

**FACTORS CONTRIBUTING TO A DELAY IN REPORTING FOR LABOUR BY  
PREGNANT WOMEN AT A REGIONAL HOSPITAL, MOPANI DISTRICT**

by

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submitted in accordance with the requirements  
for the degree of

**MASTER IN NURSING SCIENCE**

in the subject  
Health Studies  
at the

**UNIVERSITY OF SOUTH AFRICA**

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**April 2019**

## DECLARATION

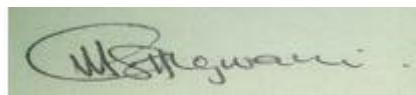
I declare that **FACTORS CONTRIBUTING TO A DELAY IN REPORTING FOR LABOUR BY PREGNANT WOMEN AT A REGIONAL HOSPITAL, MOPANI DISTRICT** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Maria Gladys Hlungwani

28 March 2019

Full names

Date



Signature

## **ACKNOWLEDGEMENTS**

- First and foremost, I praise the All Mighty God who gave me the strength, energy and the brilliance, which sustained my efforts for the entire duration of the study.
- To my Supervisor, Ms A. Mosalo, for her critical role of offering me unlimited guidance and support, especially when I felt like giving up.
- To my Co-supervisor, Prof. JM Mathibe-Neke, for her never ending encouragement to increase the speed and still stay focused on the personal study objective.
- The participants, prospective mothers who acceded to my request of being interviewed and entrusted me with their personal information, and shared experience with me.
- My children, Vutlharhi, Vutivi and Vutshila, for their unparalleled moral support, believing and encouraging me that I can scoop this degree.
- To my siblings and my mother, I send my gratitude to them for making me a proud community leader who serves with pride.

## **ABSTRACT**

The study was aimed at exploring and describing factors that influence the delay in reporting for labour by women in Mopani District and to evaluate the impact of the delay in the process and outcome of labour and to develop recommendations to address the contributory factors. The study was conducted at a regional hospital in the Mopani District. A qualitative descriptive research design was used for the participants to describe the factors that delays pregnant woman in reporting for labour in the regional hospital. A non-probability sampling design was used in the study. Data were collected through unstructured one-on-one interview. Thirteen (n=13) pregnant women who delayed reporting for labour in the regional hospital at Mopani District participated in the interviews. Data were collected and analysed through the use of content analysis approach. Seven themes developed from the findings leading to the establishment of the following recommendations including the use of theory as support system, making the availability of resources a priority, increasing capacity of all clinics to offer skilled birth, expansion of Mom-Connect into rural areas, establishment of MWHs in the rural areas, and increasing transportation such as ambulances.

**Keywords:** Factors, delay in reporting, labour, pregnancy; women

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## **ABBREVIATIONS**

ACOG	–	American College of Obstetrician and Gynaecologists
AIDS	–	Acquired Immune Deficiency Syndrome
ANC	–	Antenatal Care
AROM	–	Amniotomy or Artificial Rupture of Membranes
BBA	–	Babies Born Before Arrival
BP	–	Blood Pressure
Cell-C	–	Cell Company
CHWs	–	Community Health Workers
CPD	–	Continuing Professional Development
C/Section	–	Caesarean Section
CSVР	–	Centre for the Study of Violence and Reconciliation
DoE	–	Department of Education
EMS	–	Emergency Management Services
GDP	–	Gross Domestic Product
HIV	–	Human Immune Virus
IPTP	–	Intermittent Prevention Treatment of Malaria during Pregnancy
MAMA	–	Mobile Alliance for Maternity Action
MDGs	–	Millennium Development Goals
MTN	–	Mobile Telephone Network
MWH	–	Maternity Waiting Homes
n	–	Number
NMC	–	Nursing Midwifery Council
PMTCT	–	Prevention of Mother to Child Transmission
PTSD	–	Post-traumatic Stress Disorder
QDA	–	Quality Data Analysis
RSA	–	Republic of South Africa
SASA	–	South African Schools Act
SBA	–	Skilled Birth Attendants
SEM	–	Social Ecological Model
SIDS	–	Sudden Infant Death Syndrome
SMS	–	Short Message Services
SROM	–	Spontaneous Rupture of Membranes

STIs	–	Sexually Transmitted Infections
TBAs	–	Traditional Birth Attendants
Telkom	–	Telecommunication
UN	–	United Nations
UNHRC	–	United Nations Human Rights Council
UNISAREC	–	University of South Africa Research Ethics Committee
Vodacom	–	Voice Data Communication
WHO	–	World Health Organisation

# **CHAPTER 1**

## **THE STUDY OVERVIEW**

### **1.1 INTRODUCTION**

A trend of delays of pregnant women in reporting for labour had been observed in the healthcare facilities under the jurisdiction of the local municipality. More research studies have been conducted relating to pregnancy and birth like perceptions of Antenatal Care (Halle-Ekane, Egbe, Tamufor & Njie, 2015: 3); wellbeing of teenage mothers (Pitso, Kheswa, Nekhwevha & Sibanda, 2014: 610); indigenous and Western postnatal care practices (Ngunyulu, Mulaudzi & Peu, 2015: 1); women's experiences of delay in labour (Armstrong & Kenyon, 2017: 4) and decision to seek health care (Nabieva & Souares, 2019: 4). None of these studies and many others touched on the delay on reporting for labour by pregnant women. A continuation of these delays is likely to bring discomfort and major risk to pregnant women who delayed in reporting for labour. In respect of the topic, the researcher identified a phenomenon that had been ravaging communities within the health service sector especially the delays of pregnant women in reporting for labour. A showcase of supporting this view has seen the introduction of the maternity and child health care programmes.

The Maternity Guideline SA (2015: 13) reports that the maternity and child health care programmes are guided by the general development policies within the health sector, which are focused on meeting the basic needs of rural and urban communities, maximising human resources potential, enlarging the economy, and spreading its benefits to all South Africans. This has necessitated the Minister of Health at the time as matter of compliance to stick to those policy guidelines and announced free health care services for pregnant women and children under the age of six years in July 1994 (Maternity Guideline SA, 2015: 13). The Minister of Health has identified maternal health care as a priority area requiring urgent action in South Africa. More importantly, this is in line with the target to achieve the Sustainable Developmental Goals (SDGs 3) that is good health and well-being, as well as achieve the target set in the National Development Plan (Maternity Guideline SA, 2016: 10), which states that by 2030, deaths among pregnant women and babies must be reduced.

## **1.2 BACKGROUND TO RESEARCH PROBLEM**

Pregnant women derive a larger than life setting from the feeling of carrying an unborn child. From this perspective, that feeling develops at an individual level to family affair, which extends to the macro environment, the community and spilling over to the entire country. The relationships formulated in between the period pregnant women are expecting the birth of the child is well explained and detailed in the application of theory, Social Ecological Model (SEM) (Bronfenbrenner, 1994: 38) in Chapter 2. This is in alignment with safe motherhood from the moment the woman is pregnant, during labour and postnatal care specifically how the child survives in the uterus. Issues of safe motherhood attracted action from the World Health Organisation (WHO) Maternal-Baby Package, which emphasised that the key to safe motherhood is appropriately dependent on the availability of well-trained midwives (WHO, 1999: 18). Safe motherhood is defined as the provision of high quality maternal health services during pregnancy, delivery and in the postpartum period to ensure that the health of the mother and the infant pose less threat or is without complication (WHO, 2000: 23). Objectively, the definition is precisely what any government would wish to achieve but observations highlight a tendency of pregnant women delaying reporting for labour, which may cause unwarranted complications like postpartum haemorrhage, foetal distress and third degree perineal tear (Maternity Guideline SA, 2015: 58).

The availability of skilled attendant at birth is extremely crucial to protect not only the mother from life-threatening complications arising during child birth, but also for the new-born, who might need immediate resuscitation to survive if such a situation may arise (Maternal, Newborn & Child Survival, 2010: 20). Skilled birth attendants have a role to play in that they have to prepare pregnant women for giving birth. This includes counselling during antenatal care (ANC) about signs and symptoms of the onset of labour pain. Prior decision about the place of birth together with means of getting transport and how to avoid delay owing to diverted traffic for which if that could not be addressed are also crucial. These may cause delays in reporting for labour that can result to delivery at home or delivery en-route to the hospital when women enter the active stage of labour rapidly (Maternal, Newborn & Child Survival, 2010: 20).

In the study conducted by Mogawane, Mothiba and Malema (2015: 1) at Dilokong Hospital in Limpopo Province, it is pointed out that pregnant women delay reporting to a clinic during labour because they first use the indigenous practices, such as procedures executed for prevention of bad spirits and practices for a precipitated delivery process. Although there are similarities in terms of the main issue, which is delaying of reporting for labour by pregnant women, the objective of the study has little to do with inyangas (traditional healers) as it was found in the article (Mogawane et al. 2015: 1). The scenario placed in this study may not be addressed the same way but it creates a fertile ground for other researchers to explore the inclusion of herbal practitioners, managers, professional nurses, policy makers, and traditional elders to broaden the study.

Kumbani, Bjune, Chirwa, Malata and Odland (2013: 7) report that women are reluctant to give birth at health facilities owing to health practices attitudes. According to Pearson, Larsson, Fauveau and Standley (2006: 64), three deadly delays that can contribute to fatal consequences to both mothers and newborns are as follows:

- Delays in recognising problems and deciding to seek care whereby pregnant women do not understand complications, as serious;
- Family members delay seeking care and spiritual and cultural beliefs may reinforce delays or result in other treatment;
- Delays in transportation to reach appropriate care due to lack of transport or funds and distance and travel time to reach health facilities; and
- Delays in receiving appropriate care at the health centre owing to lack of appropriately trained staff and negative attitudes of health care workers and lack of essential equipment, drugs and supplies.

Through practical observations, delays in reporting for labour may contribute to a life-threatening situation and complications at birth. These require a rapid response from skilled professionals, failure to receive immediate assistance could lead to incidents like postpartum haemorrhage as one of the complication that can cause the postnatal death of a woman within a few hours (Maternal, Newborn & Child Survival, 2010: 10). There is also a high risk of maternal mortality for young pregnant woman who is left alone in the household (Maternal, Newborn & Child Survival, 2010: 10) for which a

young woman during labour, she may not find assistance whether in the form of finding transport means to reach the health facility or lack of information on signs of labour. This is often the case in rural areas like Mopani District where such anomalies were detected. Observation of delayed reporting has been noted in some primi-gravida and some women with previous complicated labour and deliveries (Maternal, Newborn and Child Survival, 2010: 20).

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

In the face of duties, the researcher found interest in investigating delays by pregnant women around their visits to the health facility and so prevalent as demonstrated by the selected couple of cases indicated here. First case, a woman who was delayed in reporting for labour due to community strike and she was a previous caesarean section birth x1, the baby was born with birth asphyxia and was an unbooked case who delayed arriving at the health facility fully dilated and had a complicated compound delivery where the left knee flexed to the face wherein a plaster of Paris was applied. Second case, a woman who contracted HIV and on treatment with an elevated viral load of about 139000 delivered a low birthweight child of 2kg at home putting the baby at risk while she made follow ups at high risk clinic, baby was admitted at neonatal nursery. Third case, another woman had two previous caesarean birth, attending the high risk clinic delayed reporting for labour due to lack of transport because she was refused to board on taxi due to her pregnancy for fear that she may deliver inside the taxi. A study such as this is crucial as an attempt to suggest ways that will curb delays by pregnant women in reporting for labour.

As for the case in many rural areas of Limpopo, Mopani District is facing the challenge with pregnant women in labour who are delaying reporting to the clinic during the initial phase of labour. They go through labour at home and in most cases, they only go to a health facility when the labour pains are unbearable. Reporting late in the hospital after the onset of labour pain poses grave risk to the mother and the baby of being unattended during delivery, and there could be occasionally abnormal fast labour called precipitated labour resulting in delivery on the way to hospitals. The researcher conducted this study to explore and to determine the factors that influence women to delay in reporting for labour in Mopani District. A study by Ngomane and Mulaudzi

(2010: 1) supports the above fact from the district maternal health data, collected and analysed for more than 10 years at Bohlabela District in Limpopo that pregnant women did not fully utilise the antenatal services. In that study, Ngomane and Mulaudzi (2010: 1) found that pregnant women delayed attending to the antenatal services or reporting for labour because they first experimented with the indigenous beliefs and practices.

According to survey report by Saving Mothers (2014-2016: 27), about 1 238 women delivered at a Mopani Regional Hospital, 470 (5,8%) pregnant women who delayed in reporting for labour were admitted at the hospital. The results showed that there was various postnatal complication - Postpartum haemorrhage (7,5%), retained placenta (8,5%) and puerperal sepsis (7%), maternal death (2.21%) and also reported differences in stillbirth rate (16,6%) and neonatal death rate (1,5%), babies born before arrival (BBA) 2, 2% (Saving Mothers, 2014-2016: 27). All these give an indication to establish the influencing factors that cause women to delay in reporting for labour in the Mopani District Municipality.

A study which explored the reasons for late booking and also to determine pregnant women's knowledge, perceptions and attitude towards antenatal care services was conducted in the Mthatha area in Eastern Cape, South Africa (Pitso, Kheswa, Nekhwevha & Sibanda, 2014: 611). Pitso et al. (2014: 611) intended to determine pregnant women's knowledge, perceptions and attitude towards ANC. Many of these studies focused on ANC late booking including one by Manda-Taylor, Sealy & Roberts (2017: 2) but most interestingly, the present study observed strength in paying attention on delays in reporting for labour by pregnant women. Although the aim was not necessarily to make comparison with other researchers, it was important to note weaknesses and strength of other studies so as to give credence to current study. Besides, there are similarities though because this same ANC late booking and delayed reporting for labour contribute to increasing rates of maternal mortality and morbidity.

Little knowledge or lack of knowledge shown by pregnant women has always been a hindrance of any progress and even general success. By merely looking at the frequency with which pregnant women delayed reporting for labour, the situation warranted personal commissioning of this study with the view to capacitate pregnant

women about pre/intra/postnatal care practices and improve quality of postnatal care (Ngunyulu, Mulaudzi & Peu, 2015: 2). To provide knowledge to pregnant women which could be classified as tacit knowledge, would go a long way in improving and saving their lives of the pregnant women and that of the unborn child. Tacit knowledge is according to Arling and Chun (2011: 232) oriented towards an action, an experience and a commitment of actors in a specific context in this case health practitioners and pregnant women, it goes beyond what people can express. In order to educate pregnant women about minimising delays flyers and electronic communication could be used to give pregnancy information and time remaining towards giving birth.

#### **1.4 RESEARCH AIM/PURPOSE**

The study aimed to explore and describe factors influencing the delay in reporting for labour by women in Mopani District Municipality to evaluate the impact of the delay in the process of labour and to develop recommendations to address the contributory factors.

#### **1.5 RESEARCH OBJECTIVES**

- To identify and describe factors that contribute to the delay in women reporting for labour in Mopani District.
- To assess and evaluate the impact of the delay in reporting for labour on the process and outcomes of labour.
- To develop recommendations to address the factors that contributes to the delay in reporting for labour.

#### **1.6 RESEARCH QUESTIONS**

- What are the contributory factors influencing the delay in reporting for labour by women in Mopani District?
- What is the impact of delay in reporting for labour on the process and outcome of labour?
- What recommendations can assist in addressing the factors that contribute to the delay in reporting for labour by women in the Mopani District?

## 1.7 DEFINITIONS OF KEY CONCEPTS

**Delay in reporting:** The postponement of a situation usually as the result of observation and inquiry because of something of occurrence that impedes its commencement (Blackwell's Nursing Dictionary, 2007: 171). In this study, the pregnant women in labour mostly delay in decision-making a decision to seek care and this usually occurs at the household level and include problem related to recognition of the complication and the nature of pregnancy being a life-threatening condition or emergencies.

**Factors:** Something that contribute to the production of a result (Blackwell's Nursing Dictionary, 2007: 224). In this study, the factors imply to reasons that contributed to women delaying reporting for labour at the specific health facility. There are quite a number of factors that caused delays in reporting for labour and are discussed in another section of this study.

**Pregnancy:** The state of carrying a development embryo or foetus within the female body and it is conventionally divided into three trimesters, each roughly three months long and can be indicated by positive results on an over the counter urine test and confirmed through a blood test, ultrasound, detection of fertile heartbeat or an X-ray (Blackwell's Nursing Dictionary, 2007: 476).

**Women:** In relation to the study, it refers to adult human beings who are biologically female, that are capable of bearing off-springs (Oxford English Dictionary, 2016).

**Labour:** Labour is a physiological process during which the foetus, membrane, umbilical cord and placenta are expelled from the uterus (Blackwell's Nursing Dictionary, 2007: 324). In this study, labour begins when there is persistent painful uterine contraction accompanied by at least one of the following signs: change in cervical effacement and dilation, ruptured membranes and show (Maternity Guidelines in South Africa (2016: 40). At this stage, a physical abdominal and per-vaginal examination is conducted to confirm the labour in preparation for delivery.

## **1.8 RESEARCH METHODOLOGY**

A qualitative descriptive approach was followed within the context of the study in Mopani District Municipality, Limpopo Province. Qualitative approach is the investigation of a phenomenon, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck, 2012: 739). A qualitative approach was chosen for this study, with the selected participants expected to share and express their feelings and experiences pertaining to delaying reporting for labour at the hospital. To use a qualitative descriptive approach is advantageous because it is rich and detailed information about the affected population, plays an important role of suggesting possible relationships, causes, effects and dynamic processes, can allow people to open up and for new evidence that was not initially considered, provides a holistic interpretation of the detailed processes that have and shaped people's lives, permits researchers to access data on difficult issues, does not require many respondents and due to researcher's involvement, it allows researcher to gain an insider's view of the topic on the basis of personal interest with insider knowledge characterized by intimacy more specifically to a particular group and singular group, and a singular community and can be subjective (Sikes, 2008: 145).

## **1.9 RESEARCH DESIGN**

The study adopted the interpretivist design. According to Mark (2010: 7), this type of research allows individuals to socially construct meaning from the phenomenon. The use of unstructured interviews created a dialogue between the researcher and the selected participants (Wahyuni, 2012: 71).

## **1.10 POPULATION AND SETTING**

### **1.10.1 Population**

According to Ross (2005: 2), population involves people, institutions and/or objects that have got the core function to assist the researcher collect data or find answers to the study. The target population were pregnant women who reported late for labour at

Mopani District Municipality Hospital. Those participants who have just been discharged to their respective homes were traced by using ward register including those who may have delivered a shorter time before they enter the health facility.

### 1.10.2 Setting

The study site was a maternity hospital ward within the Mopani District Municipality and surrounding villages. Mopani District Municipality is one of the five districts of Limpopo Province of South Africa. The majority of its 1,092,507 people speak Xitsonga or Northern Sotho within the area of 20,011 km<sup>2</sup>. Mopani District Municipality consists of five municipalities: Greater Giyani Municipality, Greater Letaba Municipality, Greater Tzaneen Municipality, Ba-Phalaborwa Municipality, and Maruleng Municipality.

The map below labelled Figure 1.1 is the Mopani District Municipality map showing where the study was conducted.



**Figure 1: The five district municipalities that constitute Mopani District Municipality**

Some of the following hospitals around Mopani District refer selected cases depending on the complexity from the clinics and district hospitals to the regional hospital where this study was conducted. The hospitals include Dr CN Phatudi Hospital in Tzaneen (district hospital); Kgpane Hospital in Duiwelskloof (district hospital); Maphutha L. Malatjie Hospital in Namakgale, Phalaborwa (district hospital); Nkhensani Hospital in

Giyani (district hospital); Sekororo Hospital in Trichardtsdal (district hospital); Van Velden Memorial Hospital in Tzaneen (district hospital) and Letaba Hospital in Tzaneen (district hospital). Ideally, the chosen site is based on the accessibility for pregnant women and the researcher whether during the labour stage, data collection and analysis. The pregnant women were interviewed at the healthcare facility post-delivery when they report for follow-up care or at their respective homes.

## **1.11 DATA SAMPLING**

According to Klopper (2008: 69), a sample is a subset of the population while sampling is the process of selecting the sample specifically for a particular study. A non-probability purposive sampling technique was used in this study. A purposive sample was achieved by involving only those pregnant women who delayed reporting for labour and those who delivered just before they entered the health centre (Polit & Beck, 2012: 521). There were no fixed rules for sample size in qualitative research but based on informational needs, that is women who were interviewed until data saturation was reached (Polit & Beck, 2012: 521). For the sake of control and administration, just less than 20 participants were requested to take part in the study.

## **1.12 DATA COLLECTION METHODS AND PROCEDURES**

Data collection is the gathering of information to address a research problem (Polit & Beck, 2012: 726). The current study employed unstructured face-to-face interviews to collect relevant valuable data about women who delayed reporting for labour in the hospital, which is situated at the Mopani District Municipality. Open-ended questions are preferred in order to extract answers from the participants. Participants were responding to the questions to help answer the main question, “What are the contributory factors that delay pregnant women in reporting for labour?”

The subsequent questions are more focused and are a direct manifestation to the main question. The researcher was asking probing question in order to obtain clarity on issues that may seem insufficient. All interview sessions lasted for 60 minutes and data were recorded by using audio-recording equipment. The use of an audio-recording equipment during the face-to-face interview provides accuracy of data

collected. In other words, responses are captured in verbatim mode. Field notes were written to capture non-verbal cues that were not be captured by voice recorder to supplement the data collected (Polit & Beck, 2012: 535). After the interview process is completed, data were transcribed.

### **1.13 DATA MANAGEMENT AND ANALYSIS**

According to Noble and Smith (2014: 1), qualitative data analysis (QDA) is the variety of processes and procedures followed where the collected data are transformed into a kind of explanation, understanding or interpretation of the people and situations investigated in the study.

Content analysis of data were used in this study following the three steps:

- The researcher has to know the data: This involves reading and re-reading of text and in case of listening to recordings, listening must be done for several times.
- Focus the analysis: This requires reviewing the purpose of the evaluation by identifying a few questions that the researcher wants the analysis to answer; here data were organised by following how participants have responded to questions; and
- Categorize information: In this last stage, data are coded while themes or patterns are identified (Taylor-Powell & Renner, 2003: 2).

### **1.14 LITERATURE REVIEW**

Health care related researches around the world are extremely concerned about mortality and morbidity rate amongst pregnant women in the course of delivering young life. The WHO (2012: 16) went on to classify countries where most maternal mortality and morbidity occur, that is in low and middle income countries and this could be preventable as long there is political will and power to do so. In a quest to resolve the impasse, these researches discovered factors that cause delays for women in reporting for labour including inadequate knowledge of signs and symptoms of illness and services available, cost of services (from home stead to health centres), lack of

transport options and poor quality care (Mannava, Durrant, Fisher, Chersich & Luchters, 2015: 2). The researcher is of the opinion that since this study is conducted in a different region, province and country than where other researchers had made their findings, most probably a new body of knowledge could be generated. This section served as precursor, more details on the literature shall be obtained in Chapter 2.

## **1.15 ETHICAL CONSIDERATIONS**

Ethical procedures and processes need to be considered as required by authority. Risks and ethical constraints became part and parcel of this research study. Ethical clearance was obtained from the University of South Africa Research Ethics Committee (UNISAREC).

Ethical considerations included, among others, the protection of participants' rights, informed consent and the ethical approval (Klopper, 2008: 71). Protection of rights means participants would sustain no harm whether physical or psychological, emotional or even discomfort (Scott, 2013: 79). Names of all the participants were withheld (Scott, 2013: 81) and replaced by pseudonyms as it possesses psychological meaning to both the participants and the content and process of the research (Allen & Wiles, 2015: 01). In addition, participants were informed about the voluntary participation that they may not expect to be paid since there was no sponsor for the research study and that the study was for personal development (Scott, 2013: 79).

According to Satyanarayana-Rao (2008: 1), informed consent can in simpler terms be described as an instrument of mutual communicative consensus between a researcher and participant with an expression of permission/choice by the latter for the researcher to use data collected from participant. An error of judgment in providing less adequate information (Scott, 2013: 79) by researcher could mislead the participant to arrive at an improper decision. Therefore, accurate, adequate and relevant information must be provided truthfully in a simple language that the participants understand and thereby give appropriate responses to the questions that have been posed (Satyanarayana-Rao, 2008: 1). Only participants who are 18 years

and above were selected to partake in this study because at this stage of life, they are matured and can make informed decisions.

There are similarities between informed consent and assent. The OHRRPP (2016: 2) listed factors of informed assent, the researcher has to follow the process below:

- To decide in a manner and location that ensures participant privacy;
- Giving adequate information about the study in a language understandable to the participant;
- Providing adequate opportunity for the participant to consider all options;
- Responding to the participant's questions;
- Ensuring the participant has understood the information provided;
- Obtaining the participant's voluntary agreement to participate; and
- Continuing to provide information as the participant or research requires (OHRRPP, 2016: 2).

## **1.16 SIGNIFICANCE OF THE STUDY**

Women face normal challenges that occur between the first and last day of pregnancy like amenorrhea, nausea and vomiting (Sellers, 2012: 168). In this study, the challenge of delayed reporting for labour was identified as mammoth task for pregnant women.

Therefore, with this short background the research intends to uncover the factors that cause delaying reporting for labour and assessing the impact of such delays while eventually strategies to fix the situation were sought. In summing up, the Limpopo Provincial Department of Health will know about the causes of delays in reporting for labour and therefore will put on the table sufficient resources to minimize or eradicate the scourge of delays by pregnant women. Sufficient resources could be in the form of human (in the case where healthcare staff members are not enough), extra personnel could be hired, and if fixed and movable assets are not enough, more could be budgeted for and purchased.

## **1.17 SCOPE AND LIMITATIONS OF THE STUDY**

The focus of the current study was based at Greater Tzaneen Municipality and its surrounding villages where most pregnant women population who delayed reporting for labour were selected. The researcher also utilised one of the health facilities, a hospital, clinics and households within the Greater Tzaneen Municipality as a source of information, especially details of pregnant women who delayed reporting for labour. Theofanidis and Fountouki (2019:156) describe limitations as some aspects that concern potential weaknesses usually out of the researcher's control and are closely associated with the chosen research design, statistical model constraints, funding constraints or other factors. Theofanidis and Fountouki (2019: 156) further highlight that a limitation is an imposed restriction which is therefore essentially out of the researcher's control and has the potential of affecting the study design, results and ultimately conclusions, and should therefore be acknowledged clearly in the research study.

There are quite some limitations:

- Sample size: thirteen (13) sample participants were interviewed while the initial planned target was 25 pregnant women who delayed reporting for labour. These women their ages ranged between 23 and 42 years, were willing to participate and able to give consent to participate in the study. The size of the sample which according to the limitation definition was out of researcher's control, however data saturation was reached.
- The interview was conducted in Tsonga, which is not the first language of some participants, this could have made them failed to express themselves clearly of what made them delay reporting for labour.
- Theofanidis and Fountouki (2019: 156) stress that qualitative data analysis methodology is another area of potential limitation and cannot be entirely replicated. Qualitative data analysis does not involve analysis based on numerical values which is why analysis cannot be replicated. Most importantly, all of the above limitations must be clearly stated so that results of the research

study may not be distorted and misinterpreted by the wider readership or academic audience (Theofanidis & Fountouki, 2019: 156).

- An issue of time as limitation was also found to contribute on the negative drive of little progress on the study. Simon (2011: 2) shows that a study conducted over a certain interval of time is a snapshot dependent on conditions occurring during that time. Those pregnant women who reported late for labour, were in a hurry to go home immediately after delivery of the baby, after having spent almost six hours in the ward. This prompted a change of plan since seeing them in the health centre was impossible. The researcher acquired their personal phones and arranged to meet them at home for the interview which ultimately took place.

## **1.18 CONCLUSION**

The first chapter has ended and its ultimate purpose was to provide an overview of the study. At the centre of this study was the observation of cases where a huge number of pregnant women are facing the challenge of delaying reporting for labour. The problems had necessitated drafting of the main research question and formed the basis of this research study. As the chapter progressed, it provided brief explanatory aspects of the research design and methodology; data collection and sampling; significance of the study, and its limitations as well as ethical considerations. Chapter 2 will focus on the literature review while chapter 3 will deal with research design and methodology with chapter 4 providing reports and discussion of results, and lastly chapter 5 will deal with conclusion and recommendation.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter focuses on providing the definition of labour and its signs and symptoms, the factors that cause delay in reporting for labour, the effects of delays, the importance of early reporting and strategies used to improve delays as studied by other researchers. The socio-ecological model (SEM) is applied within the context of the study. The findings and recommendations from other research studies have been referred to with the aim of shaping the current research.

#### **2.2 OVERVIEW OF THE SOCIO-ECOLOGICAL MODEL (SEM)**

Every birth counts; every death no count (Bradshaw, Chopra, Kerber, et al., 2008: 01). Maternal mortality and morbidity have widely been researched and reported in Nepal, with findings showing maternal death by haemorrhage (24%); eclampsia (21%) and death occurring while in transit to or from health facility (14%) (Krishna, Pradhan, Barnett, et al., 2009: 9). The above unfortunate incidents, delay in reporting for labour resulting into loss of life before or during labour should be condemned through deeds, working hard to minimise the problem and through research. People, society, government, and other stakeholders have a role to play in ensuring that maternal mortality and morbidity is kept under wraps to grow the nations.

A delay in reporting for labour has an adverse effect for both the mother and unborn infant with countless number of incidents occurring including for example, giving birth on the way to the health facility. The socio-ecological model (SEM) was employed based on the view that whatever happens to the pregnant women during pregnancy and towards delivery of the baby directly or indirectly affects the unborn child. The SEM is described as theory whose role is to insure that individuals dynamically interact with their environment across time by actively shaping and being shaped by their environments (Lounsbury & Mitchell, 2009: 215). For the unborn child to survive in his

or her mother's uterus, the mother has to follow certain ANC practices including constant check-ups at the health facility where health practitioners would assess the foetal condition in the maternal utero.

Ideally, the SEM in this study serves to identify participants' characteristics on how they link to the objectives of the study and the manner in which pregnant women react to the close environment wherein they live. The SEM consists of the Micro System, Meso System, Exo System, Macro System and Chrono System (Bronfenbrenner, 1994: 38). In the Micro System, the pregnant woman and unborn child occupy the immediate environment with the woman sharing the outside and the child sharing the inside, the utero environment. A pregnant woman who attends ANC would receive information of birth preparedness, signs of labour, complicated deliveries and will react positively in order to avoid delays in reporting for labour than those who did not attend. This has got more to do with a pregnant woman's choice to attend ANC.

Under the Meso System, a pregnant woman without any support from family members because they are unemployed coupled with financial constraints are at risk of delaying to report for labour as she would see no value in urgently attending to labour pains. The pregnant woman will not have family support, to talk to and without money for transport, she will have no choice than to walk a distance to the health facility and ultimately causes her to delay. Under the Exo System the pregnant woman may delay reporting for labour due to peer pressure influence from friends wherein friends may advise wrongly due to fear that she may be transferred from the clinic to the hospital for the caesarean section. This fearfulness of operation on the womb is likely to cause the delay, and leads to the pregnant woman to deliver at home or arrive late in the hospital after discovery of labour complications.

Under Macro System, a pregnant woman with mental instability who believes in different religion sees pregnancy as just another illness and may delay reporting for labour as she will firstly seek help from the surrounding environment like the prophets and traditional healers to confirm the labour pains. Under the Chrono System, the environmental changes or relocation where a pregnant woman moves from one area to the next, a move from one clinic to the other which is miles away has an element to delay the pregnant woman from reporting for labour. The role of the SEM was to assist

link the factors that cause pregnant women to delay reporting for labour to the findings that would come out from data collection and further link those findings to the recommendations as well as future research.

## **2.3 LABOUR**

### **2.3.1 Definition of labour**

Labour is a spontaneous process considered as physiologically natural prior to giving birth with limited or no intervention that occurs between 37 completed weeks and 42 weeks with the foetus presenting in the vertex and is completed within 18 hours with both the mother and the infant in good physically and psychologically wellbeing condition (Sellers, 2012: 314). Labour is a physiological process during which the products of conception that is the foetus, membranes, umbilical cord, and placenta are expelled outside of the uterus (Blackwell's Nursing Dictionary, 2007: 324). Labour is achieved with changes in the biochemical connective tissue and with gradual effacement and dilatation of the uterine cervix because of rhythmic uterine contractions of sufficient frequency, intensity, and *duration* (American College of Obstetricians and Gynaecologists (ACOG), 2003: 1445).

Labour or the moment towards baby delivery is an overwhelming event that many female individuals would like to prove their worth through giving birth to a child. While they are highly expecting more from the pregnancy, every minute, hour and days of the week bring with them many challenges which may likely lead to delays in reporting for labour.

### **2.3.2 Signs and symptoms of labour**

The Maternity Guidelines in South Africa (2016: 40) posits that labour is diagnosed if there are persistent painful uterine contraction accompanied by at least one of the following signs: change in cervical effacement and dilation, ruptured membranes and show.

## **2.4 CAUSES OF DELAY IN REPORTING FOR LABOUR**

A new concept had been coined to give perspective on consequences of delaying reporting for labour, and that is a maternal near miss. A maternal near miss is defined as an act of woman who was very close to parting ways with mother-earth because of delaying reporting for labour but survived a complication during pregnancy or childbirth (Pattinson & Hall, 2003: 231). Interestingly, these maternal near miss individuals have a second chance in life to learn from their mistakes but above all to become witnesses in the form of providing evidence in villages and health facilities to educate those who could have thought they still could maintain other forms of defiance to delay reporting for labour.

Previous literature reflects the many causes of delay in reporting for labour as observed by various researchers. In the next sections, possible factors that cause delays in reporting for labour will be discussed.

### **2.4.1 Environmental Factors**

Limpopo Province had been identified as home of multitudes of poor people and Mopani Region, one of its district municipality is no stranger to poverty. This comes as no surprise that one clinic services nearly three or more villages. The situation is similar to what Pell, Meñaca, Were, et al. (2013: 3) found in the study conducted in Kenya, Malawi and Ghana where women had to walk longer distances to health facilities to attend the ANC. This is not a temporary inconvenience but permanent since government pleads poverty when communities demand that health facilities or clinics should be established in each village.

Soma-Pillay and Pattinson (2016: 1110) listed the three phases contributing to delays in reporting for labour, that is:

- the community-level factors associated with delay in seeking healthcare;
  - Thaddeus and Maine (1994: 1092) added more aspects in relation to delays on seeking health care which included low status of women, lack of confidence;

- poor understanding of complications and risk factors in pregnancy and when to seek medical help, pregnant women taking pregnancy for granted that there are no complications;
  - previous poor experience of health care, lack of politeness from healthcare professionals; and
  - acceptance of maternal death, the pregnant woman could brush off the previous experience she may have witnessed concluding that nature took its course for that particular individual since she believes death cannot be inherited and financial implications, without money to go to the healthcare facility.
- Factors associated with delay in reaching the health system;
  - Thaddeus and Maine (1994: 1092) further added that distance to healthcare centres and hospitals could delay labour reporting, in the case where the hospital is above 44 kilometres from the village that has an impact on delays;
  - Availability of and cost of transportation,
  - Some villages are situated in awkward areas such that only buses operate in the area and they operate three times, in the morning, afternoon and evening; poor roads, use of uneven gravel roads and infrastructure,
  - Lack of privacy in delivery wards due to lack of delivery rooms and geographical setting like mountainous terrain and rivers, during rainy days, lack of bridges make it difficult for pregnant woman to access healthcare facility.
- Factors associated with delays in the health system.
  - Thaddeus and Maine (1994: 1092) concluded the three delay models by including poor facilities and lack of medical supplies;
  - no delivery beds and medication;
  - limited availability of health professionals;
  - inadequately trained and poorly motivated medical staff;

- lacking the in-service training and workshops by midwifery personnel for recent knowledge update; and
- inadequate referral systems, lacking knowledge of cases or condition of patient to be referred and not sure of referral destination as well as emergency management services (EMS) that may take time to respond to the case.

Chaudhary (2005: 118) also observed that delays of labour reporting were caused by the unavailability of transport owing to a strike or holiday. As much as this could be true even in those areas where the study was conducted, this could be supported or opposed by the findings based on the observations and experiences of the subject in the study. Earlier knowledge about the strike could have informed such pregnant individuals to plan on the routes to take for visitation to the health facilities. External interference similar to one indicated above could be avoided by way of starting treatment in time provided by trained health professionals in an adequate environment. In response, this could lead to establishing a Maternity Waiting Home (MWH) for easier access to the health facility and pregnant women could be assisted by skilled birth attendant way before the strike could commence.

Mugweni, Ehlers and Roos (2008: 10) found that some pregnant women preferred to deliver their babies at home. This gesture is a matter of choice but some women were compelled to deliver at home because the pregnant women had nobody who would remain at home while they visited the health facilities (Mugweni et al., 2008: 9). Ideally, one would raise an argument on the issue of the period taken when visiting the clinics or else it could be regarded as merely a lame excuse. Partly, this experience shows the level with which poverty plays itself in the lives of people, which demands serious intervention from government to improve such aspects by bringing health facilities closer to the people.

To trip and fall owing to misplaced items in the workstation, in particular the labour ward may not seem or look much of an issue until it becomes a matter of discussion amongst pregnant women planning to visit labour wards. Reason (2004: 28) reported in his study that identified the physical environment as having a significant impact on safety and human performance. Employees may not have an intent to err but they may

trip and fall if the area from which they work is congested in such a way there is not enough space to move and work. An environmental evaluation by pregnant women will send a negative message to those who were still planning to visit the healthcare facility with claims of workers' gross negligence.

The link between safety and delays can only be cemented as true and valid after data collection, whether participants in the study will support or reject the notion.

#### **2.4.2 Social Factors**

Phafoli, Van Aswegen and Alberts (2007: 17b) assert that social support has been reported to affect attitudes and behaviours, including satisfaction with pregnancy and labour, delivery and postpartum period. Pregnant women in labour who have high stress and low social support networks have been found to possess more neonatal and obstetric problems than those who have high stress and high social support networks. Therefore, attending antenatal clinics early will assist in the identification of such stress-related factors and/or depression that result in appropriate delay in reporting for labour to the health facility.

Pell et al. (2013: 6) found that unmarried younger women and adolescents delayed reporting for labour owing to the social implications including:

- expulsion from their natal home

For adolescent and/or unmarried younger woman to bear a child was considered a disgrace and an embarrassment to the family as well as a sign of unmannered upbringing. The implication could be that adolescent or unmarried younger woman would leave the pregnancy until the second trimester that it would make suggestion of abortion impossible.

- exclusion from school

Prior the democratic dispensation, a learner could be dismissed from attending school owing to pregnancy. Frustration of the learner could become huge causing the learner to nurse the frustration and forget the pregnancy ultimately causing delay in reporting for labour. According to the South African Schools Act (SASA),

84 of 1996, policies in relation to teenage pregnancy were enacted (General Manual for the Suspension and Expulsion of Learners from Public Schools) to oppose and replace the section contained in Circular 0077/98.

In addition, the Section 29 of 1996, RSA Constitution postulates that everyone has the right to education and therefore exclusion from school for pregnant teenagers is not an option. Hence, the regulations are in place, unfortunately schools do not have educators who are trained in such a way that they can identify labour ready learners resulting in further delays in reporting for labour.

- abandonment by partners

The aspect of abandonment by partners during pregnancy added numbers in women's risk of becoming victims of intimate partners ending in homicide or suicide of that abusive relationship (Campbell, Webster, Koziol-McLain, et al., 2003: 1090). Too much investment of emotions, money, status or pride seems to be attached between partners such that any spell of divorce triggers either homicide or suicide, whichever way goes first without thinking first of the unborn little baby. This may result in running away from the situation which makes it difficult for the pregnant women turned victim of abuse seeing no value into attending the ANC that to focus on safety first. This will delay the pregnant women in that they will not attend the ANC where they could be given information about pregnancy, labour and postnatal period.

- Gossip

A careful consideration of gossip as a concept, it may not directly affect delay in reporting for labour. Gossip is described as a loose, typically evaluative talk that emerges from intimacy with similar degree of trust or shared background at least asserted between participants and it is the talk of a dyad or small group (Adkins, 2017: 8). For instance, if a pregnant woman receives information that some people or even friends are talking about her of being impregnated by another man while she is married, that alone would create cause of delay in reporting for labour. Pregnant women may end up placing herself under self-incarceration because she may not have the guts to face the world, loosing focus on the most fundamental duty of ANC, delivery and postpartum care.

- Stigmatization

There exists an interconnectedness between gossip and stigmatisation. Quite a number of definitions have been made to simplify the meaning of stigma. In their article, Link and Phelan (2001: 1) define stigma as the co-occurrence of its components – labelling, stereotyping, separation, status loss and discrimination and further indicate that for stigmatisation to occur, power must be exercised. These listed aspects become the centre of gossip and at most may lead to solitary confinement eventually delay reporting for labour because the pregnant woman will be scared to walk in the public eye under such conditions. In most cases, these delays occur because there is limited contact and consultation, which is a natural gap between parents and children to support such individuals. The same goes to pregnancy that was caused by rape. A pregnant woman may choose to conceal the father since it was not out of consensual sex and therefore it may cause a great depression to the pregnant woman to the level where she cannot think of ANC until delay in reporting for labour mounts up.

#### **2.4.3 Psychological Factors**

A hospital or clinic both are regarded as a place where health problems needing utmost care and polite handling are priority. Women who have experienced negative perception of treatment during labour may influence prospective women in labour who are still to visit the health facility claiming that they may experience similar treatment and that will ultimately make them to delay reporting labour. A dissatisfaction had been reported involving attitude in the manner in which health practitioners (nurses) welcomed pregnant women standing at 85%; patience of nursing staff 74%; friendliness of nursing staff 73% and talking to people in an understandable way 73% (Mugweni et al., 2008: 8). This kind of treatment has the potential of driving people away for fear that they will experience similar bad treatment. Such individuals may only turn to the health facility at the later stage of pregnancy or delivery stage.

In some instances, aspects raised by pregnant women bring alarm to how professional health practitioners are and conduct themselves at work. Some findings revealed that

pregnant women stated that some health staff members were merely rude (Mugweni et al., 2008: 9).

Unprofessional conduct cannot be tolerated as it brings the name of the health profession into disrepute (Nursing and Midwifery Council (NMC), 2009:06) and can eventually lead to disciplinary action taken against the employees. At times, physically disabled persons are likely to delay reporting for labour fearing that staff members will chastise and/or speak harshly against decision to become pregnant while they are disabled (Kuttai, 2010: 92). The same experience may be shared by mentally retarded persons who fail to comprehend exactly the implications and importance of visiting the health care facilities for the ANC, delivery and postnatal care.

#### **2.4.4 Economic Factors**

Generally, the economic downturn of the country affects everybody including those pregnant women. As described in one section above, the abnormal situation of health facilities situated far from the people creates negative results for most pregnant women. From the study by Metcalfe and Adegoke (2012: 98), it was found that home delivery with an untrained birth attendant was less expensive than one conducted at the health facility. Since pregnancy visit is not a once off event, this may likely be a contributing factor to deciding on visiting during the last minute of labour. Also taking into cognisance, pregnant women need a special diet, clean environment and care about weather conditions. All these may be costly under such low economic circumstances where there is little or lack of income.

Brooks-Guun and Duncan (1997: 55) describe income poverty as the condition of not having sufficient income to meet the basic needs such as food, clothing and shelter. This type of situation has the potential to increase the probability of teenage girls to experience a non-marital birth and/or even adults (Haveman & Wolfe, 1994: 3). Although at the current stage it may not be confirmed in the South African context, teenage girls or even adults in low-income families may be tempted to have non-marital birth owing to the monetary grants provided to poor persons with children who are less than 16 years old. To counter the scourge of poverty, the Department of

Education (DoE) introduced the feeding schemes at public schools in order to encourage learners to frequently attend classes.

The economic factors did not only expose a particular weakness on the part of individual pregnant women in general but government departments. In their study, Sychareun, Phengsavanh, Hansana, et al. (2009: 5) listed maternal problems that seem to be caused by government department. These include the following:

- Poor health services, unavailability or little health infrastructure like clinics;
- Poor human and financial resources, inability to hire health employees owing to inadequate funds;
- Inadequate maternal health services, not extending provision for clinics to assist pregnant women who give birth during labour;
- Low awareness on reproductive health, less educational campaigns or marketing of safe child delivery;
- Safe motherhood, inability to continue with postpartum care immediately after baby delivery; and
- Modern contraceptive methods, unavailability of a variety of preventative measures against unplanned pregnancies.

At the centre of these uncontested territory and necessities, a huge amount of money is involved, which makes it difficult for provinces or rural municipalities to meet such demands.

The United Nations (UN) (2010: 8) posits that majority of deaths during pregnancy stage occurred in low-income countries. With South Africa rated as the third richest country in Africa, just behind Nigeria and Egypt, this could be interpreted to imply that South Africa is not a low-income country. For the researcher, it would be pleasing to explore and determine unfamiliar factors causing delays in reporting for labour since the South African context is confusing and full of contradiction in terms of affordability against its gross domestic product (GDP) income.

#### **2.4.5 Emotional Factors**

As stated by Department of Health, Western Australia (2009: 20), giving birth is an emotional feeling to high-risk women who constantly live with previous experiences in sexual abuse making them uncomfortable during genital area examinations and delivery. Owing to the previous experiences, pregnant women may develop an acute stress reaction or post-traumatic stress disorder (PTSD) caused by firm accusations from husbands, relatives and in laws regarding the abuse (Department of Health, Western Australia, 2009: 23).

Therefore, it becomes easier for the pregnant women to pick up a fight which subsequently establishes to psychosocial stress and may cause eclampsia and ultimately preterm delivery leading to delays in reporting for labour (Wadhwa, Entringer, Buss & Lu, 2011: 12). People need to understand, be cautious about their interaction and involvement, treatment and conduct when associating themselves with pregnant women. An emotionally disturbed woman may not want to expose bitterness at the health facilities during pregnancy stages hence it may influence the delay in reporting for labour.

As opposed to love, abuse is a concept that can replace love in a relationship. Although abuse in this regard was noted with specific reference to abused teenage girls only, Noll, Shenk and Putnam (2009: 373) highlight that these teenage girls are twice as likely to become pregnant than those without experience of abuse. The abuse may not be reported simply because it leads to two scenarios: if the abuse is reported at the health facilities, health practitioners may encourage reporting the matter to the police; the abuser may be arrested and eventually there would be no one to take care of the unborn child. A predicament similar to the above painted here is emotionally draining such that it might derail possible thoughts of reporting for labour and causing the unwanted delays.

Nobody enjoys a situation where his or her person is belittled, undermined or even ridiculed and if this may happen, pregnant women might as matter of self-pity delay in reporting labour. Ngomane and Mulaudzi (2010: 5) found in their study that participants raised grievance concerns in terms of treatment:

- Nurses making the pregnant women breathe like dogs during labour;

- Disallowing the pregnant women in the use of sitting posing when giving birth;
- On offering an opinion, nurses would laugh and ridicule them, making them to feel small and useless; and
- Being tied to the bed in such a way one is not able to make even the slightest of movement.

On obtaining news such as the ones mentioned in this section, a sensible person withdraw attendance to the healthcare facility with obvious consequences of delay in reporting for labour without investigating the authenticity of the news. The professional conduct of the nurses would therefore be brought into question as this act goes against code of professional ethics.

#### **2.4.6 Educational Factors**

Chaudhary (2005: 120) alludes to the fact that lower literacy had an adverse effect on the attitude and beliefs towards health care including inclination towards regular ANC and preplanning for childbirth. On suspicion, pregnant women with little educational background may find it difficult to understand the value of eating healthier and being selective with the kind of food they need to take during pregnancy. Therefore, these pregnant women may not comprehend the importance of visiting the health facilities in order to be informed about food intake or type thereof.

Lack of or little education has elements of breeding ignorance and it may not be surprising to realise that most pregnant women who delayed reporting for labour possess lesser standards or grades or educational achievement. Killewo, et al. (2006: 408) opine that a number of pregnant women from poorer countries were unable to judge the severity of their disease pathology and may only seek care once their condition becomes life-threatening. Any health educational campaign needs to be initiated by the Health Department where pregnant women could be taught about the importance of the ANC, delivery and postpartum, this could include registration with mobile phones, website such as Mom-Connect (Soma-Pillay & Pattinson, 2016: 1112). On the other hand, waiting for the department to initiate such health services of educating pregnant women could take years to be implemented. Therefore,

communities and volunteers with the help from community health workers should be in the forefront educating fellow villagers on ANC, delivery and postpartum education.

#### **2.4.7 Cultural and Traditional Factors**

Charms and myths seem to have a natural attachment with many of the charms and myths not able to be proven scientifically. Sychareun et al. (2009: 17) list the variety of myths – Myth 1: that herbs and magic water reduced labour pain, treat abnormal discharges and provide strength for women to push during labour. Obviously, pregnant women will focus on gathering strength for the biggest delivery day than waste it during visits to the health facilities. Myth 2: that applying herbal medicine and eggs could lead to easy delivery when applied on the abdomen.

Myth 3: that bad spirits are removed by blowing water on pregnant women with wrists, necks and ankles tied by either a black or red cotton. These myths turn to become magical depending on the level of traditional belief the recipient possesses and generally led to the women folks to avoid seeking care during pregnancy (Choudhry & Ahmed, 2011: 3).

Interestingly, this study is conducted during the period when culture and tradition is fading at an alarming rate and/or huge speed with people embracing what is called civilization. This means people and the society at large have become so diverse in personality with an urbanised outlook dominating the way of life. Myths as pointed above could presumably be the works of traditional healers and it would therefore put the researcher in a position of exploring how the current pregnant women would react to such beliefs. Any opposite view to cultural and traditional practices imposed could be without a doubt a contributory factor to the delays in reporting for labour as pregnant women may feel humiliated to have ankles, necks and wrists tied with a coloured cotton wool. Not only humiliation could become point of argument, but also what Ngomane and Mulaudzi (2010: 2) called the clash of cultures in that health professional midwives adopted the western style of doing things, which contradicts the traditional practices.

Confidentiality of pregnancy remained a matter exclusively reserved for close family members for fear of superstitious acts. Neither friends nor distant family members could be informed about pregnancy progress as this was labelled to be taboo within the society (Ngomane & Mulaudzi, 2010: 4). From the above statement, one could definitely assume that nurses and healthcare practitioners were viewed in light of people who could announce the pregnancy making the pregnant woman vulnerable to witchcraft with the end results being miscarriage and other forms of paralysis of the near born child. All these unofficial curses remained healthcare impediments, which ultimately lead to delay in reporting for labour because knowledge of pregnancy had to be invisible at all costs.

## **2.5 EFFECTS OF DELAYS IN REPORTING FOR LABOUR**

As a developing country, South Africa is experiencing structured socio-economic conditions. Prospective mothers have to travel distances of nearly or more than 15 kilometres with slow transport service to find child delivery assistance to and from the clinic or health facility. The Maternity Guidelines (2007: 7) found that maternal death relates to family or community setting with inadequate or no ANC. A clear solution should be attained and commitment fulfilled to communities either bringing the health services closer to the villages or provide easy access to the health facilities.

The worst-case scenario occurs when there is no income generated in the household. NCPTUP (2011: 1) posits that substantial financial burden to the family and society at large becomes inevitably costly and estimated an amount of R141,7 billion annually lost in tax revenues, public assistance, child health care, foster care and involvement with the criminal justice system. An amount such as the one shown above could be channelled into other projects if delays of reporting for labour could be prevented.

An embarrassment of teenage pregnancy is highly likely to influence teenagers to keep quiet as this would become or create a societal interest. The silent mode ultimately leads to maternal illness, miscarriage, stillbirth, and neonatal death (Maternity Guidelines, 2016: 92) with obvious connotation of such teenagers losing interest in returning to school and by extension will live in poverty as well as rely on welfare or handouts (Luker, 1996: 111).

A huge phenomenon, which establishes a trend and trail of delays in reporting for labour, could be associated with homelessness. Homeless women live in emergency shelters (Hausman, Bonnie & Constance-Hammen, 1993: 1), which is an awkward environment surrounded by alcohol and other stupefying substances that normally remove straight thinking. As a result, such women may delay reporting for labour. This phenomenon does not end in birth of a homeless child but a creation of homelessness in the family tree.

A study about unintended teenage pregnancy recorded approximately 82% in the United States (US) (Finer & Zolna, 2014: 45). Such events of unintended pregnancy cause a high risk of arguments, quarrels, blame games and at most constant stress. Stress has been linked to low birth weight (Cardwell, 2013: 01).

During this period of teenage pregnancy, two aspects come into play: the teenage girl could notify the boy about her pregnancy who might make his intention clear that he is not ready to become a father. In the process, the male teenager would suggest an attempt on abortion. Under this condition, decision-making becomes a predicament needing other people's views, experience and consultation involving parents and health practitioners. At this time, the teenage girl makes a final decision, quite a number of months have gone by without receiving basic health provision from health centres or doctors.

## **2.6 IMPORTANCE OF TIMEOUS REPORTING OF LABOUR**

Act 11, Chapter 2 of RSA Constitution in the Bill of Rights postulates that everyone has the right to life (RSA, 1996). As highlighted by Carroli, Rooney and Villar (2001: 2), early reporting of labour provides an opportune advantage towards life preservation. As a result, maternal mortality shall decline and also effective for the detection, treatment or prevention of condition that may lead to morbidity, monitoring of chronic conditions, anaemia as well as screening for and treatment of sexually transmitted infections including HIV/AIDS. The delivery of unhealthy child would be expensive for government unlike if such circumstance could have been prevented by making ANC number one priority into healthcare matters. Just a mere mention of

chronic conditions means that the individual is time and again in and out of hospital to collect medication for treatment, and this will have to continue indefinitely.

Pregnancy and childbirth complications had been identified as the first of the big five health challenges that would demand priority high impact interventions (Maternity Guidelines, 2007: 08). In relation to this study, family/community and basic antenatal care remained the core aspects priority where interventions will be channelled. The needed interventions will cover aspects on empowerment of mothers, knowledge of danger signs, family planning, and the integrated package including birth preparedness, rhesus testing, sexually transmitted infections, identification and management including syphilis, voluntary counselling and testing, PMTCT, tetanus toxoid vaccination (Maternity Guidelines, 2007: 26).

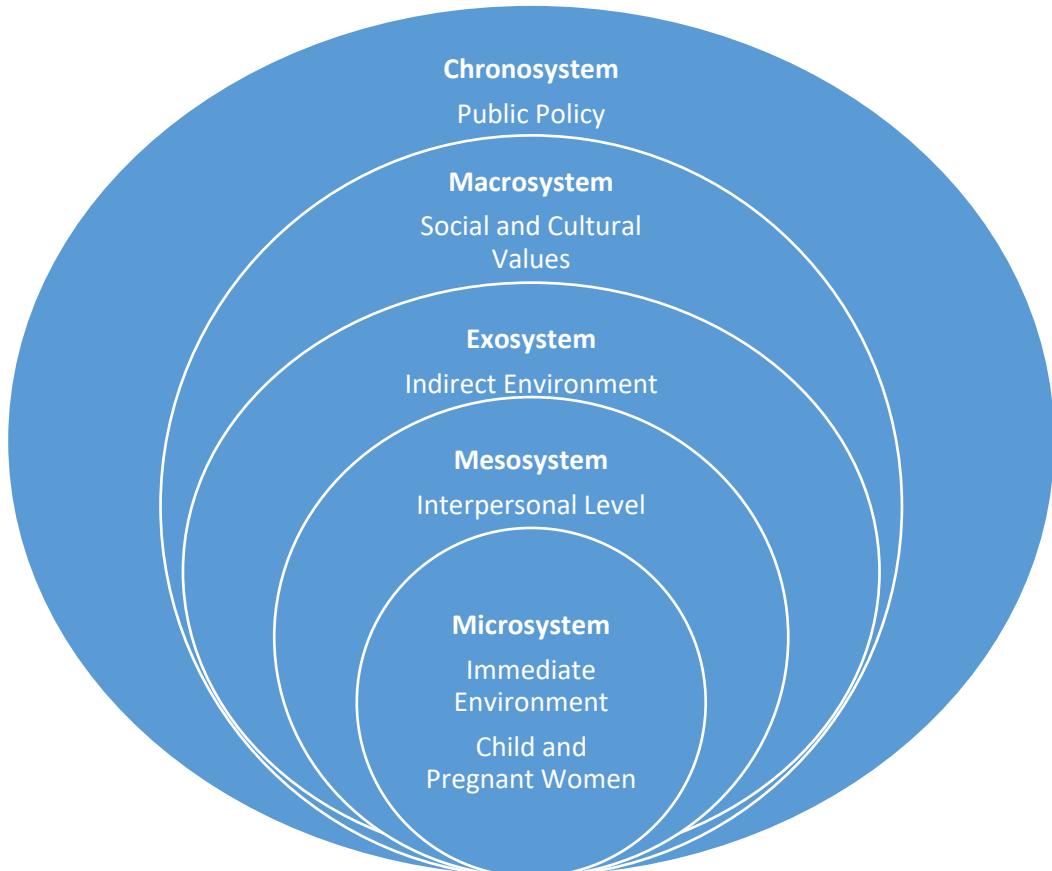
No person, institution or government would condone any form of death whether before or immediately after birth because maternal death during delivery is tragic. The condition to care for the baby does not only occur after delivery but also during the pregnancy phase. This suggests that there is a need to procure the services of skilled trained personnel with knowledge and experience of providing ANC, delivery and postpartum care (Narayanan, Shaver, Clark, Cordero, & Faillace, 2004: 04). Furthermore, the healthcare providers must ensure that they counsel, maintain confidentiality and be respectful of patients and their families.

## **2.7 APPLICATION OF SEM TO THE STUDY CONTEXT**

As one of the strategies to improve delays in reporting for labour, the researcher uses theories to establish how theories can address the phenomenon at hand. SEM became relevant as its definition was broadly analysed. The idea is to explore its association with the topic under investigation in terms of how delays in reporting for labour came about and could be addressed. The SEM was first introduced by Bronfenbrenner and refined until the end of his life in 2005 with the aim of developing understanding of the dynamic interrelations among various personal and environmental factors (Bronfenbrenner, 1994: 38). Delays in reporting labour entail delays in reporting to the health facility either towards the health facility or inside but before the maternity ward or in the hospital bed of the last moment for giving birth to

a child. At the centre of this ecological model is the pregnant women's delays in reporting labour but beyond, the theory sought to highlight the factors that caused delays and also how the delays could be improved in order to sustain human life.

At most, the SEM had been mobilised in areas of active lives of physical bodies and their environment but in this study, attention is given also to the unborn children against the background of their environment (the uterus) together with the effects of what happens to the mother within the environment outside the uterus. The next diagram labelled figure 2 bears witness of the above description considering the five levels of SEM that is the microsystems, mesosystems, exosystems, macro-systems, and chronosystems discussed below. The diagram is designed with the view that at the centre of this SEM, pregnant women are placed at the centre (microsystems) while the other levels surround to either give support or fail. With a negative effect, the environment will have failed to play its vital role of support and the opposite is also correct that the survival of the unborn children implies that the environment has contributed immensely for the survival of the infants.



**Figure 2: Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 2013)**

### Microsystems (intrapersonal level)

The microsystem is viewed as a pattern of activities, social roles and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social and symbolic features that invite, permit, or inhibit engagement in sustained, progressively more complex interaction with and activity in the immediate environment (Bronfenbrenner, 1994: 39). This description depicts all the things that occur in the uterus where the unborn child is housed (immediate environment) and outside the uterus, which now is the immediate environment of the pregnant woman. For example, alcoholic pregnant women would get drunk and miss the most important assignment of attending ANC and for fear of reprisal in the healthcare facility may often miss such visits. Ngomane and Mulaudzi (2010: 8) have discouraged pregnant woman who consistently took alcohol and tobacco as this would have an adverse effect on the child with increased risk of sudden infant death syndrome (SIDS) to the unborn child. In the case, the pregnant woman often visited immediately in reporting for labour, an advice to avoid taking alcohol and tobacco would have been given as educational lessons during ANC.

### Mesosystems (social networks)

The mesosystem comprises the linkages and processes taking place between two or more settings containing the developing person and this would involve the relations between homes of the pregnant women and the health facilities with both institutions cooperating (Bronfenbrenner, 1994: 40). Of vital importance is that for the pregnant women to receive ANC, they need to travel from home to the health facilities. In the cases where there are no means of transport, this will obviously contribute to the delays in reporting labour. Constant failure to reach the health facility denies the pregnant women opportunities to be educated about food to eat during pregnancy, checking if the child is properly settled and other important issues about pregnancy.

### Exosystems (communities)

The exosystem comprises the linkages and processes taking place between two or more settings at least one of which does not contain the developing person but in

which events occur that indirectly influence processes within the immediate setting in which the developing person lives (Bronfenbrenner, 1994: 40). A pregnant woman who is constantly stressed at work automatically transfers the stress energy to the unborn child. Moreover, she may feel exhausted culminating to a view to relax at the comfort of her home. This could eventually lead to delays in reporting labour in that she will definitely skip bookings at the healthcare facility.

#### Macro-systems (life in society)

The macro-system consists of the overarching pattern of micro, meso and exosystems characteristics of a given culture or subculture with particular reference to the belief systems, bodies of knowledge, material resources, customs, life-styles, opportunity structures, hazards and life course options that are embedded in each of these broader systems (Bronfenbrenner, 1994: 40). The study by Ngomane and Mulaudzi (see page 3, Chapter 1 of this current study) report that pregnant women delayed attending the antenatal services or reporting labour because they first experimented with the indigenous beliefs and practices. This also involved family customs where the bride cannot decide on the place of birth and how to take care of the pregnancy. All these factors contributed to the delays in reporting for labour and better strategies to address these impasses need to be sought and implemented. The macro-system subsystem envisions responses on what (need to do), how (manner of acting), when (time to act) and where (place to go) pregnant women could find help on time before they could encounter any labour complications.

#### Chronosystems (public policies)

The chronosystem involves change or consistency over time not only in the characteristics of the person but also of the environment in which that person lives (Bronfenbrenner, 1994: 40). To prove that there is growth in the womb of a pregnant woman, the tummy grows in size but beyond that, the unborn child is brought into this world where he/she brings change over the life course in family structure, socio-economic status, employment, place in residence, the heftiness and ability in everyday life. Any delays in reporting for labour, which at times becomes unfortunate by

producing lifeless child, the changes as advocated in the chronosystem would never see the dawn of the day.

The ability of the pregnant woman to understand the SEM and how the unborn children communicate with them allow that they act swiftly to respond to the unborn children's demands. It would seem that pregnant women who delayed reporting labour, never got to visit the healthcare facility because that is the space where understanding of how to respond to the unborn child's demands would have been addressed by the healthcare professionals. Without visiting the clinic, pregnant women may not be aware that herbs and magic water cannot reduce labour pain, treat abnormal discharges and provide strength for women to push during labour (Sychareun et al., 2009: 01). Health professionals will manage to reduce delays in reporting labour as long that they follow the discussions highlighted here, that of applying the SEM.

## **2.8 CONCLUSION**

This chapter has drawn deeply into what other researchers have written about delays in reporting for labour. A delay in reporting for labour is not a storyline that can be rehearsed and perfected into real action but a phenomenon embedded into our lives. These delays have been verified and confirmed as deadly, which calls for government to seek better strategies that will stimulate and sustain lives even before the infants are born.

The chapter paid more attention to the concepts that were defined to provide an overview understanding of the topic, the causes, importance, effects, and application of SEM. In concluding the section, the chapter touched on the influence of theories specifically the SEM, which highlighted the relationship and other concepts attached to it as analogical strategy to derive understanding for women's reaction of their pregnancy. The next chapter deals with research methodology, which is how data are collected.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHOD**

#### **3.1 INTRODUCTION**

The main activity in this chapter was basically to create a format of data collection process. Two remarkable ways to collect data were applied that is the unstructured interviews and the review of documents in the form of ward registers from the selected hospital. The unstructured interviews were helpful in gathering first-hand information from the pregnant women who delayed reporting labour at the selected hospital. The use of hospital documents from the ward register entries would assist with verifying dates from which pregnant women's dates of arrival and time of delivery at the ward were recorded.

This chapter presents research design, research methods, population and sampling, data collection and analysis, measures to ensure trustworthiness, and summary.

#### **3.2 RESEARCH DESIGN**

In this research study, a qualitative explorative design was used. Qualitative research design may be defined as a systematic, interactive and subjective approach that describes the meaning the participants ascribed to their experiences in the context of the research question (Burns & Grove, 2009: 22). The qualitative design method of the research study was chosen to enable the participants to describe, share, and to explore their feelings and experiences pertaining to the factors that contribute to the delay in reporting for labour in a hospital at Mopani District.

The researcher used the phenomenological approach to search for and understanding the dynamic, unique and holistic nature of the participants within the context of the research and to gain insight into women's attitudes, behaviour, value system, motivations, aspirations, culture, and lifestyle (Mohajani, 2018: 08).

Therefore, inductive logic of collecting subjective information was used to collect data that could not be understood through statistical means and it helped the researcher to understand how women view reality, behave the way they did, forming opinion and attitude and how they were affected by the events around them (Hancock, Windridge & Ockleford, 2009: 7).

### **3.3 RESEARCH METHOD**

Joubert and Ehrlich (2007: 49) describe the research method as a comprehensive description of the methodology to be used including the definition of terms. The research method refers to population and sampling, data collection, data analysis, and the measures taken to ensure accuracy (Jooste, 2010: 317).

#### **3.3.1 Sampling**

Sampling is the process whereby the subjects or participants are selected from the target population to ensure that the selected participants are representative of the total population (Jooste, 2012: 303). In this qualitative research study, the sampling process used is non-probability sampling. The researcher described below the following concepts: population and setting, sample and sampling method and ethical issues related to sampling.

##### **3.3.1.1 *Population and setting***

###### **Setting**

The research setting is the physical location and conditions in which data collection takes place in a research study (Polit & Beck, 2012: 738). The research study was conducted in maternity hospital ward within Mopani district municipality, Limpopo province and the surrounding villages. This research study setting serves as a regional hospital for the referral of other level one hospitals and clinics around it. Then the research interview was conducted inside the private room marked outside door with the sign 'don't disturb' to maintain privacy and confidentiality. Inside the room there was a chair, table and cot-bed for the mother and the baby to be comfortable.

## **Population**

Polit & Beck (2012: 738) define a research population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. One way or the other, people visit health facilities (clinics and hospitals) to register an assortment of illnesses. At this moment, the researcher's focus was based on the selection of individuals who could help answer the question of the study. The researcher targeted a particular population and according to Asiamah Mensah & Oteng-Abayie (2017: 1607), a population is group of individuals having one or more characteristics of interest.

In this study, all the women who have delayed reporting for labour and delivered their babies either by caesarean section, normal delivery or premature delivery at their homestead, and those who delivered their babies in hospital maternity wards became the target population. Those women who delivered at the hospital maternity ward was recruited from the postnatal ward after enough rest and bonding with their new born babies. Then women who delivered at home were traced and interviewed at their respectful homes or clinic after delivery as once the women delivered at home she has to visit the clinic immediately for postnatal follow up care.

Alvi (2016: 10) further alluded in addition to the population definition that the targeted population possesses specific attributes of interest and relevance. Issues of interest and relevance related to the researcher's willingness to reduce the endemic nature of research topic and its consequences as highlighted in the problem statement were maintained through data collection and data analysis.

### **3.3.1.2        *Sampling and sample method***

Sampling could be defined as the act of selecting specific data sources from which data were collected to address the research objectives or answer the main question in the study (Gentles, Charles, Ploeg & McKibbon, 2015: 1775). Purposive sampling was adopted in this study on the basis that the sample, which were the pregnant women who delayed reporting for labour, would give answers from the main question of the study. The sample size for this study was not predetermined; the researcher

conducted interviews until no new information emerged leading to data saturation (Patton, 2015: 264).

Purposive sampling was chosen because it was best for gaining in-depth understanding of complex concepts and was used to select participants that would most benefit the study. According to Jooste (2010: 303), a sample is a group of people, objects, items or units of analysis taken from the larger population for measurement. Thirteen (13) sample participants were interviewed. They were between 23 and 42 years of age, willing to participate and able to give consent to participate in the study. For ethical reasons of not inducing further trauma through the interview, only mothers who had delivered normally and through caesarean section and their babies were alive were interviewed. Mothers were given informed consent to sign first in order to participate in the study.

### **3.3.2 DATA COLLECTION**

#### **3.3.2.1        *Data collection approach and method***

De Vos, Strydom, Schulze and Patel (2011: 335) define data collection as a way of gathering information through asking question, observation, voice recordings, and taking field notes to answer rising research questions. There were quite a number of other methods to collect data but in this study, in-depth or unstructured interviews have been adopted as the means to collect data. According to Fox (2009: 7), a method such as the unstructured interviews provides the researcher with an opportunity to gain a rich picture of what is happening in a setting by discussing the details of what participants have experienced. The in-depth or unstructured interview were held with participants in this research study. Polit and Beck (2008: 372) define in-depth interviews as a one-to-one dialogue between the researcher, a method whereby the researcher asked questions without preconceived opinions regarding the phenomenon and specific content.

The length of interviews was typically lasting about 30 to 60 minutes being an intensive approach for a series of single participants (Fox, 2009: 7). Data were collected using a self-developed interview guide (Annexure E). The interview guide was prepared by the researcher following the literature in line with the purpose and objectives of the study and validated and approved by the supervisors who are conversant with research and content of the study. An interview guide was used in the research containing a set of open-ended questions that allowed the participant to feel free during participation. Techniques such as probing, paraphrasing and follow-up for clarity can be used with the researcher observing, pointing out the lead subjects and informally asking participants questions while taking notes (Adhabi & Anozie, 2017: 90). In this situation, the researcher controlled the interview and had the latitude to encourage the participants using gestures and verbal cues to prompt for more details.

An audio recording machine or equipment has been used quite fruitfully since it captured every single moment of the interview. The audio machine came in handy during transcription of data while producing exactly how the data were captured. Consent to use a voice recorder was first obtained from the participants. Privacy was ensured and maintained as the interviews were conducted in a separate room that was not in use at that time of research study.

Documents in the form of maternity registers and patients' files were retrieved. The maternity register took up the role of guiding the researcher in observing the movement of patients starting with admission, discharge and transfers. On the other hand, the patients' files assisted the researcher in accessing the necessary required personal information and procedures that were conducted. As another form of data collection, retrieval of documents and being in a wide range written materials provided qualitative data (Hancock et al., 2009: 19). However, the documents did not only serve for referral purpose in this study but always act as guidelines that assist professionals in dealing with pregnant women and the baby from conception, delivery and postpartum period.

The triangulation method of inquiry was given preference in this study. In triangulation, data collection is conducted using multiple sources of data (Patton, 2015: 544) that is unstructured interviews and use of documents. The use of triangulation method

widens the scope of validating the findings (Nøkleby, 2011: 147). Either way, the situational diversity of how participants experienced the visit to the health facility before labour was corroborated by the documentation accumulated from the health facility and vice versa.

The following are questions that shaped the study:

- What are the contributory factors influencing the delay in reporting for labour by women in Mopani district?
- What are the impact of delay in reporting for labour on the process and outcome of labour?
- What are the recommendations that can assist in addressing the factors that contribute to the delay in reporting for labour by women in Mopani District?

### **3.3.2.2        *Data collection process***

Ethical clearance certificate was obtained from the UNISAREC. Permission to collect data was obtained from the Department of Health (DoH), Limpopo Province, Mopani District, and management of sub-district (Chief Executive Officer). Informed consent was obtained from the participants. Voluntary participation, anonymity and confidentiality were maintained throughout.

The researcher used face-to-face interviews to collect data and also the permission to use the audiotape recorder was given by the participants to record the communication between the researcher and the participant so that the conversation should be kept safe for a long time.

### **3.3.3 DATA ANALYSIS**

Data analysis is the systemic organising, synthesising and a creative examination process of information, making sense of the findings and deriving meaning of the collected data during a research process (Polit & Beck, 2012: 725; Creswell, 2009:186). Data collection and data analysis were conducted simultaneously and in this regard, the content analysis approach was used. The method of content analysis using an inductive logic approach was first described by Thomas (2003: 3) and was

extended by Graneheim and Lundman (2004: 106) to include tighter definitions than Kairuz, Crump and O'Brien (2007: 372) cited the approach. Qualitative content analysis is the analysis of the content of narrative data to identify prominent themes and patterns among the themes (Polit & Beck, 2012: 564). Qualitative content analysis involves breaking down of data into smaller units, coding and naming the represent and grouped coded material based on the shared contents. Kairuz, et al. (2007: 372) had identified the key processes of data analysis that may be applied in the qualitative research that is:

- Meaning unit  
At this stage, the researcher had to read and reread the text in order to identify important strands (Graneheim & Lundman, 2004: 106).
- Condensed meaning unit (description close to the text)  
This is also known as distillation of the meaning units or data reduction into simpler words or concepts (Thomas, 2003: 3).
- Code (interpretation of the underlying meaning)  
A code is a label to define condensed meaning unit (Kairuz et al. 2007: 372). Codes are grouped by commonality to form subcategories and categories finally themes.
- Subcategory  
Subcategory is the step that follows the code and built onto category (Kairuz et al., 2007: 372).
- Category  
A category denotes a thread of meaning that runs across the data code (Kairuz et al., 2007: 372).

The column below listed as Table 3.1 highlights the manner in which the collected data were analysed.

Meaning Unit	Condensed meaning unit (Description close to the text)	Code (Interpretation of the underlying meaning)	Subcategory	Category

**Table 3:1 Example of content data analysis (Adapted from: Kairuz, et al., 2007: 372)**

### **3.3.4 ETHICAL CONSIDERATIONS**

Ethical processes and procedures were considered as required by authority during the research study. Ethical considerations include the protection of participants' right, informed consent and the ethical approval (Klopper, 2008: 71; Joubert & Ehrlich, 2007: 52). Protection of rights means no harm will be sustained by participant whether physical or psychological, emotional or even discomfort. Four ethical principles considered in the study were autonomy or respect of person, right to protection from discomfort and harm, right to fair treatment, and right to confidentiality.

#### **3.3.4.1 *Respect and autonomy for person***

According to Polit and Beck (2012: 154), respect and autonomy for person means that the participants have the right for self-determination and right for full disclosure. Self-determination means that prospective participant can voluntarily decide whether to take part in a study without risk of prejudicial treatment and they also have the right to ask question, to refuse to give information, and to withdraw from the study at any time without any negative consequences of their postnatal services.

Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities and likely risk and benefits (Scott, 2013: 79). In this study, the participants were given full information on the study and were given authority to voluntarily participate without any fear of negative consequences of their postnatal services. Those participants willing to participate voluntarily were taken through the information sheet (Annexure A) and were requested to sign an informed consent (Annexure B).

#### **3.3.4.2 *Right to protection from discomfort and harm***

The principle of beneficence imposes a duty to the researcher to minimise harm, discomfort and exploitation, and maximise benefits (Polit & Beck, 2012: 152). The researcher informed the participants that they were free from harm, exploitation and no direct benefits from the study such as monetary benefits. The recommendations from the study will help the health facility to correct the wrong practices and promote

good conduct in the health care service. By extension, it would reduce future delays reporting of pregnant woman in labour at the healthcare facility. The researcher explained that in case of emotional harm, participants would be referred to social workers for adherence counselling. Participants who were involved in the study were reassured that their participation or information they provided would not be used against them and that they possessed the right of withdrawal in case they felt uncomfortable.

#### **3.3.4.3      *Right to fair treatment***

This ethical principle of justice accentuates that all participants should be treated similarly and equally (Polit & Beck, 2012: 155). The participant in this study were selected and recruited fairly with no discrimination against them. The researcher informed the participant that there were no direct monetary benefits as is a self-stand study as indicated in information letter (Annexure A) and no financial costs were needed from them. The information and interview schedule (Annexure E) of the study were fairly and equally administered to the participant for them to be involved freely in the participation.

#### **3.3.4.4      *Right to confidentiality and privacy***

Study participants have the right to expect that the data they provide will be kept in strict confidence and right to privacy is protected through various confidentiality procedures (Polit & Beck, 2012: 162). The researcher received the permission to conduct the study from UNISAREC (Annexure G), General of Department of Health and CEO of Hospital (Annexure H & I). The researcher manages all the data collected from the participants as indicated in chapter 4 (4.2), confidentiality was maintained during data collection as the room used was private and marked outside door with a sign “don’t disturb”, participants name was not linked to the data collected, consent forms were signed and separated from data collected. All document and equipment used like audio-type, computer, consent forms, and transcribed materials were kept in the researcher’s house in a locked cabinet it can only be accessed by the supervisor in case of verification of information.

### **3.3.5 MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness was the approach used to clarify the notion of objectivity as manifested in qualitative research (De Vos et al., 2011: 419). According to Lincoln and Guba's Framework (1985) as cited by Polit and Beck (2008: 539), four principles were applied to ensure trustworthiness, namely, credibility, dependability, confirmability, and transferability. Trustworthiness of research, its content and findings are based on building relationships between object of study and its context, the researcher, research purpose, and its outcomes (Collier-Reed, Ingerman & Berglund, 2009: 6). Under qualitative studies, the collection of data has to be validated or gauged against the trustworthiness of the data.

Each criterion had been discussed as follows:

#### **Credibility**

Anything credible makes something to be believed such as stating a fact or telling the truth (truth value) (Elmusharaf, 2013) about things participants have expressed during interviews. What happens in credibility is that it considers if there was alignment between the way the participants perceive their social constructs (meaning design by society) and the way the researcher portrays their viewpoints. Polit and Beck (2012: 595) refer to credibility as confidence in the truth of the data and the interpretation thereof. Credibility has its basis firmly placed in the truth of the study results emanating from the worthy topic and richly rigorous research done (Tracy, 2010: 840).

In this criterion, the researcher strives for accuracy of collected data, not filtered or even generously decorated. In order to achieve this, the researcher prolonged engagement with sufficient time invested in the data collection activities in order to gain an in-depth understanding of the factors that contributed to the delayed women in reporting for labour and to allow the researcher to test for misconceptions and misinformation (Jooster, 2010: 319). Data collection lasted for 30 to 60 minutes, which allowed the researcher time to establish rapport with the participants and to encourage

the participants to respond freely. Trust and rapport were built through the data collection until data saturation occurred (Polit & Beck, 2012: 521).

In this study, triangulation was used in which different questions were asked to the participants and to seek support from research peers, different sources and different methods with the recording through the audio-tape recorder (Jooster, 2010: 319; Anney, 2014: 276), for eliminating any researcher bias when analysing and interpreting the results (Anney, 2014: 277). For the findings of the current study to be viewed as credible, Tracy (2010: 8) emphasises on being sincere and transparent. Towards conclusion of the study, for member checking, the researcher went to the participant to allow them to confirm if the constructions and interpretations of data of their responses were captured correctly (Jooster, 2010: 320).

### Dependability

Dependability refers to the stability or reliability of data over a time and conditions (Polit & Beck, 2012: 585). Normally, the view of becoming dependable means and serve as a guarantee that results cannot easily be distorted. In support of this idea, Bitsch (2005: 86) adjusted dependability as implying the stability of findings over time. Collier-Reed et al. (2009: 9) highlight that dependability of a research study brings about consistency of data interpretation and the findings. This implies that if another researcher could follow similar methods of the same study, similar conclusions must be reached.

The researcher used the unstructured interview guide to explore knowledge on the factors contributed to the delay in reporting of women for labour at the health facility, also the research methodology was clearly described and the researcher presented comprehensively transcribed interviews accurately (Joubert & Ehrlich, 2007: 49).

### Transferability

When the exercise of moving an object from its original environment to another, the act is conducted to determine if the object would survive the new environment. Similarly, transferability means the degree to which the results of a study could be

transferred to other contexts with some different participants but producing the same effects (Bitsch, 2005: 85). Transferability refers to generalisability of the data (Jooste, 2010: 321). The use of thick description and purposeful sampling and data saturation complement transferability because the researcher provided the comprehensive description of the research participants and the study setting which were enabling the individual to evaluate applicability of the results on other settings to ensure transferability. The data collection was done until no new information was provided, that is, the data saturation was reached (Jooste, 2010: 321).

So far in this study, indication places on record that the first aspect (context) is being dealt with because the research problem, the purpose and objectives, the design with inclusion of study setting have been completed (Anney, 2014: 305). The information in this study cannot be transferred from one facility to another.

#### Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevancy, or meaning (Polit & Beck, 2010: 585). The researcher in the study recorded all the information provided by the participants during the interview so that no information was lost to avoid research bias and motivations. The research findings reflected the participants' voices and the transcription were transcribed verbatim. Bowen (2009: 307) suggests that the researcher does an audit trail as it offered visible evidence of the study from process to product, that is how the data were collected, recorded and analysed. In the study, an independent expert researcher did the audits (Jooste, 2010: 323). Many ways to confirm were interpreted from short words such as "Ok; Yes; or the use of symbols such as a tick or thumbs up" coming from the participants.

### **3.4 CONCLUSION**

This chapter discussed research design and methodology in detail to serve as a guideline about the manner in which data were collected. The process of collecting data partly involves how research participants and sites were selected, and also how data collection procedures were interlinked. The choice of the phenomenological study came naturally since it is basically part of qualitative research and advocated inquiring

about the experiences lived by the participants in the current study. A picture of how participants were selected was carefully drawn through the use of sampling method. Also of importance is to note that at the end of the study, findings need to be trustworthy. In closing this section, the next chapter 4 will deal with findings and discussions thereof.

## **CHAPTER 4**

# **ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS**

### **4.1 INTRODUCTION**

This chapter focuses on the analysis of findings and discussion based on the data obtained during the unstructured interviews and extracted information from patients' healthcare records. The findings and discussions are solely based on the experiences that pregnant women who delayed reporting for labour have gone through with special attention to factors that led to such delays.

### **4.2 DATA MANAGEMENT AND ANALYSIS**

Data management is a systematic organisation and synthesis of research data (Polit & Beck, 2012: 725). The audio-recorded data were stored in the researcher's personal computer that were locked with a security pin and will be accessible to any personnel or stakeholder who might wish to listen to the recording.

In each day after data collection, each audio-recorded interview was transcribed verbatim. To analyse the data collected the researcher used the content analysis of data following the three steps as outline in chapter 3 (3.5.2). The researcher has read and re-read each transcript, listened several times on the recordings in order to get the overall picture of the data and writing down necessary ideas, meanings and similarities of topic in the margins. Similarities were grouped together, data coded while sub-themes and meaningful units were identified. The corresponding data were presented as sub-themes and grouped together to form themes.

## 4.3 RESEARCH RESULTS

### 4.3.1 Sample characteristics

Table 4:1 shows the sample characteristics of individual participants who made a valuable contribution to the findings in this study. Thirteen individuals participated in this study and details are given in the table below:

<b>Participant 1:</b> <b>Age:</b> 28 years old and lives at Mookgo Village. <b>Parity:</b> G3P2A1 <b>ANC:</b> 4 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 48km.	<b>Participant 2:</b> <b>Age:</b> 31 years old and lives at Mookgo Village. <b>Parity:</b> G2P2. <b>ANC:</b> 1 <sup>st</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 48km.	<b>Participant 3:</b> <b>Age:</b> 36 years old and lives at Mookgo Village. <b>Parity:</b> G5P5. <b>ANC:</b> 4 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 48km.	<b>Participant 4:</b> <b>Age:</b> 28 years old and lives at Mookgo Village. <b>Parity:</b> G3P3. <b>ANC:</b> 6 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 48km.
<b>Participant 5:</b> <b>Age:</b> 23 years old and lives at Khujwani Village. <b>Parity:</b> G1P1, <b>ANC:</b> 1 <sup>st</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 13km.	<b>Participant 6:</b> <b>Age:</b> 26 years old and lives at Morutji Village. <b>Parity:</b> G3P3. <b>ANC:</b> 2 <sup>nd</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 42km.	<b>Participant 7:</b> <b>Age:</b> 27 years old and lives at Mokgwathi Village. <b>Parity:</b> G3P3. <b>ANC:</b> 2 <sup>nd</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 56km.	<b>Participant 8:</b> <b>Age:</b> 28 years old and lives at Nkuri Sifasonke in Giyani. <b>Parity:</b> G3P3. <b>ANC:</b> 3 <sup>rd</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 118km.
<b>Participant 9:</b> <b>Age:</b> 25 years old and lives at Mhlaba Cross next to Mgebisa Cafe. <b>Parity:</b> G2P2. <b>ANC:</b> 6 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 10km.	<b>Participant 10:</b> <b>Age:</b> 27 years old and lives at Nkowa-Nkowa Township, Bamba Section D. <b>Parity:</b> G5P4. <b>ANC:</b> 6 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 07km.	<b>Participant 11:</b> <b>Age:</b> 42 years old and was born at Bungeni Village but lives at Nkowa-Nkowa Township. <b>Parity:</b> G4P4. <b>ANC:</b> 2 <sup>nd</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 07km.	<b>Participant 12:</b> <b>Age:</b> 29 years old and lives at Mookgo Village. <b>Parity:</b> G3P3. <b>ANC:</b> 2 <sup>nd</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 48km.
<b>Participant 13:</b> <b>Age:</b> 27 years old and lives at Rikhotso Village. <b>Parity:</b> G2P2. <b>ANC:</b> 5 <sup>th</sup> to 9 <sup>th</sup> Month. <b>Distance:</b> 46km.			

Table 4:1: The sample characteristics of individual participants

The characteristics of participants help with understanding of pregnancy in terms of considering the ages, parity, booking status, and the distance from where the participants live to the health facilities. Of the thirteen (13) participants, ten were found to be less than 30 years of age, with five of the participants given birth to three children; and three of the participants given birth to two children while the remaining participants had one and five children respectively. The remaining three participants who are above 30 years, one has given birth to two children, another one has given birth to three children and the last participant has given birth to four children. In brief, 12 participants have given birth to more than one child. In view of the above observation, most of the participants would be believed to have internalised the teachings they received at the health facilities during and about the ANC, the signs of an approaching labour in pregnant women. The experience acquired during their first pregnancies deletes these other suspected notions that their age and distance from their dwelling places to the health facilities would have contributed to their demise in terms of delays in reporting for labour.

After evaluating the four aspects of participants' characteristics, there is only one contentious aspect needing further analysis – the booking status. The researcher posits and argues to raise the idea on how early bookings of ANC help the health practitioners and pregnant women to keep track of pregnancy development. Participants who booked earlier would have a greater opportunity to be physically, emotionally and psychologically prepared for labour than those who booked late. Majority of participants in this study delayed ANC bookings, which as matter of fact contributed to ill preparedness of labour especially that health practitioners and pregnant women had to take a guess of the date in which labour would start.

#### **4 3.2 Themes, sub-themes and meaning**

After a thorough analysis of the data collected during unstructured interviews and information extracted from patients' documents, the following seven themes and 18 sub-themes emerged:

<b>Themes</b>	<b>Sub-themes</b>	<b>Meaning</b>
Theme 1: Ignorance and procrastination as source of protracted birth	<p><i>Sub-themes 1.1:</i> Ignorance of birth pains. <i>Sub-themes 1.2</i> Misconception of clinics working hours and 24/7 service. <i>Sub-themes 1.3:</i> Attending ANC in second trimester or late antenatal booking. <i>Sub-themes 1.4:</i> General safety of pregnant women and lack of safety during labour. <i>Sub-themes 1.5:</i> Unnatural technical birth challenge and delays miscounted by a month. <i>Sub-themes 1.6:</i> Unusual effects after birth.</p>	Although none of the participants mentioned their direct contribution to delays in reporting for labour, it would be helpful to introduce unlimited or restrained consultation whether in night or weekends, patients should find persistent assistance in the health facilities.
Theme 2: Accessibility and knowledge transfer to pregnant women	<p><i>Sub-themes 2.1:</i> Importance of ANC check-up and eliminating early transfer of illness. <i>Sub-themes 2.2:</i> Lack of ANC check ups</p>	It is important in this study to note aspects of how well ANC contribute to understanding time frame in that lack of or delays of ANC derails the holistic approach towards child birth.
Theme 3: Constant assessment of best practices and professionalism in health sector	<p><i>Sub-themes 3.1:</i> Lack of delivery expertise and insufficient professional ethics by nurses <i>Sub-themes 3.2:</i> Impolite and mistreatment of patient. <i>Sub-themes 3.3:</i> Complex chronic illnesses, a situation of high-risk pregnant women. <i>Sub-themes 3.4:</i> Effects of un-procedural or misappropriation of procedural intervention on pregnant women.</p>	The continuing professional development has been viewed in positive light that as an intervention strategy it could address most behavioural problems observed in the health facilities unlike instituting the ideal consequence management, which is highly spoken about.
Theme 4: Infrastructure development in the health sector	<p><i>Sub-themes 4.1:</i> Distance between health centres and pregnant women.</p>	Health facilities should be a walking distance away from patients so that when labour pains start, pregnant women should not delay reaching the health facility.
Theme 5: Roads and transportation of patients	<p><i>Sub-themes 5.1:</i> Lack of transport for pregnant women. <i>Sub-themes 5.2:</i> Giving up and loosing hope on ambulance service and inaccessibility of EMS vehicles.</p>	EMS vehicles and personnel are unable to gain access to potential patients or pregnant women due to unworkable roads causing delays for labour.
Theme 6: Community unrest affecting productive health	<p><i>Sub-themes 6.1:</i> Strike communities disregard of unborn life.</p>	When communities go on strike and they prevent EMS personnel to execute their mandatory duties, there seems to be likelihood for the pregnant woman to end up giving birth in the vehicle far from the health centre.
Theme 7: Participants' contextual perception of health sector	<p><i>Sub-themes 7.1:</i> Through the pregnant women's eye. <i>Sub-themes 7.2:</i> ANC informative sessions: Mom-Connect.</p>	People and communities will always have opinions about situations. In this regard, they advise on the route that should be taken by government and department in order to address the issues pertaining to health, pregnancy and birth.

**Table 4:2 The themes, sub-themes and manifestation of meaning development from findings**

#### **4.3.2.1      *Theme: 1 Ignorance and procrastination as source of protracted birth***

From the first theme, six categories have emerged that is ignorance of birth pains; misconception of the clinic's working hours; attending ANC in second trimester; safety of pregnant women; unnatural technical birth challenge, and unusual after-effects at birth. For each category, voices of the participants shall be audible as their experiences have been transcribed into the discussion.

##### **Sub-theme 1.1: Ignorance of birth pains**

Under normal circumstances, nobody could ever contemplate to ignore a pain, let alone in this condition where the participants have to deliver the most precious gift that an individual could have, that is giving birth to a child. Apparently, labour pains differ according to its tense characteristics, human being, tolerance, and parity such that when it comes, one cannot recognise true signs. All the participants one, three and four have displayed an utmost form of ignorance when they could not visit the nearest health facility at the beginning of abdominal pains, which could be found from their responses.

**Participant – 1:** *I started feeling the birth pains around 23:30. It pained for five minutes, stopped, and pained again and stopped. I never thought it was a sign I would give birth but I told myself I would deliver.*

**Participant – 3:** *There were birth signs of bursting of water. When they went to look for transport on return, I was already having the child.*

**Participant – 4:** *I gave birth to the second born at home. It happened so quick while relatives went to look for transport, on their way back, they found that I already had given birth.*

A further observation, the participants' responses confirm the truth behind the three phases of delays as stipulated by Thaddeus and Maine (1994: 1092), for which precisely the first phase highlights delay in deciding to seek care by an individual, family or both. Such a display of ignorance does not only put the life of the unborn baby in danger but that of the mother as well. In the event where participant three and four gave birth without any assistance, there are more chances they would never be able to stop excessive bleeding and other delivery steps. In light of the above finding, there is a clear indication that participants have not been taught enough about the dangers of home deliveries especially where there may not be immediate help available. The above principle of home delivery can only be achievable or possible if a decision has been made that the patient will deliver at home.

#### Sub-theme 1.2: Misconception of clinics working hours and lack of 24/7 service

Public notion on the number of hours' clinics should operate has so far not reached people on the ground whether some clinics qualify or do not qualify to service patients for 24 hours and Participant1 gave a hint in this regard.

**Participant – 1:** *What I have known all along was that our local clinic worked for 24 hours only to find that it was a misconception, they close at night.*

**Participant – 6:** *The clinics should operate during the day and at night so that we can walk in and out for services. Ambulance doesn't come due to reasons of gravel road.*

**Participant – 7:** *Our clinics are working during the day and closed at night. The problem I don't have transport and money. I tell myself that the sun will rise tomorrow I will go to the clinic.*

**Participant – 12:** *Clinic is not working at night as nurses are hijacked at night.*

A question on when do patients get sick is one that cannot be answered and in this case, clinics should readily be available even in the wee hours of the morning to assist patients especially cases of labour for pregnant women. Rispel (2018: 01) offers the rationale for extending working hours for the clinics to 24 hours because it increases access for the working population; people are able to access services at a more appropriate level; and illnesses do not keep to office hours.

An argument could be raised that the 24 notional working hours should not only be extended to people in the busy cities like Johannesburg. This study was conducted in the rural villages of Limpopo Province with most of the population engulfed by social insecurities such as poverty, lack of infrastructure and others. A debate for government and in particular the Department of Health to extend all clinics to 24 hours' service must be initiated so that home delivery by pregnant women could be eradicated.

#### Sub-theme 1.3: Attending ANC in second trimester or late antenatal booking

The first anti-natal check-up for women ranges between the eighth to 12th weeks of pregnancy, after which pregnant women visit health care facilities in every four to six weeks of pregnancy until 28 weeks of gestation and there after every week until the baby is delivered, usually at forty weeks (Gupta & Talukdar, 2017: 01). Late antenatal booking may lead to miscalculation of the number of months towards delivery of the baby.

**Participant – 3:** *I attended the ANC first visit from the fourth month especially the last-born and the pregnancy was not visible until the seventh month and people could not recognise that I was pregnant.*

**Participant 10:** *Yes, I did attend. I started while having six months. The lastborn I attended five times and every month I attended twice. At the health centre in Nkowa-Nkowa, I went four times for bookings but the centre was always full until I went to Mariveni Clinic where I started bookings until the ninth month.*

**Participant 13:** Yes, I attended. For this one, I started while having five months until the last month but for the first child I started at four months. I menstruated while pregnant for two days in a month, I was not sure if I was pregnant.

Rationale to attend ANC in the early weeks of pregnancy includes amongst others, to immediately identify and act against known risk factors that at most contribute to death from pre-eclampsia (Confidential Enquiries into Maternal Deaths, 2001: 1). Therefore, it would be appropriate to minimise all those risk factors at the beginning of pregnancy. Under normal circumstances, once a woman has early missed the menstrual period and not on contraceptives, there should be an alert that the body might have some changes that leads a woman to have conceived and it is during this period that the woman should visit the healthcare centre. Healthcare providers will set up bookings for the pregnant woman and prepare health education on each attendance until the end of labour, which is on delivery of the baby.

Maternity Guideline (2016: 32) postulates that at the end of the first visit, a pregnant woman should be given a provisional delivery, which will outline the expected dates of delivery, based on the best estimate of gestational age.

- The expected place of delivery, whether community health centres or hospitals.
- The expected mode of delivery, whether vaginal or caesarean section delivery.
- Who will deliver the baby? Whether midwife or doctor.
- Pain relief options including non-pharmacological method.
- A transport plan for an emergency from the onset of labour including important contact numbers.
- The practice of home delivery should be discouraged; all women should try and deliver in a facility with a skilled birth attendant.
- All women with unknown HIV status will be tested at delivery.

Sub-theme 1.4: General safety of pregnant women and lack of safety during labour

Criminals are brilliant individuals whom before pounding upon the victims of crime observe the weakness of the targeted person or environment. Besides the fact that

women are naturally regarded as weak, the view of her being pregnant makes her extremely vulnerable. In this case, a pregnant woman fell into this category of crime victim where as a patient, she was robbed off of her belongings which later caused a deficit to healthcare practitioners in identifying number of months had gone by for the pregnant woman, Participant – 6.

**Participant – 6:** *The last pregnancy it was four months. I only attended three times. I was booked for clinic I encountered a robbery where my clinic cards and other items were stolen when I came from Jo'burg.*

What happened to participant – 6 is categorised as criminal offence as it falls within specific offences such as assault, murder, rape, or robbery and needed the intervention of the criminal justice system (Centre for the Study of Violence and Reconciliation (CSV), 2007: 38). Unlike most studies which dealt with domestic violence where the perpetrator and victim are known to each other, in this case, the incident was pure robbery where the perpetrator was unknown to the victim such that the incident could not be traced in order to follow the route of justice. In essence, victims of abuse are encouraged to report such violent crimes even if the perpetrator is personally and emotionally attached to the victim.

**Participant – 4:** *The third born I was alone at home. I called them after the delivery of the baby.*

The safety of pregnant women all the way through to labour is highly important. Towards the last trimester of pregnancy, the pregnant women should be given proper attention of care and not to be left alone at home as those are the last days in which labour can start anytime unnoticed. Therefore, family members should always be very close to the expecting mothers, being supportive and encouraging during the last stage as this will psychologically help prevent delay accessing healthcare (Thaddeus, 1994: 1098).

Sub-theme 1.5: Unnatural technical birth challenge and delays miscounted by a month

For every pregnant woman, giving birth naturally evokes a sense of pride. Unfortunately, if the length of the pregnancy went past the due date, lasting more than 41 weeks, the view of inducement could be discussed between health practitioner and patient (Hamilton Health Sciences, 2005: 01). Owing to the condition of high blood pressure Participant – 5 found that inducement was bound to be conducted.

**Participant 4:** *There was a miscalculation of months for which I should deliver the baby. I knew I was gonna deliver in March. On the card, they left counting a month. Then I was unable to go to go to the clinic on time.*

**Participant – 5:** *They promised to induce me and was not induced on the 20<sup>th</sup>. I was induced on the 21<sup>st</sup> while I was supposed to be induced on 20<sup>th</sup>. They said they have forgotten me then the following day on the 22<sup>nd</sup> June 2018 the baby was delivered.*

**Participant – 5:** *It was a problem; it was painful. Pain caused by the pills. My spine became painful, especially the navel. I developed cramps when I walk while labour came to an end.*

**Participant – 9:** *I was delayed at hospital because they did not take me for operation the time I arrived though they knew that I would deliver through caesarean section and the time they operated me, I was exhausted and even the baby was having foetal distress.*

**Participant – 13:** *The time I arrived at the hospital they examined me and urgently prepared for caesarean section but the cervix was not fully open such that I can reach Letaba Hospital.*

Bad expectations in a situation as outlined by participant – 4 would not be surprising and most likely, the woman would have laboured in her own house.

From both Participant 5 and 13, it is evident that the delay in reporting for labour has brought in technical problems such as inducement and caesarean section.

Sometimes, if the chosen method of induction could not work in starting contractions and keeping labour going, other methods can be used to assist pregnant woman baby's birth with the use of forceps or a vacuum, or deliver the baby by caesarean section (Hamilton Health Sciences, 2005: 04).

#### Sub-theme 1.6: Unusual effects after birth

In every pregnancy, it could be expected that pregnant women make a silent prayer that the term of pregnancy goes well until the child is born alive. At times, the unexpected can occur where after birth abnormalities are identified against our will. The fact that Participant – 5 was regarded as high risk, it was evident enough that her child delivery could have some persistent complications; hence, the health practitioners suggested for her inducement. Complications associated with high-risk pregnancy include pre-eclampsia/eclampsia, threatened abortion, preterm labour, renal diseases, and diabetes mellitus (Akbarzadeh & Khajehei, 2012: 106) which do not relate much to what Participant – 5 and 7 raised.

**Participant – 5:** *It was a problem; it was painful. Pain caused by the pills. My spine became painful, especially the navel. I developed cramps when I walk while labour came to an end.*

**Participant – 7:** *I have got pains during breastfeeding and it is severe. A lot of blood was observed and they gave me a drip with medication that boasted me from becoming weak.*

At this stage, when participants complained about pains on the spine and navel, developing cramps while walking, and pains while breastfeeding, what was important at the time was provide medication for the patients. Participant – 7 indicated that she was offered a drip with medication, which ultimately boasted her from becoming weak.

#### **4.3.2.2      Theme 2: Accessibility and knowledge transfer to pregnant women**

Knowledge transfer could be simplified as an engagement of sharing what other people have experienced to those with no experience. There is a need for pregnant women to access information of safe motherhood, which is a direct result of labour. Dennill and Rendall-Mkosi (2012: 10) mentioned two aspects dealing with accessibility, namely, geographical and functional where health services should be within reach as well as assist local communities in language understood by people.

Sub-theme 2.1: Importance of ANC first booking and eliminating early transfer of illness

All the participants nearly input same views in terms of understanding the importance of ANC first booking but the researcher decided to pick information from Participant – 1, 6, 9, 10, and 13. Participants may not give a deeper sense on the importance of ANC check-ups but professionals and scientists hinted further than what participants comprehended. These include identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp) and identification and management of infections including HIV, syphilis and other sexually transmitted infections (Lincetto, Mothebesoane-Anoh, Gomez & Munjanja, 2012: 51). Furthermore, ANC also provides an opportunity to promote the use of skilled birth attendance and health behaviours such as breastfeeding, early postnatal care and planning for optimal pregnancy spacing.

**Participant – 1:** *It is important to attend the scheduled check-ups at the clinic because they are able to assess if you will be able to give birth without any difficulties and also to check the fitness of the body. It also gives me an opportunity to highlight problems about my pregnancy, my body and how I feel.*

**Participant – 6:** *It is important. Nursing sisters taught us how to do conduct antenatal. It helps when you are sick; they can help in stopping mother to child transfer of sickness, and will be able to get pill to prevent mother to child transmission.*

**Participant – 9:** *It is important, in case you are ill, they can quickly identify illness and treat it to save the life of the baby and the myself as a mother. As for me, the heartbeat was not fine including the baby.*

**Participant – 10:** *It is important also if you are not sure you are ill because illness is not HIV, they will check you and try to prevent HIV from transferring to the baby like myself. I'm having difficulties in breathing while pregnant. So, they treated me in time.*

**Participant – 13:** *Yes, it is important. Like me, I wanted to give birth normally on my own. Instead, I was told I have to go to High Risk as I first delivered though C/section. Even the doctors, I told them I wanted to give birth like normally but when they took me for sonar, they found the baby is fine I can deliver but the muscles could not stretch.*

Besides showing understanding of ANC and its importance, the participants need to be thoroughly educated about all matters related to maternal being on the basis that it reduces morbidity and mortality. Uji, Efiok, Etenikang, et al. (2017: 15) listed quite a few reasons of benefits associated with ANC especially the first trimester of pregnancy including confirmation of pregnancy, its location and number of foetuses, proper estimation of expected date of delivery to prevent inadvertent prematurity and others. Any earlier detection of something gone wrong with the pregnancy could well be managed consistently until delivery of the baby.

#### Sub-theme 2.2: Lack of ANC check ups

Antenatal care had been viewed as a vehicle for multiple interventions and programmes, which feature amongst others: prevention of maternal and neonatal tetanus; prevention and case management of maternal malaria; prevention of maternal anaemia and malnutrition and prevention of Sexually Transmitted Infections (STIs) and Mother-to-Child-Transmission of HIV (Lincetto et al., 2012: 58). Participant 1 and 8 lamented on the fact that they were never informed of anything that related to

guidance over signs and symbols of approaching labour. The space and time of this research study prevented the researcher from probing further to find out how did it come about that ANC programmes were not introduced to the participants. Beyond the above statement, health practitioners were not included in the study as participants and therefore it would have been impractical for their inclusion to confirm allegations.

**Participant 1:** *I have never been told anything valuable about signs and symptoms of labour.*

**Participant 8:** *We were not informed, not taught and no time for pregnant women in case of alerting you, we just meet things during labour.*

From the responses of Participant 1 and 8, the researcher can without a shadow of doubt stress on the effects on non-attendance ANC. This was further alluded to when Sharma and Saini (2016: 03) stated that most maternal deaths are as a result of unattended pregnancies leading to complications at the time of delivery. An advantage of regular ANC assists in the monitoring and timely detection of possible complications in pregnancy with ultimate results of healthy pregnancy (Sharma & Saini, 2016: 03). Health professionals in relation to Participant 1 and 8 have failed in their duties to inform and educate clients either way in terms of policy and operational aspects.

#### **4.3.2.3      *Theme 3: Constant assessment of best practices and professionalism in health sector***

To act in a professional manner requires dedication, discipline and self-regulatory drive to achieve the set goals of an organisation. Issues of coming late to work, non-submission and treating of clients in a bad way are just some of the symbols that reflect a lack of professionalism. No arguments could be raised if , nursing professionals could recognise the importance of practice in their work stations that conform to the philosophy of care held by the nursing profession (Baumann, O'Brien-Pallas, Armstrong-Stassen, et al., 2001: 16).

### Sub-theme 3.1: Lack of delivery expertise and insufficient professional ethics by nurses

Under normal circumstances, it is expected that one or two professional health practitioners should be placed under one roof of the clinic or health centre and that the health practitioner must be qualified as skilled birth attendant. Surprisingly, what Participant – 1 has gone through brings suspicions which suggest that she was transferred from one clinic to the next because in that particular health institution, there was a lack of skilled birth attendant or insufficient professional ethics and conduct.

**Participant – 8:** *When I went to Nkuri Clinic Sifasonke, they told me that if not delivered by the 19/06/2018. I had to go to hospital for delivery on the 20/06/2018 and they were going to give me a pill that can make me deliver but when I arrived at Nkhensani it did not happen like that they told me that is 39 weeks delivery days not yet arrived meanwhile it was my 41 weeks now.*

**Participant – 8:** *When I try to sit down and explain that my days for delivery are over now, I should have delivered but they told me that they follow sonar. No urgent decision taken by doctors even though they know what to do. They played seek and hide all the doctors that saw me. They postponed the sonar showed that I'm having 39 weeks meanwhile at Letaba Hospital the following day on a Thursday it was discovered it is 41 weeks. So, at Khensani Hospital, they have delayed me and did not help me deliver at all.*

Corrective measures that should be espoused by the nursing professionals entail managing ethical issues at an individual's level, that is, professional perspective, which includes shared goals and work values (Kangasniemi, Pakkanen & Korhonen, 2014: 02). In brief, such kind of conduct warrants the need for continuing enhanced nurses' professional ethics, more scientific discussion and nursing science studies coupled with educational support in their everyday practice (Kangasniemi, Pakkanen & Korhonen, 2014: 02).

### Sub-theme 3.2: Impolite and attitudes of nurses towards women in labour

Labour pains for pregnant women happen to be excruciating such that anyone who goes through the same level of experience needs to be treated with care, respect and dignity. An acknowledgement of this type of conduct by nursing professionals during labour had widely been reported but unfortunately, there seems to be no immediate solution to stop the abuse, conduct, impolite and mistreatment of pregnant women about to labour towards child delivery as indicated by Participant – 5.

**Participant 5:** *There was a problem, the nursing sister returned us and the child was very near. They shouted that I wanted to cause them trouble while they told us to wait. They told us that they are well educated.*

Bohren, Vobel, Hunter, et al. (2015: 02) reported in their findings that verbal abuse was among the seven domains that were classified as problematic and regarded as mistreatment of women during childbirth. Although this statement has no scientific backup, a person who shouts and hurl insults in his or her workplace reveals signs of exhaustion and emotionally drained being. Therefore, constant engagement with employees through health and wellness at work would mostly be welcomed wherein employees could be taught, advised and guided on their conduct, implications and calls for repentance.

#### Sub-theme 3.3: Complex chronic illnesses, a situation of high-risk pregnant women

For many pregnant women, chronic illnesses are perceived the same way like a jail sentence. Asthma is viewed as one chronic illness, and a pathology seen as a factor elevated risk for both the pregnant woman and the unborn child (Pinto & Machado, 2017: 02). Another chronic illness to have been identified is arterial hypertension, which the induced hypertension including gestational hypertension, pre-eclampsia and eclampsia during pregnancy encompasses (Chaim, De Oliveira & Kimura, 2008: 54). What Participant – 5 mentioned relates well with what Chaim et al. (2008) had alluded to:

**Participant 5:** *I could be induced because I was diagnosed to have high blood pressure, which is a problem that if I'm induced it would prevent internal death for the child.*

However, it can be confirmed from other literature that asthma and arterial hypertension in pregnancy as a couple of examples can cause a great deal of impact during pregnancy with complications to the foetal and maternal status (Pinto & Machado, 2017: 03). In the case of (Hancock, Windridge & Ockleford, 2009: 7). Participant – 5, the health practitioners at that time took a decision to conduct inducement and that seemed to have been the solution.

Sub-theme 3.4: Effects of un-procedural or misappropriation of procedural intervention on pregnant women

Even if women could have experienced certain risks in their previous labour, for example, miscarriage or giving birth through caesarean section, they still can decide to become pregnant once again. Being introduced to inducement and the suggestion to conduct caesarean section could be scary but the woman's determination to bring life on to mother earth makes them endure even the most horrible pains. This is so due to their unparalleled humility and hope that all shall be well considering the traumatizing experiences Participant – 8 went through:

**Participant 8:** *When I went to Nkuri Clinic Sifasonke, they told me that if not delivered by the 19/06/2018. I had to go to hospital for delivery on the 20/06/2018 and they were going to give me a pill that can make me deliver but when I arrived at Nkhensani, it did not happen like that they told me that is 39 weeks' delivery days not yet arrived meanwhile it was my forty-one weeks now.*

**Participant 8:** *When I try to sit down and explain that my days for delivery are over now, I should have delivered but they told me that they follow sonar. No urgent decision taken by doctors even though they know what to do. They played seek and hide all the doctors that saw me. They postponed the sonar showed that I'm having thirty-nine weeks meanwhile at Letaba Hospital the following day on*

*a Thursday it was discovered it is forty-one weeks. So at Khensani Hospital they have delayed me and did not help me deliver at all.*

Logically, one would expect that the clinic would follow procedure to refer the pregnant woman urgently to another health facility. The World Health Organisation (2003: B17) posits that on referring the woman transport should quickly be arranged for the possible transfer to another health facility. Participant – 8 decided on her own to transfer from Khensani Hospital to Letaba Hospital on the basis that between 37 and 40 weeks of pregnancy at Khensani Hospital, they could not give accurate delivery date. This situation forced delivery of the child by caesarean section on the 41<sup>st</sup> week after the decision to self-transfer to Letaba Hospital.

Apart from bungling over the issue of transferring the pregnant woman (Participant – 08), health practitioners gave a wrong interpretation of the sonar indicating that her pregnancy was 39 weeks while it was 41 weeks. Health practitioners further told her that they were going to give her a pill that would activate delivery of the baby but in practice did not do it. Participant – 12 was disallowed to visit the toilet and she was attended to by the health practitioners when she started vomiting and that was when it was discovered that she was about to give birth.

On observation, the health practitioners have not followed the workplace and administrative procedures as directed by the World Health Organization (2003: A3). The latter emphasises on handing over essential information to the colleague who follows on duty, always record findings on a clinical record and home-based record, and record treatments, reasons for referral and follow-up recommendations at the time the observation was made as well as complete periodic reports on births, deaths and other indicators as required according to instructions. Failure to hand over information opened a vacuum that allowed for information to go amiss resulting in no availability of traceable records.

#### **4.3.2.4      *Theme 4: Infrastructure development in the health sector***

Saikia (2014: 84) developed an understanding on the usefulness of infrastructure in that it plays a vital role in determining good health for the people of a particular country.

Infrastructure development in the health sector involves serious construction of clinics and health centres in the communities. The following category highlights the plight of the people owing to problem of infrastructure.

#### Sub-theme 4.1: Distance between health centres and pregnant women

By virtue of its responsibilities, health facilities should be accessible and able to cater for all patients whether under normal sickness or pregnancy. Clark (1983) gave a broader definition, which identified certain dimensions of access including availability (distances and travel mode to facilities), acceptability (reasons for provider choice, including reasons for delayed care) and affordability. In response to issues of health facility location, Participant – 1 & 4 showed hardships they faced travelling long distances to the clinics.

**Participant 1:** *I was later taken to Mavale Clinic, which was also not working and later taken to Mosipane Clinic where I gave birth.*

**Participant 4:** *The clinic is also far from our village, three villages apart. I was alone and called for assistance after giving birth.*

From what the participants have alluded to, they had to travel longer distances to find help and in instances where they could not timeously find transport, some of them ended up giving birth at home. For Participant – 1, the first, the second and third clinics they went to was not operating at night until they got to the fourth clinic where the child was delivered. The mere fact that those first to third clinics were non-operational at night prolonged the distance to the health facility. What separates the Mopani District health facilities and those of other countries like Nigeria, Kenya and others is distance by operational and geographical design. For example, operational design in this case means that the clinic does not operate at night unlike in Kenya patients walks for nearly one hour to reach the health facility which is a geographical design (Noor, Amin, Gething, et al., 2006: 06). Government has to intervene to reduce these aforementioned challenges by changing times of operation and building more health facilities closer to the people.

#### **4.3.2.5      *Theme 5: Roads, transport and infrastructure***

Economic prospects and growth is solely dependent on roads infrastructure and its transportation links. Failure to make a head start on this area does not only bring down the economy to its knees but also jeopardizes the livelihood of the country's citizens.

The next category, "lack of transport for patients, giving up and loosing hope on ambulance service and inaccessibility of EMS vehicles" provided a hint of what is at stake under this theme.

##### **Sub-theme 5.1: Lack of transport for pregnant women**

A question for clarification as to whether transportation of patients is the responsibility of an individual or health department is rhetoric. The Department of Health draws up a budget that would include purchasing a fleet of vehicles namely: ambulances. This clearly puts to rest the question of whether the department is responsible for transporting patients or not. Evidence as extracted from the participants highlights visible ignorance of fleet management principles and/or negligence of duties. When the means of transport to take patients to hospital at emergency calls fails, one could lay claims at the lack of planning which involves establishing as to the number of EMS vehicles needed to service several communities. Participant – 3, 10 & 12 took aim at how they tried in vain to get ambulances during emergencies concerning pregnant women prior to their labour.

**Participant 3:** *When birth pains started by the time they went to look for transport, with transport owner claiming that the vehicle would not drive off without petrol.*

**Participant 10:** *If it was at home, we tried to look for a car that can take me to hospital in which my boyfriend failed to get a car so fast until we got the car from the neighbour. We avoided to call the ambulance as we saw that when other people call an ambulance, the ambulance don't come.*

**Participant 12:** *The second born was born at home due to lack of transport to take me to the clinic. I did not have a car to take me to clinic and at home they were gone to Tzaneen.*

Bushy (1993:2) argues that that rural dwellers or villagers experience distance as a stumbling block towards accessing healthcare. However, he made provision to add accessibility to transportation, the inability to drive, lack of a drivers' licence, physical and mental impairments that may impact the use of public transportation, and severe or inclement weather as in part the causes of less access to healthcare. Participants lamented on the issue of lack of transport to the healthcare facility in times of need and emergency, which became unavailable, and later became the cause of delay in reporting for labour by these pregnant women. There may be no alternative answer to this challenge except that the health department increases the number of EMS vehicles that would be stand-by to respond to calls in times of emergencies than one ambulance servicing nearly 15 villages or more.

Sub-theme 5.2: Giving up and loosing hope on ambulance service and inaccessibility of EMS vehicles

A growing trend and a spate of attacks on ambulances seem to be on the high not only in South Africa but even in other countries. Reports show that in other countries, ambulance attacks have been frequent and widespread, which is hazardous to the health and safe working conditions to EMS staff members (United Nations Human Rights Council, 2013: 26). For whatever the reasons maybe, an attack on ambulances means an attack on the life of a pregnant woman and the unborn child. This has created the view that ambulance personnel no longer work with dedication and passion because their jobs have become much of a risk than save lives.

**Participant 6:** *The clinics should operate during the day and at night so that we can walk in and out for services. Ambulance don't come due to reasons of gravel road.*

**Participant 10:** *If it was at home, we tried to look for a car that can take me to hospital in which my boyfriend failed to get a car so fast until we got the car from the neighbour. We avoided to call the ambulance as we saw that when other people call an ambulance, the ambulance don't come.*

Participant – 6 and 10 have painted a darker picture of what the EMS personnel come across in their work lives including uneven roads, which cause discomfort and are inaccessible. When people cannot receive immediate help from the EMS personnel, beginning with phoning and delays in arriving at the scene, by the time the ambulance arrives people vent their frustration and anger on the personnel as well as their vehicle. Some members of the communities have given up and stopped calling the ambulance as experience tells them the ambulance may delay or not turn up. These situations, as explained by the participants, put pressure on the pregnant woman with a likelihood of causing anxiety that may lead to precipitated labour or miscarriage.

#### **4.3.2.6        *Theme 6: Community unrest affects productive health***

Section 17 of the RSA Constitution of 1996: 08 gives provision for people to assemble, demonstrate, picket, and petition but this should also come with a sense of responsibility. Most of the times, striking communities within their rights to a strike, they lose their common sense and allow emotions to drive the strike moment.

##### **Sub-theme 6.1: Strike communities disregard of unborn life**

An ambulance carrying a pregnant woman has carried life of an unborn child and as such blocking the way of the ambulance places the life of the child and mother at risk. Participant – 13 became the prime example as she was placed on caesarean section on arrival to the hospital but it may not be clear that the fearful consequences of the strike could have led to seriousness of delays leading to caesarean section.

**Participant 13:** *Then at the clinic they called an ambulance but along the way the ambulance find that the way has been closed and*

*cannot pass. Then they went back, then we looked for a private car that used a different route of Modjadji Area to Tzaneen.*

**Participant – 13:** *The time I arrived at the hospital they examined me and urgently prepared for caesarean section.*

**Participant 13:** *In case of strike, those people on strike should allow ambulances to pass by because when we hire cars it is expensive. Department should ask those people to open a way for ambulances and also look for a road that can be used by ambulances while on strike though that road will be closed but our plea is that department should answer the people in strike urgently in order for them to open the road for emergencies.*

Similarly, Section 27 of the RSA Constitution of 1996: 11 provides for the access to the healthcare services, including reproductive healthcare. By merely blocking the way of the ambulance, the striking communities are violating this part of the constitution. Besides the risk posed to the mother and unborn child, blocking the way of the ambulance further entrenches unforeseen and unlimited costs such fuel consumption and other damages that may be incurred along the way. As supported by what the participant indicated, those people on strike should allow ambulances to pass by because the action increases personal costs for the family as they had to rehire a private transport to ferry the pregnant woman to hospital.

#### **4.3.2.7      *Theme 7: Participants' contextual perception of the health sector***

A bad treatment given to patients at public hospital accumulates to contextual perceptions about the health sector. This aspect of bad treatment is viewed in light of persistent injustice and access barriers that need to be addressed (Maseko & Harris, 2018: 22) at different spheres of the population. The two categories, which included “through the patient’s eye and lack of ANC informative sessions” brought to light what participants have observed.

Sub-theme 7.1: Through the pregnant women’s eye

Most responses in this category, participants either lamented about ill-treatment which continually occur in the public health facilities to the level wherein one question arose whether such ill-treatment should be reported to the authority or not. Participants pointed on the wrongs done by health practitioners such as bragging about qualifications and others.

Participants also brought in issues of attitude, for example, failure for the ambulance to be dispatched to villages and people are told the ambulance cannot come because of gravel road, thereby deliberately delaying patients who should receive caesarean section and others. The Department of Health needs to intervene in an attempt to eradicate such attitude not permitted in a space of social and health care.

**Participant 5:** *Department of Health should talk to employees, nurses to treat patients well. Improving their attitude unlike telling us they are well educated. When as patients, shall we report ill treatment.*

**Participant 7:** *The department should hire more nurses that can reduce the burden at working areas so that clinics should work 24 hours. More people from villages have to come to hospital for delivery meanwhile clinics are available.*

**Participant 9:** *The department should quickly assist us especially those known patients that must deliver through caesarean section without delay.*

**Participant 10:** *Ambulance should respond immediately to the calls from people and go to those people who are in need. Improve that youth should not do abortion but they must promote contraception through injection type and preventative measures.*

Health departments possess an exclusive role to do pre-and post-service training, which is critically important in establishing competent healthcare workforce (Health

Communication Capacity Collaborative, 2016: 07). Additional to the above aspect, refresher and in-service education opportunities were suggested to be necessary to ensure that healthcare workers retain and are adhering to earlier training, and are updated on health care advancements workforce (Health Communication Capacity Collaborative, 2016: 07). Whatever patients have raised as concerns need to be treated as matter of urgency surely because it may be challenged in the court of law as it may be viewed as abuse of power and authority.

#### Sub-theme 7.2: ANC informative sessions: Mom-Connect

Technology has taken over most responsibilities in all spheres of life such as becoming the most convenient way to communicate, using applications like games and cameras. The health sector did not choose to remain behind in terms of equipping pregnant women with information hence the introduction of Mom-Connect. Seebregts, Barron, Tanna, Benjamin and Fogwill (2016: 01) described Mom-Connect as a mobile phone application that support pregnancy registration system in antenatal care facilities, allowing pregnant women to receive stage-based messages to help them improve their health and that of their babies. Participant 11 and 13 supported Mom-Connect as a better way to receive pregnancy information in a more convenient way except Participant 10 who was not registered with Mom-Connect.

**Participant 10:** *I'm not registered to Mom-connect.*

**Participant 11:** *Mom-connect information should continue as it is helpful. Women should respond to labour pains when it starts.*

**Participant 13:** *Mom-connect information, I received it on fortnight and those messages were helpful.*

In an attempt to ensure effectiveness of monitoring pregnant women, Peter, Barron and Pillay (2016: 1112) listed advantages of linking with Mom-Connect:

- Registration of pregnant women in public health ANC facilities and enrolment into a national register of pregnant individuals;

- Subscription to limited weekly messages essentially telling pregnant women to attend a health facility via public or Community Health Worker (CHW) enrolment;
- Subscription to stage-appropriate SMS messaging from the date of registration, through delivery, until the baby's first birthday;
- A virtual help-desk allowing pregnant women to ask additional questions, and submit compliments and complaints; and
- A service to allow mothers to rate the quality of care received at the facility.

Both Participant 11 and 13 confirmed that the Mom-Connect application was very useful and showed signs to approve future usage.

#### **4.4 DISCUSSION OF FINDINGS**

The study objective was mainly to investigate the contributory factors influencing the delay in reporting for labour by women in Mopani District and to answer the supportive questions.

- What are the contributory factors influencing the delay in reporting for labour by women in Mopani District?
- What is the impact of delay in reporting for labour on the process and outcome of labour?
- What recommendations can assist in addressing the factors that contribute to the delay in reporting for labour by women in the Mopani District?

After a gruesome transcription of raw data, the use of content analysis method led to the emerging of themes and sub-themes. The characteristics of the participants helped to understand not only the physical nature of what contributed to the delays in labour but other socio-economic aspects of their lives.

Seven themes and 18 sub-themes emerged from the data shared by the participants regarding what could have led to delays in reporting for labour. Three participants delivered their babies at home while six have delivered normally per NVD on arrival at the health facility with another three having delivered through caesarean section and the last one delivering through induction of labour. Not only the pregnant women

suffered the consequences of delays in reporting for labour but also the unborn babies experienced their own consequences caused by the same delays. The researcher found that this problem could have been avoided if in case early reporting was done.

At most, pregnant women have in some studies indicated that they attended ANC to monitor progress on their pregnancy or to check position of unborn child (Pell et al., 2013: 5) while other specific procedures were lacking such as syphilis testing and haemoglobin analysis. Based on the above results, pregnant women saw nothing compelling them to attend the ANC. Mangham-Jefferies, Pitt, Cousens, Mills and Schellenberg (2014: 2) suggest the demand-side strategy as a solution in influencing health practices of individuals and communities and promote uptake of preventive and curative maternal and new-born health care during pregnancy, childbirth and in the post-natal period.

This demand-side strategy is an aspect that involves the pregnant women in that they need to be taught and learn how to manage hindrances towards access to antenatal care, for example transportation. Like any other work environment, it also involves in this case training of health workers, motivating, improving the working environment, and making resources available (Mangham-Jefferies et al., 2014: 2). Current situations as observed are in direct contrast with the supply-side strategies where health workers are visibly looking exhausted and in low spirit, expressing fed-up mood and harsh conduct display. No wonder at times you visit a health centre or hospital only to be told there is no medicine for treatment or no doctors available.

A holistic approach that seeks to implement strategies to enhance maternal care, new-born care and nutrition need to be applied since it impacts directly on pregnant women and ways of reducing reporting delays in labour. Four strategies were suggested to close the health care vacuum (Schaffer & Rashid, 2016: 02):

- Ensuring access to quality maternal and new-born care including midwifery care. Experienced, knowledgeable and skilled personnel like midwives should be tasked with the healthcare of pregnant women without necessarily attaching the space, duration and date of delivery. Emphasis is made that midwives' skills to counsel pregnant women on sound nutrition practices that strengthen the

ability to carry pregnancies to term, preventing birth defects and save new-born lives.

With this strategy, one notes the presence of three concepts, namely, “access, quality and midwifery care.” The first concept does not specify whether accessibility refers to visitation by pregnant women to the healthcare centres or healthcare workers to the families of pregnant women. The second concept of quality is very much broad in that one can only suspect that it implies the efficiency, the type of service, diligence towards work, time spent servicing patients, and right attitude towards patients. The third concept of midwifery care has to do with the personnel, their conduct, utilisation of knowledge and skills. An ability to account for all these attempt to reduce delays in reporting for labour by pregnant women.

- Expand community level strategies to reach the most vulnerable women and girls. To achieve this, it needs introduction to training and deploying community health workers (CHWs) in order to provide health information for those underserved populations, including the youth and adolescents in the rural areas. To support the above aspect, there should be mobilisation of communities through women’s or community groups (Schaffer & Rashid, 2016: 03). Mobilisation and organising people into action (community mobilization) towards healthcare could be regarded as highly recommended prospects. The members, groups or organisations plan, carry out and evaluate ANC activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others (Howard-Grabman & Snetro, 2003: 01).
- Address unintended pregnancy through modern contraception and increase to safe abortion. A bigger challenge arises when those vulnerable girls and women cannot come forward to claim their stake on collecting contraceptives and doing safe abortion. In a situation in which women come forward, easy access for these girls and women to contraceptive information, counselling, products and services as well as to be able to plan for pregnancies will be

provided (Susheel & Darroch, 2012: 03). Prompt decisiveness to keep the pregnancy provides the necessary power to limit delays in reporting for labour.

Healthcare providers' constant contact with pregnant women establishes a friendly environment where they can approach, ask and get to learn about the importance of early reporting for labour. Ideally, the provision of this strategy looks perfect but does not account for the vicinity at which the activity should occur whether at home, school, and church, community buildings such as halls or even at the clinic. Only at the clinic shall pregnant women attend such an activity but the rest would demand that healthcare practitioners visit those areas for providing nutritional education and counselling. But still, this is to practically create an enabling environment not to delay reporting for labour and save lives of the unborn children.

Lutze, Higgins-Steele, Simen-Kapeu, et al. (2015: 02) suggested innovative strategies to maternal and new-born health care with the ultimate aim to improve early reporting of labour. According to the Maternity Guideline (2016: 14), the Minister of Health discouraged home deliveries whether by professional or layman midwives. This should be perceived to have serious legal implications in case something went horribly wrong in the delivery process in such unpermitted environment. The Minister of Health further indicated that health workers need to demonstrate high level of respect to the pregnant women and genuine interest in their clients, and try their utmost best avoid the elements of arrogance, rude and judgmental attitude.

Such attributes will be noticed by the pregnant women who will speak good about the better treatment, quality healthcare, quick and precise service offered and most probably serving as referral to other community members influencing early reporting for labour. The approach recommends extrinsic motivation as the basis to encourage hard work within the healthcare environment but says very little or nothing about intrinsic motivation. Intrinsic motivation is deeply embedded on the innate character, love for work, respect for clients and colleagues, care to follow policies and procedures, and willingness to share best practices by the healthcare practitioners. The consequential circumstance

of both intrinsic and extrinsic motivations would be best placed to improve delays in reporting for labour.

Regarding health financing, suggestions for incentivise through cash or money for skilled delivery at facility is put forward. Vouchers for maternal health services and related costs for example, transport costs and cash payment for delivery at facility (Lunze et al., 2015: 10) could be good gesture to be applauded by pregnant women, specifically those with socioeconomic challenges. In the face of reality, it would be extremely expensive to apply a similar approach and cater for the entire village, region, province, and country's pregnant women.

Delays in reporting labour in simpler terms translate into minimal utilisation of facilities for delivery by pregnant women. Although utilisation of health facility cannot be measured, constant utilisation means constant contact with health practitioners who could guide and educate pregnant women about the necessity of not delaying reporting labour. Based on the above understanding, Metcalfe and Adegoke (2012: 102) have listed other strategies to increase utilization of facilities for delivery:

- Maternity waiting homes (WMH) – they demand extra buildings and involves money. The health department would be expected to erect buildings for accommodating the pregnant women. Besides, the WMH houses will also be installed with water and electricity supply which add up to the financial burden. Those pregnant women will need food and other necessities of life. The current study does not intend judging the feasibility of this strategy but highlight the difficulties that may be encountered in an attempt to implement.
- Improving equity and access – not limiting, no conditions and easy admission, and it involves money too. Access does not only refer to arrival and admission at the health facility but smooth movement from home to the health facility (this in itself is a challenge since it involves other departments such as Public Works, Transport, Housing and Cooperative Governance and Traditional Affairs). The

cooperation between these departments could ease access to the health facility. For a moment, one imagines an influx of pregnant women. To manage any influx, pregnant women could be sent home immediately after delivery unless there are complications or problems with the child. None of these aforementioned strategies could function or be realised without funding from government.

According to the Maternity Guideline (2016: 40), the Minister of Health emphasised on the need to increase the amount of times pregnant women should attend the ANC to about eight ( $n=8$ ). This would result in close monitoring and assist in minimising high risks on pregnant women, giving health talks and treatment needed during ANC, delivery and postpartum period. As the days for labour come closer, it would be practical under examination that pregnant women who are ready for labour could be placed at the mothers' waiting area facility. Such facilities need to be expanded to the rural areas and in districts where transport problems and remoteness make it difficult for women to access skilled attendance at birth.

Labour or baby delivery is a sensitive matter needing care to address other situations at hand. Health professionals have to ensure improvement of poor working environment or one that is considered unsafe for pregnant women (Maternity Guideline, 2016: 14). These are some of the basic needs that could be afforded pregnant women in improving their status in society, empowering them in decision-making with regard to reproduction and other societal ills. CPD implementation should allow health professionals to interact with women, families and communities through empowerment engagements, which would at the end improve maternal, perinatal and family health (Maternity Guideline, 2016: 13). Failure to incorporate empowerment efforts to communities, government may lose its battles in addressing factors contributing to delay in reporting for labour by women.

#### **4.8 CONCLUSION**

This chapter mirrored what happened immediately after data collection and analysis of the interviews and documents. In analysing the data, content analysis approach was used eventually leading to the production of themes and categories. Findings

were developed from the themes and categories highlighting the causes, the impact and strategies of resolving delays of reporting for labour by pregnant women and literature aligning to the findings was incorporated.

## **CHAPTER 5**

### **CONCLUSION AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter provides the essence of what has been going on in the previous chapters. Furthermore, the chapter discusses the conclusions that are directly linked to the possible recommendations. The focus of the study was to address the phenomenon as observed from the following main question: "What are the contributory factors influencing the delay in reporting for labour by women in Mopani District?" Each chapter carried a specific role to play in the development of the study, with Chapter 1 introducing the problem, Chapter 2 bringing in authoritative voices from other writers of relevant topics, Chapter 3 focusing on methods of collecting data, and Chapter 4 discussion on the findings. The only approach that became suitable towards research viability of this study was the qualitative research.

#### **5.2 RESEARCH DESIGN AND METHOD**

A qualitative exploratory study was conducted in the study. Purposive sampling was used to select participants who met the inclusion criteria in Chapter 3 (3.3.1.2). Following approval from the UNISAREC and the Department of Health and CEO, data were collected from the voluntary participants using the self-developed unstructured face-to-face interview guide. The sample size was not pre-determined but data collection continued until no new information was found shared, meaning data saturation was reached. The sample size was 13 participants. Data analysis was done concurrently with data collection using the content analysis in order to answer the objective questions of the study.

### **5.3 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS**

Delays for pregnant women in reporting for labour has its adverse effects and serious complexities that may well contribute to excessive morbidity and mortality rate. For this reason, it is equally important for the health practitioners to initiate research studies similar to this in an attempt to reduce the endemic fatalities caused by delays of pregnant women in reporting for labour. The study aimed at addressing the challenges that were observed and based on the main research questions that later developed into the following objectives:

- To identify and describe factors that contribute to the delay in women reporting for labour in Mopani District.
- To assess and evaluate the impact of the delay in reporting on the process and outcomes of labour.
- To develop recommendations to address the factors that are contributing to the delay in reporting for labour.

In the beginning of this research study, the problem statement immediately quips in at an introductory level so that the readers could grab a sense of what the researcher intends to do. The objectives raised above form the foundation of this research study. While Chapter 1 has contentedly achieved its mandate, followed by Chapter 2, which deals with literature review.

One of the key functions of the literature review is to obtain ideas from other authors who have once conducted studies related to the topic of this study. The researcher has an obligation to either support, object or offer a neutral view about what other researchers have alluded to with regard to the current study. In terms of the research objectives, this study had to identify factors, evaluate the causes and finally recommend on what needs to be done to eradicate the possible delays for pregnant women in reporting for labour.

A good research study is determined by the manner in which the researcher is constantly aware of the study's contextual environment.

To address the problem in the study means the researcher should know what, who, when, why, and how to find data that will either support or disprove his/her assertion on the topic. This brings the researcher to a point where predetermined method of collecting data is invented and solidified by following all research protocols, including ethical procedures.

All the participants in the study were mothers who have just given birth with an experience of having delayed in reporting for labour. The ages of the participants ranged between 23 years (the youngest) and 42 years (the eldest) with all of them having a rural background. Thirteen interviews were held with each one of the participants where they answered predetermined questions in view of finding out the causes of delaying reporting for labour. The participants' responses were transcribed and later coded in a tabular form wherein themes and categories developed.

### **Objective 1: Identify and describe factors that contribute to the delay in women reporting for labour in Mopani District**

The following are findings, which were established after the interviews with participants:

- Ignorance of birth pains;
- Misconception of clinics working hours and lack of 24/7 services;
- Late antenatal care first booking;
- Lack of safety of pregnant women;
- Unnatural technical birth challenge;
- Unusual effects after birth;
- Importance of ANC check-up and eliminating early transfer of illness;
- Lack of ANC informative sessions and birth preparedness for labour;
- Lack of delivery expertise and insufficient professional ethics;
- Impolite and attitude of professional health practitioners towards patients;
- Delays miscounted by a month;
- Situation of high risk patients;
- Misappropriation of procedural intervention on patient;
- Delayed due to precipitated labour;
- Through the patient's eye;

- Distance between health centres and patients;
- Lack of transport for patients;
- Inaccessibility of EMS vehicles;
- Uncontrolled public transport costs; and
- Strike communities disregard of unborn life.

A thorough scrutiny on the findings revealed that there are those factors that were related to negligence of the patient, those that were related to negligence on the part of the institution (healthcare facility) and those that were related to the Department of Health's little performance. These factors as mentioned lead to a growing trend where the public may take very harsh legal stance on some of the negligence discussed here. In essence, this could lead to the Minister of Health being summoned to account in legal fights whereby negligence may have been found to occur within the department's jurisdiction. Moreover, the Department of Health may likely lose more money in the attempt to recover all the bungling committed by employees within its employment. Such legal issues could be avoided if people working for the Department of Health stick to the basic knowledge and skills for the provision of healthcare services. Monies lost owing to legal defence could be utilised for other projects that would improve the health services to the citizens of the country.

Table 5.1 shows the distribution of the findings according to the circumstances at which they occurred.

<b>Individual Circumstance</b>	<b>Institutional Circumstance</b>	<b>Departmental Circumstance</b>
Ignorance of birth pains	Unnatural technical birth challenge	Lack of safety of pregnant women
Misconception of clinics working hours and lack of 24/7 services	Unusual effects after birth	Lack of ANC informative sessions and birth preparedness for labour
Late antenatal care first booking	Importance of ANC check-up and eliminating early transfer of illness	Lack of delivery expertise and insufficient professional ethics
Through the patient's eye	Impolite and attitude of professional practitioners towards patients	Distance between health centres and patients
	Delays miscounted by a month	Lack of transport for patients
	Situation of high risk patients	Inaccessibility of EMS vehicles

	Misappropriation of procedural intervention on patient	Uncontrolled public transport costs
	Delayed due to precipitated labour	Strike communities disregard of unborn life

**Table 5.1: Findings grouped according to the contextual circumstances**

Delays in reporting for labour that was found to have been caused by individual patients or participants were placed in the first column of Table 5.1. On the contrary, those that occurred in the hospital or clinics were grouped in the middle column and the last one that involves the department or government are listed in the last column on the right hand side. Any birth defects or negligence that occur in the first column do not provide space for the Department of Health to pay legal damages unlike negligence in the second and third column. For example, if an ambulance could not reach a patient until something bad happened owing to the inaccessibility of the road, the road which is the sole responsibility of government to either revamp or built, citizens may likely take legal actions against government to compensate for damages.

**Objective 2: To assess and evaluate the impact of the delay in reporting on the process and outcomes of labour**

Consequences of delays in reporting for labour by pregnant women are not at all pleasing. Any conduct, action and even thinking, as long such conduct, action and thinking placed the life of an unborn child and its mother in jeopardy by external interference such as health practitioners' bungling, such conduct, action and thinking need to be investigated, condemned and if found on the wrong side, they should account. Unimpressive events that pregnant women who delayed reporting for labour observed after birth were picked up and no doubt, that negative near horrible aspects prevailed.

**Condition of the children and mothers**

Some of the mothers who delivered in those different days were stitched, experiencing severe pains during breastfeeding, became weak and abnormal delivery through caesarean section.

On the other side, some of the children experienced different conditions after birth including one who could only open one eye, while another child could not pass stools, and one child who remained asleep without breastfeeding until her blood glucose level was low.

What these mothers have alluded to might not necessarily be interpreted to make fundamental claims that their remarks were directly linked to delays in reporting for labour.

What the mothers have said was merely a response to the question the researcher had asked, which required them to tell observations they have experienced immediately after birth.

One imagines if these women went through all the health risks far away from the health facility, this implies that anything bad could have happened to both the mother and the child. For example, to apply a stitch after birth would practically have been impossible in the case delays in reporting for labour occurred in such a way that the women gave birth at home. By the time the woman decides to visit the health facility owing to persistent pains, the wound could have been badly damaged and also becoming difficult to apply the stitch.

Under normal circumstances, after delivery of the baby, he/she should cry immediately, breath well, passing urine and stools while umbilical cord has to be clamped (Deborah & Consolini, 2017: 01). For the mere fact that the new-born baby is not emotionally attached to Skills Birth Attendants (SBA), it becomes easier for them to conduct the normal procedure at delivery of the baby. The mother's over joyful moment of seeing the baby through birth would become a distraction that may lead to skipping other processes especially during home delivery including lack of expertise. The SBA with their expertise and high level of skills know when and where to place a drip and also why a patient should receive a drip. Incidents as the participants expressed them show that without the SBA on site during baby delivery, mothers risk their lives and those of their babies.

**Objective 3: To develop recommendations to address the factors that are contributing to the delay in reporting for labour.**

Addressing delays in reporting for labour for pregnant women should not become a one-sided matter of being either a government or individual responsibility but everyone's concern. There is not much justification for ignorance of birth pains and misconception of clinics working hours or even late antenatal care first booking because recently there has been widespread ways to distribute information such as the use of the media platform: radio announcements, newspapers, television, magazines, and flyers. Recommendations regarding improvement of delays for pregnant women in reporting for labour would be discussed thoroughly in its proper section.

#### **5.4 CONCLUSIONS**

The experiences that pregnant women have had are derived into findings that lead to recommendations and reduce future delays of pregnant women in reporting for labour. The cause of delays for pregnant women in reporting for labour were found and highlighted three categories of contextual causes, including the participants, the health facilities and government or Department of Health. Knowledge on the impact of delays for pregnant women in reporting for labour was equally important because it provided the researcher with a clue towards development of recommendations. Based on achieving the mandate of the study objectives, the recommendations would guide the researcher and other stakeholders on how to reduce delays of pregnant women in reporting for labour. The study deliberately aimed at driving government or Department of Health to work towards improving the lives of the weak, the poor and the less fortunate in eradicating delays for women in reporting for labour.

#### **5.5 RECOMMENDATIONS**

- Theory as support system

In chapter 2, the SEM had been discussed at length in a bid to highlight the importance of using a similar theory in practice within society, the health facilities, individual people who become pregnant and the health department. This SEM helps society to understand their role in the process of caring and serve as support system for the pregnant women. The stages of pregnancy and relations with the environment are covered in all the spheres of life in the uterus and immediately after delivery.

1. Microsystem - Intrapersonal Level (Individual Pregnant Women and the Unborn baby inside the womb). This stage of SEM involves the relations between the mother and unborn baby including what the mother eats while pregnant, care of the mother's condition (climate and weather), visits to the health facility, and moderate behaviour. For example, if a pregnant woman craves and eats up the soil, ashes and ice blocks, she becomes anaemic (anaemia), which affects the baby's growth to intrauterine growth retardation and ultimately death complications. This aspect needs support from society and government and failure to offer that needed support creates unnecessary tension to the mother and ultimately the unborn baby.
2. Mesosystem - Interpersonal Level (Pregnant Women Associated with Partners, Friends and Family). Care should be taken not to anger the pregnant women because partners, friends and family members should be the closest people to offer comfort and advice before turning to the outside world for help. Something should be borne in mind that unborn babies can detect love from outside the mother's body. For example, the baby can recognise the voice and tone of the person who was close to the mother while in the uterus. In case a husband beats up the pregnant woman with a punch in the abdomen, it can cause separation between the uterus and the placenta leading to antenatal haemorrhage and ultimately miscarriage. Good relations from these structures in family will reduce tensions that normally grow to hypertension and depressions.
3. Exosystem - (Pregnant Women and Social Networks/Community)
4. Macro-system - (Pregnant Women and Society)

Similarly, the above two stages of SEM take up the same approach with regard to care whether in society and health facilities. For the mere fact that pregnant women carry in their uterus unborn lives, they should be respected and given much care to save them and their unborn babies.

5. Chronosystem - (Pregnant Women and Public Policy). The Department of Health plays an important role in developing policies that will protect pregnant women in labour from abuse. Pearson, Larsson, Fauveau and Standley (2007: 76) provided practical steps into policies that will eliminate delays and mortality rate, which include policy and planning, resources, guidelines, human resources, management, infrastructure and supplies, monitoring and research.

- Making the availability of resources a priority

There seems to be a scarcity of human resources in some clinics. The aspect of human resources has been listed as an issue that should be given a priority (Pearson et al., 2007: 76) as this will eradicate the problem of health practitioners closing health centres because they want to knock off earlier. The availability of human resources would instead change the setting where health practitioners could no longer work 24/7, but work for five days because there are sufficient staff members.

- Increasing capacity of all clinics to offer skilled birth

Most clinics were found not to be operating during the night and this places the life of pregnant women at risk. This warrants that the Department of Health should increase the number of skilled birth attendants (SBA) at each and every clinic, six to be exact so that in each seven days of work, two must be working in the night and the other two during the day while the remaining two will be off. The SBA's role is clear in that they will be able to provide necessary supervision, care and advice to women during pregnancy, labour and the post-

partum period to conduct deliveries on their own and to care for new-borns (United Nations Development Group, 2003: 38).

- Expansion of Mom-Connect into rural areas

Pregnant women and new mothers are the centre of attraction to the text service for providing them with information relating to caring for pregnancy and the newly-born children.

Participants were found to encourage usage of the application, Mom-Connect as it gives information concerning pregnancy and child-birth care. Mobile Alliance for Maternal Action (Mama, 2012: 01) describes Mom-Connect as a texting model intervention in South Africa whereby text messages covering broad areas of child care and health were sent to pregnant mothers from the time they consulted at the clinic for ANC. Participants who were able to use the application commended its usefulness and its usage need to be strengthen in the rural areas where most problems regarding the phenomenon in this study is profound.

- Establishment of MWHs in the rural areas

MWHs are particularly unheard of in South African society. MWHs are described as lodgings or accommodation close to a health facility where pregnant women can stay for a couple of days before delivery of the child (Penn-Kekana, Pereira, Hussein, Bet al., 2017: 2). Although MWHs are understood to be erected within the perimeters of a health facility, they should be expanded to clinics which were not 24/7 services and beyond that be built in rural areas where there are no clinics. One or two skilled birth attendants would be placed there to attend to cases of minor or normal birth and this arrangement is better than a village without a health facility at all.

- Increasing transportation – ambulances

Around the area where this study is conducted, the Health Centre, which services more than 15 villages and a couple of farms, has only three

ambulances. In a scenario where there are two pregnant women who should be driven to hospital, a road accident involving three vehicles and four people who have stabbed one another in different settings, this is a tough call where there is no better choice. To minimise similar scenarios from turning chaotic as described above, four more ambulances should be budgeted for and four drivers also be hired for the purpose of attending to similar cases. This would also minimise situations owing to the delays of ambulances arriving late at scenes such as the above, people may not be angered by the sense of urgency with which ambulances arrive at the scene of accidents.

## **5.6 CONTRIBUTIONS OF THE STUDY**

Generally, the science of research has a specific purpose, which is to find answers to problems that are devouring human beings and/or destroying natural settings. In the health sector environment, researches that are conducted on daily basis pursue a single objective in which to encourage as well as promote health and life of all citizens in the country. From their article, and in support of the above assertion, McGaw-Binns, Standard-Goldson, Ashley, et al. (2001: 796) provide the importance of preventing maternal mortality, which should be regarded as a sensitive indicator of the women's status for access to care, adequacy and quality of healthcare in developing countries. In this study, delays in reporting for labour by pregnant women was identified as a threat to society and likely to become a huge destruction to human chain if answers could not be sought.

Therefore, this study aimed at making the following contribution:

1. Pregnant women
  - To eradicate the ignorance on the pregnant women as it was found to contribute to delays in reaching the health facility where they could be assisted earlier in the case birth complications are observed.
  - To inform and teach pregnant women about the importance of early booking in the first few weeks of pregnancy to provide nearly accurate number of weeks from which delivery of the child may be expected.

- To provide assistance to pregnant women in letting them know their rights so that the same rights could not be trampled by those within the employment of the department and authority/power as well as defuse unnecessary tension that at times occur between health practitioners and the pregnant women based on oral referral from others about the attitude of some health practitioners.
- To create an opportunity for pregnant women to air their frustrations through placing suggestion boxes wherein they can report anonymously about undue treatment they may have received in the health facility without being noticed or divulging details.

## 2. Health facilities

- To improve on the ethical work principles that look to evaporate as health practitioners spend most of their entire lives in the same area, or position or fed-up with work itself. The entire process would be to remove and renew the impolite attitude and unethical conduct observed to be lacking the professional standards for which health practitioners have signed in their code of conduct to maintain and preserve at all times towards patients.
- To harness and enforce correct procedures at all levels of patients' pregnancy without placing both the patient's life and that of the health facility in jeopardy. The issue with following procedures during labour would minimise the risk of losing the lives of unborn children and that of the pregnant women while on the other side, it reduces loss of money by the Department of Health.

## 3. Government/health department

- To inform government or the health department about the findings from this current study. This will assist both government and health department on the steps to take and correct all mishaps observed in the course of this study.

- To shape regulations in terms of drafting policies to assist in minimising issues of misconduct and attitudes developed by health practitioners that further contribute to the delays in pregnant women in reporting for labour.
- To inform government or the health department about future attempts of improving working conditions and education of staff members as this has positive results in their working relations with massive attendance of pregnant women.

## **5.7 LIMITATION OF THE STUDY**

The current study targeted a population of pregnant women who delayed reporting for labour at the health facilities around the Greater Tzaneen Municipality and its surrounding villages. At most, the researcher also utilised one of the health facilities in the Greater Tzaneen Municipality as a source of information especially details of pregnant women and served the purpose of locating those participants.

There are quite some limitations:

- Sample size: thirteen (13) sample participants were interviewed while the initial planned target was 25 pregnant women who delayed reporting for labour. These women their ages ranged between 23 and 42 years, were willing to participate and able to give consent to participate in the study. The size of the sample which according to the limitation definition was out of researcher's control, however data saturation was reached.
- The interview was conducted in Tsonga, which is not the first language of some participants, this could have made them failed to express themselves clearly of what made them delay reporting for labour.
- Theofanidis & Fountouki (2019: 156) stress that qualitative data analysis methodology is another area of potential limitation and cannot be entirely replicated. Qualitative data analysis does not involve analysis based on numerical values which is why analysis cannot be replicated. Most importantly,

all of the above limitations must be clearly stated so that results of the research study may not be distorted and misinterpreted by the wider readership or academic audience (Theofanidis & Fountouki, 2019: 156).

- An issue of time as limitation was also found to contribute on the negative drive of little progress on the study. Simon (2011: 2) shows that a study conducted over a certain interval of time is a snapshot dependent on conditions occurring during that time. Those pregnant women who reported late for labour, were in a hurry to go home immediately after delivery of the baby, after having spent almost six hours in the ward. This prompted a change of plan since seeing them in the health centre was impossible. The researcher acquired their personal phones and arranged to meet them at home for the interview which ultimately took place.

## **5.8 CONCLUDING REMARKS**

The chapter aimed at linking the findings in the previous chapter and also providing a summary of what has been achieved. At this stage, the research study was able to produce findings which developed from the participants' experiences on delays of pregnant women in reporting for labour. In addition, the research aimed at showing the impact of the delays of pregnant women in reporting for labour, which had unforeseen dangers and only experts could quickly identify and deal with such problems in a proper manner whether by way of advising or offer treatment. For the research study becoming a complete entity, recommendations have been made in order to help government or health department as stakeholder to better service the people and society by following such recommendations.

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## **ANNEXURES**

### **Annexure A**

#### **46322523 HLUNGWANI INFORMATION LETTER**

Department of Health Studies  
Pretoria, South Africa

Dear Participant

I am conducting a Master's Degree in Nursing Science study on the topic 'factors contributing to a delay in reporting for labour by pregnant women at a hospital, in the Mopani District Municipality'. I am interested in evaluating the impact caused by the delays in reporting for labour as well as suggest on what must be done in terms of policy formulation by government.

Your contribution in achieving the objective of this study relies heavily on your participation. On acceptance of participating, you will sign a consent form where you are indicating voluntary participation. In addition, as soon as the University of South Africa has awarded the ethical clearance, you will be required to spend an hour of your time for an arranged interview session.

Your participation will remain anonymous and it is strictly an issue of privacy and confidentiality. Transcripts of the interview will be kept in a safe place until after 12 months and will be set on fire.

I hope we shall have a wonderful time in an attempt to redress all the negative aspects associated with delaying reporting for labour

My details are:

Maria Gladys Hlungwani  
Cell: +2779 144 5031

Email: [46322523mylife@unisa.ac.za](mailto:46322523mylife@unisa.ac.za)

Student Number 46322523

(Researcher)

For any queries and assurance, contact my research mentors:

Ms. Mosalo A.

Contact: 012 429 6447

E-mail: [mosala@unisa.ac.za](mailto:mosala@unisa.ac.za)

And

Prof. Mathibe-Neke JM.

Contact: 012 429 6443

E-mail: [mathijim@unisa.ac.za](mailto:mathijim@unisa.ac.za)

## **Annexure B**

### **46322523 HLUNGWANI CONSENT FORM**

**Department of Health Studies  
Pretoria, South Africa.**

Dear Participant,

Thank you for agreeing to participate in the study. The study aims to explore the delay in reporting of pregnant women during labour in Mopani District. Taking part in the study is purely voluntary and you have the right to pull out at any time without implication or consequence regarding use of services in the clinic.

The Information collected during this research will be kept strictly confidential and under no circumstances will names be used throughout the study and even when disseminating the results at the end of the study. I am required to write a report at the end of the study in to share the findings with other colleagues in order to show further insights into the delay reporting of pregnant woman during labour.

Should you need to ask any further questions pertaining to the study, I will be happy to answer or you may contact my supervisor Ms A. Mosalo from the University of South Africa, Department of Health Studies.

Maria Gladys Hlungwani

Cell: +2779 1445 031

Email: [46322523@mylife.unisa.ac.za](mailto:46322523@mylife.unisa.ac.za)

Ms Mosalo

Tel: +2712 429-6647

[mosala@unisa.ac.za](mailto:mosala@unisa.ac.za)

Signed: ..... Date:.....

(Participants signature)

Signed: ..... Date:.....

(Researcher Signature)

Signed: ..... Date:.....

(Witness)

## **Annexure C**

### **46322523 HLUNGWANI LETTER OF PERMISSION TO CONDUCT THE STUDY**

### **REQUEST FOR APPROVAL TO CONDUCT THE STUDY AT LETABA HOSPITAL**

P.O.BOX 70

EKA HOMU

0831

29 AUGUST 2017.

The Director,  
District health Board,  
Department of Health  
Mopani

Dear Sir/Madam,

#### **RE: PERMISSION TO CONDUCT A STUDY ON FACTORS INFLUENCING DELAY REPORTING FOR LABOUR BY WOMEN IN MOPANI DISTRICT AT LETABA HOSPITAL, MARTERNITY WARD.**

My name is MARIA GLADYS HLUNGWANI; I am a Master's Degree Nursing Science student with the University of South Africa. As a part of the requirement of the programme, I am expected to conduct research. The title of the study is "Delayed in reporting for labour by women in Letaba Hospital, Mopani District"

I am requesting for permission to conduct the research at Letaba Hospital as I am aware that majority of pregnant women with complicated labour are refer to this Hospital which may give me an opportunity to have access to the required information. The purpose of the study is to find out the factors influencing the delay in reporting for labour by women in Mopani District, strategies used in dealing with the delays and the impact on the mother and baby. Data will be collected from consenting by post

delivered women. Data will be collected using unstructured interviews. Data collection is expected to last approximately an hour or less.

I have also attached the research proposal for your perusal  
I am looking forward to a favourable response.

Yours faithfully,

Maria Gladys Hlungwani  
(Researcher)  
Cell: +27791445031  
Email: [46322523@mylife.unisa.ac.za](mailto:46322523@mylife.unisa.ac.za)  
Student Number: 46322523

My Supervisor's details should you wish to enquire about the study  
Ms Mosalo  
Tel: +2712 429-647  
[mosala@unisa.ac.za](mailto:mosala@unisa.ac.za)

## **Annexure D**

### **46322523: HLUNGWANI CONFIDENTIALITY BINDING FORM**

Title of Research Project: Factors contributing to delay in reporting for labour by pregnant women at Mopani regional Hospital.

Researcher: Maria Gladys Hlungwani

I Maria Gladys Hlungwani, understand that I may have access to confidential information about study sites and participants. By signing this confidentiality form, indicate my understanding of the responsibility to maintain confidentiality and agree to the following:

That names and any other identifying information about study sites and participants are completely confidential. I confirm not to divulge or otherwise make known to unauthorized persons any information obtained in the course of this research project that could identify the individuals who participated in the study.

I understand that I am not to use the information gathered from study sites or participants, or any other confidential documents, nor ask questions of study participants for my personal information but only to the extent and for the purpose of performing my assigned duties on this research project.

I agree to notify my supervisor immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in violation, whether this is on my part or the part of another person.

Researcher:

---

(Print Name)

(Signature)

---

(Date)

Witness:

---

(Print Name)

(Signature)

---

(Date)

## **Annexure E**

### **46322523 HLUNGWANI INTERVIEW GUIDE**

#### **INTERVIEW GUIDE:**

Good morning/afternoon and welcome to the discussion session.

1. Please share with me, how many children have you delivered in your lifetime?
2. Were all babies delivered at a health facility?
3. Did you attend antenatal care during your pregnancy/pregnancies? If YES, how many times in your last pregnancy? If NO, what could be the reasons of not attending?
4. Do you think that it is important for one to attend ANC during pregnancy? Yes, WHY?
5. (For those who attended ANC) Have you received information of signs and symptoms of labour during Antenatal care (ANC) visits?
6. According to the hospital records, it is indicated that you reported for labour at an advanced stage. What could be the reason for your delayed reporting?
7. Did the labour process go well right from the beginning to end?
8. How was the baby delivered?
9. Was the baby well during delivery?
10. Were there any problems that occurred during labour
11. What exactly delayed you to report for labour?

**THANK YOU FOR YOUR PARTICIPATION!**

## Annexure F

### Letter of Approval to Conduct Study

CONFIDENTIAL



LIMPOPO  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH  
LETABA REGIONAL HOSPITAL

REF: S5/3/1/2

ENQ: Acting Quality Manager

DATE: 20 June 2018

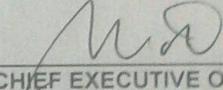
To: Hungwani G.M

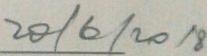
Student No: 46322523

University of South Africa

SUBJECT: APPROVAL TO CONDUCT RESEARCH: DELAY REPORTING  
DURING LABOUR BY WOMEN IN MOPANI DISTRICT AT LETABA  
REGIONAL HOSPITAL MATERNITY WARD

1. The above subject matter refers.
2. You are granted permission to conduct research at Letaba Regional Hospital as per approval granted by the Head of Department, Limpopo Provincial Health.
3. Hoping that you will find this to be in order.

  
\_\_\_\_\_  
CHIEF EXECUTIVE OFFICER

  
\_\_\_\_\_  
DATE

CONFIDENTIAL

## Annexure G

### Ethical Approval Letter



**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES**  
**REC-012714-039 (NHERC)**

6 December 2017

Dear Maria Gladys Hlungwani

**Decision: Ethics Approval**

**HSHDC/804/2017**

Maria Gladys Hlungwani

Student No.:4632-252-3

Supervisor: Mrs A Mosalo

Qualification: M Cur

Joint Supervisor: Prof JM Mathibe-Neke

**Name:** Maria Gladys Hlungwani

**Proposal:** Factors contributing to a delay in reporting for labour by pregnant women at a regional hospital, Mopani Hospital

**Qualification:** **MPCHS94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 6 December 2017 to 6 December 2019

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 6 December 2017*

*The proposed research may now commence with the proviso that:*

- 1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
  
- 2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



University of South Africa  
Pretoria Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
www.unisa.ac.za

3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

4) [Stipulate any reporting requirements if applicable].

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

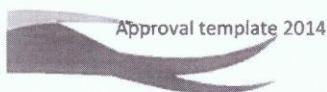
Kind regards,

*Prof J.E. Maritz*

Prof JE Maritz  
CHAIRPERSON  
[maritje@unisa.ac.za](mailto:maritje@unisa.ac.za)

*Prof M.M. Moleki*  
Prof MM Moleki  
ACADEMIC CHAIRPERSON  
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## Annexure H

### Letter from the editor

#### **EDITING AND PROOFREADING CERTIFICATE**

7542 Galangal Street

Lotus Gardens

Pretoria

0008

12 February 2019

#### **TO WHOM IT MAY CONCERN**

This certificate serves to confirm that I have edited and proofread Ms G Hungwani's dissertation entitled "**FACTORS CONTRIBUTING TO A DELAY IN REPORTING FOR LABOUR BY PREGNANT WOMEN AT A REGIONAL HOSPITAL, MOPANI DISTRICT**".

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:



Jack Chokwe (Mr)

Contact numbers: 072 214 5489

[jackchokwe@gmail.com](mailto:jackchokwe@gmail.com)

Professional  
**EDITORS**   
Guild

