of information about the structure. I also know that from their resolutions taken at some point there was a contract that came to the hospital and did tree felling because the trees had overgrown and the Doctors felt that they were no longer safe.

Any last words?

R: Just to add that some of the antenatal patients come to the clinic late. You find that they end up complicating because a lot of opportunity was missed. Conditions that were supposed to be treated were missed meanwhile they were supposed to have been prevented.

If there is nothing more, I would like to thank you for your time and participation

DATE: 18 FEBRUARY 2014

DATA SET E: "EE" HOSPITAL [Advanced Midwife]

GROUP 3: AM (1) FDG 6

Why women are not attending ANC?

R: There are those who are giving reasons that they are working and do not have chance to attend. Some are lazy. Lack of information, although they are always given information that early booking is necessary.

What makes you think that everybody has information?

R: It is because we are teaching. We are doing awareness in the ANC. We had one awareness campaign, which we took it to the streets but I think it was in “pause”2012 to give them information about the importance of early booking, prevention of maternal deaths and all this.

According to your assessment, what effect did it have?

R: Ya! It was effective because we were also discouraging them about the use of “Isihlambezo” (name of traditional mixture) and it was less for a certain period. It’s a substance that they take to make labour shortened. That’s what they are saying. At our place they will also tell you that they have taken “metsi ea morapelo” (water prayed for) from ZCC. Others it’s just certain roots that are given for them to drink when they are term and it is administered orally. They are told that they will help them to have shortened labour. Mm! I think they mix it with liquid because when we get it in their cold drink when they are admitted, you find that the substance is sinking at the bottom of the cold drink bottle.

Any other thing that you can think of? What makes them not to come to ANC?

R: “Mm”, this can be just a speculation because I have never heard them saying that. The long queues are making them to be discouraged to come to the hospital because people want to be attended to and they go home. So because of the shortage of staff, they stay for a long time. It makes them stay for a long time. Like in this hospital, they stay there, you will find that a nurse, the midwife has identified a problem and the patient, the client needs to be seen by the Doctor. The Doctor is busy and the client is sent home and requested to come back again the following day. The following day she comes back and cannot see a Doctor again. That makes them to be discouraged. Others decide not to come back even if their problems are not attended and others hate the long queues because at the moment we have only two midwives at ANC. Right now as I’m speaking there is only one midwife in ANC.

What are the reasons for not seeing a Doctor on the second day after they were told to come back?

R: The Doctor is nowhere to be found?

Nowhere to be found? Not that he is busy somewhere?

“Laugh” You may found that he is busy or you look for him and he is nowhere to be found until the client goes home.

Any other thing?

R: I think that’s all.

Comment: Feel free to always go back to the previously asked questions in case you remember something that you can add……What do you think can be done to address these challenges that you have raised?

R: With shortage of staff, we need additional staff. Because if they are 2 and they see more than 50 clients, even if they are seen, it is easy to miss some problems because they are rushing to finish so we need additional midwives to be able attend the clients well, of which I do not know where they will be coming from. But there is a dire need. About the Doctors also, there is a need for more Doctors because when they are 2 and they have to mend all the maternity units and there is also the high risk clinic is also a problem. Sometimes we can blame them but you find that they are tired. Like on Tuesdays you find that they have been in theatre doing elective c/sections, they did not eat and at 4pm when he comes out of theatre you call him to see a high risk patient and he becomes furious. I think it works well if there are 3 Obstetric Drs in the whole unit because they share the work. We only have 2 Doctors at the moment

With regards to shortage of midwives, is it that they are not there at the hospital or it is that they are there but working outside maternity and working as General Nurses? Or is it a general shortage of midwives. What is it exactly?

R: By right, although I’m not going to be accurate because in answering this because I do not know the number of midwives in the hospital. “Mm” The hospital has generally shortage of midwives. Looking at the number allocated at maternity, it seems as if there is a high number of staff mean while there are many units inside the maternity which need

to have midwives both day and night for labour ward, antenatal and postnatal wards. There is a need to get more staff to avoid long queues may be they will participate or book on time or attend ANC and not worried about that.

R: The clinics also need to work by providing ANC services to reduce the work load to the hospital ANC. Pregnant women are not using all the available resources out there as we expect them to use. You find that there is a person who is coming from the community where there is a clinic come straight to the hospital, not using that clinic in their area and do not understand the reasons why they are coming to the hospital instead of going to the PHC clinic in their area. If all of them were using their local clinics, I don't think that there will be overload in the hospital. The hospital has no Gateway clinic or antenatal clinic which is the responsibility of PHC. The midwives who are manning ANC were supposed to be working in maternity ward. It reduces the number of midwives in maternity because they are responsible for ANC which is the responsibility of PHC.

R: There is a need to strengthen community awareness on the importance of attending ANC to strengthen the issue of lack of information. And this thing of laziness, like I mentioned that some hate this thing of long queues, it goes back to the issue of need of more staff. May be they will participate or book on time or attend ANC and not worried about that.

What other challenges you are experiencing in rendering ANC? Already you have mentioned that there are those who are not attending ANC?

R: High risk patients not seen on time. During the period of going home and back without being seen by the Dr these women are busy complicating. Sometimes a high risk client was referred from ANC a week ago and only seen the following week. Some high risk patients are referred late from ANC. Some midwives do not see e.g. anaemia as a problem and refer them late. When patients are referred to the clinic very late like at 8months, it is not easy to treat it. Some midwives are just ignorant or they just don't know how to manage these patients well. You find that that the nurses are able to transfer a hypertensive patient with an elevated BP of 180 /110 and she is asked to get into a taxi alone without calling an ambulance. That is also a challenge because she may have

eclamptic fits in the taxi. But with this we have been trying to resolve them directly with the clinics where these patients are coming from.

How are you addressing the challenge?

R: Nurses are told in peri-natal meetings not to send such patients with public transport. They need to call an ambulance if the BP is elevated. The nurse should also accompany the patient. The nurses/midwives are saying that if they accompany the patient, after dropping the patient, the ambulance does not go back to the clinic to drop them.

Any other challenge?

R: Another challenge is that EMS personnel were not taking the patients to the relevant referral hospital. A patient is supposed to go to Mapulaneng Hospital, is taken to Tintswalo Hospital. We have a high number of patients who are wrongly referred. More patients come from Thulamahashe CHC and were supposed to go to Mapulaneng Hospital. When investigating it was identified that when they go to Mapulaneng, the EMS people are not allowed to just drop the patient and go. They have to get a file for the patient before they leave otherwise they can't leave a patient without a file even if it is during the night. So they prefer to come here because they just dump the patient and leave which makes things easy for them. The person in charge of EMS was called to a meeting to address the challenge.

Anything else?

R: Also have lack of equipment it as a main problem. If equipment is ordered, it takes a long time without getting it.

" noise interruption"

Other than what you mentioned like the resting place, equipment, patient' problems? Any other thing?

R: Nurses working maternity lack space where they can rest during lunch which is demoralizing. During lunch you find that nurses just linger not knowing where to go to for rest or to eat their food meanwhile they are expected to go back and continue to work

after lunch mean while they did not rest. So they just eat on the corridors because there is no conducive space for them to sit and rest. You just eat in front of the patients in the wards. Sometimes they just use the ward board room which is not the right place to use. There are neither sofas nor chairs to sit on.

R: Staffs like those who have done advanced midwifery are not cared for. They are not getting any incentives. They use their own financial resources (all tuition and accommodation) to train for the course went to school to attend the course without any assistance from government and when they come back they do not get any recognition in terms of incentives for their specialization. People get de-motivated and others get discouraged to go and specialize in advanced midwifery. It is said that they will only be recognized 10 years after they are qualified. No cash bonus, nothing and that is too long.

Do you have a governance structure in your facility and how does it work?

R: Partially I know that when they come to the hospital they look at the problems we are encountering. If there are people from outside (community) they bring them in so that they resolve them.

You don't have much information? You do not know how the function

R: No, I do not have full information as to what they are doing. When they come to the hospital they look at the problems that are encountered in the facility and assist with resolving them. If there are people from community who brings complaints, they are brought in resolve them. What I can say also is that the current board members cannot manage because the whole thing is highly politicized. The previous committee would assist with resolving problems. Those ones knew things and were well conversant with things but the current one don't seem to know much and lacks professional people. The previous ones had professionals and when they talk about issues they were wide in their thinking and were well conversant with issues.

What about their role related to promoting ANC?

R: Related to the topic we are discussing about encouraging pregnant women to attend ANC, how can the governance structure be reached because there is no direct contact

with them. It has to go through the expected channels of communication like through the supervisor who makes her own decision as to what needs to go up. Even if there are a serious issue that needs to be taken up to management and is raised with her, she gives answers and it ends there and there within the four walls. Nothing is taken up. There are so many issues that were supposed to be taken up but they don't even leave the room where they are discussed or the unit. Even if you feel that there are things that need to be changed she gives you responses even if you were not expecting her to respond but take it up for further discussion with senior management. As long as there is still the issue of "this was raised by so and so and it will not be taken up" meaning it depends on who raises the issues for it to be heard or taken up which is a problem. If you are undermined, your issues are not getting attention even if they concern patients. Nothing will be done. The situation will stay like that for years and years and will not be resolved.

Do you think the community has a role in encouraging pregnant women to attend ANC and what would be the role?

R: If we had elders who are women, in the community who are willing to support any pregnant woman, even if they do not belong to their families. Not that they will have a daily attendance register or have to meet somewhere daily but for instance in a family where there are no parents and next to them there is an elder. That elder would take responsibility of checking her if she is booked, when she is going for ANC. She would also find out how things going and may be give her support it would help. Some women come to the hospital twitching from "eclamptic" fit that was not known just because she was not booked. If there was someone encouraging and support her, which would not happen.

How do you see this implemented?

R: This can be done with if health workers worked in collaboration with these elders who will be clarified on how to go about doing it. The challenge though, could be that these days' people want money and want to be paid so they might expect to be given something. If it was in those olden days, it would work and our culture allowed it because there was that issue of wanting to help. They were doing it without expecting any incentive. It is not

known what can make people to have that “ubuntu” again, being there for another person especially when there is a need. This is done in other countries but cannot remember whether it is Egypt or Bukina Faso where they have dedicated people who volunteer to help pregnant women. That elder will just focus on a particular pregnant woman and say “I will take care of you”. When the pregnant woman craves for something she would bring it for her, whether she wants “morogo” she will cook for her. So if this was feasible it would be helpful. This could be achieved through community participation and raising awareness on the issue.

So how will these elders know that they have to support somebody? Looking at the current situation because she might be there but not aware that she can provide such support? What can be done to make her aware?

R: Yes, it is because they were doing it before. May be with the young generation we have shifted the elders to an extent that they no longer feel accepted. I don’t know but it means that something happened that made them to draw back.

But it is possible that we can bring them back…”laugh”

R: Yes, it is, though it may take long. This can be feasible in our situation because helping each other was done in the past. They need to be made aware by health workers. Only when they are informed by the health workers. The challenge could be that, as young generation we have shifted the elders away to an extent that they no longer feel accepted. It is not known but it means that something happened that made them to draw back.

R: They community leaders should also educate the community on the importance of ANC as they have regular meetings with the community. A lot was achieved with programmes like TB, steps were taken and people are now informed. One can see that people may not be educated but they have information which was achieved through the community leaders in their meetings, as the community has accepted them. Again, if health workers are given a chance to share information in those forums it would be easy because information was spreading in a large number of groups.

And the role of the church?

R: The church can be involved but it is not always the case where one can be given a platform to educate people about this. You will find that when you request a platform where you need to bring health related information, the Pastor will tell you that he will have to take the issue to the committee. They can even give you only one slot a year. If given one chance you cannot manage to cover everything. So in church you can but you may not repeat it.

R: Women's prayer meetings can be used but only few people attend those meetings. Young people who are at child bearing stage are not attending. Only old people attend. But on Sunday the church is full.

R: Health workers can also take part in educating the community although the challenge is that if you are interested you may find that it is difficult to be released from work to go and address them without an invitation and you cannot be released. In this case the community will not know that they need information from you as they do not see the problem as you are the one who identified a need. Managers in the facility will still expect a letter or an invitation.

R: Another thing that can be a problem is that it may end up being "your problem" as the one who identified it. If initiated, it may end up being my "thing" because other midwives don't care because they are demotivated and have low morale. Develop a teaching schedule in the unit, they do not participate it just become your "thing".

We have come to the end of the interview. Thank you for your participation.

GROUP 3: AM (1) FDG 7

What are the barriers preventing pregnant women from attending ANC?

R: They fear to test for HIV because they are afraid to know their HIV status. Some lack information on the importance of ANC. Some work in places where there are no clinics like in Kruger National Park and therefore come to book very late.

Based on what you said how we can address the barriers

R: As health workers we should give information on the importance of attending ANC to all those who come to the clinics on daily basis. For those who do not have clinics in their areas there should be mobile clinics going to those lodges to provide services. We have to give people information on the importance of testing for HIV as it benefits both the baby and the mother's health in order to reduce the mother to child transmission.

What are the challenges you are experiencing at the facility?

R: Shortage of staff is a problem although according to the statistics there is no shortage of staff. There is a lot of work to be done but the staff is not enough while have about 20 deliveries per month in the facility and late booking by pregnant women is a major problem. Sometimes if a client has tested positive, it can take up to an hour to see them because you have to do basic ante natal care and PMTCT which takes a long time. Lack of equipment is a problem. There is no foetal duplex or sonar machine. The sonar machine helps to determine the gestation stage of pregnant women. Not all the equipment that are required for delivery are available. Midwives just improvise as they do not have the full package required like bowl, forceps to deliver the service that is needed. Sometimes some of the clients complain as they do not get everything they need, they are not satisfied and sometimes even complicate. We also do not have RPR strips and we have to send the samples to Matikwana Hospital and wait for the results which are a problem.

Any complaints about nurses' attitude?

R: Sometimes patients complain about the nurses' attitude as we are different. There are complaints but we also get a lot of compliments from the suggestion box and verbally

How can the community be involved in promoting ANC?

R: The community must get the information from the nurses who should encourage people to go for ANC. We need to involve other structures that exist in the community to

reinforce the importance of attending ANC by pregnant women in their different meetings in the community. The church can spread this information in churches and also “sangomas” can do the same in their respective structures where they meet. When the “Indunas” and chiefs have their "imbizos”, they should give the information to the community on the importance of attending ANC. The community leadership is already assisting to spread health messages out in the community because the “induna “is a member of the health committee.

R: The clinic staff should give out this information to everyone who comes to the clinic so that they get to know the importance of attending ANC. Through the governance structure there is a health worker in all the “imbizos” and that makes it easier and ensures that the information we want to send to the community is spread; it is used as a platform to disseminate information. So the importance of attending ANC will be given to the community by the health worker in this manner.

You have already mentioned the availability of governance structure in the facility. What is their role?

R: The governance structure meets at the clinic regularly. They come and check how we are rendering the services. It is the communication channel between the community and clinic. They take information from the community to the clinic and vice versa. They also report any inquiries or challenges experienced by the community to the facility. They also assist with addressing the identified challenges in the facility like the equipment that we need. Now we have security fence because they put their feet down and fought that we get the fence. Now we are waiting for apollo light so that we can have adequate lighting in the facility. When there are “imbizos” they take the information that we want the community to know out there and bring back the information that the community wants us to know. At times they invite a nurse to those meetings for her to go and address the community on health issues or to just go and listen what the community is saying.

Any last words?

R: I’m happy that you are doing this research. I once did a research on the role of men when a woman is pregnant because it seems as if it is the responsibility of the grand-

mothers. We would like to see men participating and help their women during pregnancy through delivery to relieve them from stress.

How do you think men should support their pregnant woman? What is their role?

R: A man must support the woman. Everything should be done together; a man should come with her partner when she starts to come for ANC from day one. They should be involved when doing PMTCT. They need to support their partners during labour delivery and after delivery. If a child cries at night, a man should take part in taking care of the baby. At times the pregnant women do not take treatment after they had come to the clinic so they should encourage them to take their treatment. Some mothers bring babies weeks or 6months after birth and when they are tested these babies are HIV positive. So the partners are the ones to encourage them to bring these babies to the clinic on time.

If there is nothing more, I would like to thank you for your time and contributions.

DATE: 21 JANUARY 2014

DATA SET F: "FF" HOSPITAL

GROUP 3: M (1)

My first question to you is in your opinion what are the barriers preventing pregnant women from attending ANC?

R: Some women say that they are afraid to come because for instance, it is the seventh pregnancy and nurses do not like women who had many pregnancies. They hide the number of pregnancies they had and never tell the truth. It seems as if what we like as nurses over- ride the women's choices. Women cannot make their own choices on the number of children they want to have because they fear nurses.

What exactly makes these women to be afraid?

R: The responses that we give e.g. if you ask how many children does she have and she tells you that she has 7. Your response will be “Haaa!! So many children? What do you want to do with so many kids?” So the way we respond we give to these women reflects a bad attitude of nurses and women do not like that. Instead we should try to accept and embrace their situation, try to find out what the problem is and take it from there in the form of providing support and advice them accordingly but not make negative comments.

R: Other women would just say” I wanted to attend but……”. It seems as if they do not understand the importance of attending ANC. We should use a simple language that these women understand not a very high language. We can also educate them on the radio where we can have slots and talk about the importance of attending ANC.

R: Some will tell you that they are sick and cannot manage to attend ANC. The importance of ANC is not well understood. This should be taught everywhere, in the churches so that women understand it. Pastors should include it in their services because our women die of lack of knowledge. Some are afraid of testing for HIV and also for disclosing their HIV positive status; hence they do not want to go for ANC.

Based on the reasons you have mentioned that are barriers for pregnant to attend ANC, how can they be addressed?

R: I have already said that pregnant women should be taught the importance of attending ANC in simple and understandable language starting from their first visit and this should also be taught through media (radio) and in churches.

R: We as health workers should give information e.g. on choice on termination of pregnancy (CTOP) and let the woman decide based on her beliefs, norms and values without judging her. If her choice is to keep the pregnancy she should be advised accordingly e.g. tubaligation, contraceptives to avoid future unwanted pregnancy including options like adoption and availability of social grant. The procedures should be thoroughly explained to the women that e.g. tubaligation does not change you as a

woman. You still have feelings and can still enjoy sex like before but you will not fall pregnant. They have to be aware that prevention is better. All theses should be provided with details of the advantages and disadvantages.

And the issue of the nurse's attitude? How can we address it?

R: I don't know what can be done to these nurses who do not treat patients well. Nurses should learn to understand and accept women as they are and give advice according to their needs. They should put themselves in the women's boots because they are also women. The environment should be conducive for the women to tell the truth during history taking. It is recommended that midwives should take an oath at the completion of their training that will serve women without prejudice and the oath should not be mixed with that of general nurses because the situation in midwifery is different.

R: There are incidences where we have women who are returned from Home affairs when they go for their birth certificates because they had wrong information on their records regarding the number of children they have which was less than what they actually had. They did not tell the truth when they come to the hospital because nurses scold them instead of helping them and advising them. This is because nurses over-ride women's rights meanwhile the number of children is determined by the man and not the woman. We must make them to feel free to tell the truth. So they end up choosing not to come to the health facilities and die at home.

What can be done to resolve this challenge?

R: As I said before, I do not have an answer of what to do but just see that there is a problem. We should just understand as midwives and that they are women. In future there should be an oath for midwives only, not the general one so that they are committed to help pregnant women. This is the reason why ever since I did midwifery in 1982 I have been doing midwifery only although I have done general nursing because I have a passion in midwifery. I have a heart for these women.

Is there anything you are doing in your unit to address the challenge?

R: I want all women to leave the unit with live babies. If a baby dies in this unit, I will make you feel guilty as a midwife. Midwives who work here know that there is a commission of enquiry they have to go through should you have a baby dies in their care. They are interrogated, made to give an account of what happened and disciplined accordingly to ensure that they do not repeat the same mistakes and do things right. So they know that they have to be very careful because it is not pleasant.

R: The unit had eight (8) breech deliveries that were not diagnosed in the clinics during ANC which is a problem. If a woman comes late and has already advanced in labour, they may end up having prolapsed cord which can complicate and the baby can die. The question is “What are the nurses /midwives doing out there in the clinic that makes them not to detect how these babies are presenting”? It shows that the knowledge and skills of the midwives out there is poor and this need to be addressed by re-assessing the curriculum used or if the practice on midwifery is not adequate during training.

What are the problems that you are experiencing in the facility?

R: Women coming late to the hospital late and sometimes they end up complicating as I said before. The lack of ANC services in the hospital is also a problem as it is a District Hospital and a Public Private Partnership effort with Netcare and the policies applied are different from the public hospitals. I wanted to introduce antenatal care classes here at the hospital but because of the way the hospital is operating, it was not accepted. Misdiagnosis of pregnant women in the clinics is also a challenge. I think that the supermarket approach is a problem because the nurses see different patients like ANC now, next is the TB patient, next a chronic patient and they cannot concentrate on one thing. Their minds are just floating. So I just think that could be the problem.

R: Some patients are not booked and only come when they are in active labour and the midwife does not have time to do all the necessary tests but just deliver the woman which is a problem. Some women come without their blood results collected from the clinics where they attend ANC and this is followed up later after delivery. This is not improving although it is discussed in peri-natal meetings that are held every month.

Any other challenge?

R: The unit is small related to the number of patients who comes in because there are about 16 deliveries a day. The layout of the unit is not suitable for the services provided. Currently have patients who are in labour, high risk, waiting ANC patients in one ward meanwhile there are few beds only. Women coming to the facility are not all referrals as it was supposed to be. They flock to the hospital from all over because the clinics are not operating 24hours and they have nowhere to go. The hospital has 13 clinics that are supposed to refer patients but even those who were supposed to go to the neighbouring hospitals come here for services as they are geographically situated closer to the hospital.

Do you think the community has a role to play related to encourage women to attend ANC?

R: Health workers should empower the community with the knowledge on the importance of attending ANC. The community will spread the message everywhere in the community e.g. in churches, stokvels, societies where people meet. Slots for health education should be requested in the local Radio stations where this can be taught. The community leaders and traditional healers should invite health workers in their “imbizos” to go and educate the community. We are available to go there when we are invited to go and teach them. Using traditional healers can be useful because there are women who go to them when “vatsimbiwile” (tied/blocked to deliver normaly) for treatment. We should educate them on how to use clean equipment because the community trusts them. Whether we like it or not they are used.

R: We also randomly do patient satisfaction survey in the ward to check how satisfied our patients are and we look into those things and act on them. This is done in addition to the available suggestion box that is there to assess our facility. Open days can also be held where the information can be disseminated to the community. The community is invited to discuss anything that is of concern and we also do the same.

Do you have a governance structure and what is their role?

R: I know that there is a board in the hospital but I do not know much or sure of what they are doing. I also know that they meet every second month and also open the suggestion boxes of the patient's complaints and compliments, and give feedback on the findings. If there are issues that need to be addresses they are addressed. I know that at some point they met with staff but not sure of what was discussed because I was not in the meeting.

Any last comment?

R: I would like to raise a concern about how BANC is implemented. I see it not benefiting pregnant women but instead seeing patients who come to the hospital with complications because they are not seen by the nurses as they should. So that would help out. My concern is that the interval of 6 weeks is too long because patients come back very sick. I would like to get clarity on how BANC is implemented. It is either the system or the way it is done is not correct. Since BANC started, I have noticed that there is high number of macerated babies caused by pregnancy induced hypertension. Women develop hypertension during that period when they are told not to come to the clinic and they are detected.

R: The rate of HIV has also increased since the combination pill was initiated. It would be good to investigate my observations and find out why. If a woman came late for ANC and tested for HIV mean while she did not want to know her status. Do you think it will be easy for her to take treatment or give the baby nevirapine? No she won't.

R: That is all I wanted to say.

Thank you so much for your contribution.

DATE: 22 JANUARY 2014

DATA SET G: DCST ("GG" DISTRICT)

GROUP 3: AM (1)

What are the barriers preventing pregnant women from attending ANC?

R: Culture beliefs: People still believe that they should not tell others about their pregnancy is about 5 months. They start going for ANC at about 6 to 8 months because they fear of being bewitched, so they don't want other people to know. They may not reach term if they tell people early. Some start ANC because they cannot longer hide the pregnancy because it is visible. But when they start going for ANC booking, not that they understand why they have to do that. Some are lazy to go to the clinic. There are no people who are still far from the clinics. Some are afraid for HIV testing because it is mandatory for all pregnant women. They do not want to know their HIV status because they think they have AIDS. This delays them.

R: There are other churches that have beliefs that as long as they pray, everything will go well. There are churches that tell pregnant women not to attend ANC but just pray. So they don't attend ANC. Some prayers are from the Prophets and Pastors who tell them that even when it comes to deliveries they can help them. So they do not need to attend ANC. There are examples of pregnant women who died in church. In 2009 there are about 9 women who died in church while trying to deliver their babies. The Pastor told them to go and deliver there at church. You find that those women did not even attend ANC, so they died. One woman had delivered by operation three times and they told her that she will be prayed for. So she had a ruptured uterus in the church while prayed for and died from bleeding.

R: The negative attitude of nurses also contributes. There are nurses who would, if a woman comes after missing a period for 1 month, the nurse will tell her to go home and come back after 5 months which is already late to start ANC because it is already after 20 weeks. Sometimes they will test her and find that she is HIV positive but she is still told to come after a long time. Because they are going to be told to come back after a very long time which defeats the purpose of early booking in ANC.

R: According to Basic Antenatal Care (BANC) pregnant women should be told to start ANC immediately after missing a period for 1 month. The women do go to the clinic but the nurses return them, they will indicate on the card that she was booked at 6 weeks but she should come back after 27 weeks. And with BANC they have to come every 6 weeks and one wonders what could have happened during the period the pregnant woman was away. Some end up not coming back late for ANC.

How can these barriers be addressed?

R: There is nothing other than community involvement now there are people who have been hired to do community dialogues. And is hoped that the community will be engaged and get an understanding of why women are not attending ANC. These are people who are hired by government full time through the Reengineering of PHC which is a national mandate. Department of Health is working with Department of Communication on these issues. These people will encourage pregnant women to attend ANC out there in the community. We will engage with the community to understand exactly what is happening in the facilities and the problems that are experienced, and why pregnant women are not attending ANC. At the moment we just have this and if it can be implemented things will improve. At the moment some of the things that we are talking about are just what we observe and our speculations but we have not heard directly from the community. This will be helpful because we will understand it from the perspective of the community.

R: About the community dialogue: The programme is implemented in all the districts in Mpumalanga Province. It has already started in Thabacheuwu District but have not

attended any of the meetings personally. They have just started and are not yet effective so far but the focus is on ANC. It seems as if Department of Communication is leading the program but professional nurses/midwives are also involved. Those who provide the community outreach programme (PHC Reengineering) are supposes to work with MCWH to implement the programme. It is not yet clear so far whether the people who will do the actual work are based at Department of Communication or Department of Health. These are people who are at the level of the Carers and are working full time. They should work with who ever in the community to get information. This can help to resolve the challenges.

R: It is said that in some facilities there are some nurses who tell the security guys to turn back home the pregnant women at the gate if they come to the clinic on a wrong day. These nurses do not practice supermarket approach which is wrong. So a security turning back a pregnant woman is not right. What do they know about those women to send them back home? So all these things, the community will be able to tell us during the dialogue that they are told to go back home because they came on a wrong day. This will help to resolve the problems. All these make women not to go back to the clinic or become lazy to go there because they will be returned. So the community involvement and dialogue will help us to identify these challenges and address them with the help of the community.

R: Nurse's attitude: We have to preach the gospel to the nurses that they should treat the patients well and follow the policies like supermarket approach. When there are peri-natal meetings all facilities are represented. This should be talked about every time there is a meeting so that they can learn and understand that women are not supposed to be sent back home without being seen. They should be seen every day and not on specific days for ANC. Pregnant women should book early on time. These are facilities that are said to be just filling in the "case record" only when they come early to ANC and they are not told to come after a long time for abdominal palpitation does not have logic nor make sense. You cannot take history only and not examine the woman nor collect blood for investigation. Not also taking into consideration how the woman got into the facility,

whether she had money for transport or not. We will have to talk to all the midwives about this. Clarify what BANC is, because it shows that still there is no understanding of BANC. What was presented before as BANC does not seem to have been done correctly. There is a need to start afresh and teach them about BANC because things are not done correctly. There is a need to start training them again on BANC here at Ehlanzeni District.

R: We will have to train people who will be BANC champions and when we start cascading information, we talk of the same thing and ensure that we implement it correctly. BANC is not moving at the moment, but why are pregnant women not booking ANC on time, because it is also about motivating the community. So now we want to know why women still book late. Where is the problem?

Already there is one sister I interviewed who has raised a concern about how BANC is implemented. She sees it not benefiting pregnant women but instead seeing patients who come to the hospital with complications because they are not seen by the nurses as they should. So that would help out. Her concern was the interval of 6 weeks is too long because patients come back very sick. She needed clarity on how BANC is implemented. What you are saying supports her concern.

R: The issue is that the requirement is that these women should be classified as high or low risk and make necessary follow up, if done properly they are not supposed to complicate. This will help with not having complications if well classified (e.g. a previous caesarean section or HIV positive woman. Midwives are not yet able to classify these pregnant women correctly which cause problems. If they are classified correctly, they will be given the correct date to come back. Early identification is needed to be correctly classified and managed well. That is what they need to be taught in BANC. Women need to be classified according to their problems and told or educated accordingly. If women are classified correctly there is no way they can be given wrong dates. Midwives to be educated so that they understand BANC and how it works before the community and pregnant women are taught.

R: Culture: It is not easy but it needs counseling so that they understand that culture is there but it is important that they understand the reasons why we want them to attend ANC. It may not be easy to convince a person but it will be worthwhile. The community dialogue and health education will help. That they can stick to their culture but their culture has got a problem. The community dialogues should first target the community leaders e.g. Pastors, teachers, “indunas”, and chiefs, all community leaders should be taught so that they understand. Let’s say there was maternal death that occurred in the community, they will have to know as it is everybody’s concern. They will want to know the cause of the death. It will be un-packed to understand what the cause was and how to avoid it to happen again. So once they understand it will be easy for them to actively participate and educate the community. It will be easy for them to cascade the information to their people. They can involve health workers to come and assist in educating the community. It is imperative to start with all the stake holders (leaders) and make them understand first.

What are the challenges experienced in the facilities?

R: The introduction of many new services by the department of health that were introduced without considering the issue of staffing e.g. PMTCT, TB, IMCI, chronic clinic. These are parallel programmes that need midwives who are few. They do not give pregnant women the attention that they need because they are in a hurry and still have to provide other services. Pregnant women are neglected in that way as nurses have too much work to do. It would be good to have ANC services where there are dedicated midwives so that they take time and examine the pregnant women well. Shortage of staff is a major problem.

R: Nurses just know that there is BANC but they do not understand what it is and how it works. There is lack of knowledge and skills. Some nurses still fail diagnose breech presentation during abdominal palpation. It is only seen during delivery that the baby is presenting in breech although the woman has attended ANC about five times. Recently we had twin deliveries that were not diagnosed and were only noted during delivery. The

mother was never prepared for twins because it was missed by the midwives because they lack skill.

R: One major cause is the current training of the four-year diploma course in nursing. There is no adequate time to practice midwifery. When they complete the course they are not able to identify these problems because they do not have time to get the cases they have to do before they complete their course. The two-year diploma in midwifery was good because they used to get good practice before they completed their diploma and the nurses were very competent. It will be better if at least they were allowed to do midwifery for one full year to get enough practice. Now when they complete their course they are allocated to work on their own in the clinics where they misdiagnose patients which is a problem. It would be better if at least they had mentors for some time when working in the clinics. They have to work alone, junior as they are without knowledge and experience, hence the problems

R: Some clinics have a problem of lack of equipment but it cannot be used as an excuse to mismanage patients. Most of the clinics have adequate equipment such as BP cuffs, calendars, registers and everything that they need to manage the patients well but patients are still booked incorrectly. Some patients come for ANC few times meanwhile according to BANC they should come four times excluding the first visit. Midwives don't follow that hence a lot is missed and patients complicate. Sometimes you find that the woman came as she should but it is not recorded in the register but only appears in the case record. Record keeping is also poor. Sometimes you find that a patient is staged according to her HIV status but is not given ARV's or treated accordingly. This causes the women to complicate due to mismanagement.

How the community can be involved in promoting ANC?

R: Health education should be given daily to patients and seriously at the clinic so that they understand the importance of ANC attendance. Sometimes health education is not given because patients are told to come to clinics on specific days. If someone comes

alone it is said health education cannot be given to one person only. Health workers should be the ones who strengthen ANC health education. Older people should teach younger women the importance of ANC. This should be taught in churches, women's meetings, societies etc. Grandparents and mothers should also teach their girl children that if they have missed their periods they might be pregnant and should attend ANC. This should also include men and community leaders. Community members must teach each other about this and nurses can be invited to the church to come and teach them.

R: The governance structure can mobilize the community and call meetings where health workers can come and teach them. Facilities use governance structures to help in addressing the complaints by the community e.g. Delay when an ambulance is called. They represent the community in the facility. They are also used as a means to communicate issues that the facility wants to inform the community and they are found to be helpful. It is hoped that your research will come with recommendations that will help to improve the services for pregnant women. If published, the recommendations will be implemented as women continue to die from pregnancy and delivery. Nurses have noted that some women take a certain drugs called "cytotac" which precipitates their labour which is dangerous and can cause death from ruptured uterus. It is hoped that the community dialogues will bring all these issues out so that they are addressed.

In the absence of more contribution, I would like to thank you for your time and your contribution.

DATE: 14 JANUARY 2014 1

GROUP 5: GS (1)

In your understanding what are the reasons for women to attend ANC?

R: For their own safety and the safety of the baby, so that they are able to detect when there are problems. May be the baby is not well placed or the mother is ill. These days there is HIV, so that they know their HIV status so that they can be treated on time otherwise the baby can be born with HIV.

In your opinion how can men support their pregnant woman?

R: Taking my wife to the specialist so that you know when the baby will be coming so that you can plan well. You will also be aware of the progress that the baby is making. The Doctor will indicate the problems she can have like getting tired when walking for a long time. Then you make arrangements to address that. Support her when she is ill by informing her employers and cannot go to work. Have to support her throughout the pregnancy until she delivers. A relationship of people who are married and outside marriage is different. It is not easy to offer support if the pregnancy was outside marriage because as a man you cannot be free to do that due to the nature of the relationship. It becomes a "stolen support" …." laughing"

Any other kind of support from other members of the family?

R: Parents do provide support and other family members. It depends on the background where you are coming from, the issues of culture. Women are emotional and you will have to understand the way they behave. Parents give advice related to those things.

Other experiences other than psychological, financial, emotional support?

R: Support groups for women can be helpful because they do not understand their partners when pregnant. They need to know how to deal with these issues and need to be educated

The role of Governance Structure. As member of governance structure is there anything that you are doing at the moment to promote ANC?

R: At the moment there is nothing but I can see that we have to do something as we speak.

What is your role in supporting the facility?

R: Assisted in motivating to the MEC with senior management to get equipment and ensure that there are drugs in the clinic which was a problem. When the clinic was opened, it was planned to be opened for 24hours and the community had to be informed that it was not possible because of the challenges like shortage of staff. That could not

be achieved by the clinic staff only we had to work through the MEC's office who delegated the HOD to work with us. We had to present to him with the list of things that need to be corrected. Then more staff was employed, equipment and furniture was bought and other problems addressed and the clinic now functions 24 hours. If we were not there this could not have been achieved.

Are you also involved with management of the clinic?

R: No, that is not the responsibility of the governance structure; we do not interfere with that.

Are you involved in the policy development related to health issues?

R: Not at all. Everything dealing with patients is the responsibility of health. We do not contribute to policies…

.."Interruption- phone ringing" …..

There is also a suggestion box that is used to get views of the patients on how they feel about the service. The box is opened by the committee every time there is a meeting. Things that are raised are addressed to improve the services that are rendered at the clinic.

How often do you meet?

R: Once a quarter.

Do you have some health programs that you do?

R: No. We just have a plan that we developed and as committee for the school where someone from the clinic comes to the school and educate the kids on things like teenage pregnancy. We had a problem with it. We have never had a campaign that embraces the whole community. This helps a lot because we have seen the number of teenage pregnancy reduce since that was started.

Is this happening in other neighbouring schools?

R: No, so far it is only at this school. Need to develop a plan as a committee to work in collaboration with other stake holders in the community and other schools so that we can take the program out to the community.

What could be the barriers that make pregnant women not attend ANC?

R: Fear for testing HIV positive, fear to know their status. Not taking into consideration that it is for her health and for the own baby. Some women could be negligent not that they don't know that it is important to attend ANC. Lack of education. Those who are not educated do not understand why they have to go for ANC. Poverty like lack of money to go to the clinic including not getting good services like that of private doctors who are able to keep your status confidential if you tested positive.

How can the community be involved?

R: Using forums that exist in the community. The problem is that some of the community structures are highly politicized making it difficult to push such things as it is not all the people who attend those meetings. Reaching everybody will be a problem. It would be good to always have somebody from health in every community meeting to make a presentation in such meetings because health is an important aspect of life.

If the community forums can be united and agree that in all the community meeting there will be someone from health who will come to address the people. It will assist on issues like HIV and AIDS, teenage pregnancy and other diseases the community will benefit on health matters. These are neutral issues because when we talk about water, it becomes political.

Any other thing?

R: The local Radio stations can also assist. We can request slots where health workers educate the community. We should talk about health matters in our families, Parents should the message from the community meetings and educate their families,

Do you think the church has a role?

R: The church can also play a role. The women and men's ministries should be able to take up the responsibility.

Any other thing?

R: No.

If not, I would like to take this opportunity to thank you for your time and accommodating me while you are pressed with time. Thank you.

GROUP 4: CL (1) 2

I would like to know from you why pregnant women attend ANC?

R: They go the clinic so that these women can get help. They will get checked if the baby and mother are well. There is also a high death rate of babies, so they go there so that the death rate can be reduced. They also identify illnesses that affect them and treat them.

As a man and a father what your role when a woman is pregnant? What kind of support do you give?

R: It is to encourage women to attend ANC. There was a girl who did not attend ANC because the parents did not remind her. When it was time for delivery there were problem with this girl. So at times, men should also be involved in encouraging them to go to the clinic. It does not have to be women only who are doing that. Sometimes you find that in a family the father is the one who is enlightened. He must be the one encouraging them to avoid complications. Traditionally, men are not supposed to take part in the pregnancy of the woman because it is said that it is issues of women, but times have changed now. They should be there for her in every way. If you are a man and know better, you have to be involved in such things.

As a leader, is there any role you are playing at the moment related to this issue but we are not doing it?

R: Now that we are having this discussion, I can see that we have a role to play. We can also work with women in the churches and raise the awareness of the community about the importance of ANC. My other observation is that it seems as if young women are competing about falling pregnant because of the child grant. They forget about their life and future and the future of the baby. We were supposed to take these issues up and talk about then because they do not care who they get the baby with, as long as they get a baby. As men, we should remind women to go for ANC and ensure that they drink their pills that they got from the clinic to make sure that there are no problems that affects the pregnant woman.
At times you find that there are pregnant women who do not go for ANC. What could be their reasons for not going there?

R: Most of them they are afraid to do blood test. They are afraid to test HIV positive because they do not want to know their status. It is like if you are partners and you ask that you go for HIV test and the partner refuse to go for testing. So what we need to do is to encourage them to go for testing especially these days there is treatment for HIV, it should be easy to test.

Is there any family circumstances that can contribute to that?

R: I cannot think of any other thing. These days there are clinics all over including mobile clinics. Some people like coming here who will go to the clinic and also enable them to go to the shopping centre and do all the other things well. I do not see a reason why a person cannot go to the clinic. Sometimes when I was a member of the clinic committee, we had nurses who complained that many patients were leaving their clinics and came to this one and they had many patients. A survey was done which showed that it was more convenient for them to use the clinic because when they come, they are also able to go

to the shopping centre and do other things like going to the bank, buy food etc. in a single trip. This made things to be easier, cost effective and convenient for them.

How can we address the barriers you have identified?

R: People need to be educated on the importance of attending ANC. They should also be encouraged to test for HIV and that being HIV positive is not a death sentence because there is treatment available for free.

Do you think that the community has a role in promoting ANC?

R: There are so many societies out there with groups of women where they can teach each other that it is important to attend ANC when you are pregnant.

Who can teach these women in societies?

R: These societies have nurses who are members. They are the people who can educate them. There are also Home Based carers who know the community well and do their work out there in the community on daily basis. There are those who are old and those with chronic illness. They can educate those who are pregnant in the household they visit. The health workers can educate the Home Based Carers who will spread the information to the community as they are always doing house to house visit in the community. These people work hand in hand with the clinics.

Do you think the church and school have a role to play?

R: The clinic can work with schools where there are teachers who are responsible for such things. They can request to have a meeting with young girls who can be taught about these things so that they go out and spread the information. An arrangement could be done with schools where the school children can be given the information and they can take the message home. I also serve in the Victim Empowerment Team and at time

we have campaigns. Now that we have been engaged in this conversation and have seen the importance of it, I can ask a slot where a health worker and other departments can be asked to come and address us so that we are able to spread the information to other people who are not aware or do not know. The different stakeholders can be involved.

Any other addition?

R: Community leaders should educate older women in the community who in turn should educate everybody in their families. Community leadership and health workers should work together to send out the information that is needed. Can conduct campaigns with the support of different stakeholders

Who could be the one involving the other stakeholders.

R: The people who are planning the awareness campaign can involve the different stakeholders and address the problem.

Any other thing?..... "shaking head" ……*If none, I would like to thank you for your participation*

Group 4: CL (2) 3

I would like to know from you why pregnant women attend ANC?

R: They have to go for ANC to know the position of the baby as nurses are trained to do that. If she stays at home she will not know how things are. At the clinic they determine the health of both the baby and the mother and they get pills that will help both the mother and the baby. They will also check if the woman will deliver normally or need an operation.

As a man and a father what is your role when a woman is pregnant? What kind of support do you give?

R: I used to assist my wife in everything she needs like taking her to the clinic when she is in labour. I am the one who is accountable and have to take responsibility pertaining to the mother and the baby as a father. I have to understand what is happening with her and am answerable because I'm always there for her, all the time. A man should encourage his woman to go for ANC. I also helped with house chores especially heavy duties in the house like doing laundry, cleaning and cooking when my wife was pregnant. Parents of the couple should also assist in providing moral support and in giving advices to the couple

At times you find that there are pregnant women who do not go for ANC. Even if they go they do not attend as they should. What could be their reasons for not going there?

R: I think these women may not know the importance of ANC. They do not know the assistance and the information they will get from the nurses. The care givers can also be of assistance because they go house to house helping people. They are knowledgeable on health issues and they can be of good help.

Any other reason?

R: I also think that poverty can contribute to that may be in cases where there is no one who is working in the family. This can make them not to go to the clinic due to lack of money for transport or proper clothes to wear.

Are there any family circumstances that you think can be barriers?

R: No.

In your opinion, do you think nurses could be the reason why women are not going for ANC?

R: The attitude of some of the nurses is a problem. Nurses these days no longer have “ubuntu”, they no longer have a calling for the work they do and do not treat patients well. They just want to earn money. Sometimes they spend time on their cell phones while the patients are waiting for their assistance. You sometimes find that patients are treated differently i.e. according to the status. Sometimes nurses want to be pushed to do their work. One day the nurses were seen sitting down and chatting and immediately stood up when some white guys came in and pretended as if they were busy. So African people are neglected and the services given to them are slow which is wrong.

R: The other thing is that some churches do not allow their members to go for ANC they tell them that they must just pray. There is a woman who died in the church after she had severe bleeding but was told not to go to the clinic.

How can we address these challenges?

R: Nurses should have “ubuntu” to be able to help the members of the community. They should treat people the same way and not humiliate them. Nurses should educate women about the importance of ANC in the clinics and in the community. The Caregivers should be used to spread information on the importance of ANC as they always do house to house visits helping other people in the community. They are knowledgeable and trained.

Do you think that the community has a role in promoting ANC?

R: If the health workers teach the members of the community, they can teach others when knowledgeable. There is a need to love each other because where is love, educating each other will be easy. Nurses should give health education on the importance of ANC in community meetings. Available media like radio and local papers can be used to spread the information.

What role can the church play in this regard?

R: As churches, we should also meet the needs of those who are in need like providing food, clothes etc. so that when they are taught they can listen because their physical needs are met. We can work with councillors, the municipality and other structures like the clinic governance structures and business people who can also assist. I do my work as a Pastor and as a member of the civic. Business people should also be involved in educating the community as their voices can be heard. The Caregivers should be used to spread information on the importance of ANC as they always do house to house visits helping other people in the community. They are knowledgeable and trained and they are already doing the work.

Any last words?

R: No.

If none, thank you so much for time and contributions.

GROUP 4: GS & CL (3) 4

I would like to know from you your understanding, why pregnant women attend ANC?

R: It is for the reason that they want to know their status regarding the pregnancy because if they don't they might have problems later in the pregnancy. They need to be checked from the beginning to see if the baby and the mother are both progressing well. It is also for the reason that the nurses can detect if there any disease or viruses that might affect the pregnancy so that they can prevent a failed pregnancy. They also check their HIV status.

As a man and a father, who do you think should provide support to ensure ANC attendance? What is the role of men?

R: As a father you are the head of the family and have to take the responsibility that everything with this woman goes well. The partners should give them support. As men

we should also make sure that we do not make her angry but live in peace because that can affect her and the baby. A pregnant woman is like a baby, we have to avoid harsh words that can upset her. We should allow them to be managers and leaders at home. If there are misunderstandings in the family, the women will be unhappy and will not be interested in going for ANC. She needs to be reminded to go and attend ANC. You have to support her and show love and are always close to her. Love plays a very important role. Let her know that you love her. To also ensure that she gets a healthy diet and support her on whatever she wants.

Sometimes you find that pregnant women do not attend ANC. What could be reasons for not attending ANC?

R: Sometimes it is because of lack of knowledge regarding the importance of attending ANC. At time you find that there are no clinics around the area where she lives and she does not have money for transport. Sometimes women wait for a long time before they are seen because there are long queues meanwhile they come early to the clinic and leave late. If the clinic staff is not treating them well at the clinic they may decide not to go to the clinic. The staff attitude can also make the pregnant women mothers not to attend ANC; it makes it difficult for them to go to the clinic. At times they go to the clinic and find that there are no drugs and that can discourage them

R: There is also fear of getting tested for HIV and if going early the child can be saved. The partner should show interest in the pregnancy. Some are just lazy which should stop because ANC helps the pregnant women. Going to the clinic becomes a problem for those without enough clothes, food etc. so such should be provided for by the family members.

How can we address the barriers that you have identified?

R: The problem of ignorance can be addressed by having the clinic to run campaigns that will make the community aware of the importance of ANC. If it is lack of drugs, the

department should make sure that there are drugs available. If drugs are finished, they should give them the return dates where drugs will be available. These are some of the issues we come across as the health committee of that clinic. Related to the nurse's attitude, nurses should behave well and treat patients well and with respect and make sure that they fell welcome. About the long waiting time, patients should be given appointments so that people only come when they have appointments and they will be evenly distributed to avoid that they come at the same time and be over crowded.

R: Regarding the attitude of nurses, they have codes and conducts so they should follow them the way they were taught. Some nurses just go to work because there is no work; most do not like their work. Nurses to be alert all the times and should have inductions to help them. To educate the women on the need to test for HIV

As a member of the governance structure, is there anything that you have done to try and address the problem of long waiting times?

R: We, as members of the clinic committee meet regularly to address the challenges that the facility is experiencing. We talk to the clinic management to identify the challenges that they have. We then write letters to the leadership of the department and they help us to address the problems. Like the issue of shortage of drugs, the district used to order drugs for the facilities, but now the clinic is able to order drugs directly from the depot which has reduced the problem of drug shortage. Patients are no longer complaining much about drugs. We are currently dealing with problem of staff shortage. The clinic had a problem with shortage of water which made it difficult for them to work, we then talked to department of water affairs and the problem is now sorted. That is what we are trying to do and help with here at the clinic.

The suggestion of patients given appointments, have you ever suggested it to the clinic?

R: Yes, it was suggested and implemented although it is not yet very effective but the nurses are finding it to be helping them because they no longer have those very long queues for pregnant women.

How does this appointment idea get implemented? Do they give them the exact time they are going to be seen or what?

R: What they do is just to reduce the number of patients to be seen in a day by distributing them throughout the week but not to give them the exact time they will be seen. Another thing that we did was to motivate for renovation of the clinic as things like tiles were worn out. That was agreed and the clinic was renovated. We also have trees that are overgrown in the yard, we have negotiated with department of Agriculture and they are busy trimming the trees so that the facility looks neat.

You have already answered my next question of what your responsibilities are as a governance structure so I cannot ask that question any more. Now I would like to know if you think the community has a role in promoting ANC.

R: As ward committee we have programmes where we meet every month and we have some discussions with the clinic committee. So if there are issues that need to be taken to the community, it is easy to do it in those meetings. They can be used to disseminate information to the community. The leaders can convey messages in community meetings on the importance of ANC. We can involve the clinic and the governance structures to help in feeding the community with the information. In December the clinic told us that they wanted kids to be immunized and that was conveyed to the community and that was achieved.

Anything else?

R: A community campaign can be done to encourage pregnant women to attend ANC including any other health promoting issues that can help people. There are also community care workers who can also help in encouraging pregnant women to attend

ANC. We also have CDWs, Community Development workers who can also assist. We attend meetings together with them.

R: In schools, campaigns are done, this can be integrated with what is currently happening since it is already happening like teaching school kids about drug abuse etc. In societies, any groups and churches, there should be a reminder about the importance of ANC. All must show interest in a member's pregnancy and advise them to go for ANC. To involve the media like radio and local newspapers to spread the information.

I would like to thank you for your time and the responses that were given.

GROUP 4: CL& GS (4) 5

What could be reasons why pregnant women attend ANC?

R: It helps them to check the progress of the pregnancy like if the mother is healthy, does she have other diseases that can infect the baby. They also check for the position of the baby in the womb. There is also health education that is given so that the woman knows what to do and how to live correctly. They also learn how to share how they feel with other women. If she does not attend the clinic, there are a lot of difficulties that a woman can experience.

As a community leader, how do you think you can assist in promoting the importance of ANC?

R: By chance I happened to be a member of the ward committee and a member of the governance structure. We have programmes that we do which make us meet with the community. We use that opportunity to spread information. We use platforms like the church, funerals and we use that opportunity. There are other programmes that we do as ward committee, we spread the information including there at the clinic.

What do you think is the role of men in encouraging pregnant women to attend ANC?

R: To encourage women to attend ANC. A man can accompany the woman to the clinic so that you are able to understand what is happening with her. You also need to go for HIV testing together to make sure that the baby is safe. As men, we have to encourage each other and ask men to be part of the pregnancy of his woman. If your baby gets affected there will be more costs related to the illness, so it is better to prevent so that you are on the safe side.

Why are pregnant women not attending ANC?

R: Clients are not well treated in our clinics by the clinic staff, starting from the administrative staff when they have to collect their cards. The admin staff harasses them. Some patients take a long time to be seen and people are just sited and not rendering the services but doing “up and down”. In some clinics there is no confidentiality therefore this makes them not to go, like if you are HIV positive everybody will know. If the community can hear that, they will not use that clinic. Some facilities also lack of equipment and medicine.

How do we address the problem of culture?

R: We are from different families with different cultures. The background of people is not the same as we have different cultures; some might want a woman to give birth at home. Some people (traditional people) claim that they can deliver babies without proper training. Long distance to the clinic and poverty makes it impossible to go to the clinic. We also have a problem of young girls get pregnant so that they can apply for social grant.

How can these barriers be addressed?

R: We always have this problem of nurse’s attitude every time from the suggestion box that we always deal with as a committee every time when we meet and we try to resolve

it by talking to the staff. The nurses need to understand the members of the community and treat them well. To address the community about the importance of ANC in different structures as leadership and also use the church as platform including at funerals. In the clinics as well the information on the importance of attending ANC should continue to be shared.

How do you address the issue of culture?

R: I also serve in the committee that serves the chief, and we have programmes that we do to address issues like AIDS. What we tell them is that people can stick to their culture but if there are health issues that need their attention they should not resist. The governance structure can assist with addressing problems like shortage of drugs, lack of equipment through the political structures,

What about the distance?

There are mobile clinics that are there to provide services. These mobiles are also not enough because the villages are vast, so they are not enough.

Do you think the community can be involved in promoting ANC and what would be the role?

R: The community has a major role. The **c**ommunity needs education on the importance of attending ANC. Workshops should be done especially in deep rural place. The private sector can assist by getting and training Home Base Carers so they can teach the community, in the “imbizos” by municipality, churches, and soccer tournaments, cultural dances etc. if all these are targeted then the message can be conveyed and heard. If there could be pamphlet that could be distributed to the community so that people can read on their own.

R: There are several “imbizos” that are called by the municipality, the church, traditional dancers, soccer, societies etc. if these can be targeted with education it can be helpful.

Visits should be done to the community and schools where you can get people and educate them about this important message. There is a need to plan for campaigns should be done and come with ways on how to address these problems.

How do you function as a governance structure?

R: We have our monthly meetings where we identify problems and address them. Like recently there was a campaign for immunization and we had to take the message to the community. It was a successful campaign

Any last words?

R: Just to say that we as people of Bushbuckridge are fortunate that you chose to come and do the research here for our benefit. Please do not forget us when you are done.

I would like to thank you for your time and contributions you have made.

GROUP 4: CL (5) 6

I would like to know from you what could be reasons why pregnant women attend ANC?

R: They want to find out about the health of the baby and mother so that they are able to live a healthy lifestyle. If the baby doesn't play they can help and make sure the baby is fine and the mother is fine. When pregnant, a woman needs to know that she has to go to the doctors or the clinics. She has to be regularly checked by the Doctors so that a lot of diseases can be prevented or identified and get treatment.

Do you think you as men have a role to play when a woman is pregnant and what kind of support do you give?

R: Once she is sure that she is pregnant she has to tell her husband who will make sure that she goes to the clinic. I can take her there or check if she has got the pills and take

them regularly. The men must make sure she attends the clinic by making a follow up and accompanying her. Ensure that when she is working she should get a lot of limits; she should not do hard work so that when the time for delivery comes she is strong enough to give birth to the baby. All members of the family should provide support and remind her of going for ANC

At times pregnant women are not attending ANC as they should, what could be the problem?

R: Some women are stubborn and hard headed. They say that they do not want to go to the clinic because they have been bearing children without going to the ANC. They say in the past they delivered at home. These are some of the causes why women die because they were not attending ANC. Some know that they have certain diseases and viruses and STI having the knowledge can make them decide not to go.

Any other thing?

R: Some believe that “n’wana itshamiwile” which means something is sitting at the back of the baby’s head shown by blue or red discolouration of the skin and every time the woman gives birth, the baby dies because of that. So in the second pregnancy the same thing can happen again so that makes them not to go to the clinic or hospital. This is treated by the traditional healers.

Any other causes like family circumstances that you can think of?

R: If the male figure is abusive the woman might decide not to go for ANC because she feels neglected. When a woman is pregnant, some men go out and have girlfriends and they always fight because of that. These sorts of problems at home can lead to an unsuccessful pregnancy. At times they will always be fighting and the baby might lose its life. The woman might always be drunk and cannot think of going to ANC. Some may just not want to go for ANC. They just need to be encourage them and advise them even going with them to the clinic will help if it is someone I know or in the family.

How can these barriers be addressed?

R: Traditionally they are able to remove the thing that kills the baby at birth "xakutshamiwa" but some are afraid of that. I wonder if Doctors know these things. We have to talk to each other about these issues. For those who are always fighting they need to discuss and iron out their differences. There has to be love and peace in a family. At times they need a mediator if they fail to resolve their issues or even go for counseling. Men who do these things because they are drunk need to stop drinking. There is also a need to educate all women on the importance of attending ANC.

How can we involve the community in promoting ANC?

R: The message on the importance of attending ANC should be communicated to the community. In community meetings let it be announced and addressed in a large scale, give reminders and give the importance of ANC appointments. Last week we had our community meeting, if you came before the meeting, we would already include sending out the message that pregnant women should attend ANC. As neighbours, we should get closer to a person who is pregnant and their family so that we are able to advice them to attend the clinic. We can also get the HBCs and involve them as they are very important, they will educate the community when they do house to house visits. Everybody should encourage pregnant mothers to go for ANC.

Is there any other thing you would like to add?

R: No

If there are no additional points, I would like to thank you for your time and participation.

GROUP 4: CL (6) 7

In your understanding what could be reasons why pregnant women attend ANC?

R: They want to determine and prevent any complication of the pregnancy that might happen and treat them. To check if there are diseases like hypertension, STIs, sugar that can be identified and treated. They also keep a record of the baby and mothers' health so that at the end there shouldn't be any problems. The nurse in the clinic is supposed to go through the pregnancy with the expecting mother and explain the different stage of the pregnancy so the mother knows what to expect.

Do you think you as men have a role to play when a woman is pregnant and what kind of support do you give?

R: We are all aware that in every pregnancy that happens, there is a man involved therefore men must support their women in every way; they must understand and accept them of who they are. There is not pregnancy without a man. So men must always be there for their partners. The pregnant women need emotional, physical support and even going to the clinic with her, show her love in every way. Parents must accompany their pregnant teenagers to the clinic to show support and make sure that they go for ANC. He should provide psychological support, always try and always make her happy. The most precious time for a man is when the woman is pregnant. That is when sex is also enjoyable. I have 7 kids as I enjoyed seeing my wife being pregnant. She needs to be massaged on her feet and the back and also brush her tummy……" laughing" …… Always be around her and understand. Do not wait for her to demand stand up and do it for her.

At times pregnant women are not attending ANC as they should, what could be the problem?

R: The fear of being tested for HIV, without any counseling because they fear to know their HIV status. Sometimes there is no support from the partner and if he just stands up and takes the 1st step with her it would be easier for her to go to the clinic

"Noise…..car passing"

R: Poverty- because the woman needs to go to work but cannot take time to go to the clinic. So she will not have time to go to the clinic. The distance to the clinic might be very long for her and without any finances it is difficult for her to walk. By the time she decides to go, it is already late.

“Noise…..car passing and hoot”
Any other thing that you can think of?

R: Sometimes it can be laziness for those who are close to the clinics.

Are there any problems at the clinic that could make them not to attend ANC?

R: There is no problem at the clinic; the problem is when the patients have complications, due to of lack of the equipment. There is no adequate equipment in the clinics so they have to refer patients to the hospital. Our facility is a Community Health Centre which is bigger than the clinic. There were supposed to be Doctors who see such patients but they have to refer them to the hospital. While referring the patient, the baby might have problems on the way and not coming out alive and that makes the referring part a problem hence the clinic should have all the necessary equipment so that most problems wouldn’t occur. Patients have to use taxis to go to the hospital. And our roads are also not very good which makes the problem worse.

How can these barriers be addressed?

R: The government and community must identify the problems and work together to solve them. Expectant mothers must be taught from an early stage the importance of attending ANC. The Health Centers should be well equipped with everything that is needed so that they have no referrals to the hospitals. Women should be encouraged to go for HIV testing so that they know their status.

How can we involve the community in promoting ANC?

R: We as men, are supposed to help the women and play the role actively as husbands. The older women and men in the community should speak about the importance of attending ANC in community meetings. If you have a neighbour who is pregnant, you need to encourage her to attend ANC. Teenage mothers should be given information about the importance of attending ANC in their families and at the community.

Do you think that a church has a role?

R: In churches the Pastors should preach the message to the community in their churches. In schools it should be included in the Life Orientation syllabus. The community should be told that without the ANC card it is like a driver who drives without a driver's license. Attending ANC should not be an option but a "must" to attend ANC appointments. We have to be one as a community and help each other as the community. Every child in the community should be ours irrespective of who their parents are. As a parent, if I have a pregnant child, I have to encourage her to attend ANC. The message has to be taught in families, churches and schools.

Any last words?

Just a word to all men, that they should support their partners. They must avoid fights and live peacefully with them.

If there are no additional points, I would like to thank you for your time and participation.

GROUP 5: GS (1) 8

In your opinion why do pregnant women fail to attend ANC? What could be the barriers?

R: Some people are afraid of being seen that they are pregnant, they hide the pregnancy because they know that HIV testing is mandatory and they are afraid to test. Some do not know that they are pregnant because it is unplanned pregnancy. Drinking alcohol and not taking care of themselves. Some fell pregnant by mistake and they tried to terminate the pregnancy but failed so they go to the clinic late.

Are there any family circumstances that you can think of?

R: One woman fell pregnant with her husband's brother and it was an embarrassment that how she was pregnant so she did not want to go to the clinic. Some get pregnant with another woman's husband and that makes them to fear. Poverty makes the women want to abort the pregnancy so that they will not go to ANC. Travelling long distance to the clinic is also a problem especially if there is no money for transport. Some end up delivering on the way because of transport delay. Some do not have money for transport.

Any other thing?

R: The things that happen at the clinic are not good. There is sometimes ill-treatment of patients by the clinic staff makes them to be afraid to go there because they fear to be embarrassed. The people who live far away from the clinic sometimes complain that they get here at the clinic very early and the clinic only opens at 07H30 which delays them and makes them tired too.

How can these barriers be addressed?

R: Let the clinic staff treat each person with respect and have the confidentiality about the client's health and their HIV status. Not all women are afraid to test for HIV but they are afraid of lack of confidentiality. The staff should be educated about the importance of confidentiality. They should treat all patients equally. Some nurses' only treat patients well only when the supervisors are there.

What about the issue related to long distances?

R: The department of health should take ANC services to the community by mobile clinics or create a visiting point at the community as the facilities that are far from the people. The services should always be there but not on specific days because people also need help in the middle of the night and there are no services. There are meetings that are held in the community which can be used to spread information on the importance of attending ANC. Let the Home Base Carers visit these women when they do house to house visit

and educate them about the importance of ANC. Pregnant women should be taught about the dangers of alcohol abuse when pregnant and the importance of attending ANC.

Any other thing?

R: I think as members of the governance structures we should take the responsibility to educate them on the importance of attending ANC. We should work hand and hand with the community leadership.

How can the community be involved in promoting ANC?

R: The importance of ANC should be stressed in every church meeting on Sunday and women's prayer meetings during the week. Women can be taught separately from men so that they are free to talk. In schools as well let there should be some campaigns conducted to teach both boys and girls about these issues. Children get sexually active at an early age these days so they have to be taught to prevent teenage pregnancy. The family and neighbours should be equipped with the information so that they can give others the advices about going to the clinic for ANC and tell them the reasons why.

What is your role as governance structure?

We check if the nurses are doing their job. We check if the staff treats patients well and the care they give to the patients. We are the eyes of the community and we help to address their complaints. We also do informal interviews to the patients so that they give us feedback on how they are treated at the clinic. The people who travel long distances are the ones who are always complaining that they come very early in the morning mean while the staff starts work at 7:30 am. You find that they end up being hungry and need something to eat meanwhile they do not have it. The health committee is the communication channel between the community and clinic. Sometimes we resolve issues like shortage of drugs and delay when an ambulance is called in a case of emergency due to ambulance shortage.

GROUP 4: CL (1)9

In your opinion why do pregnant women attend ANC?

R: I do not have knowledge related to that.

When your wife went to ANC why was she going there?

R: Ah! I didn't know. I never entertained it because it was women's issues. I just think that they wanted to check if what is inside is the baby or not and is alive and growing. Other than that I do not know.

What could be the barriers preventing pregnant women from attending ANC?

R: I think they are just stubborn, they lack of information and they are ignorant. They do not see the need. The daily chores at home may keep her busy and she may see them being the most important thing because she is not ill. It could be laziness from the pregnant mother but they know that they need to go. At times the nurses are not treating them with respect; they are sometimes rude to them. Some old people still use "muti" (traditional medicine) for those who live deep in the rural areas and believe that they do not need to go for ANC.

How do you think the barriers can be addressed?

R: The day she decides to go to the clinic, the midwives must give her information so that she understands and she can come back. The nurses must treat them with respect and not be rude because it would lead to the expected mother not to come. Let the supervisors and management in the Department of Health teach their staff members on how to treat pregnant women well with respect.

What about you as community leaders? What role can you play?

R: We are already doing that in our meetings. We encourage them to go to the clinics and hospital when they are ill. We do that in general but not only focusing on ANC as such. In

such meetings that is where we are getting complaints that nurses are not treating them well. The community leaders and especially the Home Base Carers should give information to the community on the importance of attending ANC.
Any other thing that you can think of?

R: There are people who still trust in traditional medicine “muti” and continue to stick to that. People should learn to trust the scientific measures that are there these days rather than using the traditional “muti”. If we talk about it as community leaders, some people will listen to them, so they should be the ones involved in educating the community on the importance of ANC. Nurses in the Department of Health should go door to door and teach people so that things can change and we should support them

As a man do you think you had a role in promoting ANC attendance?

I was a migrant worker then and my support was through providing financial support. Now that I’m back home I have to participate in spreading the gospel that women should attend ANC. I have to remind them to go to the clinic.

How do you think the community can be involved in promoting ANC?

R: If it was possible to get volunteers like Home Based Carers who will do door to door campaigns to ensure that every one is reached.
As traditional leadership we should give a directive to the community “ebandla” that pregnant women should attend ANC.

Do the schools have a role?

R: Yes, they do have a role. In schools there are child bearing age boys and girls and these should be given the information so that they know. In schools they can get it into the curriculum in schools and make it a subject where the students will be taught. It should

be taught in churches and should always be mentioned as a reminder on the announcements every Sunday.

Any last words before we close?

If it was possible, this was supposed to be taught in schools to save our people and people should learn to move away from the traditional practices and stick to the scientific things which is done in hospitals and clinics.

Thank you so much for your time and contributions.

ANNEXURE G: INVITATION TO PARTICIPATE IN RESEARCH, PHASE 2

35 Harmse Street
The Orchards Ext 11
Akasia
0182
27 February 2016

Dear Sir/Madam

Re: Invitation to participate in research study for PhD purposes REF: Student Number - 12217825

My name is Evangeline Shivambu and I would like to conduct research titled “Developing guidelines to promote community participation in and local accountability for pregnant women’s access to basic antenatal care in the Mpumalanga Province, South Africa”. The research study is part of the requirement for my doctorate studies. The University of Pretoria Ethics committee and the Provincial Department of Health in Mpumalanga have approved this study.

The aim of the study is to develop implementation guidelines to enhance community participation and local accountability for health by exploring ways for involving the community in basic antenatal care for the reduction of maternal mortality and morbidity in Bushbuckridge, Mpumalanga Province. This will be done in two phases. Specific objectives of the study per phase are:

Specific objectives are:

Phase 1:

- To explore and describe factors associated with pregnant women's access to antenatal care services.
- To explore and describe factors associated with community participation and accountability local of governance structures for antenatal care services.
- To explore and describe the perceptions of health workers on how to involve the community in supporting pregnant women to access antenatal care.
- To explore and describe the perceptions of health workers on community participation and accountability of local governance structures for antenatal care.
- To explore and describe the functionality and accountability of the governance structures within local communities in health.

Phase 2:

- To develop and describe implementation guidelines for community participation and local accountability for antenatal care services in Bushbuckridge, Mpumalanga Province.

You are invited to participate in the second phase of the study that will be conducted during the period of March to June 2016. Participation is voluntary. You are requested to participate in the study because you have been identified as an expert in the field of PHC re-engineering and or Maternal, Child and Women's Health who will make a meaningful contribution to the development of the said guidelines.

Kindly read the information below, which will enable you to make an informed decision on whether to participate in the study or not.

Procedure

Delphi technique will be used to gather opinions from the panel of experts without having to meet physically. It provides for a consensus-based structured communication process to gather opinions and make decisions. As a member of the panel of expert, you will be expected to respond to a set of open-ended questions over a series of rounds to generate expert opinions on the drafted guidelines until consensus is reached.

Potential risks and benefits

There are no personal risks involved and confidentiality will be maintained. Should discomfort occur, you are free to withdraw from participation. The study will inform development of relevant policies, inform programming and practice and eventually contribute to the reduction of maternal deaths in the community.

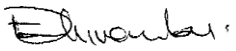
Compensation of participants

No compensation will be given to the participants and there is no cost in participating in the study. The participants will incur no costs.

Confidentiality

No names will be used in the study. All the information will be kept confidential and will be disclosed only with your permission.

Yours Faithfully,



Ms Evangeline Shivambu

Principal Researcher

ANNEXURE H: INFORMED CONSENT

I give my consent to participate in this research study: “Developing guidelines to promote community participation in and local accountability for pregnant women’s access to basic antenatal care in the Mpumalanga Province, South Africa”. I confirm that the person asking my consent has informed me about the nature, process and the benefits of the study. Participation in the study does not involve personal risks and confidentiality will be maintained. I understand that participating in the study is voluntary and I am free to withdraw at any time.

Signature of participant: Date:

Signature of witness: Date:

ANNEXURE I: FINAL SUMMARY SHEET OF THE RATED GUIDELINES

ROUND 1	CRITERIA																			
Rating scale 1=Strongly disagree 2=Disagree 3=Agree 4=Strongly agree	**Clarity**				**Validity**				**Reliability**				**Applicability**				**Flexibility**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Guideline 1			**3**	**15**			**3**	**15**			**3**	**15**			**2**	**16**			**3**	**15**
Guideline 2			**2**	**16**			**2**	**16**			**2**	**16**			**3**	**15**			**3**	**15**
Guideline 3			**4**	**14**			**8**	**10**			**5**	**13**			**4**	**14**			**5**	**13**
Guideline 4			**3**	**15**			**3**	**15**			**4**	**14**			**6**	**12**			**8**	**10**
Guideline 5			**5**	**13**			**6**	**12**			**5**	**13**			**5**	**13**			**3**	**15**
Guideline 6			**6**	**12**		**1**	**2**	**15**			**7**	**11**			**6**	**12**			**4**	**14**
Guideline 7			**3**	**15**			**3**	**15**			**7**	**11**			**5**	**13**			**3**	**15**
SUB - TOTAL (n)			**26**	**100**		**1**	**27**	**98**			**33**	**93**			**31**	**95**			**29**	**97**
TOTAL SCORE (n)			**126**		**1**		**125**				**126**				**126**				**126**	

ANNEXURE J: LETTER FROM LANGUAGE EDITOR

Pho Z
Editing Services

229 Gwai Place; 10 Kudu Heights
Faerie Glen
Pretoria
0081

Email: pholilemaseko@yahoo.com
Cell: 076 103 4817

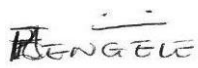
24 July 20176

DECLARATION OF PROFESSIONAL EDIT

I declare that I have edited and proofread the PhD Nursing Sciences Thesis entitled: **DEVELOPING GUIDELINES TO PROMOTE COMMUNITY PARTICIPATION AND LOCAL ACCOUNTABILITY FOR BASIC ANTENATAL CARE IN MPUMALANGA PROVINCE, SOUTH AFRICA** by Mrs E Mthethwa.

My involvement was restricted to language editing, proofreading, sentence structure, sentence completeness, sentence rewriting, consistency, referencing style, editing of headings and captions. I did not do structural re-writing of the content. Kindly note that the manuscript was not formatted as per agreement with the client. No responsibility is taken for any occurrences of plagiarism, which may not be obvious to the editor. The client is responsible for the quality and accuracy of the final submission.

Sincerely,



Pholile Zengele

Associate Member, Professional Editors Group