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## LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal clinic
ANC	African National Congress
ARV	Antiretroviral
ARV/T	Antiretroviral Therapy
ASSA	Actuarial Society of Southern Africa
AU	African Union
BANC	Basic Antenatal Care Programme
BP	Blood Pressure
CAFRA	Caribbean Association for Feminist Research and Action
CBO	Community-Based Organisation(s)
CBHP	Community-based health programmes
CD4	Cluster of Differentiation 4, also known as Helper T-lymphocytes cells, in human blood are the coordinators of the immune response. The destruction of CD4 or T-cells leads to progressive weakening of the immune system in HIV infection and ultimately results in the acquired immune deficiency syndrome (AIDS).
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CHCs	Community Health Centres
CHERG	Child Health Epidemiology Reference Group
CHWs	Community Health Workers
CI	Confidence Interval
CSDH	Commission on Social Determinants of Health
CTOP	Choice on Termination of Pregnancy
DHB	District Health Barometer
DHIS	District Health Information System



DHS	District Health System
DoH	Department of Health
DWAF	Department of Water Affairs and Forestry
DSD	Department of Social Development
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunisation
ESAP	Economic Structural Adjustment Programmes
FBO	Faith-Based Organisation
FFS	Fiscal Federal System
FWCW	Fourth World Conference on Women
GCIS	Government Communication Information System
GDP	Gross Domestic Product
GEAR	Growth, Economy and Redistribution Strategy
GNI	Gross National Income
GNP	Gross National Product
HDACC	Health Data and Coordinating Committee
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
HST	Health Systems Trust
ICPD	International Conference on Population and Development
ICPD PoA	International Conference on Population and Development Programme of Action
IAPG	Inter-American Parliamentary Group
IEC	Information, Education and Communication
IHME	Institute for Health Metrics and Evaluation
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device

KPC	Knowledge Practice Coverage
KZN	KwaZulu-Natal
KZN DoH	KwaZulu-Natal Department of Health
LAM	Lactational Amenorrhoea Method
LBW	Low Birth weight
MC&WH	Maternal, Child and Women's Health
MCDI	Medical Care Development International
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health and Family Planning
MDG	Millennium Development Goal
MEC	Member of Executive Committee
MMR	Maternal Mortality Ratio/Rate
MNCH	Maternal, Neonatal & Child Health
MCNWH	Maternal, Neonatal Child & Women's Health
MNCWH&N	Maternal, Neonatal, Child & Women's Health and Nutrition
MNCWH&N	strategy means Strategic Plan for Maternal, Neonatal, Child & Women's Health and Nutrition in South Africa <i>2010-2015</i>
MRC	Medical Research Council
MOUs	Medical Obstetric Units
m2m	Mothers-to-mothers (a non-governmental organisation)
NALEDI	National Labour and Economic Development Institute
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NDoH	National Department of Health
NFPP	National Family Planning Programme
NGO	Non-governmental organisation(s)
NHS	National Health System
NMR	Neonatal Mortality Rate
NSNP	National School Nutrition Programme
NSP	National Strategic Plan
ORS	Oral Rehydration Solution

PDP	Population Development Programme
PDoH	Provincial Departments of Health
PHC	Primary Health Care
PHCCs	Primary Health Care centres
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNC	Post-natal Clinic
PNMR	Perinatal mortality rate
PoA	Programme of Action
PIIP	Perinatal Problem Identification Programme
PPH	Post-partum haemorrhage
PSU	Primary sampling unit
REC	Research Ethics Committee
RH	Reproductive Health
SA	South Africa
SACO	South Africa Country Office
SADC	Southern African Development Community
SADHS	South African Demographic and Health Survey
SA DoH	South African Department of Health
SA DSD	South African Department of Social Development
SAIRR	South African Institute for Race Relations
SAPs	Structural Adjustment Programmes/Policies
SBR	Stillbirth Rate
SDH	Social Determinants of Health
SDL	Sexual Division of Labour
SMI	Safe Motherhood Initiative
SA NDoH	South African National Department of Health
SA PDoH	South African Provincial Department of Health
SRH	Sexual and Reproductive Health
StatsSA	Statistics South Africa
STI	Sexually transmitted infection

TBA	Traditional birth attendants
TFR	Total fertility rate
TOP	Termination of pregnancy
UKZN	University of KwaZulu-Natal
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund (Formerly United Nations Fund for Population Activities, name changed in 1987)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
U5	Under-five years
U5M	Under-five years mortality
U5MR	Under-five-years mortality rate
VA	Verbal Autopsies
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization
WPPA	World Population Plan of Action

# CHAPTER ONE

## INTRODUCTION AND BACKGROUND TO THE STUDY

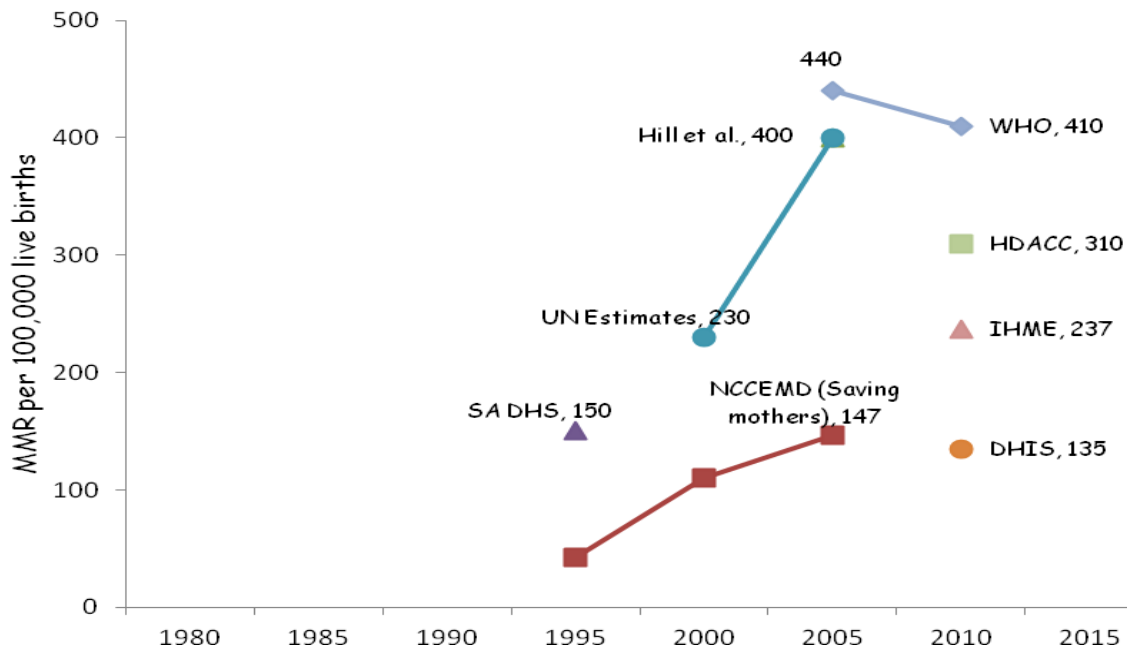
### 1.1 INTRODUCTION

Maternal and child deaths are outcomes of the socio-economic, civil-political and cultural conditions (Gruskin, Cottingham, Hilber, Kismodi, Lincetto & Roseman 2008). High rates of maternal, reproductive and child morbidity and mortality are evidence of deprivation of women's health needs. This could be attributable to many factors, amongst which is inadequate attention to reproductive health needs, leading to an inability to cope with the health problems posed by pregnancy and childbirth.

South Africa (SA) was one of the 189 countries that endorsed the United Nations' Millennium Declaration in 2000 (United Nations 2000), thus committing to meeting eight goals, referred to as the Millennium Development Goals (MDGs) by 2015, using 1990 as a base year (Statistics South Africa & National Treasury 2007). The MDG 5 calls for countries to improve maternal health and reduce the maternal mortality ratio (MMR) by three-quarters (Ronsmans & Graham 2006). The Millennium Declaration, according to Ronsmans and Graham (2006), marks the first time that maternal mortality has featured so prominently in the high ranks of a global pronouncement, calling for action to ensure that the risk of maternal death is minimised for all women in different settings. The proposed action needs to be informed by an understanding of who is dying, when, where and why (Ronsmans & Graham 2006). MDG 4 calls for a reduction in the child mortality rate by two-thirds (Statistics South Africa & National Treasury 2007).

However, despite this commitment, the MMR remains high in South Africa, as reflected in Figure 1.1 below.

**Figure 1.1: Trends in the maternal mortality ratio for South Africa from 2001 to 2010**



**Sources:** Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, et al. 2009 ;District Health and Information System (DHIS) 2011; Health Systems Trust (HST) 2011;Hill, Thomas, AbouZahr, Walker, Say, Inoue, et al. 2007;Institute for Health Metrics and Evaluation (IHME) 2010;NCCEMD 2005-2007;SA DoH 2008c; SADHS 1998;SAIRR 2009;StatsSA 1998;The Health Data and Coordinating Committee (HDACC) 2011;UNICEF 2007 & 2009;WHO, UNFPA, UNICEF & the World Bank 2010)

Figure 1.1 shows that the MMR was estimated to be 96 per 100,000 live births in 2001, 104 per 100,000 live births in 2002, 110 per 100,000 live births in 2003, 147 per 100,000 live births in 2004, and 400 per 100,000 live births in 2005 (South African Institute of Race Relations 2009). Recent data collected by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) also points to the increasing MMR, for example the *Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa 2005-2007* has indicated that there was a 24% increase in the number of maternal deaths notified, compared to the period 2002 to 2004 (NCCEMD 2008:276).

An analysis of progress towards achieving the targets set by the MDGs in respect of maternal, neonatal and child mortality shows inconsistency regarding estimates of

the South African MMR between international and national sources. The estimates vary from an MMR of 230 per 100,000 to 702 per 100,000 live births (Blaauw & Penn-Kekana 2010; Buchmann 2011). Dorrington and Bradshaw (2011) concur that the estimates for the MMR for South Africa remain considerably uncertain. These investigators further assert that South Africa has not been able to reverse the inclining trend of its MMR and highlighted that:

- The NCCEMD estimate the MMR to be 73 per 100,000 live births in 1998 increasing to 152 per 100,000 live births for the period 2005-2007 by basing their estimates on institutionally reported data
- Hill *et al* (2007) estimate the MMR to be in the range of 369 per 100,000 to 820 per 100,000 live births based on the 2001 census
- StatsSA's estimate for the MMR is 625 per 100,000 live births while Garenne and his co-workers *estimate* the MMR to be 700 per 100,000 live births based on the 2007 Community Survey.

In 2010 the Institute for Health Metrics and Evaluation (IMHE) estimated the MMR to be 237 per 100,000 live births in 2008 while the World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Bank (2010) reported an MMR of 440 per 100,000 live births in the same year, that is, 2008. The South African Department of Health's recently appointed Health Data and Coordinating Committee (HDACC2011) estimate the MMR as 310 per 100,000 live births in 2008. The South African DoH's District Health System (DHIS) estimate the MMR to be about 135 per 100,000 live births in 2010 (DHIS 2011).

These reported differences in the rates of maternal mortality result from measurement problems related to underreporting, misreporting, poor data collection, lack of data, misclassification of causes of maternal deaths and misdiagnosis. Bradshaw and Dorrington (2012) note that the HDACC recommended that the use of vital registration data be adjusted for under-registration and misclassification of the causes to monitor maternal mortality. The HDACC's approach in this regard is in contrast to that of international agencies. The HDACC further recommends that the number of maternal deaths be scaled up by 50% to account for general reporting differences (Bradshaw & Dorrington 2012). Based on the approach of the HDACC,

the MMR was estimated to be 310 per 100,000 live births in 2008. Hence Bradshaw and Dorrington (2012) came to a conclusion that by 2009, South Africa had not yet reversed its high levels of MMR. Moreover, Bradshaw and Dorrington (2012) raise concerns about the IHME estimations of the South African MMR, particularly given that the IHME alleges to have included HIV related deaths, occurring during the pregnancy risk period including 42 days post-delivery. According to Bradshaw and Dorrington (2012), the South African MMR could have reached the level of 700 per 100,000 live births if such deaths alone were taken into account.

Buchmann (2011) also agrees that there is a significant degree of underreporting of maternal deaths especially home deaths and adds that the NCCEMD or saving mothers' reports provide only facility-based numbers of maternal deaths in South Africa. The absence of reliable and consistent locally produced national MMRs estimates poses challenges in accurately estimating the South African MMR. This means that making conclusive statements about whether the MMR is on the increase or declining difficult. Figure 1.1 depicts the various estimates.

Child mortality is also on the increase, having been estimated to be 46 per 1,000 live births in 1990, according to the 1998 South African Demographic and Health Survey (SADHS), 43 per 1,000 live births in 2006, and 68 per 1,000 live births in 2007, according to the district health barometer (UNICEF 2009). Chopra, Daviaud, Pattinson, Fonn and Lawn (2009) confirm that maternal mortality and child mortality in South Africa have both increased since the baseline of 1990 for the MDGs. However, as is the case with MMR, Lozano and colleagues in Keber, Tuaone-Nkhasi, Dorrington, Nannan, Bradshaw, Jackson and Lawn (2012) raise concerns about unreliable child mortality estimates. Kerber *et al.* (2012) identify the need for dialogue and consensus about IMR estimates to inform priority interventions and resource allocation. These authors further confirmed that South Africa is not on track in terms of achieving MDG 4 by 2015 (Kerber *et al* 2012). Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, *et al.* (2009) further warn that, amongst others, a very high burden of morbidity and mortality in South Africa results from HIV and tuberculosis.



Based on the researcher's experiences as a public health specialist and policy analyst in the Department of Health and Developmental Social Welfare and as a Maternal and Child Survival Specialist in the United Nations Children's Fund South African Country Office (UNICEF, SACO), she feels that there is little appreciation at the level of policy in South Africa, of the root causes of the persistently high levels of maternal and child morbidity and mortality. Moreover, attempts to address this problem often resulted in a focus on finding solutions to complications related to pregnancy and childbirth through narrowly defined, 'quick-fix' medical-technical solutions, instead of improving women's health and reproductive health specifically. The latter, reproductive health, refers to '*a state of complete physical, social and mental well-being in all matters relating to the reproductive system, its functions and processes*' as defined in the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) held in 1994 (United Nations 1994). According to the Commission on Social Determinants of Health (CSDH), medical-technical solutions are important but not sufficient interventions to improve the health status of a population (CSDH 2007). A poor conceptualisation of the social determinants of health at the level of policies and interventions renders women vulnerable to the risks posed by factors such as low income, poor social security, poor quality of and access to education, food and housing (Raphael & Bryant 2006). A basic premise for this study is that a broader approach based on integrating social interventions into the primary health care (PHC) system could be a more effective approach to improving reproductive outcomes.

The study focuses on overall women's health as a priority to reducing the MMR and the closely related neonatal mortality rate (NMR) along the continuum of female reproductive health care. New-born and maternal health and survival are closely linked, suggesting that it is important to treat mothers and their off-spring as a dyad through all the phases of pregnancy, delivery and post-delivery (UNICEF 2009).

## **1.2 THE STATEMENT OF THE PROBLEM**

Maternal and child deaths still present a significant burden in South Africa, indicating slow progress in improving maternal health, and the intimately linked perinatal and

new-born health (The Partnership for Maternal, Newborn and Child Health 2008). In 2004 the MMR was reported to be 147 per 100,000 live births by the NCCEMD (2008). For the same year, the perinatal mortality rate (PNMR) for babies weighing 1,000g or more was 30,7/1,000 births, with a stillbirth rate (SBR) of 20,7/1,000 live births and a neonatal mortality rate (NMR) of 10,3/1,000 live births (MRC 2004; SA DoH 2008c). However, these figures do not apply equally among the various South African population groups.

Previous studies conducted in South Africa have reflected that infant mortality is 8 to 10 times higher for the blacks than whites, especially in the erstwhile 'homelands', reflecting that those with the lowest socio-economic status have the poorest health outcomes (Aliber 2002). Not much has been achieved to narrow this gap since the democratically elected government of the Republic of South Africa came into existence in 1994 (Sachs 2002). Studies conducted in 2002 reflect that the infant mortality rates varied between 7/1,000 in the white population and 67/1,000 in the black population, while the white females enjoyed a 50% longer life expectancy rate compared to their black counterparts (Coovadia, Jewkes, Barron, Sanders & McIntyre 2009). The differences were further evident between and within the provinces whereby in the year 2000, the under-5 mortality ranged from 16/1,000 in the Western Cape to 116/1,000 in KwaZulu-Natal and almost threefold higher in the squatter camps of Western Cape than in the metropolitan areas (Coovadia *et al.* 2009). Coovadia and co-workers (2009) highlight that the marked differences in the rates of diseases and deaths between the races clearly reflect the geographical, class, sexual and racial divisions in accessing the basic needs and other social determinants of health. Sachs (2002) asserts that the spread of HIV/AIDS in South Africa today could be attributed to the residuals of the apartheid system. Coovadia *et al.* (2009:18) made a remarkable observation on the HIV prevalence rates in South Africa showing that white and Indian men and women have lower prevalence rates of HIV (0,6% and 1,9% respectively), while higher rates of 13,3% were reported in the black population.

A review of data from the *Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa* further indicates that deaths

associated with childbirth have been a major concern to health managers and planners and take place during and post-delivery as reflected in table 1.1 below:

**Table 1.1: Selected core indicators for reproductive health and reproductive outcomes in South Africa, 2001-2010.**

<b>Outcome Indicators</b>	<b>Occurrence in percentages (%)</b>	<b>Duration after birth</b>
Maternal deaths	50	Within one (1) day
Neonatal deaths	30-50	Within 24 hours
Neonatal deaths	75	Within 1 <sup>st</sup> week of life
Stillbirths	40	During labour
People living with HIV/AIDS	11%	
<b>Process Indicators</b>		
Antenatal care coverage	64	
Skilled Attendant Deliveries	95,5	

**Sources:** (Lawn, Cousens & Zupan 2005; HST 2004); SA DoH 2008d; SAIRR 2011)

Maternal and new born deaths remain high In South Africa despite considerably high coverage of antenatal care (95,5%) and skilled attendant deliveries (64%) according to the Health Systems Trust (HST 2004) and the 2003 SA Demographic and Health Survey (SA DoH 2008d), respectively. Some studies which were undertaken in other developing countries such as Bangladesh have reflected that women remain at an increased risk of dying after childbirth (Ronsmans & Graham 2006). For example, in a study conducted in Matlab, a rural area in Bangladesh, the MMR was more than 100 times higher on the first day after birth and 30 times higher on the second day after birth, compared to the second year post-partum (Ronsmans & Graham 2006). These findings seem to suggest that these deaths are closely related to the health of

the mother and the care provided to her before and during pregnancy as well as post-natal. Such outcomes reveal cumulative inadequate attention to women's reproductive health needs.

The poor reproductive health outcomes can also be explained as a result of the unequal power relations that women and mothers experience in daily interactions in virtually all life circumstances (Varga 2003). These power relations are channelled through gender, race, class, income, education, occupation and residential location, both in society and at the health service delivery points (Greenberg 2004). Gender-based inequalities, for example in education, income and employment, and gender-based violence continue to limit the ability of girls and women to protect their health (Global Health Council 2010; Kirstner 2003). A study conducted in South Africa indicated that women subjected to physical, sexual or psychological violence in South Africa were up to three times more likely to contract HIV than their female counterparts who had not been abused or treated violently (Kirstner 2003).

Women are further exposed to the risk of contracting illnesses due to their poor nutritional status. When it comes to decisions about their own health and nutrition, and the health and nutrition of their children, women tend to choose to eat last to ensure that children and male family members are provided with enough food (Piwoz & Bentley 2005).

Furthermore, many women are still disempowered and subjected to patriarchal control, and as a result they do not fully control their lives. Moreover, the tradition of lobola, which is a bride's price paid by the man's family to the woman's family prior to marriage, supports the notion of male ownership and the subjugation of women to the male demands (Tolan 2005). In a study conducted in the rural areas of South Africa, Tolan (2005) found that women were aware of the risk of contracting HIV from their husbands who were involved in casual, short-term sexual liaisons or who had second wives. The author notes that these women had little control over the situation because they were financially dependent on their husbands and it was culturally acceptable for men to have more than one sexual partner (Tolan 2005). The practice of polygamy or plural marriage exists not only in South Africa but in many other parts of the world particularly in Africa, the Middle East and most Moslem countries (Wing

2001). In African countries polygamy predates European colonialism and the arrival of Christianity. It has been retained as a legal practice despite the adoption of Western lifestyles (Wing 2001). Moreover polygamy has been legalised under the Islamic personal statutes and laws in some of the Muslim and Middle Eastern countries (Nasir 2009; Wing 2001). In their analysis of polygamy, Palmer and Perrin (2004) articulate that multiple marriage practices exist in many different forms even in countries where it is not legal.

Much of women's unpaid work (such as domestic chores, child care, elderly care or care for the sick) is obligations rather than a choice. Some women are subjected to rejection and ostracism if they are unable to perform gender-assigned societal duties during the ante- and post-natal periods (Annandale & Hunt 2000).

Maternal deaths are classified as caused by direct and indirect causes (Ronsmans & Graham 2006). A proportion of maternal deaths classified as caused by indirect factors are often higher in areas with high prevalence rates of HIV (Ronsmans & Graham 2006). Ronsmans and Graham (2006) warn that there is growing evidence that the HIV and AIDS epidemic has become a leading indirect cause of death, reversing the gains in maternal mortality reduction in the southern African countries such as Malawi, Zimbabwe and South Africa. The South African Confidential Enquiry into Maternal Deaths provides an illustration of this apparent trend, highlighting the fact that between 1998 and 2002-2004, the proportion of maternal deaths due to indirect causes rose from 33,4% to 43,4% (Cross, Bell & Graham 2009).

The policies of the pre-1994 South African government did not address the health needs of the majority of women or the conditions under which black, poor and rural women lived (McIntyre & Gilson 2002). For example, the Maternal and Child Health (MCH) policy was biased against black people and the racist population policy had an explicit aim of reducing the fertility of black people while neglecting the overall health needs of black women (Klugman 1994). Black women's health risks increased progressively as a consequence of racism and maternity population policies (Klugman 1994). Socio-economic concerns were directed at the age of black motherhood and at teenage pregnancies instead of the economic and social conditions under which reproduction occurred (Klugman 1994; Sen & Snow 1994).

South Africa has seen far-reaching changes for addressing the oppressive situation that blacks were subjected to in the past. These include the introduction of free health care for pregnant mothers and children under 6, the construction of more than 1,300 new primary health care clinics, and new legislation and policies such as the choice on termination of pregnancy act (Chopra *et al.* 2009). However, the new dispensation has not sufficiently penetrated the lives of ordinary women judging from the worsening reproductive health outcomes (Chopra *et al.* 2009). The problems associated with poor access to health care services and the resultant high reproductive morbidity and mortality rates still persist (Treiman 2005). The present policies that address the reproductive health needs of women are incoherent and disintegrated across the different state departments at a national level (SA DoH 2000). The 1994 ICPD PoA has called for countries to move beyond family planning to a client-centred, integrated and comprehensive approach to reproductive health (United Nations 1994). Successful integration embraces the understanding of the conceptual meaning and practical linkages between administrative and service integration of services for effective service delivery to meet individual reproductive health needs (Family Health International 2003: 306). The Population policy (developed by the South African Department of Welfare in 1998), the Population Policy + 10-year Review (developed by the South African Department of Social Development in 2008), the Maternal and Child Health (MCH) policy and the Strategic Plan for Maternal, Neonatal, Child and Women's Health (MNCWH) and Nutrition (N) in South Africa 2010-2015 (developed by the South African Department of Health in 1995 and 2008 respectively) were examined to find out whether these policies resonate with the prescriptions of the 1994 ICPD PoA.

An assessment of the population policies revealed that the objectives of the national population policies are consistent with the 1994 ICPD PoA. The formulation of the stated objectives was backed by evidence on the state of the population variables including measures of sexual and reproductive health. The policies put emphasis on the coordination between health care services and income generation activities and skills development training for women. Further assessment of the population policies reflected that reproductive health issues have been addressed, but that the policies are unclear as to how they will do that.

However an assessment of MCH policies reflected that the policies still hold to the traditional maternal and child health and family planning (MCH/FP) approach and do not embrace the spirit of the 1994 ICPD approach. The Department of Health (SA DoH) addresses women's health, but its main focus is on mother and child health care services. Further examination revealed that the programmes within the SA DOH are still vertically managed and are not evidence-based. This implies that these policies may potentially undermine the population health orientation of the health care system and as a result perpetuate health inequity (FHI 360 2003).

Further assessment of the policies reflected that:

- Priority setting of health interventions is often *ad-hoc* and does not focus on reducing the health inequalities of historically disadvantaged or vulnerable women or respond to risky and life-threatening situations.
- the voices of women in health issues or reproductive health are missing; and
- There is little coherence between the 1994 ICPD PoA and the MCH policies.

The researcher's concluding analytic observation is that reproductive health policies have been developed independently and in isolation of each of the departments that have been mandated to address reproductive health within South Africa. The disintegration could still subject poor, black, rural women to vulnerability.

In 2008 the SA DoH formulated a *Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH) and Nutrition (N) in South Africa 2010-2015*, which in the opinion of the researcher does not address all the reproductive health needs of women, and will not contribute to a decline in the levels of reproductive morbidity and mortality. The plan is silent on the social factors that underpin maternal and child mortality. A critical re-evaluation of the organisation and provision of female reproductive health services in South Africa, a redefinition of women's health needs and an investigation into the social determinants of reproductive health are needed to inform a model that would address the maternal and child morbidity and mortality (WHO 2009).

In South Africa, female reproductive health outcomes have not improved, yet policy makers continue to develop policies and programmes for reducing maternal and child mortality which are embedded in narrow curative approaches. Such tactics developed within Western biomedical approaches neglected the broader social and economic issues (Raphael & Bryant 2006). For Doyal and Pennel (1979) the problem with curative, individualistic and interventionist approaches is that they deny people their agency as social beings. Doyal and Pennel (1979) argues that to simply demand more medical care of the same kind to reduce illnesses and deaths is to ignore the fundamental ways in which the health care system has been shaped by current policy makers. In this regard, the assertion by Raphael and Bryant (2006) that social determinants of health and decisions made outside the health care sector are crucial in promoting health, yet the politics of health have been neglected.

The central research problem that guides this study is therefore: What would a model for reducing maternal and child mortality in South Africa that integrates social interventions into the primary health care system, look like?

### **1.3 THE CONTEXT OF THE PROBLEM**

An understanding of the South African high rates of maternal and child morbidity and mortality, relative to its level of economic development, requires a brief mention of the global and South African history and developments. Some of the challenges which were faced by implementers of policies are how to introduce the social dimension whilst retaining an emphasis on the prevention of ill health and incorporating the promotion wellness.

#### **1.3.1 An historical background to the problem**

For the past 50 years more or less, the international health care agenda has oscillated between, on the one hand, a focus on biomedical, technology-based health care and public health interventions, and on the other hand an understanding of health as a social phenomenon that requires inter-sectorial and cross-cutting policies and action (CSDH 2007). For example, in 1948, after the 1945 United Nations Conference in San Francisco and the 1946 International Health Conference,



the World Health Organisations (WHO) was established (CSDH 2007). Leaning very much on public health, the original WHO constitution's first principle defined "health" as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (CSDH 2005). The second principle of the 1948 WHO constitution emphasised health equity and stated that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

Subsequently the 1978 Alma-Ata Declaration and the subsequent 'Health for All' movement gave prominence to health equity and inter-sectorial actions to address the social determinants of health, in line with the original prescriptions of the 1948 World Health Organization's (WHO) constitution (CSDH 2007). However, the economic thinking of the 1980s and 1990s impeded the translation of these ideas into effective policies in many countries (especially in the developing countries), by spearheading the macroeconomic policies that marginalised health and related services sectors (CSDH 2007). Sanders (2004) observed that amongst the most important components of the recent phase of globalisation in Africa have been the Structural Adjustment Programmes (SAPs) which had an effect on the global economy through the imposition of stringent debt repayments and the liberalisation of trade. According to Sanders (2004) and Simms, Rowson and Peattie (2001), the SAPs have further dictated changes in public policies, sectorial restructuring and reduced social spending with negative effects on health, education and other social services to the poor during the 1980s and the 1990s.

In addition to the deteriorating economic conditions and their impact on health, the demographic transitions, HIV/AIDS, and other emerging or re-emerging diseases became too much of a burden on the already strained health care systems (Simms *et al.* 2001). These factors have notably contributed to the collapse of many public health care systems, particularly in sub-Saharan Africa (Sanders 2004; Simms *et al.* 2001).

By the late 1990s and early in the new millennium, accumulated evidence pointed to a failure of the existing health care policies to reduce health inequities (Briggs &

Garner 2006). At the same time, such evidence failed to acknowledge the important role of community level efforts to equalise access to health care (Briggs & Garner 2006; Bhutta, Ali, Cousens, Haider, Rizvi, Okong *et al.*). Bhutta *et al.* (2008) suggest that mother and child health care strategies can be strengthened at the primary health care level through the involvement of the beneficiaries and through a clear referral mechanism for ensuring equal access to the services.

It is against this background that a momentum grew for the new, equity-focused approaches, particularly in the wealthy countries. In 2004, the WHO established a Commission on Social Determinants of Health (CSDH), whose goal was to advance health equity. The CSDH embraced an international human rights framework as the appropriate conceptual and legal framework within which to advance health equity through action on the social determinants of health (CSDH 2007).

In South Africa, the roots of poverty and the associated high maternal and child mortality are a response to the numerous unjust laws such as the 1950s and 1960s Group Areas Acts which were passed during the apartheid era, forcing physical separation between races by creating different residential areas for different races (Sanders & Chopra 2006; Coovadia *et al.* 2009). The apartheid laws required that all economically inactive blacks live in poverty-ridden homelands which were 13% of the land, while the remaining fertile land (87%) was reserved for exclusive access and control by the whites (Coovadia *et al.* 2009). Blacks were consequently deprived of their land which has been their traditional source of subsistence, resulting in suffering from massive malnutrition (Treiman 2005).

Sanders and Chopra (2006) suggest that the persistently high poverty levels amongst the blacks are also a result of the migrant labour system, the backbone of the capitalist class system. In the latter, capital accumulation was the source of impoverishment, underdevelopment, substandard living conditions and population pressure of the rural population, affecting women especially, as they remained behind when their husbands were recruited to the mines (Sanders & Chopra 2006). The apartheid system was further marked by the practice of racial job reservation and low wages to generate wealth for whites, as reflected by the income levels in the

past (McIntyre & Gilson 2002). Whites earned eleven (11) times more than blacks did in 1935 and 20 times more in 1970 (McIntyre & Gilson 2002).

The South African Education system under the apartheid regime ensured exclusion, gross inequality and inferior education for those blacks who did make it to school (Sachs 2002). In 1980/81, expenditure per head on education for the white children was double that for the Indian children and five times more than for the black children (McIntyre & Gilson 2002). The effect on women's education was huge as the majority remained under-educated and illiterate, which in turn affected women's social positions and access to improved health (Treiman 2005).

Inequality is persisting despite the fact that wealth distribution was identified as a key goal of the post-1994 government (Coovadia *et al.* 2009). The Gini coefficient (a measure of income inequality) increased from 0,56 in 1995 to 0,73 in 2005 (Coovadia *et al.* 2009). Currently, the richest 10% of the South African population accounts for 51% of the income, whereas the poorest 10% accounts for just 0,2% of the income (Coovadia *et al.* 2009). The mean household income per year in the poorest decile is R4,314 (about \$516) compared with R405,646 (about \$48,462) for the richest deciles (Coovadia *et al.* 2009). Treiman (2005) and Coovadia *et al.* (2009) are of the view that part of the reason for the growth in income inequality in the past decade has been the almost exclusive focus on the current South African macroeconomic policy (Growth, Employment and Redistribution – GEAR) introduced in 1996, which fosters growth and not redistribution.

Socio-economic factors have been inseparably linked with the very high burden of poverty-related diseases and the vulnerability of women (McIntyre & Gilson 2002). In the late 19th and the 20th centuries, low wages, domestic overcrowding, inadequate sanitation, malnutrition and stress caused the health of blacks to deteriorate (McIntyre & Gilson 2002). The health care system faced the challenge of transforming institutions and promoting equity in development when apartheid ended in 1994 (McIntyre & Gilson 2002).

### **1.3.2 Contemporary developments and reproductive health outcomes in South Africa**

The South African Constitution binds the state to work towards progressive realisation of the right to health (McIntyre & Gilson 2002). However, after 17 years of democracy, South Africa is still grappling with massive health inequities (McIntyre & Gilson 2002; Coovadia *et al.* 2009). For example, the South Africa Survey 2002/2003 confirmed that a new era of democracy in South Africa is still characterised by high levels of poverty, especially in the rural areas, where approximately 70% of the country's poor live (South African Institute of Race Relations 2003). About 7,5 million households have an income of below R1,200.00 ( $\pm$ \$171), from this category, 50% have an income of less than R399 ( $\pm$ \$57) and have reported difficulties with securing access to food (South African Institute of Race Relations 2003). Table 1.2 (see next page) provides a summary on disparities in respect of the socio-economic indicators across the main South African racial groups.

With the transition to a democratic government in 1994, equity and particularly health equity gained prominence on the South African social policy agenda (McIntyre & Gilson 2002). Health care in particular was seen as a channel for achieving rapid equity gains (McIntyre & Gilson 2002). Health was to be delivered through a single and integrated health care system with equitable distribution of resources and delivery, organised through the district health authorities within the primary health care (PHC) approach (McIntyre & Gilson 2002). Implied here is that health care delivery would be the responsibility of the districts.

At present, the public health care system has been transformed into an integrated, comprehensive national service, but failures in leadership, weak management and the absence of the core pillars of PHC have led to inadequate implementation of what started off as good policies (McIntyre & Gilson 2002). Health care allocations still favour the private sector at the expense of the public sector, even in the new government, and efforts to promote cross-subsidisation between the private and the public health care sectors have been lacking (McIntyre & Gilson 2002). The initial efforts and good intentions to promote coherency in social policies through the Reconstruction and Development Programme (RDP) have seemingly not been

sustained (McIntyre & Gilson 2002). The country has four concurrent epidemics, often referred to as poverty-related illnesses, such as infectious diseases, maternal death, malnutrition, and a growing burden of non-communicable diseases (McIntyre & Gilson 2002).

**Table 1.2: Selected socio-economic indicators by different racial groups in South-Africa, 2010-2011.**

Socio-economic indicators	Population Groups			
	Blacks	Whites	Asians/Indian	Coloureds
Poverty: Number of persons living on less than US\$2 a day	18, 480, 917	37,169	139,135	1,219,162
Unemployment rate (%)	29%	5,9%	11.7%	22,6%
Average household income (SA Rand) per annum	81, 557	400,344	218,737	127,439
Sanitation (% households)				
• Flush toilet connected to a public sewage system	47,.2%	90,7%	96,4%	87,0%
• Pit latrine without ventilation pipe	23,2%	0,0%	0,3%	1,4%
• Bucket toilet	0,9%	0,0%	0,0%	0,7%
Provision of clean water (% households)				
• Piped water inside dwelling	27,8%	93,9%	96,7%	80,9%
• Piped water from public tap	23,6%	0,1%	0,8%	3,1%
• Spring water	2,1%	0,0%	0,0%	0,0%
• River/Stream	4,3%	0,0%	1,3%	0,2%

**Sources:** (SAIRR 2009; SAIRR 2010; SAIRR 2011)

Although South Africa is considered an upper middle-income country in terms of its economy, the health outcomes are worse than those in many lower-income countries (McIntyre & Gilson 2002). The World Bank divides and classifies economies according to the 2010 Gross National Income (GNI) per capita, using the World Bank Atlas Method (World Bank 2012). According to the World Bank classification, upper middle-income countries are those with income between \$3,976 - \$12,275 (World Bank 2012). An overview of a group of countries in Sub-Saharan Africa which have the Gross Domestic Product (GDP) comparable to that of South Africa, yet with better health outcomes compared to South Africa is presented in Table 1.3 below.

**Table 1.3: Selected socio-economic indicators and health outcomes: South Africa and other upper middle-income countries in Sub-Saharan Africa, 2009/2010**

<b>Social and Economic Conditions</b>	<b>South Africa</b>	<b>Namibia</b>	<b>Gabon</b>	<b>Mauritius</b>	<b>Seychelles</b>	<b>Botswana</b>
GDP (2010) expressed in millions of US \$	10,109	6, 343	14, 527	12, 079	21, 530	13, 392
Population living below \$ 1,25/day, %	26	n/a	5	n/a	n/a	n/a
Access to improved drinking water , %	93	93	87	100	87	96
Access to improved sanitation, %	59	35	36	94	n/a	47
<b>Health Outcomes</b>						
Life expectancy at birth, total years	51	63	61	72	73	57
Maternal Mortality Ratio Per 100 000 live births	400	210	520	15	57	380
Antenatal care, at least one visit, %	92	95	94	n/a	n/a	97
Skilled attendant deliveries	92	81	56	98	n/a	47
Infant Mortality Rate (IMR)	46	47	60	13	12	33
HIV/AIDS prevalence rate, 15-49, Total %	18.1	15,3	5.9	1.7	n/a	23.9
HIV/AIDS prevalence rate, 15-49, Female	21.8	18.6	7.1	1.0	n/a	28.9
Contraceptive prevalence rate, any method, %	60	55	33	41	n/a	44
Unmet need for family planning, Total, %	5	7	28	4	n/a	n/a
Recent Births, Unwanted, %	46	44	20	n/a	n/a	n/a

**Sources:** (UNFPA and Population Reference Bureau 2010; World Bank 2011; World Bank 2012; UNICEF 2011)

Table 1.3 above reflects that South Africa has a higher MMR (400/100,000 live births) than the four other upper middle-income countries in Sub-Saharan Africa, namely, Namibia (210/100,000 live births); Botswana (380/100,000 live births); Mauritius (15/100,000 live births) and Seychelles (57/100,000 live births). From a group of six (6) upper middle-income countries in Sub-Saharan Africa, the only country that has a higher MMR than that of South Africa is Gabon (580/100,000 live births). Therefore, the upper middle-income countries in Sub-Saharan Africa, in exception of Gabon and South Africa, provide relatively good health in relation to wealth. Furthermore closer look at table 1.3 shows Namibia had a GDP of only US \$ 6, 343 and the lowest of the six countries whereas its MMR was 210/100,000 live births, lower than that of South Africa, Gabon and Botswana during 2009/2010.

Further analysis revealed that Gabon, like South Africa, has high levels of inequality, hence the large proportions of the populations of the two countries remain poor and as a result the two countries have poor health indicators (UNFPA and Population Reference Bureau 2010). The health indicators, especially the IMR and MMR, are sensitive to deprivation, hardship and are a better reflection of the extent of satisfaction of basic needs (Wuyts *et al.* 1997). In addition to high levels of MMR, table 1.3 shows that both South Africa and Gabon have high levels of IMRs in relation to the wealth of the two countries. The IMR of South Africa is 46 and that of Gabon is 60. As has been observed from the MMR estimations, the IMR of Gabon is higher than that of South Africa. The slow pace in reducing MMR and IMR in South Africa has been attributed to HIV/AIDS (Simms *et al.* 2001). South Africa has HIV/AIDS prevalence of 5.9% and Gabon recorded HIV/AIDS prevalence of 18.1% in 2009/2010.

Table 1.3 further reflects that Botswana has an estimated MMR of 380/100,000 live births which is almost at the same level as that of South Africa in spite of a relatively high GDP of US \$ 13,392. From this analysis one can conclude that HIV and AIDS epidemic has accelerated the challenges in health care provision, not only in South Africa but also in Botswana. Within South Africa, HIV/AIDS accounts for 31% of the total disability-adjusted life years of the South African population (Coovadia *et al.* 2009). In addition to the regional contextual health problems such as HIV/AIDS, low coverage of skilled birth attendance in Botswana 47% could be one of the factors

responsible for an increased MMR compared to Namibia and Mauritius. It is remarkable to note that the IMR of Botswana is lower than that of Namibia, Gabon and South Africa. In the light of this analysis, one can further conclude that Botswana's low IMR reflects a better satisfaction of the basic survival needs.

With regard to contraception, table 1.3 reveals that South Africa has higher coverage compared to other countries in the group (except for Seychelles which has no data on contraception), but also has a higher percentage of recent unwanted births. The latter could be a result of unmet need resulting from contraception failure.

Some differences have also been noticed on the life expectancy at birth across the six countries. Table 1.3 shows a positive relationship between the life expectancy at birth and the levels of GDP. Countries with a higher GDP tend to record a higher life expectancy as observed from Mauritius and Seychelles. South Africa has a lower life expectancy (51) than all the countries in this group followed by Botswana (57). Data further reveals that there could be inequalities in access to health services where women bear the brunt and the pattern of state spending is not in their favour, judged from a high MMR; women still form part of the majority of the people who were previously kept poor and socially excluded from the services. Violence and injuries constitute a further cause of premature deaths and disabilities in women (Coovadia *et al.* 2009).

Although data on poverty levels is lacking from the selected countries only two (2) countries, namely South Africa and Gabon, had data on population living below \$1,25/day. South Africa shows a higher percentage (26) of the population living below \$1,25/day than Gabon (5). Comparable data was also lacking for the population living below national poverty line. Since 1994, several policies, strategies and programmes have been developed to prioritise and address the health needs of pregnant women and children. In 1994, The South African government adopted a Primary Health Care approach as a policy guideline for ensuring equitable, accessible and affordable health care to the majority of populations who were marginalised during the apartheid era (SA DoH 1997). The focus was on preventive and promotive services, with more emphasis on the provision of Maternal and Child



Health services and as a result, the policy of Free Health Care services for children below six (6) years and pregnant mothers was introduced (SA DoH 1997).

**Primary Health Care** according to SA DoH is:

*essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them, through their own participation, and at a cost that the country and community can afford to maintain, at every stage of their development, in the spirit of self-reliance and self-determination ... it is the first level of contact of the individual, the family and community with the national health system, bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process ( WHO 1978, as quoted in SA DoH 1997).*

A 1997 white paper for the transformation of health care services in post-apartheid South Africa had a separate section on maternal, child and women's health on one hand and HIV/AIDS and STD on the other (SA DoH 1997). Missing from the white paper for the transformation of health care services in the post-apartheid South Africa and from the conceptualisation of the structure of the health care services at the national and provincial levels, is reproductive health as an organising central concept to delivering an essential and integrated reproductive package of MCH/FP and HIV/STD and services (SA DoH 1997). The national policy vaguely points to the importance of having integrated services; however, its performance on implementation is weak, demonstrating a lack of directed and focused planning and programming and poor institutional capacity, especially in enforcement and monitoring (SA DoH 1997). For example, the services are still vertically organised with different services being offered at different times. The HIV/STD services are handled elsewhere in a different chief directorate and not within the MC&WH directorate nor within family planning services (SA DoH 2000). Furthermore, the notions of 'women's health' and 'reproductive health' are used interchangeably (SA DoH 1997).

The 1995 Maternal, Child, and Women's Health (MC&WH) policy of South Africa, within which reproductive health service delivery is positioned, was formulated within the Primary Health Care framework. Reproductive health issues, including contraceptive provision, were shifted from Population Development to Primary Health Care as a result of the influence of women movements who argued for quality of health care for women, rather than striving to achieve demographic goals through family planning units. However, like the 1997 white paper for the transformation of

health care services in post-apartheid South Africa, the MC&WH policies and strategies place considerable focus on pregnancy and childbirth and little attention to the reproductive health of non-pregnant women.

The 1995 MC&WH policy had stated goals, objectives and indicators to plan for the provision of adequate health resources, especially to the rural areas, highly dense peri-urban areas, and informal settlements, and to the workers in farming communities (SA DoH 1995). The policy recommended that women and men be provided with services that will enable them to achieve optimal reductions in the maternal morbidity and mortality rate by 50% (SA DoH 1995). Through the MC&WH policy, the SA DoH committed itself to achieving universal access to health services for infants, children under 5, adolescents and women and to increase clinic attendance of contraceptive services (SA DoH 1995). Although a mention was made about addressing inequity in the MC&WH policy, not much was said about improving the socio-economic position of the majority of women such as addressing their employment, education of the girl child, measures to improve their nutritional status and increasing their self-esteem, autonomy and self-determination (SA DoH 1995). The current MC&WH policies and the strategies are also silent about co-ordinating the SA DoH with other departments such as education, welfare, transport, population development, labour and work as well as the NGOs and the private sector, for addressing the empowerment position of women so that the high rates of reproductive morbidity and mortality could decline (SA DoH 1995; SA DoH 2008e).

Furthermore, all the MC&WH policies that were developed since 1994 are silent about addressing discrimination against women on the basis of race, class and gender. The private hospitals and clinics have since been well equipped during the apartheid era to serve the interests of the minority whites. Apart from whites, it is only a few elite black women who have access to such facilities in the post-apartheid era. McIntyre and Gilson (2002) note that even in the new government, health care allocations still favour the private sector at the expense of the public sector. The majority of women are excluded from good facilities and quality care, hence they suffer and die. The extent to which women were involved in the formulation of the policy and defining their needs is not stated in the current MC&WH policies.

The MC&WH policy is presented in gender-neutral terms. It does not question the unequal relations between men and women and the subordinate position of women as being responsible for reproductive outcomes. Both the 1995 MC&WH policy and the 2008 Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition in South Africa 2010-2015 concentrate only on the biological dimension of women's needs. The focus is on women in their gendered roles as mothers. Men's responsibility role in reproductive matters is neglected, that is, the policy mention only vaguely that men have to play a role in reproductive matters by assisting their wives, in reproductive matters.

The MC&WH policy mentions vaguely that high-quality antenatal care services will be provided, but does not state how. It is also remarkable that the quality of care in family planning services is rarely stated as a policy goal in policy documents.

The South African National Department of Health (SA NDoH) and most Provincial Departments of Health (PDoH) have units responsible for maternal, child and women's health and other units for STDs, HIV and AIDS (SA DoH 1995). In some provinces, health care services for STDs, HIV and AIDS are included in the section on health care for communicable diseases. In North West Province, maternal and child health care services are in one category and reproductive health in another, whereby the latter is defined as including family planning and women's health care (Phetoe 1998). Again the services for STDs and HIV/AIDS are separate (Phetoe 1998). None of the national or the provincial officials are responsible for the implementation of these structural arrangements. Instead, this is the responsibility of the PHC or district health service. All of these factors need to be addressed by the government, if women's health including sexual and reproductive health is to be improved and the risk to reproductive ill health, the maternal mortality ratio and the neonatal mortality rate are to decline in South Africa (Coovadia et al. 2009).

#### **1.4 THE PURPOSE OF THE STUDY**

The purpose of this study is to develop a model that integrates social interventions into primary health care services for improving female reproductive health in such a

way that a reduction in maternal and neonatal mortality rates in South Africa will be achieved. Although reproductive health (RH) is not an explicit Millennium Development Goal (MDG), it has been acknowledged that universal access to RH is fundamental for development, fighting poverty, and meeting the MDG 5 which calls for countries to improve maternal health (WHO 2009). For example, in 2005, the World Summit adopted a universal access to RH as a development goal (WHO 2009). Subsequently, in 2006, universal access to RH was added to the targets for MDG 5 (WHO 2009)<sup>1</sup>.

The South African government has launched several national policies and programmes since 1995, including the recently developed Strategic Plan for MNCWH & N in South Africa 2010-2015, in an effort to reduce the high rates of reproductive morbidity and mortality; however, reproductive health outcomes do not seem to be improving. These programmes have not succeeded in addressing the more fundamental questions of reducing the real causes and the risk of reproductive morbidity and mortality such as the living conditions to which women are exposed (Raphael & Bryant 2006). These issues are linked to women's health and their social position, and not necessarily to the improvements in their physical health.

Based on this argument, the study will look beyond health issues to the broader social context of empowerment. The study will further argue that if the social, political and institutional processes which mediate between the context and outcome are addressed, different results in terms of the maternal and neonatal morbidity and mortality will be realised within South Africa.

The value of an alternative model is that it can be developed to consider the 'causes of the causes' or the social determinants of health as the root of female reproductive ill health and poor reproductive health outcomes (CSDH 2007). The model envisaged for this study should illustrate the pathways through which the social determinants affect reproductive health and reproductive health outcomes (WHO

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<sup>1</sup> In this study, reproductive health and reproductive morbidity and mortality refers to maternal health and maternal morbidity and mortality respectively. Accordingly, reproductive outcomes refer to maternal or neonatal survival or death and these concepts shall be used interchangeably. Child morbidity and mortality shall mean neonatal morbidity and mortality in this study.

2009). The contribution of this study lies in the development of an African and a South African perspective on these issues.

## 1.5 THE OBJECTIVES OF THE STUDY

Central to this study is the premise that high rates of maternal and neonatal deaths are evidence of deprivation of reproductive health needs due to, among other factors, lack of women's empowerment. Such deprivation is channelled through many paths until a woman dies from the direct causes such as maternal anaemia, pregnancy hypertensive disorders, infections, et cetera. Similarly, the neonate's survival chances are directly linked to maternal health and women's empowerment position (Kovsted, Portner & Tarp 2002). A key assumption of the study was that the empowerment of women has the potential to improve their social and life circumstances as these impact on their health.

**The objectives of the study were to:**

1. Identify the structural determinants, social determinants (also referred to as intermediary factors) and direct factors (also referred to as the proximate factors) which affect female reproductive morbidity and mortality rates in South Africa;
2. Describe the structural determinants, social determinants and direct factors which affect female reproductive morbidity and mortality rates;
3. Study and critically analyse different models describing social determinants and direct factors of female reproductive ill-health and mortality and models for reducing it;
4. Construct an alternative model that links structural determinants, social determinants and direct factors which affect female reproductive morbidity and mortality, and reproductive health outcomes in South Africa; such a model must be context- and needs-based; and to

5. Clarify the policy and programme implications of such an alternative model.

## **1.6 THE RESEARCH QUESTIONS**

Based on these objectives, the following research questions guided the study:

- 1.6.1 What are the current direct determinants of deaths of women during their reproductive ages?
- 1.6.2 What are the structural determinants and the socio-economic positions of women who died from pregnancy or childbirth?
- 1.6.3 What pathways lead from the root causes to the stark differences in health status observed in women during their reproductive ages (intermediary factors)?
- 1.6.4 What are women's real needs at service level (primary health care facilities) and household community level before pregnancy, during antenatal delivery and post-natal periods? (What do women want?)
- 1.6.5 What are experts' views on interventions which have the potential to reduce the maternal and child morbidity and mortality rates within South Africa?
- 1.6.6 What services do faith-based (FBOs), community-based (CBOs) and non-governmental organisations (NGOs) deliver to poor women, and what do they perceive as possible strategies to improve services for better reproductive health outcomes for women?
- 1.6.7 What have been the effects of current models, policies and strategies on reproductive health outcomes?
- 1.6.8 What model can make a difference in addressing the living conditions, including the empowerment of women for better reproductive health outcomes?

## **1.7 RATIONALE FOR THE STUDY**

There is no doubt that South Africa continues to experience high maternal and child mortality, yet the link between maternal and child morbidity and mortality and the vulnerability of women are often not sufficiently problematised and addressed by policy makers, resulting in less compatible plans of action.

There is a need for a reappraisal of knowledge and information regarding the socio-economic determinants of the continuing high levels of maternal and child deaths. The study generated data about the main inhibiting conditions among the most affected, namely black, poor and rural women, which if addressed would lead to a decline in this phenomenon. A model was developed which integrates the social determinants into PHC, to address the maternal and child morbidity and mortality, thus contributing to achieving improved reproductive outcomes in South Africa.

## **1.8 THE CHOSEN RESEARCH APPROACH**

The study is based on the premise that mothers and children die due to the accumulation and prolonged exposure to health risk factors which are largely determined by socio-economic factors. Thus, the direct causes of deaths for children and for mothers are to be found in socio-economic deprivation. In patriarchal societies, the socio-economic position of women in respect of access to resources, prestige and power operate independently through multiple intermediate variables to influence the risk of maternal, neonatal and child morbidity and mortality. In this study, women's empowerment is therefore a proxy and an important explanatory variable for the overall women's health and child survival in South Africa. Empowerment in this study thus refers to the level of education, income level, employment and decision-making power of women in their households.

The chosen approach is that of a multi-stage qualitative research design. Thus the study draws on existing models, with the intent to extend these to a new, more comprehensive model. Following a multi-stage qualitative research design, the study

used existing statistics and generated new data through qualitative methods. The research design is further elaborated on in Chapter 3.

The intention was to build a model that lists the structural determinants and intermediary determinants/social determinants deemed to be non-proximate variables and the direct factors deemed to be proximate determinants of the female reproductive health outcomes, including HIV/AIDS.

## **1.9 DEFINITIONS OF CONCEPTS AND KEY TERMS**

### **1.9.1 Maternal Health, Maternal Morbidity and Mortality, Reproductive Health and Child Health, Morbidity and Mortality**

Maternal health refers to the health of women during pregnancy, childbirth and the post-partum period. Maternal health care is a concept that encompasses family planning, preconception, prenatal, delivery and post-natal care (WHO 2009).

Maternal morbidity and mortality is defined in the International Classification of Diseases as illnesses and deaths of women while pregnant or within 42 days of the termination of a pregnancy. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Direct causes result from obstetric complications during pregnancy, labour and puerperium (a period immediately after delivery of a baby), and any condition related to or aggravated by pregnancy or its management. Indirect obstetric deaths result from a previously existing disease prior to pregnancy, or a disease that developed during pregnancy (WHO 1977, in the South African Department of Health 2005). According to the WHO (2007a) and the NCCEMD, the distinction between a direct maternal death and an indirect maternal death is that the former mentions the results from complications of pregnancy, delivery and puerperium, whereas the latter refers to the pregnancy-related death of a woman with a previously existing or newly developed health problem during pregnancy which were not due to direct obstetric causes, but were aggravated by the physiological effects of pregnancy. Other fatalities during but unrelated to a pregnancy are termed accidental, incidental, or non-obstetrical maternal deaths.



Cases with 'incidental causes' include deaths secondary to violence against women but may be related to the pregnancy. It has been reported that about 10% of maternal deaths may occur late, that is, after 42 days of the termination of a pregnancy or after delivery. Furthermore, it is well recognised that maternal mortality numbers are often significantly underreported. For the purpose of this study, the concept maternal morbidity and mortality includes other illnesses and deaths of women due to matters related to the reproductive system, its functions and processes before, during and after pregnancy.

The three (3) measures of maternal deaths are the maternal mortality rate, the maternal mortality ratio and lifetime risk of maternal deaths. The maternal mortality rate is calculated as the number of maternal deaths in a given time period per 100,000 women of reproductive ages (that is, women aged 15-49 years), or woman-years of risk exposure in same time period (Wilmoth 2009; WHO 2007a). The maternal mortality rate measures the impact of maternal deaths on the population of women as a whole, and not just on pregnant women. Wilmoth (2009) notes that the maternal mortality rate reflects the level of fertility in a population.

The maternal mortality ratio (MMR) is the number of maternal deaths during a given time period per 100,000 live births during the same time (WHO 2007a). This measure only captures the risk of death of a woman once she is pregnant, in other words, the obstetric risk (WHO 2007a). To Wilmoth (2009), the MMR depicts the risk of maternal death relative to the frequency of childbearing.

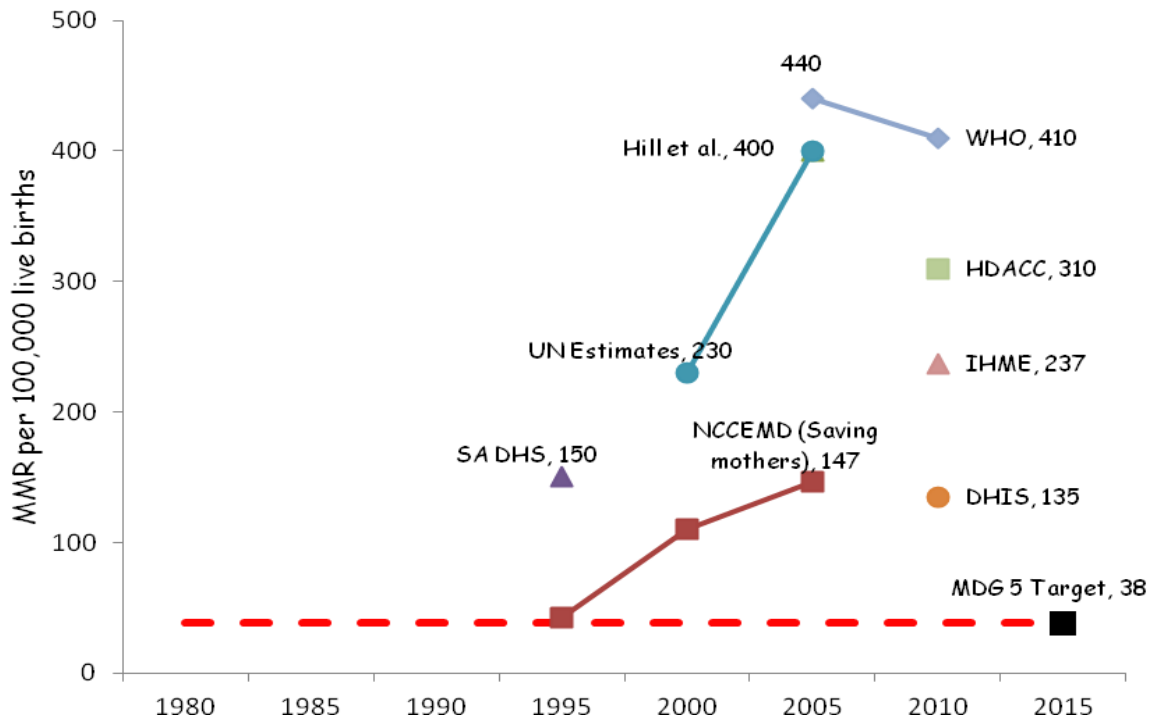
The third measure of maternal mortality, the lifetime risk of maternal deaths, takes into account both the probability of becoming pregnant and the probability of dying as a result of that pregnancy, cumulated across a woman's reproductive years (WHO 2007a). The lifetime risk of maternal death accounts for a number of pregnancies and risk (Wilmoth 2009). In sub-Saharan Africa the lifetime risk of maternal death is 1 in 16, while for developed nations it is only 1 in 2,800 (Maine 2001).

Maine (2001) asserts that maternal mortality ratios in low-income countries are mainly modelled estimates and one cannot discern trends. Countries with documented success in reducing maternal mortality ratios have used systematic, incremental approaches often tied to multi-sectorial efforts, including roads, communication links, education, water and sanitation (Maine 2001). The South African MMR is estimated to remain around 140-150 per 100,000 live births over the last 15 years, despite South Africa being one of the countries that have the highest coverage of maternal services in Africa. Data from the South African Department of Health (2005) show that higher maternal mortality ratios were observed in the Free State (FS), Northern Cape (NC) and North West (NW) consecutively, compared to the remaining provinces (National Committee on Confidential Enquiries into Maternal Deaths [NCCEMD] 2008e). The socio-economic determinants of health such as poverty, illiteracy, inequality and gender inequities have contributed to significant disparities in the maternal health outcomes. In 2004, the National Committee on Confidential Enquiries into Maternal Deaths [NCCEMD] calculated a MMR of 147 per 100,000 live births (SA DoH 2005; South African Institute of Race Relations 2009).

The United Nations' Millennium Declaration, which South Africa has signed up for, provides a framework for the countries to work together toward a common end. South Africa needs to decrease its MMR to 38 per 100,000 live births by 2015 and child mortality to 20/1,000 live births in order to meet the MDG target; however, Figure 1.2 above indicates that midway through the target reporting period there is still no progress in that regard.

The government has implemented a number of interventions aimed at improving overall maternal and child health over the last few years. However, available data, as reflected in figure 1.1 and figure 1.2 shows that meeting MDGs 4 and 5 by 2015 is unlikely.

**Figure 1.2: Trends in the maternal mortality rate for South Africa by MDG target**



**Sources:** (UNICEF 2009; UNICEF 2007; StatsSA 1998; SADHS 1998; SA DoH 2008c (NCCEMD's Saving mothers report 2005-2007): fourth report on confidential enquiries into maternal deaths in South Africa; SAIRR 2009; Hill, Thomas, AbouZahr, Walker, Say, Inoue, et al. 2007; World Health Organization (WHO), United Nations Population Fund (UNFPA), UNICEF and the World Bank 2010; The Health Data and Coordinating Committee (HDACC) 2010; Institute for Health Metrics and Evaluation (IHME) 2010; South African District Health and Information System (DHIS) 2011; Health Systems Trust (HST)2011; Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, et al. 2009).

The Health Data and Coordinating Committee (HDACC) as quoted in the recently launched *Strategic Plan for Maternal, Neonatal Child and Women's Health and Nutrition (MNCWH) and Nutrition (N) in South Africa 2012-2016* (SA DoH 2011)

suggests the indicators in respect of the current and projected MMR, U5MR, IMR and NMR as shown in Table 1.4 below.

**Table 1.4: Current and projected maternal and child mortality rates in South Africa, 2009-2016**

<b>Indicator</b>	<b>2009</b>	<b>2014</b>	<b>2016</b>
MMR	310	270	
U5MR	56	50	40
IMR	40	36	32
NMR	14	12	11

**Source:** SA DoH 2011

At institutional level, problems such as poor coverage of key maternal, new-born and child health and nutrition interventions along a life cycle; vertical programs within and across the sectors and inadequate quality of care have been cited as bottlenecks to achieving both MDGs 4 and 5 (The Countdown to 2015 Working Group 2008). Literature study points to challenges in measuring maternal deaths in South Africa as reflected by differing and diverging ratios from different sources (Buchmann 2011; Blaauw & Penn-Kekana 2010). Comprehensive, reliable qualitative and quantitative databases which allow linkages between population, education, health, poverty and gender disparities still needs strengthening to be able to provide disaggregated and appropriate information for policy-making, programming, monitoring and evaluation. Indeed significant and notable progress in achieving the MDGs 4 and 5 will remain a dream in the absence of:

- clear monitoring and evaluation framework
- a clear link between the MDGs and the budget process
- Inadequate national capacity to implement the interventions to meet the health MDGs.

Dorrington and Bradshaw (2011) note that the MMR remains high and yet the recommendations of the committee for the confidential enquiries into maternal

deaths have not been put in place. The WHO (2008a) cites lack of acknowledgement of the social determinants of health as the main reason why there is such slow progress in achieving the MDGs.

In line with Aitken and Reichenbach (1994), reproductive and sexual health as used in this study refer to a set of health problems and diseases associated with physical and social risks of human reproduction and sexuality. According to Aitken and Reichenbach (1994), reproductive and sexual health should not be viewed as merely a medical or a technical challenge, but should rather be seen as the enablement of people to pursue socio-economic opportunities as part of individual and social development. As a concept, reproductive health should be viewed as a part of equity-oriented human development (Aitken & Reichenbach 1994). In this study, child health is used as an umbrella term to refer to the health status of all children from birth to the age of 5 years (WHO 2003).

Child morbidity and mortality includes all illnesses and deaths within the first five years after birth, including neonatal, infant and under-5s' mortality (U5MR). The neonatal mortality rate is the number of deaths during the first 28 completed days of life, expressed as a rate per thousand (1,000) live births in a given year or period (WHO 2010b). Neonatal deaths account for a large proportion of child deaths. Neonatal deaths may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths occurring after the seventh day but before the 28 completed days of life (WHO 2010b). According to WHO (2010b), the neonatal deaths account for a large proportion of child deaths. Mortality during the neonatal period, commencing at birth and ending at 28 days after birth, is considered a good indicator of both maternal and new born health and care. For the purpose of this study, child morbidity and mortality mean neonatal morbidity and mortality.

The present average neonatal mortality rate in South Africa stands at around 40 per 1,000 live births. The national goal is to bring this down to less than 30/1,000 live births by 2015 (WHO guidelines 2008b). The leading causes of neonatal deaths include birth asphyxia, sepsis and low birth weight (WHO guidelines 2008b). Post-neonatal mortality includes only deaths after 28 days of life but before the baby's first birthday.

The infant mortality rate (IMR) is calculated as the number of deaths of infants\_(from birth to one year of age) per 1,000 live births in a given year or time period. Several demographic and socio-economic factors are related to the survival of the child and these are intricately linked to those of the mother (Every Death Counts Writing Group 2008). Mosley and Chen (1984), who did seminal work on models for maternal and child health, alluded to the fact that the determinants of infant mortality include maternal factors, ranging from fertility factors such as age at childbearing, parity, birth interval, environmental contamination with infectious agents such as contamination of air, food, water, fingers, skin, soil or other vectors, availability of nutrients for the foetus and infant, and personal disease control factors.

The U5M is expressed as a rate per 1,000 live births. It is the probability that a child born in a specified year, would die before reaching the age of five years if subject to current age-specific mortality rates. The U5MR reflects the socio-economic status of a population and it is a sensitive indicator of the availability; utilisation and effectiveness of health care in services in general (Tomlinson, Chopra, Sanders, Bradshaw, Hendricks, Greenfield *et al.* 2007).

### **1.9.2 Social determinants of health**

This study assumed that high rates of maternal mortality are evidence of the lack of power for women and the resultant deprivation of reproductive health needs, which is channelled through many paths until a woman dies from the direct causes such as maternal anaemia, pregnancy hypertensive disorders, infections et cetera. Likewise, a new-born's death, which is usually linked to the mother's health, is the ultimate consequence of a cumulative series of social and biological attacks rather than an outcome of a single biological factor (UNICEF 2009). The effectiveness of a model which intends to reduce maternal and child morbidity and mortality will therefore depend on the extent to which it addresses the root causes of such problems.

The WHO's Commission on Social Determinants of Health (CSDH) embraces a human rights framework as the appropriate conceptual and legal framework within

which to advance health equity (WHO 2009). Furthermore, the CSDH analytical framework is conceptually similar to Mosley and Chen's and Davis and Blake's analytical frameworks, to the extent that it argues that the background social, economic, cultural and health system variables influence a set of proximate determinants, which in turn directly influence the outcome variables (WHO 2009). Therefore, in line with the CSDH and for the purpose of this study, a conceptual framework for identifying and addressing the 'causes of causes' of maternal and child mortality was pursued.

### 1.9.3 Abortion

Abortion, also referred to as pregnancy termination, means the removal of a foetus from the uterus before it is mature enough to live on its own (International Planned Parenthood Federation [IPPF] 2008). An abortion may be induced (voluntarily performed) or spontaneous (IPPF 2008). Unsafe and illegal abortions are claiming a toll on women's lives, especially in developing countries where the rates of unsafe abortions seemingly do not change (IPPF 2008). Responsible sexual behaviour, including voluntary sexual abstinence for the prevention of HIV infection, should be promoted and included in the education and information programmes in order to minimise the need for abortion (IPPF 2008). The United Nations (UN) through the United Nations Population Fund (UNFPA), its agency for population and reproductive health, warns that it has never promoted and does not promote abortion as a method of family planning (UNFPA 2005). The UNFPA (2005) further highlighted the fact that the UN's position has always been that every attempt should be made to eliminate the need for abortion. Paragraph 8.35 of the 1994 ICPD PoA holds that:

- the status of a country's population policy, including the legal status of abortions, is the sovereign right of each nation; and
- An unsafe abortion is a serious public health concern, hence prevention of unwanted pregnancies must always be given the highest priority (United Nations 1994).

The UNFPA has called for countries to obey the prescriptions of the 1994 International Conference on Population and Development Programme of Action

(UNFPA 2006). Emphasising the issue of abortion, the UNFPA (2005) commit to supporting governments to strengthen their national health systems so as to prevent the abortions and to ensure that the management of complications from the abortions are part of reproductive health, family planning and sexual health programmes, thereby saving women's lives. The UN acknowledges that, while it emphasises that countries should take every measure to prevent unplanned pregnancies, pregnancies could still result from an unmet need and contraceptive failure, resulting in unwanted pregnancy and a need for its termination (UNFPA 2005).

Within South Africa the choice on termination of pregnancy (92 of 1996) took effect in 1997. The choice on termination of pregnancy (CTOP) Act (1996) suggests that a woman of any age who is eligible for an abortion can be provided with abortion services upon request, even without giving reasons, provided that she is less than 13 weeks pregnant (SA DoH 1996). According to the SA DoH (1996), a woman who is more than 20 weeks pregnant can be provided with abortion services only if her life or the life of the foetus is at stake or if the foetus is likely to have serious birth defects.

The 1996 CTOP act according to the (SA DoH 1996) further stipulates that eligibility for the abortion further includes the gestational status of between 13 and 20 weeks, provided that:

- the woman's physical or mental health is at stake;
- the unborn baby will have severe mental or physical abnormalities;
- pregnancy resulted from incest or rape;
- The woman's economic or social situation (health professionals may advise a woman who is under the age of 18 and requesting an abortion to consult her parents; however, the ultimate decision to consult or inform will be hers).

With respect to which facility is eligible for performing terminations of pregnancy, the CTOP (1996) states that any health facility that has a 24-hour maternity service may terminate pregnancies of up to and including 12 weeks without having to obtain an approval of the Member of the Executive Council (MEC), provided the provisions of



the CTOP (1996) have been complied with. Although it is not a legal requirement, most abortion centres do provide pre- and post-abortion counselling.

#### **1.9.4 Antenatal care (ANC)**

Antenatal care is care of the pregnant woman at a health facility with the main aim of ensuring the birth of a mature, live and healthy infant (WHO 2010a). The ANC constitutes the following, according to the WHO (2010a):

- screening for the health and socio-economic conditions likely to increase the possibility of specific adverse pregnancy outcomes;
- providing therapeutic interventions known to be effective;
- Educating pregnant women about planning for safe birth and emergencies during pregnancy and how to deal with them (WHO 2010a).

Although the antenatal care coverage is used as an indicator of access to and use of health care during pregnancy, the WHO (2010a) recommends collection of additional indicators such as the timing of the first visit and the number of visits. The WHO (2010a) provides that ideally, the initiation of ANC should be within the first twelve (12) weeks of pregnancy and the ANC attendance should be four visits at least before giving birth. Although the two indicators do not indicate the content of the care during pregnancy, the WHO (2010a) regards them as most useful.

#### **1.9.5 Birth spacing**

Knodel (2002) defines birth spacing as a birth interval. In this study birth spacing will be measured as an interval between the subsequent births. An interval of less than 18 months shall be regarded as inadequate birth spacing. Child survival is closely linked to the timing, spacing and number of births and to the reproductive health of mothers (United Nations 1994). Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where health care facilities are scarce (United Nations 1994; Norton 2005). The risk of neonatal and infant mortality and maternal deaths decrease with increasing birth interval of up to 36 months, suggests Norton (2005).

### **1.9.6 Birth weight**

The average weight at birth is 3 kilograms and infants weighing less than 2,500 grams at birth are considered to be low birth weight (Shore & Shore 2009). Shore and Shore (2009) made an important observation, namely that parental factors (including the father's) prior to conception might affect birth outcomes, including the birth weight. To Mosley and Chen (in Hill 2003), the low birth weight or a low weight-for-age can be regarded as a measure of the health status of children rather than solely of their nutritional status. In addition, subtracting one kilogram of infant birth weight is correlated with the doubling of the risk of maternal death (WHO 2007a).

### **1.9.7 Gestational age**

This is considered to be the duration or maturity of the pregnancy, or of the embryo or foetus or an inborn infant from the first day of missing a menstruation (IPPF 2008).

### **1.9.8 Female reproductive age group or childbearing ages of women**

The UNFPA (2005) suggested that reproductive health problems constitute the leading cause of ill health and death for women in the childbearing age (15-49 years).

The United Nations (quoted in Yadav, Choudhary, Narayan, Mandal, Sharma, Chauhan et al. 2008) has warned that delayed childbearing and early childbearing are health risks to both the mother and baby. A study in Belgium confirmed that some categories of women are particularly at risk of reproductive morbidity and mortality by establishing a strong relationship between an increasing maternal age of from age 35 years, multiparous women and primiparous, and an increase in maternal mortality ratio (Temmerman, Verstraelen, Martens & Bekaert (2004).

Yadav et al. (2008) suggest that teenage pregnancy, that is pregnancy between ages thirteen (13) and nineteen (19), is one of the most important public health problems, not only in South Africa but globally, and point out that this phenomenon often occurs in the context of poor social settings. Teen pregnancy often results in

maternal complications such as maternal anaemia, pre-term birth and Caesarean delivery, and neonatal complications including low birth weight, perinatal mortality and increased infant mortality (Yadav *et al.* 2008).

In this study, women in the upper end of the reproductive age group would be teenage mothers (teenage women who are pregnant or have been pregnant before). Women in the lower end of the reproductive age group are pregnant women who are older than 35 years.

### **1.9.9 Mother-to-child transmission of HIV**

This refers to the passing on of HIV from an HIV-infected woman to her baby, and can occur during pregnancy, labour and delivery, or breastfeeding (SA DoH 2008b). The term is used because the immediate source of infection is the mother; however, it does not imply any blame on the mother (SA DoH 2008b). By the year 2006, one in every three South African pregnant women attending antenatal care in public health facilities was HIV-infected, whereby 19% (100,000) were new mother-to-child-transmitted infections (United Nations Joint Programme on AIDS (UNAIDS 2008). Without intervention, around 35% of babies born to HIV-positive women are at risk of being infected with HIV during pregnancy, delivery and breastfeeding (UNAIDS 2008).

### **1.9.10 Skilled birth attendants**

These are people with midwifery skills (such as doctors, midwives, or nurses) who have been trained and are proficient in the skills necessary to manage deliveries and in diagnosing, managing or referring delivery-related complications (WHO 2010a). These health care professionals must be able to manage normal labour and delivery and be able to recognise the onset of complications, perform essential interventions, start treatment and supervise the referral of the mother-baby pair for interventions that are beyond their competence or not possible in a particular setting (World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Bank Statement 1999). The World Health Organization recommends that all women should have access to skilled care during

pregnancy and at delivery to ensure detection and management of complications (WHO 2010a). The proportion of live births attended by skilled health personnel in a given period of time is used as a proxy indicator for measuring maternal mortality (WHO 2010a).

### **1.9.11 Live birth**

It is a complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after such separation, breathes or shows signs of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached (WHO 2010a). The number of live births is often used as a denominator for calculating maternal and child mortality. For example, the neonatal mortality rate, the infant mortality rate, and the maternal rates are usually expressed per 1,000 live births (WHO 2010a). The United Nations (2008) highlighted the fact that live births are more accurately registered than live births plus foetal births.

### **1.9.12 Literacy level**

The literacy rate is the percentage of the population in a country who can both read and write with understanding a short simple statement on everyday life (United Nations 2009b). In this study, the literacy level will be calculated according to the number of women with at least a Grade 7 level of schooling. Likewise illiteracy in this study refers to women who have a qualification that is below Grade 7 and who cannot read or write. A relationship between the literacy levels of women as an aspect of socio-economic standing and morbidity and mortality will be established. The extent to which a woman is literate and the level of education she has received determines her future autonomy and status as it determines an entry point to employment and the level of economic power, decision-making in matters of reproduction and childbearing (United Nations 2009b). Education also has implications in terms of health care-seeking behaviour such as contraceptive usage, planned and unintended pregnancies and seeking antenatal or STI services (United Nations 2009a).

### **1.9.13 Urban and rural populations**

The terms urban and rural areas are based on some criteria which are both qualitative and quantitative, including amongst others, the density and size of populations, the distance between built-up areas, and economic activity (United Nations 2008). The Demographic Year Book 2005 indicates that the definition of an urban area would then differ from one country to another, because of the national differences in the characteristics that distinguish urban from rural areas (United Nations 2008). It is for this reason that countries would have their own national definitions according to the Demographic Year Book 2005 in the United Nations (2008). In a broad sense an urban area would include a city or large town and the suburban or densely settled geographical areas lying in its outskirts (WHO 2009). Urban population therefore usually incorporates the population in a city or town plus that in the suburban areas lying outside of the city boundaries (United Nations 2008). In the context of South Africa, an urban area refers to a place with some form of local authority (United Nations 2008).

Like an urban area, a definition of a rural area is often based on population size, other socio-economic variables such as access to health care, occupation and political proclamations (WHO 2009). In the same vein, the WHO (2009) refers to rural areas as those which do not have the characteristics of an urban area, as explained above. Compared to urban communities, rural communities have limited access to health care, suffer more preventable morbidity and mortality and have lower numbers and diversity in speciality of health professionals per population (WHO 2009). The rural populations are therefore relatively resource poor or under-served compared to their urban counterparts (WHO 2009). WHO (2009) defines 'under-served areas' as those geographical areas where relatively poorer populations reside and have limited access to qualified health care providers, and health services are of inadequate quality.

The situation in South Africa is that by the 2001 census, Statistics South Africa (StatsSA) classified areas which were proclaimed as municipalities as urban (Statistics South Africa 2004a). These were previously the cities and towns reserved for occupation by whites, and the nearby townships were occupied by the blacks.

Currently all parts of South Africa fall within a municipality and StatsSA no longer reports on 'rural' versus 'urban' populations because there is no official definition of rural (SA DoH 2006a). The rural areas of South Africa have a higher burden of morbidity and mortality than urban areas, as reflected by the 1998 and 2003 SADHS respectively (SA DoH, MRC and Measure DHS+ 2002 and SA DoH 2008d). The 1998 SADHS found differences in urban/rural infant mortality rates (IMR). The IMR was 32,6/1,000 live births in urban areas and 52,2/1,000 live births in non-urban areas (SA DoH, MRC and Measure DHS+ 2002). The urban/rural differences in IMR had not changed much five years later; the 2003 SADHS reported an IMR of 41/1,000 in the urban areas and 45/1,000 in the rural areas (SA DoH 2008d).

The 2003 SADHS suggests that there are noticeable differences in the skilled attendance delivery between the urban and rural areas; urban areas have 34% of skilled delivery compared to only 13% in the rural area (SA DoH 2008d). Home delivery for the urban women population was only 2% compared to over 8% for rural women (SA DoH 2008d). The young mothers living in rural areas had low literacy levels and were less likely to have been informed about possible pregnancy-related complications, as reported by the findings of the SA DoH (2008d).

A 2007 national survey on the ANC attendees using public health facilities found that 28% of the women were HIV-positive, indicating a decline of 1% for the second successive year (SA DoH 2007). The iLembe district in KwaZulu-Natal pitched the prevalence rate at 41,5% in 2007 from 39,1% in 2006, thus being the highest of the 22 rural and highly deprived districts, and Vhembe the lowest with 15,2%, apart from the West-Coast in Western Cape which was 10,2% (SA DoH 2007). The average prevalence for the 22 districts was 22,5% (SA DoH 2007).

#### **1.9.14 A need**

A need is a claim for a service (Narayan, Chambers, Shah & Petesch 2000). A need is also defined as a state of deprivation or a relationship between the identified problems and the responses available (Narayan *et al.* 2000).

An unmet need has often been linked to the practice of family planning and specifically to a gap between someone's stated fertility preferences and contraceptive availability and use at a given point (Bhandari, Premarajan, Jha, Yadav, Paudel & Nagesh 2006). A study in Nepal established that the more the people were educated the more they wanted to regulate their fertility and the more they would experience an unmet need (Bhandari *et al.* 2006). In this study an unmet need shall mean a lack of or inadequate response to a problem in the area of maternal, neonatal and child survival. A positive association was established between an unmet need for health care and being poor or uninsured or young, in a study that assessed factors associated with the likelihood of having an unmet need for medical care, which was conducted in the United States (Bhandari *et al.* 2006). In the same study, researchers found a link between education and unmet needs, namely African American children whose mothers had less than a high-school education faced twice the odds of having an unmet need in respect of medical care (Bhandari *et al.* 2006).

## **1.10 ORGANISATION OF THE THESIS**

This thesis comprises five chapters that are organised as follows:

Chapter 1 forms the introduction and includes the background, the statement of the problem, the context of the problem, the purpose of the study, the objectives, the research questions and the rationale for this study. The chapter concludes by defining the key words underpinning the study.

In Chapter 2 the theoretical framework on which this study is based is described. The meaning of *maternal and child health*, and *maternal and child morbidity and mortality* in the context of the study is discussed. The chapter elaborates on the connections between health outcomes, power and women. The major tenets of existing models of maternal and child health are described. In addition, case studies detailing policies and approaches to address the high rates of maternal morbidity and mortality and child mortality are presented in this chapter.

In Chapter 3 the researcher discusses the methodology in respect of the research design, data sources, data collection techniques, issues of reliability and validity, the sampling techniques and the key variables. The chapter also details data analyses and interpretation, ethical considerations as well as the pre-testing of data-generating instruments.

In Chapter 4 the findings are discussed. The gap between reality and women's reproductive health needs, and how they should be addressed, is mapped out.

Chapter 5 is a summary of the findings in terms of the stated research objectives and a discussion of the implications of a model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa. A model that lists the structural determinants and intermediary determinants/social determinants as well as the direct factors of the female reproductive health outcomes, including HIV/AIDS, is presented in this chapter and recommendations are made for further actions.



## CHAPTER TWO

### THE LITERATURE REVIEW

#### 2.1 INTRODUCTION

This section discusses the literature related to the research topic, the theoretical framework on which this study is based and lessons learnt on the models, public policies, approaches, programmes and services to reduce the risk of maternal and child morbidity and mortality.

Maternal morbidity and mortality and child morbidity and mortality as concepts are 'unpacked'. The concept of risky conditions is defined as it is used in this study. This study argues that health provisioning is unequally distributed in South Africa and that discriminatory allocation of resources including health care services leads to differential health outcomes for women, mothers and children in South Africa. The meaning of health, power and women in the context of a model that aims at improving reproductive health outcomes is discussed, commencing with an overview of macro-level policies and their impact on women's health, followed by contributions from women's perspectives and demands to eliminate risks to reproductive health.

The section concludes with a discussion of the lessons and experiences from the models, public policies and approaches in developing countries to enhance maternal and child health care, thus reducing the risk of dying. The emphasis is on how these countries, through the models, public policies, programmes and services, managed to reduce maternal and child morbidity and mortality. The lessons learnt from experiences might assist in formulating a model that could contribute to reducing the high rates and consistent reproductive morbidity and mortality in South Africa.

## **2.2 UNDERSTANDING MATERNAL AND CHILD HEALTH, MATERNAL MORBIDITY AND MORTALITY AND CHILD MORBIDITY AND MORTALITY**

Maternal and child morbidity and mortality are outcomes of a complex web of causal factors that include social, economic, educational, cultural, geographic and environmental factors, the state of physical infrastructure, and the health system (Pandey, Shankar, Rawat & Gupta 2007). According to Maine (2001), progress in the improvement of maternal health and the intimately linked perinatal and new-born health is too slow in the poorest countries, irrespective of increased implementation of the policies to improve maternal and new-born health. Maine (2001) further warns that it is essential to intensify efforts to reduce poverty alongside strengthening health systems in low-income countries for better reproductive health outcomes.

Scholars in several disciplines have begun to examine how women's agency, including their health-related decision-making, political participation, and organised social movement activities, affect their social circumstances and health (Weisman 2000). The women agency factor offsets the all-embracing view of women as victims of social and political institutions that are assumed to be too remote from women's experiences (Weisman 2000). The WHO has also begun to recognise that a reduction of women, maternal and child mortality requires a shift from a narrow curative medical approach to a broader comprehensive promoting and preventive approach that looks at causal factors at the social level (WHO 2007b). The proposed approach should facilitate change by reducing health inequities and set up a momentum for new, equity-focused approaches (WHO 2009). To this end, a Commission on Social Determinants of Health (CSDH) was set up by the WHO in 2004 and launched in 2005 (WHO 2009). The main goal of the CSDH was to advance health equity and propose actions to reduce health differences, thus reducing differential mortality rates among the social groups and within and between countries (WHO 2009). The guiding principle of the CSDH is health equity, and the primary responsibility for the protection of health equity rests with national governments (CSDH 2007). The CSDH embraced the international human rights framework as an appropriate conceptual and legal framework within which to advance towards health equity through action on the social determinants of health

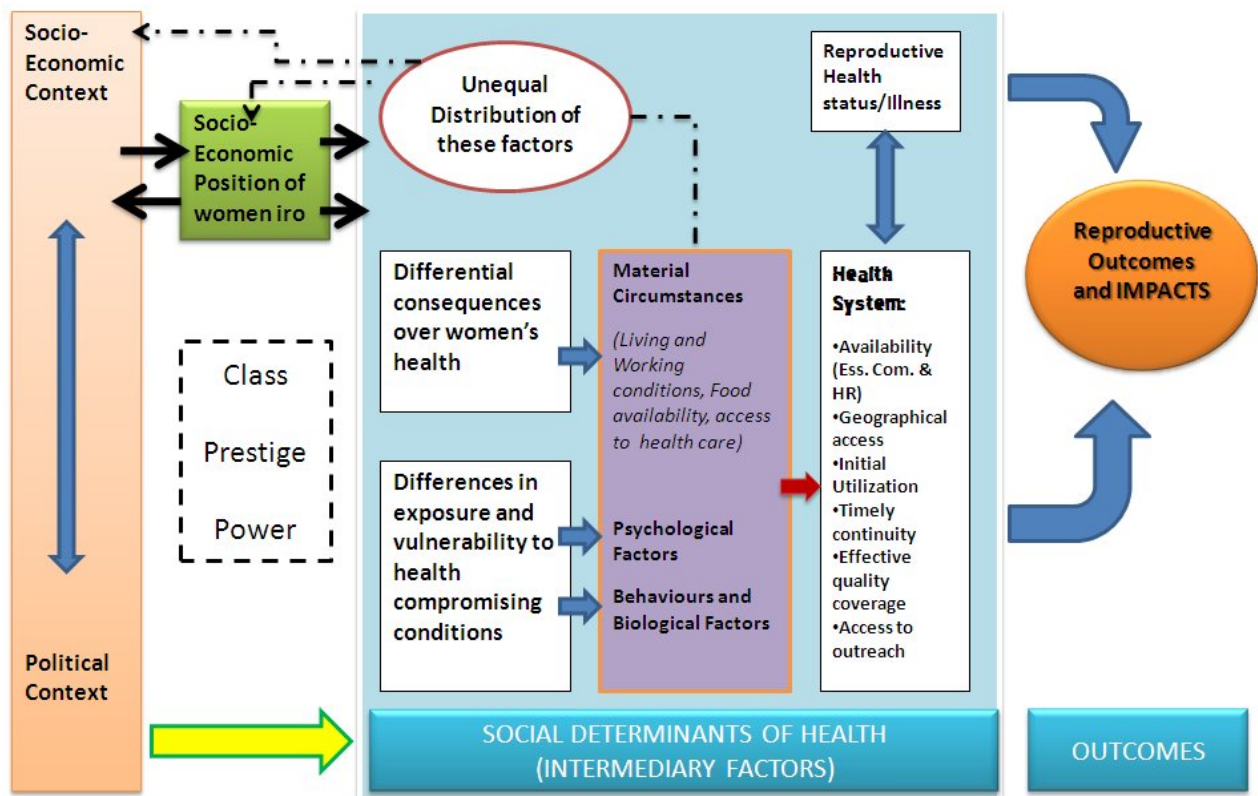
(CSDH 2007). The CSDH has developed a conceptual framework to address 'the causes of the causes' of ill health and premature deaths (CSDH 2007).

In light of the above, the present study assumes that socio-economic factors affect the empowerment position of women, which in turn influences their decision-making capability for their health and the health of their children. The socio-economic determinants of health therefore indirectly determine the reproductive health outcomes. The study is based on the premise that women and new born babies eventually die due to accumulation of and prolonged exposure to such risk factors as the social determinants of health or the intermediary factors. The socio-economic position and power of women or structural drivers operate independently on more than one intermediary variable/social determinants of health, to influence the risk to maternal, neonatal and child mortality. In this study, the socio-economic position and power of women leading to inequitable distribution of resources include income and the differences in exposure to vulnerability of women and consequently their children. The position and power of women are the structural drivers of the intermediary variables/social determinants of health, and are deemed to be the root causes of the persistently high maternal and child mortality. Any effort to reduce maternal and child morbidity and mortality must operate through these events. Implied here is that the interventions and policies to reduce maternal and child health inequities must not limit themselves to intermediary determinants/social determinants of health, but must include models and policies crafted to tackle structural determinants.

The conventional use of the term 'social determinants of health' has often encompassed only the intermediary factors. However, interventions addressing intermediary factors only can improve average health indicators while leaving health inequities unchanged. For this reason, action on structural determinants is necessary; however, it must come from outside the health sector (CSDH 2007). The researcher uses the WHO's conceptual framework to analyse the pathways leading to exposure, vulnerability and risk to ill health and mortality.

Below is a diagram on the determinants of maternal morbidity and mortality which shows how structural determinants work through the intermediary factors to affect the health of women thus contributing to the occurrence of maternal and child morbidity and mortality.

**Figure 2.1: The analytical framework of the social determinants of health including women empowerment in relation to maternal and child health at a policy-setting level**



*Adapted from the Commission on Social Determinants of Health 2007*

### 2.2.1 The framework of the social determinants of health: elements

It has been highlighted above that within South Africa population groups experience different reproductive outcomes along the racial, geographical, class and gender lines (Coovadia *et al.* 2009). The choice of the framework on the SDH was informed by:

- its approach and the guiding principle of reducing health differences on the social groups

- its ability to identify the root and trace the pathways from the root that lead to the stark differences in women's health status

The three (3) core elements of the framework are the socio-economic and political context, the structural determinants and socio-economic position of women and the intermediary determinants that produce certain reproductive health outcomes (CSDH 2007). The first element, socio-economic and political context exerts power and influence that produce patterns of social stratification and hierarchies that determine people's opportunities. This element encompasses a broad spectrum of factors that cannot be measured directly at individual level (CSDH 2007).

The second element, the structural determinants and socio-economic position constitutes what the CSDH (2007) calls the social determinants of inequities. The structural determinants of health generate, reinforce and define social positions along social hierarchies of power, prestige and access to resources. The socio-economic position is defined by income, education, occupation, social class, gender, race and geography.

The third element of the framework on the social determinants of health, the intermediary determinants, has been referred to by the CSDH as the social determinants of health (CSDH 2007). The categories in this level include the material circumstances such as housing, income and consumption, social environment, behavioural factors, health system as a determinant of health which informs access, differences in exposure and vulnerability (CSDH 2007).

The social determinants of the health inequities are causally antecedent to the social determinants of health which on the other side influences or are linked to a set of individual level influences which includes health related behaviours and psychological factors (CSDH 2007). The intermediary factors therefore determine differences in exposure and vulnerability to health comprising conditions.

### **2.2.2 The framework of the social determinants of health: a critical analysis**

The framework for the social determinants of health fit quiet well with the PHC approach which itself is informed by the social model of health and the recognition

that only comprehensive PHC will actively improve the quality of life and the health status of the people in any society including women (Mahler 2008). The PHC seeks to address the range of social determinants of health which incorporate inter-related circumstances of poverty, wealth and income distribution as well as the discrimination associated with sexism, gender and powerlessness.

The conceptual framework guide empirical work to enhance the understanding of the determinants and mechanisms of women's health or ill health which in turn guide policy making to highlight entry points for interventions and policy. The SDH framework frames health as a social phenomenon and enables approaches that deal with health, risk to health, ill health and the consequent mortality from the root. The SDH framework requires inter-sectorial approaches due to its nature of having to tackle the structural as well as intermediary determinants of health (Adeleye & Olifi 2010).

On the other hand the social determinants of population health and health inequalities are characterised by working through long causal chains of mediating factors which tend to interact with each other. Many of these factors tend to cluster among the socially deprived individuals (Adeleye & Olifi 2010). This poses a challenge of how to estimate these mechanisms for the health professionals and social scientists.

The model emphasises integration and collaboration among the sectors (inter-sectorial) with core tasks however policies for education, labour market, agriculture are not primarily put in place for health purposes. Moreover PHC is not on the agenda of non-health sectors for their operational attention (Adeleye & Olifi 2010). The process for policy making will need to be enhanced in such a way that other sectors find themselves adding value to health issues. In addition, implementation of social determinants of health mandate will require strategic reallocation of resources (Lefebvre, Warren, Lacle & Sutcliffe 2006). Proposals for implementing policies that tackle SDH may face scepticism due to increased budget requirements (Lefebvre *et al.* 2006).

A public and professional perception and understanding of the link between the SDH and health is lacking. Further, there are gaps in the traditional evidence and knowledge transfer related to the social and economic determinants of health. Extensive training will be required to be able to understand the link and implement the framework (Adeleye & Olifi 2010).

Progress on implementation of the SDH models will most likely occur in the long term and attribution to public health or social programs will be difficult (Lefebvre *et al.* 2006). Action on the SDH is further influenced by a variety of political and community stakeholders therefore making accountability and responsibility difficult (Lefebvre *et al.* 2006).

### **2.3 HEALTH / POWER / WOMEN**

Weber (1946) (quoted by England in Presser & Sen 2000) pointed out that power is related to the ability of human beings to make others do what the ones who have power want, regardless of the wishes of the powerless, their interests or rights. Empowerment in this study is based on an analysis of power relations, that is, those who have power and those who are powerless. Power relations begin at a very high global level and extend to a micro-level to impact the individual social lives. This section touches briefly on macro-level imperatives and implications for women and reproductive health; thereafter power as a concept and how it affects health is discussed. The narrow focus on dealing with the unyielding high maternal and infant mortality that is adopted by most governments in the Third World, and the downplay of the impact of global policies influence the way in which people live and work in many parts of the Third World (Wuyts, Mackintosh & Hewitt 1997:185). Most developing countries have made major improvements in the area of child and infant mortality and education since the 1950s, but the debt crisis and the recession of the early 1980s which forced them to the door of the International Monetary Fund (IMF) and the World Bank (WB), seeking finance to continue trade, and thus succumbing to adopt Structural Adjustment Programmes (SAP) have threatened many of the gains made in the earlier periods (Wuyts *et al.* 1997:185).

The SAPs were directed at getting a country's national economy back into shape. In the mid-1980s, the petrol prices fell which led to a severe economic recession. Most developing countries started having problems in paying the capital and even interest of their debt. The IMF together with the WB started a programme of Structural Adjustment based on Neo-liberal ideas. Among others, Neo-liberalism is against the notion of a welfare state. The argument of the IMF and the WB was that the crisis happened because states spent too much on social services, thus creating an unfavourable climate for investment and economic growth. In their view, what was needed was a complete overhaul of economic policy, state action and the general climate for investment and growth in these countries. State action had to be redressed through comprehensive economic reform policies which were of two kinds, namely, directly structuring taxation and social provision and altering the way the state intervenes in the markets (Wuyts *et al.* 1997:184). Social provisioning in particular had to face expenditure cuts, a shift towards targeting those in need and charging user fees to boost revenue and limit excessive use. The main policy measures aimed at getting the prices right were a devaluation of the local currency, the raising of interest rates and the abolishment of subsidies and price controls. The poor, women and children were the hardest hit by the SAPs (Wuyts *et al.* 1997:184).

The United Nations Children's Fund (UNICEF) sponsored a study in the 1980s on the situation of children in ten developing countries affected by structural adjustment policy packages. The study revealed that in most of these countries, the decline in child mortality rates slowed down, malnutrition rates for women and children increased and the educational attainment indicators worsened, while disease prevalence rates increased (Cornea, Richard & Frances 1987). This is evidence that SAPs have increased the vulnerability of the poor, mothers and children. Therefore, policy making in the North and West should also be questioned when designing models for reducing reproductive morbidity and mortality in the Third World countries, including South Africa. The health and welfare needs of children and how they are addressed also have a bearing on other aspects of development such as reducing population growth, for example; faced with high infant and child death rates, parents may opt for a larger family in order to achieve what they consider an ideal family size (Wuyts *et al.* 1997:185).



Hartmann (1995) endorses this view and further states that global policies such as SAPs, which largely translate into steep reductions in public expenditure, have deepened the health crisis in many Third World countries through cuts in public health services, imposition of user fees, dramatic increases in the prices of drugs and overall deterioration of the standards of living. In Tanzania, female life expectancy declined by six years during the adjustment process imposed by the WB and IMF in the 1980s; in Zimbabwe, maternal mortality rates doubled in the first three years of adjustment in the early 1990s, while women and girls were forced into commercial sex due to the deteriorating economic conditions in Nigeria (Hartmann 1995). Nigeria further introduced and launched a first population policy entitled the National Policy on Population for Development, Unity, Progress and Self-Reliance (Kisekka & Okeshola, quoted in Hardon & Hayes 1997). This policy was criticised for its non- inclusion of women associations in its formulation and a prescription of a four-children limit for women, whereas men were merely encouraged to have a limited number of wives and optimum number of children they could foster within their resources (Kisekka & Okeshola, quoted in Hardon & Hayes 1997). The policy further reinforced patriarchal ideas in family organisation and reproductive choice to the extent that it explicitly stated that in the Nigerian society, a man is considered the head of the family when he provides economic support and he has to make decisions on the family size (Hardon & Hayes 1997). This practice confirms Truong's view that the patriarchal tradition and the lack of rights afforded to women serve as the root causative factor of women, maternal and child deaths (Truong 2006).

Reproductive health, reproductive outcomes and reproductive rights and responsibilities have their roots and are dealt with in international documents from three interrelated fields, namely, human rights, population programmes and women's rights. Boland, Rao and Zeidenstein (1994) noted that the 1945 United Nations Charter was the first international treaty to enunciate the principle of equality in specific terms. In 1948, the United Nations (UN) reaffirmed as its aims, 'the fundamental human rights, the dignity and worth of the human person, equal rights for men and women'. In its article 1, the principle of equality and non-discrimination states that all human beings are born free and equal in dignity and rights (Boland *et al.* 1994). The concerns and rights of women were addressed further and codified for the first time in specific terms at the first international treaty, the Women's

Convention in 1981. The UN general assembly adopted the Convention on Elimination of All Forms of Discrimination against Women (CEDAW). According to Boland *et al.* (1994), the document legally binds countries that have signed the agreement to eliminate all forms of discrimination against women.

Boland *et al.* (1994) mention that there are two major population documents, namely, the World Population Plan of Action (WPPA) adopted at the 1974 World Population Conference held in Bucharest, and the recommendations for implementing the plan of action that was adopted at the 1984 international conference on population held in Mexico City. Referring to these two documents, Boland *et al.* (1994) assert that, while the documents address reproductive rights both directly and creatively, though very rhetorically, some fundamental ambiguities and conflicts were glossed over to reach a political consensus. These include that women's rights have generally been neglected because they have been treated as social or second-generation rights; they lack gender-sensitivity and fail to address discriminatory practices arising from the biological and reproductive differences between men and women (Boland *et al.* 1994:91). The authors further mention that because of such shortcomings, the equality prescribed in the international instruments has limited significance for women in the real world. For example, discriminatory practices that hold women in a subservient position, leading to their exclusion from public life, have generally not been seen as violations of the human rights and fundamental freedoms of women. Of note is the failure of the international policies on population, human and women rights to address the real issues and suggestions to control the population through coercive reproductive policies (Correa & Petchesky, in Boland *et al.* 1994:91).

As viewed by feminists, population control is a philosophy without a heart in which human beings, especially women, become objects to be manipulated. It is a philosophy of domination as people of different sex, race, and class are viewed as inferior to its architect (Hartmann 1995). Population control negatively affects people in the most private and intimate areas of their lives. According to Hartmann (1995), instead of promoting ethics, empathy and true contraceptive choice, population policies encourage and condone coercion and they are no solution to the serious economic, political and environmental problems faced by the globe, including

countries in the developing world. Such policies will not resolve the problem of increasing reproductive morbidity and mortality (Hartmann 1995).

Women's empowerment became a stated priority of governments, multilateral and bilateral institutions, and private foundations concerned with the current demographic trends (United Nations 1994). For example, the Plan of Action of the 1994 International Conference on Population and Development (ICPD), agreed to by 183 countries, states that *'the empowerment and autonomy of women and the improvement of their political, social, economic, and health status is a highly important end in itself and it is essential for sustainable development'* (Presser & Sen 2000:3). The ICPD PoA further maintains that power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from *'the most personal to the highly public'* (United Nations 1994) It states in its key paragraph (paragraph 4.1) that women face threats to their health and well-being as a result of their lack of power and influence (United Nations 1994).

The lack of power of poor women in several developing countries arises from a conjunction of three primary systems of stratification, namely race, class and gender, which interact with and mutually reinforce one another through social, political, economic and health institutions (Batiwala, in Sen, Germain & Chen 1994:130). At the creation of the Commission on Social Determinants of Health (CSDH) by the WHO, Bartley (quoted in Moore 2004:1) points out that factors which define empowerment such as social class, education and income are *'the three main social determinants of health'*. Accordingly, he (Bartley, quoted in Moore 2004) notes that the best measures of social class relate to a person's autonomy and freedom to decide what to do and when to do it. The less control one has over these empowerment factors, the more insecure and powerless one will feel and the more others will decide and dictate what to do with one's life. That, on its own, further causes increased levels of stress hormones and illness and is related to the social class position (Bartley, quoted in Moore 2004). The Commission on Social Determinants of Health (CSDH), established by the WHO in 2004, has since identified that empowerment operates along three interconnected dimensions: material, psychosocial, and political (WHO 2009). The CSDH (quoted in WHO 2009) asserts that for people to be healthy, they need:

- the basic material requisites for a decent life,
- to have control over their lives, and
- A political voice and participation in decision-making processes.

Following the ICPD, a seminar was organised in Lund, Sweden in 1997, themed 'Moving beyond Cairo', where conceptualisation of female empowerment proved to be an overriding issue. No single definition of female empowerment emerged. Instead, the seminar revealed the complexity of defining empowerment and the need to view it as incorporating many dimensions and facets (Dixon-Mueller 1998). England, Sen and Batliwala presented empowerment in different contexts in that session. England focused on conceptualising women's empowerment, while Sen and Batliwala's focus was on empowering women for reproductive rights (Dixon-Mueller 1998). England regarded access to resources (that is, economic resources, favourable laws, institutional rules and favourable social norms) as key to empowering females. Both Sen and Batliwala emphasised extrinsic control over resources as women's rights (Dixon-Mueller 1998).

A number of presenters viewed empowerment as a means to an end, both social and individual, while others viewed it as an end in itself, arguing that women have to be empowered first to obtain certain demographic outcomes such as declines in fertility and birth rate, or positive reproductive health outcomes such as maternal and infant mortality declines or dealing with the problem of infections. It was generally agreed that empowerment was about the transformation of power relations, including: control over material resources and a change in self-perception and confidence in oneself; that empowerment could and should be viewed both as an outcome and a process; and that women's empowerment involved transformation of power relations at four different levels, namely the household/family, the community, the market and the state (England, quoted in Dixon-Mueller 1998).

The concept of empowerment depends upon the idea that power can expand (Page & Czuba 1999). However, precisely how we define empowerment within our programmes and projects will depend on the specific people and context involved, according to Bailey (1992). George (2001) alludes to the fact that women are often

denied human rights which determine power such as economic opportunity, social equality and personal rights, even in matters of sex and childbearing and access to health care. George (2001) further maintains that, without the power to work and earn a good income, women's voices are silenced.

The process of 'empowerment' is seen in this study as inherently linked to women being actively involved in changing their life circumstances, thus bringing about and defining the parameters for their desired end state. According to Moore (2004), people's health prospects worsen as they descend the social ladder. Sen and Batliwala (2000:18) refer to empowerment as a '*process by which the powerless gain greater control over the circumstances of their lives*'. Implied in this definition is that empowerment cannot be assumed to be automatic, but rather operates at different levels along a continuum. Page and Czuba (1999) concur that empowerment occurs at various levels, such as individual, group, and community. They suggest that there are three components that are basic to any understanding of empowerment, namely that empowerment is multi-dimensional, social and is a process. It is multi-dimensional in that it occurs within sociological, psychological, economic and other dimensions. Empowerment, by definition, is a social process, since it occurs in relationship to others. Furthermore, empowerment is a process that is similar to a path or journey, one that develops as we work through it (Page & Czuba 1999).

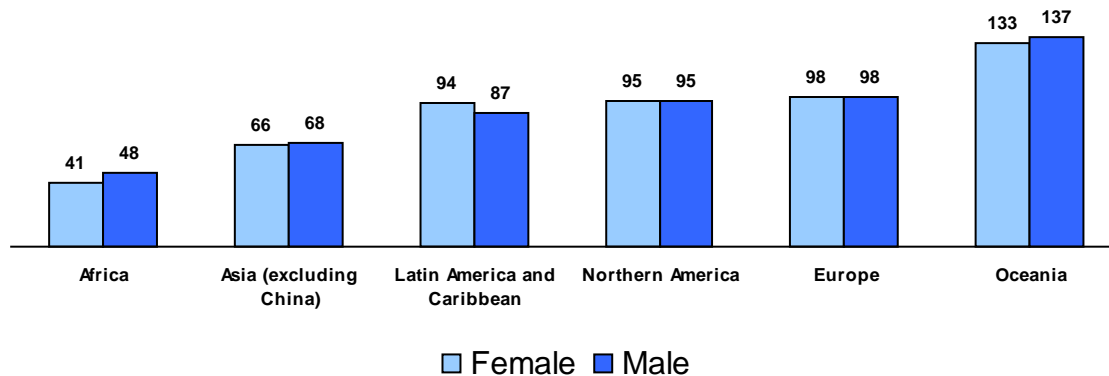
From the literature, social status, as determined by social class, income and level of education, seems to define empowerment for women. Du Plessis (2008) confirms that several observers connect the empowerment of women to extrinsic factors such as education and access to financial resources. Such analyses, she notes, often point to the equally important role played by intrinsic and interpersonal factors (Du Plessis 2008). On the link between female education and autonomy, Cleland and Kaufmann (1998) found in their study in Bangladesh, that as far as reproductive decision-making and control over household resources are concerned, uneducated and educated women are equally disempowered. Commenting on the link between female education, the empowerment of women and demographic change, Bradley (1995) suggests that the status of women can change in many directions under the influence of education but may also have unforeseen consequences.

More importantly, Bradley (1995:171) observes that empowerment of women through education relies in great measure on the availability of jobs and other economic opportunities to which they could apply their newly acquired skills. Du Plessis (2008) warns that the empowering potential of education, however, fades in the face of structural powerlessness. Kabeer (1999:3) links resources not only to the above-mentioned extrinsic factors, but also to structural elements coupled with the actual allocation of resources (distributive resources). The CSDH confirms that conflating social determinants of health and the processes that shape the unequal distribution of these determinants can seriously mislead policy (WHO 2009). Moore (2004) argues that governments have been quick to recognise that social factors such as wealth, education, ethnicity, gender, or job are sources of power and key determinants of health. However, few governments so far have attempted to tackle the problem head-on, South Africa included. Added to this equation are authoritative resources that enable social agents to delineate priorities and impose claims to resources. Drawing on authoritative resources, for example, chiefs, relatives, heads of households and so on can exercise decision-making power that exceeds that of the individual woman or couple (Du Plessis 2008). Sen and Batliwala (2000:18) in Du Plessis (2008), add that over and above control over physical, intellectual, emotional and financial resources, the empowerment of women includes control over their beliefs, values and attitudes.

Power relations determine access to both material and non-material resources, including health care, ability to control life, and decision-making capability (CSDH 2009). The researcher concurs with the view that women are powerless, must fight subordination in multiple roles and identities, both as members of poor households who are struggling to meet the basic needs and as participants in several social institutions (United Nations 1994). The empowerment process within the gender and development setting seeks to address the powerlessness of women and has the greatest potential of reducing maternal and child morbidity and mortality. In line with this argument is the idea that there is a relationship between the health, gender empowerment and self-determination of women (Stein 1997:261; Klugman 2000a).

Figure 2.2 below shows disparities in the educational levels along the gender lines in several regions.

**Figure 2.2: Secondary School Enrolment, by Region**



Source: (Population Reference Bureau (PRB) 2011: *The World's Women and Girls Data Sheet*).

School attainment above secondary level is one of the five indicators of inequality index. Figure 2.2 above reflects that girls and women still perform unfavourably on the educational front in five of the six regions listed above. The Latin American and Caribbean region is the only one from the six regions whereby women outnumber men in education (PRB 2011). The educational level of women influences decision making in respect of fertility preferences, obtaining skilled assistance when giving birth and child care thus having an impact on reducing MMR and IMR.

## **2.4 A THEORETICAL DISCOURSE: FROM WELFARE TO EMPOWERMENT AND WOMEN'S HEALTH**

Views about considering the involvement of women in the development process and policy-making to improve their socioeconomic status, general well-being and health have been shifting with different theories ranging from women in development (WID) gender and development (GAD) to women and development (WAD including women empowerment approach. This move was motivated by the realisation that women could no longer be treated as a special group but as an integral part of any

development strategy. The relations between men and women were problematized as playing a major role in subjugation and subordination of women. Below is a schematic presentation of shifts in theories and policy approaches to development and empowerment of women.

**Table 2.1: Schematic presentation of shifts in women development and empowerment discourse**

Dimension of Theory	Historical Context	Explanation	Outcome and criticism
<p><b>Welfare Approach:</b> Characterised pre-Women in Development (WID) thinking: Earliest approach concerned with women of developing countries. Was directed at vulnerable and socially deprived families through women who were identified as low-income earners after World War 2. The provision of welfare for the family targeted women, along with the disabled and the sick. Since then, welfare remained the responsibility of the marginalised Ministries of Social Welfare.</p>	<p>The approach was introduced during the period 1950 and 1960</p>	<p>Purpose: To bring women into development as better mothers; women were seen as passive beneficiaries of development; reproductive role of women was recognised as policy sought to meet practical gender needs through that role by top-down hand-outs of food aid, measures to combat malnutrition and the MCH/FP package. The approach focused on the mother-child dyad. The role of women as mothers was not seen as problematic. Women rather than lack of resources were seen as a problem</p>	<p>Still widely used and popular as the approach is non-challenging. Motherhood is the most important role. Welfare policy is still identified as women's work. Welfare is regarded as less important than economic and physical planning. Since the 1970's welfare policy has been extended to include population control through family planning. Approach has been criticised for reducing women to non-productive dependents and concerned with family welfare only.</p>
<p><b>Women in Development (WID).</b> The WID draws its theoretical base from the modernisation theory. WID has three sub-approaches, namely: equity; anti-poverty; and efficiency approach.</p> <ul style="list-style-type: none"> <li>• <b>Equity:</b> It's regarded as first WID approach.</li> <li>• <b>Anti-Poverty:</b> It is linked to redistribution with growth and basic needs. It draws part of its theoretical base from the dependency theory. It does not challenge the basic social relations of gender on the</li> </ul>	<p>Introduced between 1976 and 1985, during the UN Women's Decade.</p>	<p>For the first time the position of women was studied separately from that of men in the various sectors of the economy. Women were seen as active participants in the development process. The theory argued for equality of opportunities in development.</p>	<p>WID was criticised for lack of baseline information about women's economic, social and political situation as the basis for measurement. The implicit redistributive power suggested by the equity approach and the tendency to avoid tempering with unfamiliar and unknown social variables led to the hostility of development</p>



Dimension of Theory	Historical Context	Explanation	Outcome and criticism
<p>assumption that the relations will change themselves as women become full partners and active participants in the development discourse.</p> <ul style="list-style-type: none"> <li>• <b>Efficiency:</b> The efficiency oriented discourse draws from neo-liberal development theory and suggested that development needs women and not vice versa.</li> </ul>			<p>agencies towards it and its displacement within the mainstream development efforts.</p>
<p><b>Gender and Development (GAD).</b> Theoretically, GAD aligns itself with the socialist feminism. Within GAD, the social construction of production and reproduction has been identified and problematized as the basis of women oppression and subordination.</p>	<p>GAD was also introduced in the 1980's as an alternative to WID.</p>	<p>The GAD focuses on the socially constructed differences between men and women and emphasises the need to challenge and deconstruct the existing social gender roles and relations. The approach pays special attention to women oppression and analyses assumptions within which conjugal relationships are based. It further questions the underlying assumption of the current social, economic and political structures.</p>	<p>The approach has been criticised for leaning on and being guided by Western feminism and economic development thinking with limited inclusion of the local context. The transition to a modern society is presented as the solution to women, especially of the developing countries. GAD IS further criticised for being pre-occupied with male-female inequalities.</p>
<p><b>Women and Development (WAD).</b> Also draws its theoretical stance from dependency theory. The WAD holds the view that women are not a neglected resource, but overburdened and undervalued.</p>	<p>The WAD emerged within the second half of the 1970s Women</p>	<p>Within the WAD approach, women are seen as agents of change and the approach stresses the need for effective organisation for a strong political voice. International structures are seen as contributing to inequality and subordination of women. The WAD hold that vulnerability of women will decrease and their position will improve if international structures were to become equitable. A 'bottom-up' process of transforming gender power relations</p>	<p>On paper WAD recognises the impact of class however in practice it tends to group women together without analysis and consideration of class, race or ethnicity which have influence on women actual social status.</p>

Dimension of Theory	Historical Context	Explanation	Outcome and criticism
		through individuals or groups; developing awareness of women's subordination as well as building their capacity to challenge the status quo has the potential to change their circumstances	
<b>The empowerment of women approach</b> is located within the WAD discourse and largely influenced by Marxist theory and Paulo Freire.	Beginning in the 1980s, the empowerment approach continues to be popular, especially among the social activists, feminists, researchers and NGOs as well as the donor agencies who are interested in transformative potential of development initiatives.	Goal: challenges subordination and subjugation. Ultimate goal is to transform all structures, systems and institutions of inequality. Women issues were seen as men's issues for the first time. Focus on removing gender bias in development planning that overlooks women's economic role in economic activities. Women development issues were interpreted from women's perspective by the Development Alternatives with Women for a New Era (DAWN). Women argued that development effort has been guided by Western patriarchy and capitalist domination	The theory has been criticised for being conceptually ambiguous since it is not clear as to how it distinguishes itself from other participatory approaches. Empowerment approach tends to rely too much on self-study and self-uplifting. The theory is highly contested.

**Sources:** (Kabeer 1994b; Macdonald 1994; Moser 1993; Rathgeber 1989).

## 2.5 PUBLIC POLICIES AND APPROACHES TO REDUCE THE RISK OF REPRODUCTIVE MORBIDITY AND MORTALITY, AND LESSONS FROM OTHER DEVELOPING COUNTRIES

Miller (quoted in Stein 1997:269) defines a health policy as an *'aggregate of principles, stated or unstated, that characterise distribution of resources, services and political influence that impact on the health of the population of concern'*. According to Stein (1997:270), many players, ranging from international to local level, are involved in producing and shaping health and development policies through policy statements, implementation and funding. There is a need to recognise

such dynamics when formulating women's health policies as these affect decisions on resource allocation among the competing needs. Stein (1997) further argues that an understanding of these dynamics will not only reduce pressure on women who do not have power and are the human links between different policies, but such an understanding and conceptualisation could make policies more effective in achieving the goal of reducing high rates of maternal and child morbidity and mortality. Hobcraft (quoted in Stein 1997) argues that among the most important gains for children from female empowerment, are those for the girl child, better survival of the mothers and improved infant and child health.

Women's empowerment and health outcomes emerged as a central theme in the international development and policy agenda. Barroso and Jacobson (quoted in Dixon-Mueller 1998), provide a historical perspective of how women's issues have evolved from being ignored in the policy realm, to being confined narrowly to family planning (FP) policies, and lately to its current focus on empowerment. Barroso, Jacobson and Cook (quoted in Dixon-Mueller 1998) see the future policy focus as one of deepening the empowerment agenda and the scope of public intervention beyond just health and rights to the overall context of the family, community and the state. Cook (quoted in Dixon-Mueller 1998), for example, speaks of moving beyond Cairo by setting up explicit standards by which governments can be held accountable for women's rights issues. Women's rights are prerequisites to women's empowerment and finally their survival (Dixon-Mueller 1998).

Public policies for reproductive health care should aim at directing the resources towards strengthening the power base of women through increasing education, skills, job opportunities, autonomy and their self-esteem at a household level. Sen (quoted in Wuyts *et al.* 1997) argues that, provided with these capabilities, women may achieve a strong sense of recognition for their reproductive decisions, responsibilities and the rights they are entitled to. This should, however, be followed by accessible, quality reproductive health care to all. This approach could have a great impact on women's reproductive health status, thus reducing reproductive maternal and child morbidity and mortality (Sen, quoted in Wuyts *et al.* 1997).

### **2.5.1 Population control, demographic transition and implications for women's health**

Theories abound as to what will unlock the door of demographic transition in Third World countries. Population control advocates claim that family planning programmes are the most effective way to bring about demographic transition from high to low birth rates, as evidenced from the experience of the Western European countries that have completed their demographic transition (Hartman 1995). They argue that development is no longer the best contraceptive. To them, any intervention that will reduce fertility rates will reduce maternal, neonatal and child mortality rates as there will be no need to replace children who would die in the countries which still experience high birth rates and high child death rates (Hartman 1995). In addition, a woman's chance of dying from pregnancy-related complications are nearly 50% higher in developing countries than in the developed world, and nearly half of maternal deaths in the developing world occur during labour, delivery or in the immediate post-partum period (Birdsall, Gupta & Ibrahim 2005). According to Hartman (1995), the population control advocates argue that the third world countries simply do not have the necessary resources to carry them through a demographic transition as these are being 'eaten up' by the population growth. Hartmann (1995) disagrees with this view and suggests that in a number of places such as China, Korea, Sri Lanka, Taiwan and the Indian state of Kerala, birth rates started to drop when their per capita income were still only several hundred dollars. The author suggests that in reality, the demographic transition is much more complex than such a simple reasoning and does not justify massive spending on the population programmes. Hartmann (1995) sees population growth as only a symptom rather than a cause of the problematic economic and social development. The improvements in the living conditions of women and empowering them through equitable social and economic development would lead to voluntary decreases in family size. She (Hartmann 1995) argues that effective birth control measures can only thrive within a comprehensive system of health care delivery responding to people's needs, and supported by social justice.

If development is measured in terms of gross national product (GNP) per capita, then one finds that countries with high GNPs generally have lower birth rates, though

there are exceptions to the rule, as shown by middle-income countries such as South Africa with crude birth rates of (31), Saudi Arabia (37), and Gabon (42). If one defines development differently, in terms of the people who actually benefit from economic growth, then one discovers that a more equitable distribution of resources could lead to lower birth rates and consequently the associated maternal, neonatal and child mortality, even at relatively low levels of GNP per capita; such is the case with China (long before the draconian one-child policy) and Sri Lanka (Hartmann 1995). Fertility rates and mortality rates, especially for women and children, are a matter of income distribution and a raised standard of living across the population, leading to better overall access to health, education and jobs. These are all factors that allow people to choose smaller families, according to Hartmann (1995). Many countries that have more equitable income distribution policies also consciously gear services toward the poor majority, for example, emphasising mass primary education rather than expensive higher education for a privileged few. Similarly, countries such as Sri Lanka, China, and Cuba which have developed extensive public health systems, have managed to bring down infant mortality rates at relatively low levels of GNP per capita, while much richer countries, for example, the former apartheid South Africa, failed (Hartmann 1995).

Also of critical importance, according to Hartmann (1995) and Wuyts *et al.* (1997), is an equitable distribution of resources between men and women. One of the reasons many relatively rich Middle Eastern countries have high birth rates could be due to the restrictions imposed on women's participation outside the home, whereas in Asian countries such as Sri Lanka and Thailand, women's education and employment not only give them greater control over financial resources but also over their own reproduction (Hartmann 1995). The author further alludes to the fact that the recognition of these factors has led to a recasting of traditional demographic transition theory, in which social and economic justice play a major role (Hartmann 1995). Elaborating on the lessons on how equality was a driver behind reduction of mortality rates, Hartmann (1995) discusses the unsung success story of Cuba.

Economic and social reforms combined with a highly effective public health system led to dramatic improvements in the quality of life in Cuba. Today Cuba has one of the lowest mortality rates in Latin America, a life expectancy only two years less than

that of the United States, and high employment and adult literacy rates. Income differentials are modest and women are much more emancipated than in many other Latin American countries. The Cuban family code legislation even specifies that men should share equally in household tasks. Cuba stands out as an example of how equality can affect fertility without ever once having a population control campaign. Instead, family planning services are freely available to all who want them, through the health system.

### **2.5.2 The social approach to health**

The recognition that other factors in the social arena affect health can be tracked as far back as the 19th century from the founding fathers of modern public health (Keleher 2001; CSDH 2005). The founding fathers of modern public health established and argued that there was a relationship between social position, living conditions and the health outcomes (CSDH 2005). It was against this observation that the earlier constitution of WHO, drafted in 1946 and famously known for its current definition of health, approached health from a social model (Keleher 2001). The CSDH (2005) sums up that the WHO constitution drafted in 1946 and launched in 1948 embraced the following as requirements for achieving progress in health:

- the promotion of improvements in nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; and
- The integration of biomedical/technological and social approaches as supportive to the cause.

The WHO constitution provided space for a social model linked to broad human rights commitments, asserts the CSDH (2005). The vision of WHO was hampered by several historical developments, including promoting an approach that was based on health technologies characterised by major drug research breakthroughs which produced new antibiotics, vaccines and other medicines (CSDH 2005; Mahler 2008). Such historical developments instilled in the minds of the people the idea that health problems would be resolved by technological means (CSDH 2005). By the mid-60s, it was clear to many parts of the world that the dominant medical and public health

models were not meeting the health needs of the socially excluded populations, including women and children (Mahler 2008). The local communities and health care workers in the developing countries began searching for an alternative means to the vertical disease campaigns with their emphasis on urban-based curative care (Mahler 2008). A concern for the social, economic and political dimensions of health emerged (CSDH 2005; Mahler 2008). New concepts such as the empowerment of the people and health promotion emerged and were received as tools for the disadvantaged people to conduct community diagnosis of their health problems, followed by an analysis of the causality factors and planning for the solutions (CSDH 2005). The community-based health programmes (CBHP) grew into movements linking health, social justice and the human rights agenda in several countries including South Africa, Central America and the Philippines (CSDH 2005; Mahler 2008).

By the 1970s, the community-based approaches had gained cumulative authority and acquired an international profile, while awareness was growing that technologically driven approaches to health care had failed to improve the health of the population in many developing countries (WHO 2005). The WHO began publishing documents which outlined success stories from a series of community-based health initiatives in Africa, Asia and Latin America titled 'health by the people' (WHO 2005). These publications demonstrated that many common causes of health problems were from the society itself and could be resolved by inter-sectorial approaches (WHO 2005).

As the Director General of WHO in 1973, Mahler was also convinced that the vertical disease campaigns were incapable of resolving the most important health problems suffered by the poor and the marginalised people (Mahler 2008). Mahler was equally convinced that an excessive focus on advanced curative technologies was distorting many developing countries' health systems (Mahler 2008).

At the 1976 World Health Assembly, Mahler proposed action to address non-medical determinants in order to overcome health inequalities and achieve 'Health for All' by the year 2000 (Mahler 2008). It was against this background that in 1978, the WHO and UNICEF co-sponsored the International Conference on Primary

Health Care at Alma-Ata – a conference that became a milestone in public health (CSDH 2005). The Alma-Ata PHC model provided health services but also addressed the underlying social, economic and political causes of poor health (Mahler 2008). This marked a re-emergence of social determinants as a major public health concern. Hence, the PHC included among its pillars inter-sectorial action to address other health determinants beyond the health sector (Mahler 2008).

### **2.5.3 Primary health care**

Primary health care is derived from the social model of health and at its core, it is a strategy of public health (Keleher 2001). The PHC recognises that only a comprehensive primary health care approach will actually improve the quality of life and health outcomes of the people in any society. According to WHO (1978), the PHC must be modified to suit the differing needs of the population groups. The WHO further recommends that if we are serious about overcoming health disparities in our society, such modification should not be at the expense of a comprehensive PHC approach.

If some sort of active assistance is sought and drawn from the biomedical model, it is evident that the comprehensive PHC sphere of activity extends much more broadly and with different intent to primary care, which is commonly considered to be a client's first point of entry into the health system. Unlike primary care practitioners, the PHC practitioners work from a social model of health which is partly based on the understanding that in order for a health gain to occur, people's basic needs must first be met. These include shelter, support, sanitation, housing, safety from violence and reliable, affordable food supplies. In 1984, the WHO suggested that, in addition to basic provisions, the essential PHC package should include maternal and child health care, community-based affordable medical care, the provision of essential medicines and immunisation. In that sense primary health care is linked to primary care (WHO 1984).

At the heart of PHC is health promotion, which is an important ingredient of this powerful strategy (Weisman 2000). When conducted from PHC foundations, health



promotion is as transformative as PHC and like PHC, health promotion is a strategy of public health. Health promotion is at the health gain end of the continuum, sharing the social justice and equity principles of PHC, because both aim to create an enduring social change. The PHC and health promotion seek far-reaching solutions to problems that defy biological, genetic or biochemical solutions; problems that demand new thinking, innovative approaches and values, one of which is universal access (Mittelmark 2000). In other words, because PHC and health promotion are integral to public health, the two should be provided universally in order to meet the objectives of accessibility and affordability. Services of such a nature should not have financial imposts through consumer co-payments because those who are most in need of PHC are least likely to access services for which cash payments are required.

Characteristically, PHC seeks to change the social, political, environmental and economic determinants of illness in order to create better health. The range of social determinants of health incorporate inter-related circumstances of poverty, wealth and income distribution, psycho-social deprivation, discrimination such as sexism and racism, powerlessness, factors related to gender, age, race and ethnicity, socio-ecological environments, literacy and health service utilisation. The WHO's blueprint for Primary Health Care (WHO 1978) is therefore a comprehensive PHC approach that addresses a whole range of social and environmental factors that cause ill health as well as those that create and sustain good health.

**The principles of PHC include:**

- Equity on the basis of need,
- Affordable access to needed services,
- The sustainability of PHC services, and
- Empowerment of people alongside efforts to help them to be more self-determining.

In other words, a PHC service operates on social justice principles. A systems approach is paramount to PHC, whose practitioners are committed to the building of skills in individual clients and in communities in order to develop their capacity for

self-determination (WHO 1986). It is these principles which distinguish comprehensive PHC from primary care.

### **Primary Health Care versus Primary Care**

The comprehensive PHC is different from the primary care, which is currently being practised in most parts of the developing world and which is consistent with the health care reforms contributing to the objectives of health system costs containment (Keleher 2001). Primary care compared to PHC is drawn from a biomedical model of health care and it is targeting individuals for change rather than the social and environmental surroundings that underlie the diseases (Keleher 2001).

Wass (2000) states that primary care is oriented towards disease prevention which can be at primary, secondary or tertiary levels. Prevention of illness at primary level is concerned with lessening the health risks through health education; secondary-level prevention is about early treatment of disease to minimise complications; and tertiary-level disease prevention is concerned with rehabilitation (Wass 2000).

The WHO warns that the comprehensive PHC approach demonstrates a commitment to on-going action or advocacy to deal with the causal circumstances of the relentless health problems presenting (CSDH 2005). By the same token, WHO further affirms that no one sector can deal with all the social determinants of health, thus integrated and inter-sectorial mechanisms are required for effective and efficient implementation of the PHC approach. It is also very important to recognise that the PHC requires participation of those mostly affected by the problem, and health worker accountability for that participation (WHO 1978). Indeed, health requires a whole range of government efforts, not just those of the health system (Keleher 2001).

#### **2.5.4 Empowerment of women**

The contextualisation of women's health as well as maternal and child's health in terms of poverty, quality of life, and overall empowerment of women, remains crucial. Empowerment of women should, however, be within the overall framework on the

social determinants of health, so that the underlying structural determinants of reproductive health and the socio-economic position of women are also addressed (WHO 2009). Consistent with the principles of PHC, the Commission on Social Determinants of Health points out that action on social determinants of health empowers people, including women, communities and countries. Empowerment in turn is a powerful route to changing both the social structure and conditions of the people and it is through such changes that people are empowered (WHO 2009). The success of the Kerala model was due to the unusual position of women in the society, where an important social caste which was matrilineal and matri-local demonstrated that empowered women can transform the society to make a better place for them to live in. The position of women in Kerala ensured that when health and education expenditures were made, women were not excluded, either as workers or recipients. Their roles as agents of change made it possible for the society to absorb health and education expenditures more effectively (Wuyts *et al.* 1997:263; Drèze & Sen 2002).

Women participation in public health matters and taking responsibility for meeting the routine health needs in the state of Kerala helped reduce the rates of infant and maternal mortality, in addition to providing preventive and curative care (Wuyts *et al.* 1997:273; Drèze & Sen 2002). The society and government ensured that girls become literate and that had a direct impact on their own health. Public awareness in Kerala became one of the instruments that improved the performance of the health system through accountability, enforced by the women at grassroots level. Public awareness further contributed to broadening and democratising the definition of social needs for all people including women and children in the region, thus enforcing accountability (Wuyts *et al.* 1997:275; Drèze & Sen 2002).

Some studies link education of women with health outcomes, as demonstrated in a study conducted in Tanzania, where women with lack of education and information about birth control, became pregnant too young to give birth safely. In such a situation, husbands and in-laws may decide where a woman gives birth and often insist that she stays at home to save money (Grady 2009). The significant others, for example, chiefs, relatives, heads of households and so on, can exercise decision-making power that exceeds that of the individual woman or couple, as noted in

Nigeria, among the Ubang people (Izugbara 2008). The culture of the Ubang, notes Izugbara (2008), dictates that when the community gives out a woman's body in marriage, only one right is being transferred to the community of her in-laws, the reproductive right (the right to her 'underneath'). This is to link the children borne out of the union with their patri-lineage and to determine how and where the woman gives birth to her children, and the care advanced to the mother-baby pair (Izugbara 2008:159-167). Malnutrition, stunted growth, malaria and other infections, anaemia and closely spaced pregnancies all add to the risks for both the mother and her infant (Grady 2009). WHO (2009) highlights that in El Salvador, if mothers have no education, their babies have 100 chances in 1,000 per live births of dying in the first year of life, whereas infant death rate for mothers who have at least secondary education is a quarter of that (World Bank 2006, quoted in WHO 2009).

Grady (2009) notes the following prevailing factors in the rural areas of Tanzania: income levels are often too low and professional health care is unaffordable; many women use traditional birth attendants (TBAs) instead of going to the hospital; the attendants usually have no formal training in medicine or midwifery, and doctors blame them for high rates of maternal death and complications, saying they let labour go on for too long, cannot treat complications and fail to recognise emergencies that demand hospital care. However, many women are loyal to these TBAs due to their affordable services (Grady 2009). Around Berega, they charge about US\$2 (or R16.00) per birth. A normal birth at the hospital costs about \$6 or R48.00 and an emergency Caesarean US \$15 or R120.00 (Grady 2009).

According to Martens (2009), women have been instrumental in the PHC through village health workers who are TBAs. The PHC programmes have helped reduce high rates of maternal and child mortality and birth-related diseases by providing TBAs with access to PHC facilities and training, providing mothers with prenatal care and by promoting simple hygiene measures (Martens 2009). Martens (2009) points to the family disparities as a result of social and cultural bias, referring to the preference for sons, leading to the daughters being given less food, girl children being expected to do more work and have less access to education and medical care than boys. Consequently, the girls become ill-prepared to marry and bear children. They bear children before they are physically, psychologically and

financially equipped to take on the responsibility. This leads to a vicious cycle of malnutrition, where underweight mothers have underweight babies who are at the risk of suffering from nutritional and educational deprivations (Martens 2009). While the WHO constitution (quoted in Van Geluk 2005:5) states that '*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition*', the WHO still has to recognise that a major obstacle to enjoying the right to health is being born female.

In addition to increased access to health care programmes and health education, empowerment through increased access to finance increases women's responsibility in prevention illness. A study conducted in 14 (fourteen) countries in Africa, Latin America and Asia on women empowerment through participation in microfinance institutions investigated the dimension of women's sexual and reproductive health and the extent of empowerment (UNFPA 2010b). Amongst others, the study found that the use of male condom and female sterilisation were higher among those who participated in microfinance institutions than the non-participants. Table 2.2 below further reflects that education and awareness on HIV/AIDS issues influenced safer practices related to prevention of the spread of HIV/AIDS among participants and non-participants.

Table 2.2 indicates that women who had exposure to HIV/AIDS education services were likely to perform better than those without HIV/AIDS education services in all five components of awareness on ways of prevention of contracting HIV/AIDS. The study concluded that empowerment and sexual and reproductive health should be intertwined to bring about different outcomes (UNFPA 2010).

**Table 2.2: The effect of education on HIV/AIDS awareness among the women who participated in microfinance institutions in fourteen (14) countries in Africa, Latin America and Asia**

Ways to become infected with HIV/AIDS	HIV /AIDS awareness among the women who participated in microfinance institution in percentages (%)	
	Women without HIV/AIDS education services	Women with HIV/AIDS education services
Through unprotected sex with HIV/AIDS –positive person	89	95
Increased mother to child transmission (MTCT) of HI virus to infants born to HIV-positive mothers	85	91
By sharing needles and syringes with HIV-positive persons	89	95
From HIV-contaminated blood supplies	89	94
Awareness of all four ways of contracting HIV/AIDS	79	86

**Source:** (UNFPA 2010b)

### 2.5.5 Maternal and child health and family planning programmes

Policies for provision of reproductive health care in developing countries have been implemented through Maternal and Child Health (MCH) programmes and Population Development Programmes (PDP) that were operating through Family Planning (FP) units, each with its vision, goals and strategies. The common components of MCH programmes in developing countries are prenatal screening, immunisation of babies, weighing of babies to monitor their growth, encouraging women to breastfeed their babies for ensuring their survival, and six-week post-natal follow-up clinics. The PDP and FP were issuing contraceptives in developing countries with the primary aim of reducing fertility. However, the decrease in fertility should occur through a woman's choice and not through coercive population policies. De Pinho (1998:14) feels that *'any factor which decreases fertility should decrease maternal morbidity and mortality by decreasing the number of clandestine abortions where pregnancy was mistimed or unplanned'*. Accordingly, McCarthy and Maine (1992) assert that maternal, neonatal and child morbidity and mortality could be prevented if women with high parities, the youngest and oldest childbearing ages, were to avoid falling pregnant.

To reduce the risk of maternal, neonatal and child morbidity and mortality at service level, the demand and supply sides should be strengthened by quality and access, especially at the provider-client interface. If services are to be effective, on the demand side the MCH programmes should aim at improving and optimising health care delivery by ensuring that health workers have the requisite skills along with appropriate equipment, drugs and supplies at all levels of care. In prenatal services, pregnant women should be screened and supervised by trained staff to identify those at risk. Referral and emergency facilities have to be strengthened in respect of trained staff, appropriate equipment, alarm system and transport. The home-based supervised maternity structures, adequate prenatal, delivery and post-natal facilities, appropriate technology and well-equipped dispensaries could improve maternal, neonatal and child health provision, thus reducing the risk of reproductive morbidity and mortality (Caribbean Association for Feminist Research and Action 1998; Maine & Rosenfield 1999).

The quality of the relationship between the provider and the client is equally vital to the quality of care, which in turn should be given by a motivated worker. Aitken and Reichenbach (1994) note that the quality of client relations depends not only on the frequency of contact but also on the attitude of the health workers. Both these require that health workers have acceptable living conditions, an appropriate workload, adequate training, realistic work targets and supportive supervision (Aitken & Reichenbach 1994). In the same vein, the health workers must be technically connected in a well-functioning health system at three levels, namely the community, the health centre and the referral centre. The supply side should be dominated by the bulk of the reproductive health services which are community-based, for example, awareness programmes, communication for development, prenatal care, low-risk deliveries and recognition and referral of complications. Referral and supportive services are also essential for facilitating services that must be provided at more sophisticated facilities. The health centre based in the community is usually the first professional level and is a critical, pivotal point for women who might have difficulties in travelling to hospitals as a result of physical, economic or social barriers. To reduce the maternal, neonatal and child morbidity and mortality, public policy should adopt the following strategies:

- seek political commitment for reallocation of resources for making possible the implementation of plans for reducing the risk of reproductive morbidity and mortality;
- embark on partnership with the private sector and other government departments;
- adopt a woman-centred approach and involve women in all efforts directed towards improving their reproductive health care through women representatives such as non-governmental organisations (NGOs) and women organisations; and
- Strengthen information, education and communication programmes for educating people about the prevention of unwanted pregnancy and the spread of HIV/AIDS and other sexually transmitted diseases.

The Population Programmes implemented in the 1980s had a major goal of reducing the fertility rate in most developing countries. Justification for such policies is that they should be designed by governments to ensure a balance between population and resources (Ahlburg, Kelley & Mason 1996). In the study on the impact of population growth and well-being in developing countries, Montgomery and Lloyd explored the link between population growth and maternal and child mortality rates, and concluded that high fertility rates affect the health and survival of women and children (Ahlburg *et al.* 1996). According to the United Nations (2008), meeting the unmet needs for contraception alone would reduce up to a third of maternal deaths globally. Fewer pregnancies and better spacing of births increase the survival rate of both women and their children. Girls aged 15-20 are twice as likely to die during childbirth as those in their twenties, while girls under the age of 15 are five times as likely to die during childbirth. The United Nations (2008) further warns that achieving the MDG 5 target of universal access to reproductive health remains a distant dream in many countries, and this includes South Africa.

Recently (in 2009), the United Nations Commission on Population and Development met to underline the ICPD's contributions to the MDGs, and declared that the full implementation of the ICPD Programme of Action has a direct impact on the ability to achieve the MDGs linked to health, social and economic outcomes in the areas of children, mothers, HIV/AIDS, gender, poverty and employment (United Nations



2009b). The meeting maintained that in the context of population and development, the MDG targets that were aimed at reducing by half the proportion of people living in poverty by 2015, and achieving significant improvement in the lives of at least 100 million slum dwellers by 2020, are even more significant (United Nations 2009b).

The FP's role in poverty reduction was quantified by an Assistant Director of the Population Division of the United Nations, Philip Guest, who held that the demographic change alone accounted for a 14% reduction in poverty levels in the developing world during 1960-2000, and could produce an additional 14% reduction during 2000-2015 (United Nations 2009b). The improvement of FP programmes include expanding contraception to all sectors of the community through strengthening community-based FP clinics; better management of STDs and HIV/AIDS; and networking with other sectors of the community like NGOs to make contraceptive services accessible (Maine, Rosenfield & Wallace 1987). Within South Africa, population control took place mainly through two programmes, namely the FP, set up in 1974 with an explicit aim of lowering the fertility of the black South Africans, and the PDP, introduced in 1984 (Klugman 1994). The PDP also had an explicit demographic target of reducing the total fertility rate (TFR) to two children per woman by the year 2010. The PDP was operating through population Information Education Communication (IEC) programmes, which targeted individuals and groups with expected high levels of fertility, with no regard to ensuring their reproductive health.

Guided by the International Conference on Population and Development (ICPD) held in 1994, which marked a critical shift in the population programs, in 1998 the South African government developed a Population Policy for South Africa to provide the necessary guidance and framework for the promotion and implementation of reproductive health programs, plans and activities (South African Department of Welfare 1998). In 2008 a review of the implementation of the 1998 Population Policy since the inception was undertaken and highlighted that sexual and reproductive health conditions have worsened in the last decade, mainly due to the HIV and AIDS epidemic (DSD 2009). The 2008 Population Policy + 10-year Review highlighted further reiterated one of the Population Policy's strategies to meet reproductive health needs as *"improving the quality, accessibility, availability and affordability of*

*primary health care services, including reproductive health and health promotion services (such as family planning), to the entire population in order to reduce mortality and unwanted pregnancies, with a special focus on disadvantaged groups, currently underserved areas, and adolescents; and eliminating disparities in the provision of such services”* (South African Department of Welfare in South African Department of Social Development 2009:11).

The 1994 ICPD PoA had identified reproductive health concept as more comprehensive and effective than maternal and child health and family planning, thus representing a paradigm shift (United Nations 1994). Through the population policy for South Africa, the 1994 ICPD PoA facilitated a critical and specific shift from a focus from population control to quality of care in the proposed integrated reproductive health units, empowerment of women, involvement of men in reproductive health and the need for both men and women to make informed reproductive decisions (South African Department of Welfare 1998; Cooper, Morroni, Orner, Moodley, Harries, Cullingworth *et al.* 2004; South African Department of Social Development 2009).

The revised laws that affect women’s reproductive health rights and adopt a woman-centred health perspective, such as legalising and making abortion services safe and freely available, may improve access to contraception and effective reproductive health care. Any effort in this regard needs to be published widely so that women are relieved from problems related to reproduction and sexuality (Caribbean Association for Feminist Research and Action 1998; IPPF 2008). However, extensive reforms should be preceded by a radical change in the economic and social structure itself in order to improve the status of women and consequently their health (Zaidi 1996; CSDH 2005). The UN Commission on Population and Development alluded to the fact that there are currently about two hundred million (200,000,000) women in the developing world with an unmet need for effective contraception, and the highest unmet need is in Africa (United Nations 2009b). The meeting concluded that the time to re-energise a voluntary family planning is now; however, this has to be backed by financial support. The meeting expressed a concern that funding for reproductive health and family planning was below target and mentioned that the developing nations asked donors to increase financial and technical support.

The Executive Director of the United Nations Fund for Population Activities (UNFPA) warned that poor resources and low funding for international family planning threatens to derail efforts to achieve the MDGs, and especially the target under MDG5 on universal access to reproductive health. The Executive Director of UNFPA further said that *'donor assistance for family planning, as a percentage of all population assistance, has decreased from 55 percent in 1995, totalling \$723 million, to a mere 5 percent in 2007, totalling only \$338 million'* (UNFPA 2009).

## **2.6 A CRITICAL OVERVIEW OF MCH/FP SERVICES**

While studies in Kerala (a state in India), Mongolia and Cuba report a relationship between reduced rates of maternal, neonatal and child morbidity and mortality and policies that were introduced, it is not necessarily so in Africa. For example, Botswana and Zimbabwe, countries that are hailed by literature as having had impressive gains in providing good health care to their citizens in the past, also report high maternal, neonatal and child mortality rates, as do other countries in Africa. Maine (1998) suggests that the causes of high reproductive deaths in the two countries reflect the same pattern, that is, the haemorrhage-infection-toxaemia triad, reflecting that the root causes of such deaths are the same and are yet to be removed. Maine (1988) further argues that continuing implementing variations on the same MCH/FP programmes hoping that maternal and the associated neonatal deaths will decline, is false. None of the two programmes address more fundamental questions for reducing the risk of maternal morbidity and mortality, such as women's lack of control over economic resources; discrimination against girls; women's non-access to food and health care; male dominance in sexual relations and non-responsibility in reproductive matters; women's lack of control over their sexuality; the gender division of labour; and the denial by many societies of women's right to determine the number of children they want. These issues are linked to women's health and their social position, and are not necessarily affected by reduced birth rates or improvements in women's physical health. Furthermore, according to the WHO (2009), the experience in giving birth shows that women giving birth in poorer countries have maternal mortality ratios that exceed 500 per 100,000 live births, while in richer countries such as Sweden, the maternal mortality ratio is 2 per 100,

000. Based on this argument, the researcher supports the view that poor maternal health outcomes cannot be treated in isolation of the social, political and economic context in which they occur. This problem should be seen as a consequence of interrelated and interdependent factors including the powerlessness of women, and will need vigorous policies and programmes to address it. Thus, the researcher will need to analyse how context leads to maternal and neonatal morbidity and mortality, and how it should be taken into account in models to reduce reproductive morbidity and mortality in South Africa.

## **2.7 WOMEN'S PERSPECTIVES AND DEMANDS**

Birth control methods and activities in developing countries, including sub-Saharan Africa, were shifted from the field of Population Development to Primary Health Care, following the concern that the design of policies for reproductive health care should be shaped by a concern for quality care and not the demographic objectives. These concerns were raised by women's health movements, who argued that if fertility reduction is the primary goal in family planning units, quality care tends to be neglected and the risks of reproductive morbidity and mortality increase (Garcia-Moreno & Claro, in Sen *et al.* 1994:47). The panel on reproductive health in developing countries at the ICPD held in 1994 concluded that a reproductive health policy should aim at achieving the following goals: that every sex act should be free of coercion and infection; every pregnancy should be intended; and every birth should be healthy (Tsui, Wasserheit & Haaga 1997:1).

Following the ICPD, the WHO promoted the concept of reproductive health care in the context of Primary Health Care at its workshop on reproductive health in Southern Africa (Hall 1997). Amongst others, the workshop recommended that countries:

- Embrace a gender perspective as a fundamental underlying aspect of a reproductive health care approach;
- Review existing programmes and services which address reproductive health concerns from a broad reproductive and sexual health perspective, then identify gaps and duplications and propose the necessary change.

When commemorating the International Day of Action for Women's Health in May 1998 with the theme 'quality reproductive health', a Call for Action proposed, amongst others, the collection and analysis of gender-specific data in order to plan, monitor and evaluate health and development policies and programmes. The international agencies were warned against turning health and health care into commodities to be purchased (Caribbean Association for Feminist Research and Action 1998). Models and policies that embrace this call could reduce risky situations to women's health.

To ensure the implementation of a policy that ensures the achievement of reproductive goals, a framework that assesses the quality of care in reproductive health units was developed by Bruce (1990) with the following elements:

- Choice of methods: This refers to the range of contraceptives that the provider is in possession of for all clients, regardless of class, race, gender, locality or age.
- Information given: This element of quality of care includes the information that should be given to the client regarding what is available in terms of different types of contraceptives, how each prevents pregnancy, and the side effects of each method. Clients should also be educated about the physiology of their bodies, for example, the menstrual cycle as well as how the hormones work.
- Technical competence: At the heart of programme performance are the skills and competence of staff. The reproductive health care staff needs to be sufficiently trained on how each method works although each method could treat clients differently.
- Interpersonal relations: Quality of care is affected by, amongst other things, the interaction between the service provider and the client. The relations between the provider and the client are strongly influenced by a programme's mission and ideology, management style, resource allocation and the ratio of workers to clients. Rapport, trust and confidence, if well established between the provider and the client, will avoid premature female mortality arising from

illicit abortions, because clients will be willing to come back for the means to prevent unwanted pregnancy.

- Follow-up and continuity of care: The service should aim at ensuring continued care after the first and subsequent visits.
- Appropriate constellation of services: The adequacy of appropriate constellation of services is mostly conditioned by context. The possibility for the constellation of services will be determined by the client's needs and availability of resources, backed up by a theory that influences the policy. An expansion of constellation of services would include integration of conventional MCH services and Family Planning services that promote the use of barrier methods, and also offer services such as diagnosing and treating infertility, preventing and treating sexually transmitted diseases, including HIV/AIDS, and early detection of cancer. Such services are expected to be provided if the programme aims at reducing high rates of women morbidity and mortality rather than fertility only.

In a study done in the rural households of Transkei in South Africa, reproductive malnutrition was identified as a consequence of a traditional practice in home situations where women and young girls eat last after everybody else has eaten (Klugman & Weiner 1992:2). Adverse consequences of always eating last after everybody has eaten become evident during pregnancy, delivery or the post-natal period as women's bodies are already weakened by prolonged under-nourishment. Malnutrition predisposes women to poor resistance to prolonged morbidity and anaemia. The latter increases the women's mortality risk, both directly and indirectly through post-partum haemorrhage (WHO 2003).

Klugman and Weiner (1992) found that reproductive morbidity and mortality was also associated with the gender division of labour, whereby excessive manual work and lack of rest exposed women to risky situations, in a study conducted in the rural areas of South Africa. Rural black women work strenuously for longer periods compared to their urban counterparts, and are continuously overburdened with

domestic chores such as collecting heavy loads of water from wells and firewood for fuel, usually walking distances far from their homes. Over and above those factors, which to a large extent weaken their bodies, they are engaged in child care, cleaning, cooking, and giving emotional and physical support to the children (Klugman & Weiner 1992:11). Traditional expectations are that they should continue to perform these production and reproduction roles even during the ante- and post-partum periods, subjecting them to the risk of reproductive morbidity and mortality. However, this does not mean that urban black women are not overworked. For example, Klugman and Weiner (1992:14) found that the majority of urban women worked for between 16 and 18 hours a day.

The risk of reproductive morbidity and mortality is associated with home deliveries as a result of lack of transport to the health care facilities which are at a distance in the squatter settlements, townships and other rural areas of South Africa. The North West Province assessment report by the Reproductive Health Transformation project reflected that 81% of clinics did not have acceptable transport for emergencies and subjected women and their neonates to all sorts of risks, including delivery by unskilled people (Budlender 1997).

Limited access or low use of health care services and consequent high reproductive morbidity and mortality ratios have also been associated with poor interpersonal relations and attitudes of the health workers (Budlender 1997). Women come into contact with unsympathetic and insensitive health care providers in health care centres. The negative attitude is mainly experienced by the poor, rural and black women in South Africa, while the elite black and white women are served well. Attitudes impact on quality health care. The problem is that services are target oriented, rather than quality care oriented.

The next chapter discusses the methodology for collecting and analysing data for this study.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 THE RESEARCH DESIGN**

As was mentioned above, this study is based on the premise that mothers and children eventually die due to accumulation and prolonged exposure to risk factors. The social and economic circumstances of women, deemed in this study to be the root of their health status, operate independently on more than one intermediate variable that influences the risk of maternal, neonatal and child morbidity and mortality. The effectiveness of a model which intends to achieve a significant reduction in maternal and child mortality will therefore depend on the extent to which it addresses the root or 'the causes of causes' of the problem.

The study is based on analysing the existing models, with the intention to extend these models (see Figure 3.1 below). The aim was to build a model that lists the structural and intermediary/social determinants (deemed to be non-proximate variables) and the direct factors (deemed to be proximate determinants) of the female reproductive health outcomes. The model developed through the analysis of data collected via the chosen research design should offer a constellation of factors that could point the way to possible solutions to reduce the consistently high rates of maternal and child mortality in South Africa.

The multi-stage qualitative study design was found to be appropriate for the present study. The chosen design demonstrated the ability to analyse the complex issues under study, namely, the inter-relationship between female reproductive health, the socio-economic background of women and the risk of maternal, neonatal and child morbidity and mortality.

The envisaged model should be populated with qualitative data that had been collected from the individual in-depth interviews from the 'women at risk', the



significant others of mothers and new born babies who have died from the verbal autopsies, the national experts working in the area of reproductive health at a national level, and the NGOs working in the area of reproductive health in KwaZulu-Natal, iLembe district. Therefore, using a multi-stage qualitative research design, data collection began with face-to-face interviews with the 'women at risk', followed by the verbal autopsies whereby face-to-face interviews were held with the significant others of women and new born babies who have passed on recently (in the last two years). Face-to-face interviews were further conducted with representatives from the local NGOs working in the area of reproductive health in iLembe district, KwaZulu-Natal province. The three mentioned phases were conducted in KwaZulu-Natal province. The face-to-face interviews were concluded by interviewing experts working in the area of reproductive health at the national level. The interviews with the national experts were conducted mostly in Gauteng province; of the six (6) experts interviewed, only one (1) was based and interviewed in KwaZulu-Natal. Data generation further included studying and analysing secondary sources on female reproductive health in South Africa. The findings from all the sources were integrated and conclusions drawn to inform the prospective model.

### **3.2 MULTI-STAGE QUALITATIVE DATA GENERATION**

Qualitative data generation strategies were included in the design in order to gauge insights into the root, paths, causes and any other factors leading to women's vulnerability. The women's perspectives were particularly sourced in order to better understand the depth and breadth of reproductive health issues as a lived experience within the context of family, community and the broader society. Similarly, women's perspectives were necessary to listen to their views on the health services offered to match their health needs and ultimately improve the quality of their lives.

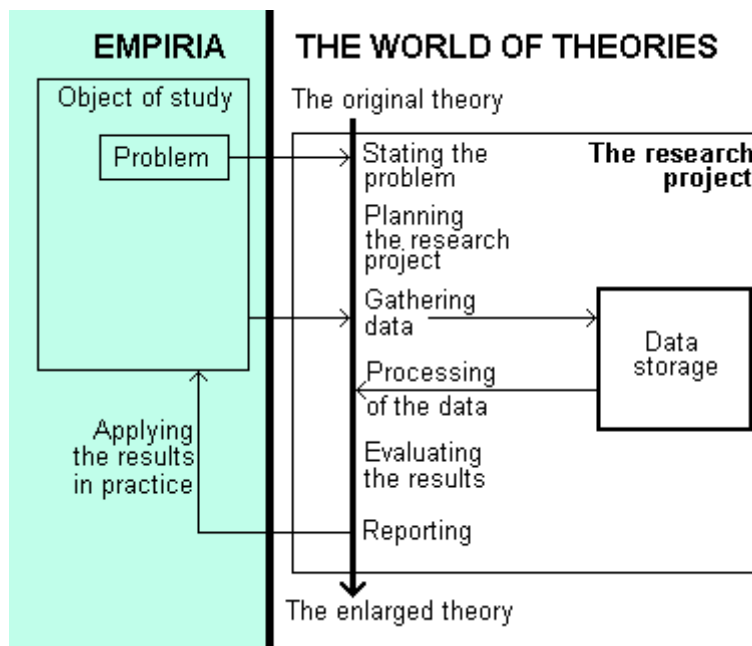
Further qualitative data gathering included qualitative verbal autopsies conducted, by:

- interviewing a relative or the 'significant others' of women of reproductive age who have passed away recently (in the last two years)

while pregnant, giving birth or in the post-natal period, both within and outside public health institutions; and

- interviewing the significant others of a new-born that has died in the last two (2) years; this included the mother of a new-born that had died or a caregiver of a new-born that died following a mother's death.

**Figure 3.1: Depiction of the research orientation**



Source: (Routio 2007)

Additional insights were gained by interviewing experts in the field of health service delivery to women and representatives of community-based organisations (CBOs) or non-governmental organisations (NGOs) that deliver health care services to women. The experts and the NGOs supplied the necessary information that could best assist in elucidating the results.

The interviews for generating qualitative data were conducted face-to-face during January and February 2011. The face-to-face interviews with the women 'at risk' of reproductive ill health were conducted from one of the public hospitals at iLembe district and the verbal autopsies with the significant others were conducted in the villages of iLembe district. The face-to-face interviews with the representatives of the

non-governmental organisations (NGOs) providing reproductive health services were held at iLembe district KwaZulu-Natal, while the interviews with the experts in the field of reproductive health were held nationally and provincially in their offices.

### **3.2.1 Selection of interviewees for face-to-face interviews**

Different strategies were followed to identify and recruit interviewees for the qualitative data generation. These strategies are discussed below.

#### **3.2.1.1 Selection of women at risk for face-to-face interviews**

Inclusion criteria for the women in the 'at risk' categories were that they had to be black, reside in a rural area in South Africa, and be dependent on public health care. In addition, two interviewees fitting each of the following criteria were recruited for volunteer participation in the study and individual face-to-face interviews were conducted with them:

- Teenagers (that is, women younger than 18 years) who were pregnant or had given birth to live children in the last two years;
- Women at the lower end of the reproductive age group who were pregnant, that is, pregnant women who are 35 years or older;
- Women with very closely spaced births, in other words, women between the ages of 18 and 35 years who have had live births (excluding multiple births) spaced 24 months or less over their lifetimes;
- High-parity women, that is, women who have had five or more live births over their lifetime; and
- HIV-positive women in their reproductive age (that is women aged 15 to 49 years with a known HIV-positive diagnosis).

A volunteer sample of 10 women 'at risk' was recruited from Stanger Hospital in the iLembe district of KwaZulu-Natal (KZN) Province. Recruitment of volunteer interviewees meeting the 'at risk' inclusion criteria was done in consultation with the Stanger Hospital staff. Stanger Hospital is a public hospital, serving most of the nearby rural communities and the vulnerable groups of women in the surrounding areas. The hospital has various maternal and child-care programmes, which made it possible to collect data to inform the envisaged model.

### **3.2.1.2      *Selection of interviewees for verbal autopsies***

Working through the staff at Stanger Hospital, Primary Health Care centres (PHCCs) and surrounding clinics, and through the staff of the FBOs, CBOs and NGOs included in the study, details of women who had died due to maternal causes and of new-borns who had passed away in their first week of life in the last two years, were sourced. Cases were identified and selected for the study through the registers in the provincial and district departments of health, hospitals, clinics and medical obstetric units (MOUs), health staff members and other records of the PHCCs. The health registers were the main source of information for providing the details of the kin or 'significant others' of the women and children who had died in the last two years as a result of birth-related circumstances.

The staff of the CBOs and NGOs included in the study were exceptionally helpful in assisting the researcher to access the relevant kin or 'significant others' for verbal autopsies in the sparse, mountainous rural iLembe district of KwaZulu-Natal Province. This category has been added in order to establish a relationship between the socio-economic conditions, the health status of women and their reproductive health outcomes.

The next of kin (husband, boyfriend, mother or sister) or significant others of women who died during pregnancy, giving birth or after having given birth were then contacted and asked whether they would participate in the verbal autopsy part of the study to obtain qualitative information about the circumstances and determinants of their deaths. The mothers or caregivers of the new-borns who had died were also recruited for this session of the study.

**Maternal deaths:** A total of three (3) next of kin or significant others for the subcategory of the women who died in the last two years due to a maternal event were interviewed, and a total of two (2) next of kin/significant others for the subcategory of the new-borns who also died in the last two years were interviewed.

Two significant others were selected and interviewed for the first maternal death, a 16-year-old teenager who died post-Caesarean section in December 2010. These were an uncle and a mother of the deceased teenager (however, the interviews were conducted at different places and at different times). An uncle was the first to be called for an interview as he was most accessible. The uncle was working in the Stanger Hospital and was regarded by the hospital staff as a close family member to the deceased teenager, for example, he was the last to speak to the deceased after her Caesarean section, a few hours before her death, and the first to hear the news that the teenager has died, just hours after the incident. The nurses thought he was close to the circumstances around the maternal death of a teenager, hence they advised the researcher to interview him.

The mother of the deceased teenager was second to be interviewed. The researcher felt that she still needed to interview the mother of the teenager so that she (the mother) could provide the details about the social circumstances of the deceased. The mother was the one staying with the teenager, she took the teenager to the hospital and paid her a visit during the day before the teenager was sent for a Caesarean section in the evening and died a few hours later. The mother of the teenager is the one currently taking care of the baby of the deceased.

The significant other of the second maternal death was a sister to the deceased. She was living with the deceased before she (the deceased) moved out to live with a boyfriend in an area close to a health facility, in preparation for the delivery of her baby. After the deceased had delivered the baby in the toilet and was thereafter taken to the clinic by the neighbours, the sister to the deceased rushed to the clinic to accompany the deceased to the hospital for further clinical management, as the condition of the deceased was getting worse. She was the closest family member visiting the deceased at the hospital until her death, and the last to be with the

deceased hours before she died. This particular sister to the deceased was recorded in the hospital registers as her kin, hence she was identified and selected for the study. The sister to the deceased took the baby to their mother who lives in the rural areas of Eastern Cape.

**New born babies' deaths:** The significant others who were interviewed for the two (2) new born deaths included the mother of a new born that had died recently, that is few days before the interview, and the caregiver of a new born that had died a few weeks before the interview. The mother of a deceased new born was interviewed first and the caregiver of a deceased new born was the second to be interviewed.

The first interview for a new born death was conducted telephonically with the mother of the new born that had died recently. The mother of the deceased new born would not allow the researcher to interview her in person at her home as she was not ready yet to interact with any health professional. She was still emotionally very hurt and blamed the negligence of the health professionals for the death of her baby. The new-born had died three days earlier after the mother-baby pair were discharged from the hospital, and was buried the previous day. According to the mother, she delivered herself right in the hospital maternity ward and sustained vaginal injuries. The baby was frothing a bloody substance a day post-delivery and died.

The second interview for a new born death was held with a caregiver of the new born that died in December 2010. The caregiver took custody of the baby immediately after the death of its mother. The mother delivered at Stanger Hospital on the 15th of December 2010, and died on the 16th of December 2010 from HIV/AIDS complications. The caregiver was a site coordinator of Mothers to Mothers (m2m), an NGO working in the area of HIV/AIDS-positive mothers in the iLembe district. She became attached to the mother who was HIV-positive during pregnancy. She (the caregiver) was not staying with the mother nor was she a relative of the mother or of the new born that died. The mother had instructed the boyfriend to put the baby under the care of this particular caregiver if she were to die from HIV/AIDS-related complications, hence the baby was brought to her. The baby later died when it was only 5 days old on the 20<sup>th</sup> of December 2010.

### **3.2.1.3 Selection of interviewees for representatives involved in service provision to women (the representatives of the NGOs)**

The representatives of the FBOs/CBOs/NGOs who are providing services to women in the iLembe district were recruited from the iLembe district, KZN and interviewed. A list of FBOs, CBOs and NGOs that offer services to mothers and children was generated in consultation with the health professional staff of iLembe District Health offices as they were more conversant with the health service providers in the district. From the list, senior staff of Stanger Hospital purposefully identified and selected three (3) CBOs/NGOs, which were subsequently contacted and asked to participate in the study. The criteria for selecting the CBOs/NGOs were that they should be working closely with the Department of Health to complement the services of the government. The researcher and the senior health professional decided to choose one (1) NGO that is providing community HIV/AIDS services to women and children, one (1) that is focusing on PHC-based PMTCT services, and one (1) focusing broadly on community women, maternal, neonatal and child health.

From the list, the following NGOs were found to satisfy the criteria of the study:

- (i) Kheth'impilo (choose life) focusing on rolling out the ARVs to women at community level;
- (ii) Mothers to Mothers (m2m), focusing on PHC and community PMTCT; and
- (iii) Medical Care Development International (MCDI), focusing on the broader issues of rendering community services for the improvement of the health status of the mothers, neonates and children. Each of the identified CBOs/NGOs selected the representatives who were senior members in their organisations to participate in and be interviewed for this study.

#### **3.2.1.4 Selection of interviewees who are experts in the field of reproductive health**

A list of the experts in the field of policy making and health service delivery to women was compiled with the help of the staff from the National Department of Health in December 2010. In addition, available literature about women's health in South Africa was surveyed in order to find the names of experts in the field. From the list, six experts in the field of health service delivery to women were identified and purposefully selected for the study.

In line with the proposal, the intention was to interview only five (5) experts in the field of reproductive health; however, six (6) names of experts were identified and purposefully selected from which to choose five (5), and an extra one (1) was intended to replace whoever might not have made it for the interview. The researcher successfully began the interviews with the first five (5) experts, who all had strong biomedical backgrounds, for example, four (4) experts were clinicians and one (1) was a nurse with public health expertise. The order of the interviews depended very much on the availability of the interviewees. The sixth (6<sup>th</sup>) expert on the list who was not yet interviewed was the only one with a social background particularly on women and reproductive health. It was for this reason that the researcher went ahead to interview her to seek her perspective and valuable contribution for the envisaged social model.

Expertise from the interviewees in this category ranged from public health to reproductive, maternal, neonatal and child health. During the study period the experts occupied the following positions and specialities respectively: the National Cluster Manager for Maternal, Neonatal, Child and Women's health was an obstetrician; the KZN Provincial Director for Maternal, Neonatal and Child Health and HIV/AIDS was a public health specialist; the National Specialist: Child Health was a paediatrician; the National Programme Manager for Child and Youth Health was a nurse with a postgraduate qualification in public health; and the National Chairperson of the Saving Babies Committee was a neonatologist. The sixth expert in women's health and reproductive health was an independent consultant with vast expertise in



women and reproductive health and was working closely with the National Department of Health.

Interviews with the experts were important for this study to gauge their views on how South Africa can further reach the MDGs as far as women, mothers and children are concerned. Specifically, the interviews with the experts aimed at finding out what in their opinion are problems of effective service delivery. The interviews further sourced experts' opinion on measures that have the potential to reduce maternal and new born ill health and mortality.

**Table 3.1: Study population by sub-samples**

<b>Sub-Sample</b>	<b>Main features of the sub-sample</b>
1. Women 'at risk'	<p><b>Teenaged interviewees:</b> women younger than 18 years who had given birth to live children in the last two years and were pregnant</p> <p><b>Interviewees older than 35 years:</b> women at the lower end of the reproductive age group and were pregnant</p> <p><b>Interviewees with closely spaced births:</b> women between the ages of 18 and 35 years who have had live births (excluding multiple births) spaced 24 months or less over their lifetimes and were pregnant</p> <p><b>Interviewees with high parities :</b> women who have had five or more live births over their lifetime and were pregnant</p> <p><b>HIV-positive Interviewees:</b> women who were HIV-positive and pregnant at the time of the study</p>
2. The 'significant others' participating in the verbal autopsies	<p><b>The relevant kin or close relatives of the women</b> who had died in the last two years as a result of birth-related circumstances</p> <p><b>The mother, relevant kin or close relatives of the new-borns</b> who had died in the last two years as a result of birth-related circumstances</p>
3. Representative of the NGOs or CBOs	<b>Representatives of the FBOs/CBOs/NGOs</b> who are providing services to women in the iLembe district, KZN, South Africa
4. Experts in the field of reproductive health	<b>Experts in the field of policy making and health service delivery to women:</b> Expertise ranged from public health to reproductive health and maternal, neonatal, child and women's health

### **3.2.2 The process of interviewing**

A set of questions that reflected the issues to be explored with the various categories of the research participants was formulated by the researcher prior to the study period.

**3.2.2.1 interviewing women 'at risk':** The researcher chose to hold face-to-face discussions with the women 'at risk' to allow her to explore issues in respect of their social backgrounds, the circumstances and the intricate realities of their lives as they affect their reproductive health, and their response to reproductive health policies, models and services. The face-to-face interviews with the women 'at risk' took place at Stanger Hospital, iLembe district, KwaZulu-Natal between the 10<sup>th</sup> and the 14<sup>th</sup> of January 2011.

All supporting documentation was submitted to the chief executive officer (CEO) of Stanger Hospital, who further provided approval to conduct a study. The supporting documentation included the researcher's approved proposal, an ethical clearance for the study by the higher degrees committee of the Department of Sociology, UNISA, application letters for the study to and approvals from the iLembe Health District office,, KwaZulu-Natal Provincial Department of Health and the National Department of Health.

The CEO delegated a matron in charge of the reproductive health units to set up research sites and provide all the assistance and support needed by the researcher. As a point of departure, the researcher was introduced to the professional nurses in charge of the antenatal clinic (ANC), the post-natal clinic (PNC) and the labour wards. The researcher was allocated a research site at the ANC which was quite private and very convenient for the interviews. Having indicated to the professional staff who the sample of my study should consist of, the researcher was advised on the weekly days to visit the ANC, thus finding and interviewing the different categories of women 'at risk'. The researcher was also advised to arrive early at the clinic (between 08h00 and 10h00), as most women arrive at the clinic in the mornings so that they can find transport back home while it is still available. This was quite helpful in terms of maximising the response rate.

The women 'at risk' were identified by the professional nurses as they were queuing up and receiving the services within the reproductive health units. They were then purposefully selected by the researcher to ensure adequate representation. The women 'at risk' were then grouped together, and the outlines of the research and what was required from each one of them were explained. The researcher then invited the volunteering participants for face-to-face interviews in a consultation room that was set up as a research site in the ANC.

Participants were assured of the confidentiality of the discussion before the interview commenced. On average, the discussion lasted for 1-2 hours. After each discussion, the woman would be given information and answers to confirm what they had said. The women had similar backgrounds, i.e. they were black, from rural areas and relatively disadvantaged. The language that was spoken during the interview was isiZulu, the language spoken most widely in the area.

Approximately two (2) – three (3) women were interviewed each day of the five (5) days. By the 14<sup>th</sup> of January, the researcher had successfully interviewed the intended number of the women 'at risk' category. However, this study does not claim that the views, experiences or feelings expressed by the women 'at risk' visiting the reproductive health units at Stanger Hospital during the study period were by any means representative of women of KwaZulu-Natal Province of South Africa. Time and financial constraints failed the researcher to embark on a fully fledged evidence gathering.

**3.2.2.2 Conducting verbal autopsies:** These were conducted during the same period as the interviews with the women 'at risk', that is between the 10<sup>th</sup> and 14<sup>th</sup> January 2011; however, in the afternoons (between 14h00 and 18h00). The verbal autopsies were also conducted in isiZulu. Each interview lasted for about an hour. After identifying the kin or the significant other, either at the hospital or from the nearby PHC or clinic, they were called first to verify their identity and availability, then visited at their homes. The uncle of the teenager who died post-Caesarean section, who was invited for an interview to the research site at the hospital in person because he was working there, and the mother of the new-born that died a few days

before the interviews for this study, who was interviewed telephonically due to the reasons already cited 3.2.1.2 above, were two exceptions.

The mother of the teenager who died post-Caesarean section was called telephonically first to request a face-to-face interview, which she agreed to. She was still emotionally devastated by the death of her daughter and cried before the interview took place. She expressed gratitude that someone from the 'health care profession' showed up and inquired into the circumstances around the teenager's death.

The sister of a woman who had died after delivering the baby in the toilet and was taken to the hospital, where she died after a few days, was called and visited at a far-flung small village in iLembe district. The researcher and her assistant (a staff member of one of the local NGOs) travelled for more than one hour to the area. The area was difficult to reach due to the mountains and rivers which had to be crossed to access the interviewee. On arrival, the interviewee, who was expecting the researcher, was called to the car as driving up the mountain was not possible. The interview took place in the car.

The caregiver of a new-born that also died following the mother's death was visited and interviewed at the m2m site at Shakaskraal Clinic at one of the villages in iLembe district.

**3.2.2.3 Interviewing CBOs/NGOs:** The interviews with the NGOs took place between the 14<sup>th</sup> and the 15<sup>th</sup> of January 2011. The interviews were conducted in English. All three of the NGOs had allocated senior members in their organisations for the interviews in this research study. The interviews with the two (2) NGOs were conducted during office hours, while an interview with one of the NGOs was conducted after hours, the reason being that the senior representative who was allocated for the interview was attending a conference during the week of the interviews.

The three (3) NGOs that were interviewed were the Medical Care Development International (MCDI), Mothers to Mothers (m2m) and Kheth'impilo. The MCDI and

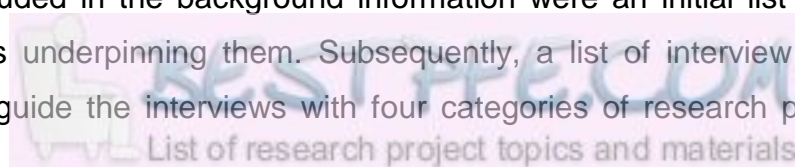
Kheth'impilo provide services for both mothers and children. While the MCDI's focus is on rendering the community health services for maternal, neonatal children and women, Kheth'impilo supports the Department of Health in increasing access to quality services for the management of HIV/AIDS in the primary health care sector. The m2m focuses exclusively on mothers who are HIV-positive at facility level.

The first NGO to be interviewed was the Medical Care Development International (MCDI) representative, who was visited at their offices at Mhlanga. The second NGO to be visited for an interview was m2m. An appointment was set up and a representative was met at one of their nearby sites in iLembe district. The third NGO to be visited and interviewed was Kheth'impilo at one of their sites established at the Kwadukuza Clinic, iLembe district.

**3.2.2.4 Identifying and interviewing the experts:** The identified experts were contacted telephonically and in-person interviews were arranged. All the experts requested the background material before the interview, which the researcher e-mailed with a confirmation for the interview a few days before the interview. Most of the experts were visited and interviewed in their offices in Pretoria (National Department of Health), SOWETO in Johannesburg (Chris Hani Baragwaneth Hospital) and Pietermaritzburg in KwaZulu-Natal (KZN Provincial Department of Health), except for one, who was operating from home; hence she was interviewed at her home in Johannesburg. The interviews with the experts lasted longer due to the difficulties in scheduling the interviews according to their availability. The first expert was interviewed in the first week of January 2010 and the last expert was interviewed in the last week of February 2011.

### **3.2.3 Instrumentation for qualitative data collection**

**3.2.3.1 Developing interview guides:** Following an engagement with existing literature to identify what information was needed for this study and from whom, background information on research questions and data sources were compiled (see Annexure A). Included in the background information were an initial list of themes and the questions underpinning them. Subsequently, a list of interview questions was compiled to guide the interviews with four categories of research participants



who had been identified to provide information for this thesis, namely the women 'at risk' of reproductive ill health, the significant others who were to be interviewed during the verbal autopsies, the experts in the field of reproductive health, and the NGOs providing the services to women. The interview guides for the category of the significant others was divided into two subcategories, that is, those for the women who had died in the past two years and the ones for the new-borns who had died in the past two years. The questions were accordingly grouped into the interview schedules with the categories mentioned above, into appendices as follows: Appendix B as an interview schedule for the experts; Appendix C as an interview schedule for the women 'at risk' of reproductive ill health; Appendix D as an interview schedule for representatives from the NGOs; Appendix E as an interview schedule for kin/a significant other of a woman who had died in the past two years, and Appendix F as an interview schedule for a caregiver or significant other of a new-born who had died in the past two years.

**3.2.3.2 Obtaining consent for participation:** In line with the ethical requirements, the research participants were given an opportunity to choose or to refuse to participate in the research, and to also choose what should and should not happen to them during the interviews, by signing the pre-prepared consent forms which were previously reviewed and cleared by the UNISA Ethics committee.

Copies of the consent forms for the different categories of the research participants have been annexed in this thesis as follows: Annexure G for the experts; Annexure H for the women at risk and the kin or the significant others of women and new-borns who died in the past two (2) years; and Annexure I for the NGOs.

The consent to participate in the study was obtained only after the researcher had disclosed the relevant information to the prospective participants and explained:

- The purpose of the research and the expected duration of the subject's participation;
- Why they were invited to participate;
- Whom to contact for answers to the pertinent questions about the research and the research subjects' rights;

- A statement describing to what extent the records would be kept confidential;
- That they were free to withdraw from the interview at any stage should they wish to;
- What would happen if the participant had decided to withdraw from the research and how the withdrawal would be handled?

The participants were given a copy of the signed document. The signing of the consent form paved the way for the interview to be conducted.

**3.2.3.3 Administration of the research instrument:** For better understanding and information exchange, a data collection tool for the interviews with the women 'at risk' of reproductive ill health and the verbal autopsies with the significant others were translated from English to the local language (isiZulu).

The interviews with the women 'at risk' were preceded by pilot-testing a data collection tool to establish reliability and validity. A pilot test was undertaken by administering the tool to two (2) volunteering interviewees who had categories that were similar to those of the women 'at risk': one (1) was a teenager and one (1) a woman with HIV/AIDS. The tool was adequate in many respects, except that the interviews were quite lengthy, with each interview was taking approximately one (1) hour or more, instead of the planned 20-30 minutes. Not much could be done to revise the tool to shorten the time of the interview, as all questions were very important and could not be eliminated from the tool. A contributing factor to increasing the time for interviewing the women 'at risk' could be that some questions required a thorough explanation or rephrasing the translated version, while others allowed the researcher to probe for more information.

Subsequently a few adjustments were made on the instrument and improvements were made where there were weaknesses and ambiguities. The improved instrument was then used to collect data for the study. The women 'at risk' were asked information about themselves, their babies, their socio-economic circumstances and the services they were receiving.

The cultural issues were taken into consideration when the interview guide for conducting the verbal autopsies was adapted for use in the rural areas of KwaZulu-Natal. The interview schedule for the verbal autopsies was just adequate in terms of the time and the length of the interview. The tool was also clear as the researcher did not need to explain the questions at length. The interviews with the significant others provided information about the circumstances around the death of women and babies who died in the past two years.

The data collection tool for the experts was developed in English and all the interviews were conducted in English. Through a semi-structured interview schedule, the experts were asked about the causes, determinants and the adequacy of the strategies and interventions, and also about a possible course of action to reduce maternal and child deaths. The tool further probed for the experts' perceptions regarding their role and readiness to deliver the services for responding to MDGs 4 and 5. The experts were asked to provide their perspective about the capacity of the health facilities to deliver the services for the women during pregnancy, delivery and post-partum. The experts were prompted to suggest and recommend feasible strategies and activities that would make an impact in improving the life circumstances of women, improving their health status, and thus meeting MDGs 4 and 5.

An interview guide was again used to collect data from the NGOs. The tool was developed in English and the interviews were conducted in English. The NGOs were asked about their services before and after the event of maternal and child deaths.

Over and above recording in the notebook, a recording device (tape recorder) was used to capture information during all the interviews.

### **3.2.4 Factors affecting reproductive health outcomes**

Although the chosen research design was qualitative, the researcher uses the words 'variables' or 'factors' here to refer to those features that make up the explanatory framework of phenomena that affect reproductive health outcomes. Various socio-economic factors affect females during their reproductive years which could have



implications for their survival and the survival of their new-borns. The study assumes that, the poorer the woman's socio-economic conditions, the worse will be the reproductive outcomes. This section lists the socio-economic and demographic variables which will be used as independent variables to predict the dependent variables, namely maternal and child mortality.

#### **3.2.4.1 Explanatory factors**

(a) Socio-economic position: These variables reflect stratification of populations along the lines of income, education, occupation, gender, race/ethnicity, class and other factors. Intermediary determinants are reflective of people's place within social hierarchies, based on their respective social positions and vulnerability to health-compromising conditions.

Conditions under which women live and work as measured by:

- Access to safe water
- Good sanitation
- Electricity
- Efficient waste management systems
- Food availability
- Access to services such as education, health welfare, public transport
- Living environment – urban living versus rural living
- Level of education
- Occupation
- Income

(b) These variables denote gendered differences in social action and include:

- Cultural practices
- Governance
- Action to prevent or treat illness when it occurs
- Decision making on reproductive health or human reproduction
- Contraception availability with more accurate information and services accessible

(c) Reproductive health behaviour at the individual level. These include:

- Age at which woman begins or stops bearing children
- Maternal age younger than twenty (20) or older than thirty five (35) years
- Antenatal clinic attendance
- The interval between births
- Breastfeeding practices
- Parity – total number of live births
- Termination of pregnancy (TOP)
- Marital Status
- Poor outcomes of prior pregnancies
- Nutritional status
- Low weight prior to pregnancy
- Infections (STI or HIV/AIDS)
- Illness during pregnancy
- Delays at household level in deciding to seek appropriate health care

#### **3.2.4.2 Outcome variables**

This section lists the reproductive outcomes. For the purpose of this study, the reproductive health outcomes are mostly influenced and dependent on the socio-economic position of women and are as follows:

- Contracting HIV/AIDS
- Obstetric haemorrhage
- Hypertensive disorders
- Anaemia
- Sepsis
- Intra-partum asphyxia
- Spontaneous pre-term labour
- Hypoxia
- Prematurity
- Stillbirths
- Maternal disability and sickness

- Neonatal disability and sickness
- Maternal mortality
- Neonatal mortality

### **3.3 THE STUDY OF DOCUMENTS**

The literature was studied to gain knowledge of gaps in the South African approaches, models, policies and strategies addressing reproductive health and child health. In particular, the 2008 document by the South African Department of Health titled Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015 (SA DoH 2008e) was scrutinised to find out:

- Whether the Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015 adopts a holistic approach and addresses the empowerment of women through programmes which would strengthen the socio-economic position of women. These are among others, the employment of women, education of the girl child, acceptable standard of life including good nutrition, an increase of women's self-esteem, autonomy and self-determination;
- Whether the Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015 addresses equity and equality in terms of race and class and whether services are gender-sensitive;
- Whether women were involved in the formulation of the Strategic Plan for MNCWH & N in South Africa 2010 – 2015;
- How inter-sectorial collaboration with the private sector, other government departments, civil society, NGOs and women organisations influenced the development of the Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015; and
- Whether the Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015 has the support of politicians.

The Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWH & N) in South Africa 2010 – 2015 was further analysed to find out whether strategies to achieve the desired reproductive outcomes have been clearly elaborated on.

The findings of the 2008 Population Policy + 10-year Review were analysed as they review focused on the state of population development in South Africa over the last ten (10) years. In addition, the recommendations of Progress review of the implementation of White Paper on Population Policy for South Africa (1998) and the ICPD Programme of Action (1994) were studied to check if they shed light on processes for reproductive health. The inclusion of sexual and reproductive health in the population policy of South Africa was informed by the international developments on improving the socio-economic position and the health status of the women. For example, South Africa has been signatory to the Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women (FWCW) in 1995 and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1995. The 2008 Population Policy + 10-year Review of the Population Policy implementation in South Africa hold that:

- Before 1994, women's health services consisted mainly of maternal and child services and family planning (MCH + FP) and that there were no comprehensive reproductive health policies in South Africa (DSD 2009).
- Post 1994, informed by the global trends, the MCH services + FP were broadened to sexual and reproductive health (SRH) and included other aspects of women's health. The importance of including men in SRH was also emphasised (South African DSD 2009).

Informed by the 1995 ICPD and the 1995 FWCW conferences, the Population Policy + 10-year Review of the Population Policy implementation in South Africa made explicit the link between SRH and women's socio-economic status and women's rights (South African DSD 2009).

### 3.4 ISSUES OF RELIABILITY AND VALIDITY

The quality of the data was considered. In particular, the researcher critically analysed and commented on aspects of the research methodology followed, namely the sample size, response rate, questionnaire design, questionnaire administration and modes of analysis.

The research instruments were pilot- tested for validity and reliability. The validity of the questionnaires was ensured through their administration to the pilot participants exactly the same way as they were to be administered to the main research study population as follows: For each of the pilot participants, the identity of the researcher and the reason for the visit were made clear; an informed consent was sourced and the respondent was informed that she had the freedom not to participate in the study or discontinue answering the questions at any stage should she feel like. During the interview the respondents were asked if each question was clear. The feedback from the pilot proved that the questionnaires were conveying the same messages to all the participants.

With regard to coding, validity and reliability were ensured through developing a coding framework from the list of key themes and used to code raw data from the transcripts. The internal validity and reliability of coding data of themes extracted from the interviews and transcripts were tested through consultation with the researcher's supervisor for correctness.

For the assessment of reliability and validity of the qualitative data, the researcher established the credibility and integrity checks for the data generated. The credibility check included taking full background notes on the recruitment and selection of the research participants and data generation, and transcribing the data immediately following its generation. Threats to credibility in terms of distortion, bias or inadequate portrayal of the participants/phenomenon were addressed, for example, separate sessions were held with the nursing professionals to verify some of the responses or to seek clarity on issues without disclosing the names of the participants. The medical records were occasionally used where there were still

doubts on the credibility of information provided. This was done on a daily basis after the interviews with the women 'at risk'. The integrity of the data was safeguarded via reflexive, open inquiry, and critical analysis of all aspects of data generation and data analysis (Whittemore, Chase & Mandle 2001).

Data was analysed using the framework that was developed from insights gained from literature, focus group discussions and interviews.

### **3.5 THE ANALYTICAL FRAMEWORK**

The analytical framework of social determinants of health, discussed in sections 1.9.2 and 2.2 of this thesis, was used as an appropriate framework and a tool for analysing the relationship between the determinants of health/ill health, including lack of empowerment of women and risks to reproductive health outcomes at the level of the household, community and society. It is based on a model of interacting factors as developed by the WHO Commission on Social Determinants of Health (CSDH). The guiding principle of the CSDH is health equity, and the primary responsibility for protecting health equity rests with the national governments. Any model, public policies and programmes which will effectively reduce maternal and new-born deaths, should correspondingly ensure that the powerlessness of women is addressed. Conceptually, the CSDH analytic framework is similar to that of Mosley and Chen's (1984) and Davis and Blake's (1956) analytical frameworks, as both frameworks argue for changing the nature and direction of systemic forces that subject individuals to inequality, ill health and death through marginalising them in a given context.

The main added value by the CSDH framework is that it considers 'the causes of causes', which in practice translates to the need to look at the determinants and not only the direct causes or proximate variables and reproductive health outcomes. The framework provided a way to illustrate the pathways by which social determinants affect reproductive health outcomes, given the increasing evidence of significant social stratification in the health status.

### **3.6 DATA ANALYSIS AND INTERPRETATION**

Data was analysed using the socio-economic determinants framework which was developed through insights gained from the literature. Qualitative data was derived from the primary data obtained from the interviews. Information and raw data that was obtained through a recording device was transcribed from the recording device to MS-Word documents. The transcribed information was then coded using the questionnaire responses. Data was analysed and categorised into themes, for example, the questions in the questionnaire and responses were summarised to illustrate key themes in each question. Similarly, the key themes that emerged across a set of interview transcripts were summarised. The themes were then contextualised into a feasible model that could be compared to people's lived experiences. Data was also derived from secondary data obtained from studying and analysing past and current reproductive health policies and service provision in South Africa to identify factors that are not addressed by the policies, programmes and services.

### **3.7 ETHICAL CONSIDERATIONS**

Firstly, the researcher asked advice from the South African National Department of Health (SA NDoH) and the South African Department of Social Development (DSD) on how they deal with the ethical issues in research in general, and with confidentiality and informed consent in particular. An inquiry was further made into the existence of an ethical committee and whether the two departments had moral precepts or guidelines that guided the research work. The latest legislation, recommendations or policy on ethical issues were specifically analysed. The researcher established that the KwaZulu-Natal DoH has prescribed guidelines for guiding data gathering, which require that a full research protocol including questionnaires and consent forms, ethical clearance from a recognised ethics committee in South Africa, and letters of support for the study from the district and facility managers be submitted by a principal investigator. Accordingly, the researcher complied with the requirements by submitting an approved proposal for conducting a study regarding developing a model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa together with an ethical clearance

granted by the higher degrees committee of the Department of Sociology, UNISA on the 3<sup>rd</sup> of August 2010. A letter of support for the study from the health district manager for the iLembe district was also submitted.

On the 19th of November 2011, the interim chairperson of the Provincial Health Research Committee, KwaZulu-Natal Department of Health approved the proposed study. Compliance with the prescribed guidelines paved the way for the researcher to begin the interviews in January 2011. The acting CEO of Stanger Hospital granted the researcher a permission to conduct research at Stanger Hospital, iLembe Primary Health Care centres and clinics on the 10<sup>th</sup> January 2011. The study was further approved and supported by the National Department of Health.

### **3.7.1 Confidentiality**

The principles of confidentiality were maintained as far as possible to protect the interests and identities of the participants even if the research participants did not perceive any danger to themselves of data disclosure. The identities and records were kept confidential regardless of whether or not confidentiality has been explicitly pledged, in line with the research principles and requirements. Throughout the inquiry, the researcher ensured that the identity of the individual participants was protected. The concern for individual rights was at all times balanced against the benefits to society which may accrue from the research study. Caution was taken on dealing with private issues for public knowledge, for example, each interview was conducted in a private consulting room allocated to me by the nursing professionals. In addition, the researcher strove to protect the participants from harm of any form that would arise as a consequence of their participation in research.

### **3.7.2 Informed consent**

It was mentioned above that a request letter to conduct the research, the proposal and an ethical clearance letter were submitted to the research committees of the National DoH, KZN Provincial DoH and iLembe Health District office, to obtain consent and approval to carry out the study. Approval letters from the KZN Provincial DoH and the iLembe Health District offices were produced at the PHC centres where



the interviews were conducted. Inquiries involving the human participants were based as far as practicable on the freely given informed consent of the participants. The participants' participation was therefore voluntary and as fully informed as possible. A consent form for the study, which the researcher developed prior to the interviews, was signed by each research participant before the interview was conducted. These were used to obtain permission/ consent for the interview from the participants in the study. The participants were made aware that their participation in the research study was voluntary. The participants were further made aware of their right to refuse to participate in the study at any stage of the research for whatever reason, and to withdraw data previously supplied. Information that could affect a subject's willingness to participate was not deliberately withheld, since this would remove from them an important means of protecting their own interests. Where necessary, greater statistical use of administrative records was made by conducting secondary analysis of existing data for which informed consent had been granted.

### **3.7.3 Provision of debriefing, counselling and additional information**

A debriefing session was scheduled to help any participant to come to terms with the thoughts and feelings that arose out of the interview. A debriefing session was arranged mainly for women 'at risk' of reproductive ill health in their different categories, and representatives from FBOs/CBOs/NGOs who were providing services for women.

Whenever possible, such a debriefing session was further arranged for everyone interviewed in the community who was a 'significant other' of a mother or a new-born who had died recently (that is, those interviewed in the 'verbal autopsies' for maternal or new-born deaths).

**Locating a debriefing site:** The invitations and their acceptance provided an opportunity to get an estimate of the number of persons that might attend planned debriefing sessions and allocate space for them. The matron of the Stanger Hospital maternity ward identified and allocated a site in the maternity ward for a planned debriefing. Those who were interested in the session attended; however, this turned out to be only a small number each day.

**Appropriate educational material:** Any appropriate educational hand-outs such as pamphlets from the local NGO/CBO and some relevant material from the NDoH and KZN DoH were obtained and handed to the participants.

### **3.8 SYNTHESISING THE DATA COLLECTED THROUGH VARIOUS MEANS**

#### **3.8.1 Study design**

This was a multi-stage qualitative study design, wherein qualitative data collections were conducted with various units of observation. The findings from all the research participants were integrated and conclusions drawn.

#### **3.8.2 Methods used in the multi-stage qualitative study design**

Face-to-face, in-depth interviews were conducted with various subgroups of women 'at risk', significant others in verbal autopsies, experts in the field of reproductive health and the NGOs working in the field of reproductive health at iLembe district of KwaZulu-Natal Province as follows:

The interviews were conducted with a sample of twenty four (24) research participants (n = 24), using a semi-structured questionnaire. The research participants were made up of representatives from five (5) different categories representing women 'at risk'; the significant others of mothers who died from a maternal event in the past two (2) years and the mothers or significant others of the neonates who died in the past two (2) years; six (6) experts working in the area of reproductive health at National level, and three (3) representatives of the NGOs working in the field of reproductive health in the iLembe district of KwaZulu-Natal Province.

Data was further obtained via a secondary data analysis of the existing data sources from the 1998 and 2003 SADHS, StatsSA, the Human Sciences Research Council (HSRC), the Medical Research Council (MRC), National and Provincial Departments of Health as well as the direct and indirect sources from the United Nations, World

Health Organization, World Bank and United States Agency for International Development. The researcher further surveyed and analysed the previous programmes and other related fields.

The national policy documents that address women's reproductive health needs in South Africa were studied as these serve as guidelines from which provinces could formulate their own policies according to their situations. Particular reference was paid to the national MC&WH and Population policies. The Strategic Plan for Maternal, Neonatal, Child and Women's Health & Nutrition in South Africa 2010-2015 was studied to identify the gap between reality and identified reproductive health needs.

The documents were also studied on the interrelationships between race, class and gender bias in the national population policies and programs and their effects on reproductive health. The South African women's health records provided me with the women health status in the provinces. In addition to service data obtained from KwaZulu-Natal Province.

### **3.8.3 Selection of research sites**

The study was conducted nationally, provincially and at district level. The national and provincial levels were chosen as research sites for recruiting experts to ensure representation at policy and strategy development levels and also to gain an overview of maternal and child health issues from the top.

The selection of iLembe health district, KwaZulu-Natal as a research site was based on the findings of the District Health Barometer 2007/08, which classified the iLembe district as one of the socially deprived in South Africa (Health Systems Trust 2008). The district was further classified as one with high maternal death rates as a result of the rapid spread of HIV/AIDS in KwaZulu-Natal (Health Systems Trust 2008). The Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition in South Africa 2010-2015 of the National Department of Health identified iLembe as a health priority district which needs high impact interventions to bring down the maternal and child death rates (SA DoH 2008e). iLembe district in KwaZulu-Natal

province was therefore chosen as a site for this study and a representative district for the deprived and vulnerable women in South Africa, with the hope that the results will better inform any effort directed at improving the health status of the mothers and children of the area.

#### **3.8.4 Study populations**

Participants from the women 'at risk', the significant others in the verbal autopsies and the NGOs categories were recruited from iLembe district, KwaZulu-Natal province. Participants were recruited through the health professionals of Stanger Hospital. All women from the 'at risk' category/subgroup were public service users, while the verbal autopsies were conducted with lay community members. The national experts, recruited through the staff of the National Department of Health, and the representatives of the local NGOs were service providers at policy and strategy development level and policy implementation level respectively.

#### **3.8.5 Eligibility criteria**

Common eligibility criteria across subgroups: women 'at risk' had to be black, reside in a rural area in South Africa and be dependent on a public health care facility. To be included in the study, the NGOs had to be providing health and community services to women and children in iLembe district, and the experts had to have a health, public or social background and had to have specialised with some reproductive women or neonatal health.

#### **3.8.6 Protection of participants: informed consent, confidentiality and ethics**

The research proposal was reviewed and ethical clearance granted by the higher degrees committee of the Department of Sociology, UNISA. The UNISA Policy on Research Ethics was followed. Informed consent was obtained from all participants. At the beginning of each interview or focus group, the interviewees were provided with information about the purpose of the study, and the established conditions for anonymity and confidentiality. The participants were asked whether they had understood the information and whether they were still willing to participate. The

participants were made aware of their right to withdraw participation at any stage of the research should they wish to.

### **3.8.7 Sampling techniques**

#### **i. Sample size**

A total of twenty four (24) research participants composed of a total of ten (10) women 'at risk', five (5) significant others, six (6) experts and three (3) representatives of the NGOs were recruited across the sites.

#### **ii. Sampling procedures**

All research participants were recruited through non-probability techniques.

#### **iii. Research instrument**

Semi-structured interview questionnaires designed specifically for various categories or subgroups were administered by the researcher. Information was collected about: socio-economic-demographic characteristics, reproductive health knowledge and practices, the birth and deaths information, support, abuse or violence by family or anyone in the community by virtue of being a woman, the services provided for women, mothers and children, and a perspective of women about women's health and empowerment.

All questionnaires were originally drafted in English, translated into isiZulu for the women at risk and the verbal autopsies, and then translated back into English again. Questionnaires were pilot-tested in isiZulu and the questions were further refined to make them comprehensible to the target participants. The questionnaires for the experts and the NGOs were in English.

The participants were interviewed in private rooms at the hospital and in their homes as well as in the offices of their organisations to ensure privacy. No names or any other personal identifying information were collected. The average time to answer all the questions was about one (1) to two (2) hours.

### **3.8.8 Data analysis**

Analyses of qualitative data from the face-to-face interviews with the various categories and the study of documents were conducted separately.

### **3.8.9 Reliability and validity**

Selection of research participants and of the study sites was purposive. Selection of the main research site, namely iLembe district, was based on the findings of previous studies and the Department of Health having categorised the district as showing the worst indicators in women and children's health and well-being. Participants in the women-at-risk category were receiving services from the study site.

Internal validity was ensured through employing strategies such as:

(i) Multistage qualitative methods of data collection where data was collected from multiple sources such as holding interviews with women 'at risk', conducting verbal autopsies, interviewing experts in the field of reproductive health and the NGOs who were rendering services to women.

(ii) The credibility check through taking full background notes on the recruitment and selection of the research participants and data generation, and transcribing the data immediately following its generation.

## **3.9 CONCLUSION**

This chapter aimed at discussing the methodology for generating data and evidence that will support the development of a model that integrates social interventions into primary health care services for improving female reproductive health in such a way that a reduction in maternal and neonatal mortality rates in South Africa will be achieved. The existing maternal and child models were studied with the intention of extending them and building a model that lists the structural, intermediary/social

determinants and direct causes of female reproductive morbidity and mortality, followed by proposing solutions for improved reproductive outcomes.

Data generation included a multi-stage qualitative research design whereby data was collected in phases from different categories as follows:

- face-to-face interviews with the women 'at risk';
- verbal autopsies whereby the face-to-face interviews were held with close relatives or significant others of the mothers who have passed away recently (in the last two years) due to maternal causes or new born babies that have died in the last two years,
- experts in the field of reproductive health; and
- Non-governmental organisations (NGOs) providing reproductive health.

Data generation further included studying documents that address women's reproductive health in South Africa.

Using the frameworks developed by the CSDH (2007) and Mosley and Chen (1984) as guidelines, data was analysed to establish associations among the variables in respect of maternal and child deaths and the structural, intermediary/social and proximate factors. The qualitative data was analysed through transcribing data obtained by means of face-to-face interactions, summarising these into themes and contextualising it to inform the envisaged model.

The prescribed ethical guidelines for conducting research developed by the DoH were followed, by submitting my approved comprehensive proposal for the study, an ethical clearance by the Department of Sociology, UNISA, and letters of support by the National and Provincial Departments of Health. Confidentiality of the research participants was ensured through among others, protecting their identity by holding individual interviews in a private room allocated to me for the research purpose. Prior to each interview, a thorough explanation of what the study was all about was provided, and a signed informed consent was obtained from each and every research participant.

The interview sessions benefited the women in various ways, for example, sharing information by providing the hand-outs on reproductive health issues from the local NGOs and highlighting issues needing urgent attention from the experts in the area of maternal and child health. A disciplinary inquiry into one of the maternal deaths was instigated as a result of my feedback from the interviews. The following chapter discusses the findings of the study.



## CHAPTER FOUR

### FINDINGS

*'There is a social gradient in health – the lower a person's social position, the worse his or her health'.*

(Marmot, Allen, Goldblatt, Boyce, McNeish, Grady *et al.* 2010:9)

#### 4.1 INTRODUCTION

This chapter reports the results and discusses the findings of the study. The discussion follows the main themes that emerged from the research questions and the coding and reduction of the data gathered through the qualitative research techniques. The discussion also presents the quotations from the transcribed interviews. Having employed a multi-staged qualitative design, the chapter further discusses findings from the study and analysis of the documents.

The purpose of the study was to move beyond a mere description of the reproductive practices, the quality of the living conditions of women 'at risk' and the quantity and quality of the health care services provided to them, toward uncovering the social, political and economic forces that shape the availability and distribution of income, housing, social and health services among the majority of South African women, and subsequently their vulnerability to illness and death. The chapter focuses on the root of ill health and mortality of women in South Africa by analysing and discussing the findings from the study on reproductive health status, the circumstances around women's and neonatal deaths in iLembe district, a case study in KwaZulu-Natal Province, South Africa.

Having conducted an inquiry among women, the chapter explores and reports the findings on the factors which render women vulnerable to ill health and impact on their reproductive health status. The chapter further reports on the findings of verbal autopsies on the circumstances surrounding the deaths of women and the neonates who have died. The experts' views on the causes and determinants of reproductive

morbidity and mortality in South Africa are reported, analysed and discussed, with a specific focus on exposing problems in effective reproductive health care service delivery. This is followed by a discussion of the services which local NGOs deliver in support of the government's efforts to address maternal mortality.

The narrations and verbal autopsies are augmented by findings from secondary analyses of documents in respect of the current reproductive health policies and services or interventions in South Africa. Based on the findings, recommendations are made for a model which sets forth factors that impact reproductive needs.

The study assumes that high levels of reproductive morbidity and mortality are a result of unequal power relations which women experience in daily interactions in virtually all local circumstances. These power relations are channelled through race, class, gender and residential location.

The objectives of the study were to:

1. Identify the structural determinants, social determinants (also referred to as intermediary factors) and direct factors (also referred to as the proximate factors) which affect female reproductive morbidity and mortality rates in South Africa;
2. Describe the structural determinants, social determinants and direct factors which affect female reproductive morbidity and mortality rates;
3. Study and critically analyse different models describing social determinants and direct factors of female reproductive ill health and mortality, and models for reducing it;
4. Construct an alternative model that links structural determinants, social determinants and direct factors which affect female reproductive morbidity and mortality, and reproductive health outcomes in South Africa; such a model must be context- and needs-based; and to

5. Clarify the policy and programme implications of such an alternative model.

Based on the objectives above, this chapter has the following sections discussed under the following subheadings:

- In subheadings 4.1 to 4.4 the researcher provides background information, namely subheading 4.1 introduces the chapter; subheading 4.2 gives the context and background to the study site; under subheading 4.3 the biographical details of the women at risk are discussed, and subheading 4.4 details the reproductive health status of the women at risk of ill health and mortality.
- The discussion under subheading 4.5 - 4.9 addresses objectives 1 and 2, because the researcher came to the realisation that the structural determinants, social determinants and direct factors that affect female reproductive morbidity and mortality rates in South Africa have a mutually constitutive relationship. Subheadings 4.5 – 4.8 discusses findings from the face-to-face interviews with the various subgroups, namely women 'at risk' of reproductive ill health, the significant others of women who had died due to maternal causes and new-borns who had passed away in their first week of life in the last two years, the national experts in the field of reproductive health and the NGOs working in the field of reproductive health in iLembe district, KwaZulu-Natal. Subheading 4.9 discusses findings from the study and analysis of documents related to female reproductive health including a critical analysis of the SA DoH's Strategic Plan for MNCWH & N in South Africa 2010-2015.

It should be noted that Objective 3 was addressed in Chapter 2 and objectives 4 and 5 will be addressed in Chapter 5. It should further be noted that the researcher focuses on maternal health issues as a priority, with neonatal health included as a subcategory in the continuum of female reproductive health care. Therefore MDG 5 remains the primary focus of this thesis, with pre-pregnancy care regarded as equally important as antenatal, intra-partum/delivery and post-partum/post-natal care.

## 4.2 CONTEXTUAL BACKGROUND OF KZN

KwaZulu-Natal (KZN) is the second most populous province in South Africa, covering a total area of 92,100 square kilometres of the total land surface of South Africa (Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana *et al.* 2000). According to South African Institute for Race Relations (2011), slightly less than half of the population in the province, (49.5%), lived on less than US\$2 a day (or approximately R15.60 a day) in 2010. KwaZulu-Natal had 5,162,815 people, the highest number of all the South African provinces, who lived in poverty. Among these, 5,044,217 were African compared to only 3,336 whites (SAIRR 2011).

A survey conducted by the South African Institute for Race Relations (SAIRR) in 2006 indicated that the province's contribution to the national GDP is low considering the size of its population (SAIRR 2006). The proportion of working age adults who are economically active is low, the unemployment rate is high, and the average household and *per capita* incomes are low (SAIRR 2006).

Table 4.1 below depicts KwaZulu-Natal (KZN) as the province with the population size of 10,819,130 people; an approximate 21,4% of the total South African population (SAIRR 2011). Fifty three per cent (53%) of KZN's population live in rural areas where there is an average of only six doctors per 100,000 people (SAIRR 2009). Slightly more than one-third of the population are under 15 years of age, and over half are women. One in every five children has already lost at least one parent, and one in five adults has a Grade-12 level of education, but one in nine adults has received no formal education at all (StatsSA 2001). KwaZulu-Natal emerged as a province with the highest percentage of adults who have received no formal education in their life time in both 2001 and 2007 according to Table 4.1. Both in the years 2001 and 2007, the provincial figures exceeded the national figures in literacy, for example, table 4.1 further suggests that in 2001 the percentage of adults who had no schooling in KwaZulu-Natal was 21.9 % while the national figure was 17.9%. In 2007 the provincial figure of adults with no schooling had risen to 26.8% whereas the national figure had decreased to 17.9%. According to Aitchison and Harley

(2004) the vast majority (93.9%) of adults who have had little or no education in KwaZulu-Natal in 2001 were Africans.

The municipalities of several districts in KwaZulu-Natal experience an increase in the number of orphans and child headed families. In some instances children have lost both parents hence the number of double orphans is 278,000 while the national figure is 875,000.

An analysis of income levels reflects that the KwaZulu-Natal province has the highest percentage (20.9%) in the R0-50,000 income group compared to Western Cape which has only 8.4% of R0-50 000 income earners. Table 4.1 below reflects selected socio-economic indicators for KwaZulu-Natal province and the comparative national rates (SAIRR 2011).

**Table 4.1: Selected population indicators for KwaZulu-Natal province and South Africa, 2001-2011**

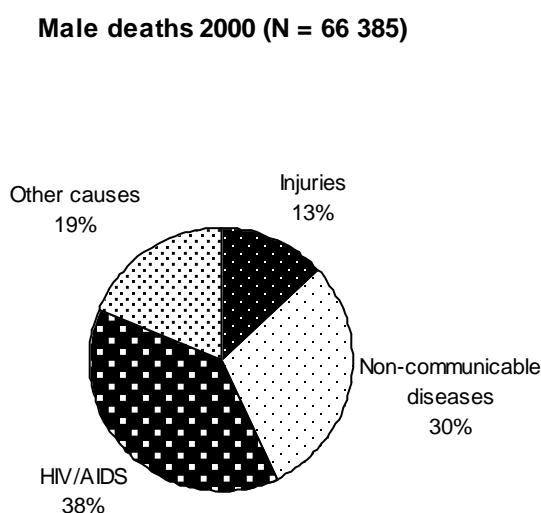
<b>Indicators</b>	<b>KwaZulu-Natal</b>	<b>South Africa</b>
Total population in 2010	10,645,400	49 991 300
Total population in 2011	10,819,130	50,586,757
% of the population living in rural areas (2009)	53 %	57%
Number of households living in traditional dwellings (2010)	582, 000	14, 304, 000
Number of the population that is female (2010)	5, 512, 600	25, 662, 300
% of the population with access to piped water(2010)	84% %	89%
% of population younger than 15 years 2010	23%	21%
% of adults (20 years and older) with no formal education (2001)	21,9%	17.9%
(2007)	26.8%	9.2%
% of adults with Grade 12 (2007)	22%	32.7%
Number of children who are double orphans (2011)	278, 000	875, 000
Number of children who are maternal orphaned (2009)	210 000	633 000

**Sources:** (Actuarial Society of South Africa (ASSA) 2002; SA DoH 2004; Aitchison & Harley 2004; KZN DoH 2011a; KZN DoH 2011b; South African Department of Social Development 2000; South African Department of Social

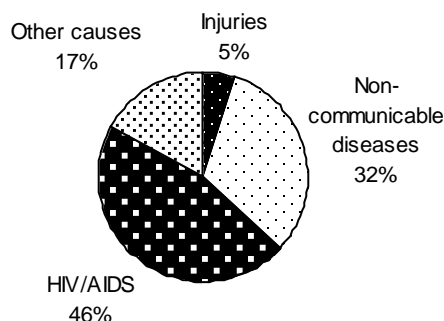
*Development 2010b; SAIRR 2003; SAIRR 2006; SAIRR 2009; SAIRR 2010; SAIRR 2011; StatsSA 2001; StatsSA 2003; StatsSA 2004a; StatsSA 2007a; StatsSA 2007b; StatsSA 2010).*

Although just under two-thirds of the population live in formal dwellings, one in four live in a traditional dwelling, and 10% of the urban population live in poorly developed informal settlements (StatsSA 2001; SAIRR 2006). Some households in the informal settlements have access to basic services such as piped water, electricity, sanitation and weekly municipal refuse removal, but the quantity and quality of the services are often limited (SAIRR 2006). The high levels of poverty, inequality, under-developed infrastructure, and the scattered distribution of homesteads in the rural areas all contribute to the poor health status of the population and pose transport and access challenges in terms of delivering equitable health services.

**Figure 4.1: The mortality profile of KwaZulu-Natal (2000)**



### Female deaths 2000 (N = 63 473)



(**Source:** Bradshaw, Nannan, Laubscher, Groenewald, Joubert, Nojilana *et al.* 2000b).

The provincial mortality profile for KZN shows a higher number of deaths amongst males compared to females in 2000. The proportion of deaths due to injuries is higher for males than for females. However, when combining non-communicable diseases and other causes (which include maternal and perinatal causes and nutritional deficiencies), the proportion of male and female deaths are both 49% (Bradshaw *et al.* 2000b). HIV/AIDS-related deaths account for 46% of female and 38% of male deaths in KZN (Bradshaw *et al.* 2000b:5).

KZN has been organised into 11 health districts amongst which is iLembe, a district chosen as study site for this thesis (Ndhlovu, Searle, Miller, Fisher, Snyman & Sloan 2003). The iLembe district covers 3,264 square kilometres (km) with a total population size of 592,443, and incorporates four sub districts, namely Ndwedwe (169,570), Maphumulo (132,507), Mandeni (144,838), and KwaDukuza (145,528).

iLembe district is home to 12,5% of the children under 5 years of age in the province. The gender distribution is 46,5% males and 53,5% females in the district (iLembe District Municipality 2008b). iLembe has the highest percentage (42%) of people living outside a 5-km radius from a health facility, and health care expenditure *per*

*capita* is the lowest in the province. The district is served by four hospitals (Montebello, Umphumulo, Stanger and Untunjambili), two community health centres (Ndwedwe and Sundumbili), 33 clinics, and three state-assisted hospices.

iLembe was classified by the District Health Barometer 2007/08 as one of the districts that are socially deprived in KZN (HST 2008:18). The recently developed Strategic Plan for Maternal, Neonatal, Child, Women's Health and Nutrition (MNCWH & N) in South Africa 2010-2015 of the SA DoH identified iLembe as one of the National Department of Health's 18 priority districts that requires acceleration of proven, low-cost but high-impact maternal, neonatal, child and women's health and nutrition interventions (SA DoH 2008e).

The district is characterised by widespread reliance on agricultural subsistence. The improvement of infrastructure such as roads, electricity, water and sanitation is hampered by a challenging landscape. Oscillating male migration between the cities and the district is fuelled by the hope of better earnings and livelihood (iLembe District Municipality 2008a).

Unemployment in KZN, including iLembe district, has increased significantly during the last nine years to the current rate of 42,1% (iLembe District Municipality 2008b). A recent Labour Force Survey (StatsSA 2004b) confirmed that unemployment affects women more than men, black South Africans more than other racial groups, and rural population more than urban ones.

Women face vulnerability in terms of insecure incomes, food insecurity, poor shelter, poor access to health care and other essential services, which results in poor health outcomes for women. For example, women walk long distances to fetch water and gather wood for cooking (personal observations of the researcher during field visits as a community maternal and child survival specialist for UNICEF 2007-2010).

iLembe District Department of Health (2005) found that the IMR and U5MR rates for the district were 102 (95% CI 85-129) and 148 (95% CI 120-191) respectively. The most common causes of child morbidity are HIV/AIDS (35%), neonatal factors



(30%), diarrhoea and pneumonia (18%). The majority of these deaths (60%) occur in malnourished children (Every Death Counts Writing Group 2008).

The Second Report on Confidential Enquiries into Maternal Deaths in South Africa 1999-2001 indicates that a reliable estimate of the national MMR is impossible due to poor reporting (SA DoH 2002c). The estimates developed for KZN pointed to an MMR of 144 per 100,000 live births in 2001, which were caused primarily by non-pregnancy-related infections (38%), hypertension (21,6%), pregnancy-related sepsis (9,6%) and post-partum haemorrhage (6,8%). This mortality profile represents a change since 1998, when hypertension was the most common cause of maternal mortality (SA DoH 2002c).

Antenatal care is available at all hospitals, community health centres (CHCs), and at 29 clinics (KwaZulu-Natal DoH 2011a). Clinics normally refer labour and delivery cases to CHCs and hospitals, where basic essential obstetric care (EOC) is available. Outreach services include 10 mobile clinic teams, which visit about 10 sites each day, plus community health workers (CHWs) in the rural areas, primarily to provide health promotion and to link communities with the health system (Medical Care Development International (MCDI) 2005; SA DoH 2002a; KwaZulu-Natal DoH 2009)

Although some parts of the district have easy access to health services, residents of deep rural areas such as in Ndwedwe, Maphumulo and Mandeni face a number of access challenges, particularly during emergencies and at night. Access to medical care is limited due to lack of transport available or lack of funds to pay for it. This situation becomes even more difficult during rainy seasons, when approximately 50% of the roads are impassable. At night, the clinics are only open to receive maternity cases, and ambulances do not go out, for security reasons (MCDI 2005).

The *Knowledge, Practice and Coverage* (KPC) survey conducted in iLembe during 2005 indicated that only 51% of mothers attended three or more antenatal visits in the course of their pregnancies (MCDI 2005). The findings of the KPC (MCDI 2005) further note that the number of antenatal care visits per client is the lowest in iLembe. According to Barron, Day, Loveday and Monticelli (2006), about 70% of all

pregnant women were tested for HIV and 63% received Nevirapine in 2005. The survey findings suggest that a reluctance to be tested for HIV is still a widespread problem, and as a result many HIV-infected women are failing to access PMTCT services (MCDI 2005).

The minutes of the meeting held on the 26<sup>th</sup> of February 2009 between iLembe DOH and partners such as the iLembe District Department of Health, UNICEF, Medical Care Development International (MCDI), mothers2mothers (m2m) and the University of KwaZulu-Natal (UKZN), noted that the lack of infrastructure, equipment and expertise in neonatal care remain challenges in some of the hospitals.

**Table 4.2: Selected health indicators for iLembe district and KwaZulu-Natal province, 2001-2011**

Indicators	iLembe District	KwaZulu-Natal
Total population (2010)	563,073	10,645,400
Total population in 2011	No data	10,819,130
Number of the population that is female (2010)	51.60	5, 512, 600
HIV prevalence among the ANC women, 2010	42.5%	39.5%
U5MR (2005: Ndwedwe)	148	132
IMR (2005)	102	No data
IMR (2010)	124	60
Perinatal mortality rate (at facility)	32.6 (2010)	29.6 (2008)
Neonatal mortality rate (2010)	30.2	74.5
Teenage pregnancy (2011)	No data	25.8
Maternal Mortality Ratio (2001)	No data	144/100,000
(2010)	No data	210/100,000
(2012)	131/100,000	160/100, 000
Delivery rate at facility	63.3	78.1
Contraceptive prevalence	No data	76.8%
Diarrhoea incidence for under 5 years	497.1	436.5

**Sources:** (iLembe District Municipality 2008a; iLembe District Municipality 2008b; iLembe District Municipality 2011; iLembe District DoH 2005; SA DoH 2004; SA DoH 2010b; KZN DoH 2011a; KZN DoH 2011b; KZN DoH 2012; MCDI 2005; KZN office of the Premier 2011; KZN DoH Annual Report 2005/2006; South African DSD 2000; South African DSD 2010b; SAIRR 2003; SAIRR 2006; SAIRR 2009; SAIRR 2010; SAIRR 2011; StatsSA 2001; StatsSA 2003; StatsSA 2004a; StatsSA 2007a; StatsSA 2007b; StatsSA 2010).

KwaZulu-Natal province constantly records the highest number of HIV/AIDS infection and thus has become a source of concern not only in the province but in the rest of South Africa. The concern on the increasing levels of HIV/AIDS arise from its effects on increasing risk to life, the life expectancy rates as well as the economic, social, political and technological development of the country. Evidence further suggests that there are more women than men infected by HIV/AIDS in KwaZulu-Natal (Dorrington, Bradshaw & Budlender 2002). The latest ANC prevalence rates among the ANC women in KwaZulu-Natal are estimated to be 39.5% and the highest in the country (SA DoH 2010b).

Of all the districts of KwaZulu-Natal, iLembe has been mostly affected by the HIV/AIDS epidemic with the HIV prevalence rate of 42.5% among the ANC women in 2010 (SA DoH 2010b). The implication is that iLembe is the most affected district not only in KwaZulu-Natal but nationally. The iLembe District AIDS Council (2008) suggests that 30% of the KwaZulu-Natal is HIV-positive.

Although the actual rate of teenage pregnancy in iLembe district could not be established by this study due to lack of data, indications are that the prevalence is quite significant, judged from some statements made by the province's politicians. For example, on the 15<sup>th</sup> September 2011, at the opening of one of the clinics in iLembe district, the MEC for health in KwaZulu-Natal raised a concern that iLembe district "*is faced with a big problem of teenage pregnancy*" (KZN DoH 2011b). 190 girls who were between 15 and 20 years, with a fourteen year old amongst them, were reported to have been pregnant in the period between April and June 2011 (KZN DoH 2011b). Teenage pregnancy in iLembe district is occurring in the context of high provincial prevalence rate which stood at 25.8% in 2008 in KwaZulu-Natal (SAIRR 2011).

#### **4.3 BIOGRAPHICAL DETAILS OF THE RESEARCH PARTICIPANTS**

This section presents the biographical and socio-economic background of the women 'at risk' and their reproductive health status. The details of the research participants in the verbal autopsies for the mothers and new born babies who died, the background of the representatives of the NGOs in the field of service delivery for reproductive health care, the biographical account of the national experts in the field

of reproductive health have been discussed in Chapter 3, subsections 3.2.1.2; 3.2.1.3 and 3.2.1.4 respectively.

Ten women made up the sample of the women 'at risk' who were interviewed for this study. These women, who were all in the reproductive age groups of 15-49 years, were purposefully divided into five categories as follows:

- two teenagers (Ntombi and Zodwa),
- two women older than 35 years (Thandeka and Busi),
- two women who had closely spaced births (Thuli and Boni),
- two high parity/multiparous women (Masesi and Zanele), and
- two HIV-positive women (Lolo and S'mangele).

The biographical details of these participants are presented below, and each woman is given a pseudonym to protect her true identity. The reader should note that some of the interviewees fit into more than one category of risk – for example Thuli, interviewed as part of the closely spaced birth risk group, were also a teenage mother. Zanele, interviewed in the high parity/multiparous risk group, was also HIV-positive and older than 35 years. Lolo, interviewed as part of the HIV-positive group, had a high parity of four previous births and a fifth pregnancy.

#### **4.3.1 Teenaged interviewees**

Ntombi and Zodwa were two teenaged participants. These two young women reported to have poor knowledge about sexuality and reproductive health. Many of the difficulties they experienced were related to beliefs, perceptions and expectations that made them vulnerable to reproductive ill health. Ntombi was 16 years old and had passed Grade 11. At the time of the interview she was 7 months pregnant and not formally employed. She earned some money by assisting her mother (a petty trader) with selling groceries. This was Ntombi's first pregnancy. The father of her baby was 17 years old and has passed Grade 12, but was unemployed. The young father's parents provided some financial and emotional support to Ntombi and her boyfriend.

Zodwa was 15 years old and shared a dwelling with her younger brother, her parents, an uncle (who is the sole provider) and his own family. Zodwa had passed Grade 7 in 2010. At the time of the interview she was 8 months pregnant. The researcher met her at the antenatal care clinic for her first booking visit.

#### **4.3.2 Interviewees older than 35 years**

Thandeka was a 39-year-old woman and had 2 living children. She was 7 months pregnant at the time of the interview. She announced to the researcher that she was very unhappy that she was pregnant. This was an unplanned pregnancy that resulted from discontinued contraceptive use, because to Thandeka the nearest health care facility was inaccessibly far. She reported:

First I was on a pill, but then I moved away from the clinic to a place that was far. But my sister-in-law continued to bring me the tablets (*meaning contraception*) when she was still working at the clinic. I then decided to use an injection because at least with an injection you do not have to go back to the clinic many times. Later I stopped the injection because it made me sick, hence I fell pregnant. I felt very bad when I became pregnant but now I am accepting that I will have another baby.

Thandeka survived on the money that she was given by her mother and her brother, with whom she shared the household. She had a boyfriend who would sometimes provide some financial assistance.

Busi was 9 months pregnant at the time of the interview and had only one child who was 21 years old. She struggled to fall pregnant; hence she welcomed the current pregnancy. Busi was employed as a domestic servant and earns only R600,00 a week. At the time of the interview, Busi was 40 years old and apprehensive about a successful delivery at Stanger Hospital. Busi suggested to the researcher that Western medical care can be improved only by embracing traditional values and practices and by incorporating traditional care methods during pregnancy, delivery and post-partum. She commented:

Nowadays there are many more questions than answers. The government needs to recognise that our grandmothers and mothers can play a part in delivering. They used to deliver young women at home, but now it's no longer safe to have a baby.

### **4.3.3 Interviewees with closely spaced births**

Thuli was 5 months pregnant and appeared anaemic, tired and highly strung. She was 19 years old at the time of the interview and was pregnant for the third time. Her other two children were born in October 2007 and September 2009. She has passed Grade 12 and her mother had hoped to send her for further studies at a tertiary institution. However, Thuli fell pregnant at the age of 16 in 2007. Thuli's mother has threatened to chase her away should she fall pregnant for the third time and she therefore did not disclose to her mother that she was again pregnant. She went to great lengths to hide the pregnancy and worked hard at household chores to please her mother and gain her favour. Thuli has been admitted to the hospital with anaemia with each pregnancy, that is, in 2007 and 2009, and lately in December 2010. She has had a Caesarean section twice. According to Thuli, the doctor told her that she also has a heart problem.

Thuli lived with her two children, her mother and her two sisters in the same household in one of the informal settlements of iLembe district. She was unmarried. Thuli did all the household chores at home as her sister and her mother were working. She also cared for all the children – her own children as well as her elder sister's child.

Her two children have different fathers, who both (allegedly) had been physically, emotionally and mentally abusive towards Thuli before eventually leaving her. The father of her current pregnancy was supportive, but Thuli was uncertain as to how long he would remain so, as she had lost her trust in men. She was also afraid that her mother would chase her out of the house when discovering the pregnancy. When the researcher probed for the reasons for this, Thuli responded that:

Umama (*mom*) warned me that if I should fall pregnant again she will chase me away. That was when I was pregnant with my

number two child. She (*mom*) said she is struggling and I am adding onto her burdens with extra mouths to feed. Her attitude towards me changed when I was expecting my number two (*second child*). She loves my number one (*referring to the first child*) but not my number two, because she thought it was senseless of me to have another child when I fell pregnant for the second time.

No one at home knows that I am pregnant. I paid my aunt a visit in December 2010; she noticed a change in my body and suspected that I could be pregnant. She asked me, but I denied that I was indeed pregnant. She called my mom and requested her to watch me. I was scared to death.

Boni was 20 years old and had one child who was born in August 2009. At the time of the interview she was 9 months pregnant and due for delivery in January 2011. The spacing between her last child and the baby to be born was thus 1 year and 5 months. Boni had passed only standard 5 (Grade 7). She lived with her mother, sister and a brother. She delivered her first baby through a Caesarean section and during the previous post-natal period, she was readmitted for a septic Caesarean section.

#### **4.3.4 Interviewees with high parities**

Masesi, a 38-year-old woman, attended a clinic for her first booking in preparation for delivery of her sixth child. She has five living children. At the time of the interview she was 8 months pregnant. She is not married but has a partner who is, according to her, '*a soul mate but not a provider*'. Masesi told the researcher that she intended undergoing tubal ligation (female sterilisation) post-delivery. The ages of her children range from 18 years to 2 years. The child to be born was an unplanned pregnancy, but Masesi has accepted the pregnancy.

Masesi informed the researcher that, if she had had a choice, she would have terminated the current pregnancy, but that she did not have information or the

necessary knowledge regarding whom to consult or where to ask for advice. Masesi has been informed by the health professional staff that she is at risk due to her chronic hypertension and should therefore deliver her baby at the hospital. She shared with the researcher, *'I am so sacred, and I do not know what to do. It's like I am going to die'*. Her fears were related partly to her own understanding of her health status and partly to her perceptions of the treatment she received. She commented, *'If you can please plead with the Stanger nurses to be sympathetic when they treat us. Stanger is not a good hospital. People go there to deliver but they do not come back alive'*.

Masesi was a petty trader. She sells groceries from her yard where she has put up a small structure which she calls a spaza shop.

Zanele, a 40-year-old woman, was HIV-positive and had been pregnant nine times. She went for her antenatal care booking on the day of the interview. As part of the antenatal care routine, she had an HIV test and tested positive. She appeared emaciated and shared her deep concern over the fact that she had tested HIV-positive with the researcher. Not all of Zanele's previous pregnancies had resulted in live births. She has had one abortion and two of her children had died.

After the interview, the researcher gave Zanele a lift home. Her dwelling was a shack with steel partitions. It contained no furniture and a few dirty blankets were used as a bed. There was no toilet in the dwelling or the yard and there was no running water.

#### **4.3.5 Interviewees who were HIV-positive**

In social, economic and health terms, the HIV/AIDS epidemic hits women hardest and increases the vulnerability of poor rural women in particular. Rural women in South Africa, who are mostly black, are disproportionately affected by poverty and unemployment and hardest hit by HIV/AIDS (Whiteside, as quoted in UNICEF South Africa 2010; Geffen 2006). Women living with HIV in poverty-stricken and rural areas of South Africa face multiple burdens including discrimination and economic marginalisation. They live in an environment rife with high levels of sexual and other gender-based violence.



Lolo, an HIV-positive woman, had been pregnant five times with the inclusion of her current pregnancy. Before she had her youngest child in 2007, she had a premature delivery in 2004 which resulted in the death of that baby. She had three live children. She discovered recently (October 2010) that she was HIV-positive. Her boyfriend also tested HIV-positive. Her CD4 count was 249 at the time of the interview, but she was reassured by the health professionals that it would improve if she ate well and adhered to her treatment regime. Although she was aware of her risk status, she came for her first antenatal care booking only in January 2011 when she was 8 months pregnant.

S'mangele was a mother of one child, born in 2007. She was 9 months pregnant at the time of the interview. S'mangele discovered that she was HIV-positive in 2010. Like other HIV-positive women, S'mangele is in urgent need of effective care and support interventions. She narrated her perceived expectations on the part of her in-laws to perform her duties as a new bride, which include continuing the family name by giving birth to many children.

#### **4.3.6 The marital status of the at-risk interviewees**

Only one of the ten women was married at the time of the interviews. The nine unmarried women in the study were not cohabiting with the male partners who had impregnated them. Some received visits from these men on a regular basis, for example, Busi commented:

I am very happy with my current partner. He looks after me and my other child who is not his own. He knows that a woman has to be looked after. We do not live together but he comes to see us often. I am even happier because he made me pregnant when I thought I wouldn't have a child again.

Through probing, the researcher discovered that, although all of the women 'at risk' claimed that they were still in relationships with their partners, they struggled financially and had to fend for themselves. Zanele, for example, was a single mother living in poverty and surviving abuse:

I do not know what I have done to God. I have been pregnant nine times. I was never married. I had a partner who was the father of my other children. He was abusing me physically until I left him. I left him with my other children. One of my children died, but he never even told me. I picked it up on the street that he had died ...Now I have this partner who visits me most of the time. He is aware that I am pregnant but sometimes he does not buy food. I have to feed him. I am struggling ... I went to the clinic for my first (*antenatal care*) booking only today, although I am already 9 months pregnant. I didn't have money to go for my booking. I was then told that I am HIV-positive. This man gave me HIV because he runs around with other women. The nurses have asked me to tell him to also go for the test. I will not tell him that I am HIV-positive because he will beat me up. I want him to go to the clinic, get tested and get the results for himself. He must feel it too.

Although all of the interviewees 'at risk' were pregnant, most of them were unmarried and were the heads of their households. In this regard, Youssef and Hetler (1983:232) classify woman-headed households into those:

- a) with no male spouse or partner present at any time,
- b) where the male partner is a transient resident,
- c) from which the male spouse or partner is temporarily absent,
- d) in which the male spouse or partner is present, but his contribution to the financial maintenance of the household is marginal, and those
- e) from which the male spouse or partner is absent, but one or more adult males are in residence.

Of the nine interviewees 'at risk' who were not married, five belonged to category (b), namely Ntombi, Zodwa, Thandeka, Thuli and Boni. They were *de jure* heads of households as their partners were not living with them permanently. Busi, Masesi, Zanele and Lolo's partners were temporarily absent, but would sometimes visit them for several days. Of the nine women, eight were receiving minimal financial support from their partners, while Busi maintained that she was happy with the financial and emotional support she received from her partner.

#### 4.3.7 The educational attainment and employment status of the at-risk interviewees

**Table 4.3: Women at risk disaggregated by level of education (N = 10)**

Educational Level	Head count
None	1
Grades 1-4	1
Grades 5-8	3
Grades 9-12	5
Tertiary education	Nil
Total	10

Table 4.3 above shows that only one woman did not receive any form of education, while nine women had some level of education. Amongst them one woman had completed Grade 4, three had attained Grades 5 to 8, and five had attained Grades 9 to 12.

Seven out of the ten interviewees were unemployed, indicating that most of the interviewees had no independent incomes and depended on the limited resources of the family. Among the three who were employed, two worked as domestic servants, while one woman was engaged in a small trading business.

#### 4.3.8 Domestic arrangements of the at-risk interviewees

Half (five) of the interviewees resided in the rural area of iLembe, three lived in informal settlements, one lived on a farm and one in a township. None of the interviewees lived in an urban settlement. This has a particular bearing on the possible access to health facilities, since modern health care provision tend to concentrate in urban areas.

One of the women 'at risk', a teenager who lived in an informal settlement, was living in and sharing a caravan with her parents, a brother and an uncle and his wife. The caravan which they were using as a home was a donation from the uncle's white employer. The caravan had no toilet facilities or clean water supply. The household used a communal tap, but the water reportedly has to be boiled before it can be used. None of the interviewees had running tap water inside their dwellings. Seven women had access to tapped water in the yard, two used a communal tap and one fetched water from a dam.

**Table 4.4: Women at risk disaggregated by type of toilet available to the household (N = 10)**

<b>Pseudonym and at-risk status</b>	<b>Flush</b>	<b>Bucket</b>	<b>Pit</b>	<b>None</b>
Ntombi (teenager)			✓	
Zodwa (teenager)			✓	
Thandeka (> 35 years)			✓	
Busi (> 35 years)	✓			
Thuli (closely spaced births)			✓	
Boni (closely spaced births)			✓	
Masesi (high parity)	✓			
Zanele (high parity)				✓
Lolo (HIV+)	✓			
S'mangele (HIV+)			✓	
<b>Total (N = 10 women 'at risk')</b>	<b>3</b>	<b>0</b>	<b>6</b>	<b>1</b>

Table 4.4 above shows that only three women 'at risk' had flush toilets; however, all of these were situated outside the dwelling. Six women used pit latrines, while one had no toilet at all.

Clean water provision, sanitation and waste removal remain a problem in the rural areas of South Africa, notwithstanding the promises of the democratic South African government to provide the basic services especially to historically disadvantaged

individuals and households. The socio-economic characteristics of the interviewees indicate that they were poor, deprived, and lived in strife.

In 1998, the then Deputy President of South Africa, Mr Thabo Mbeki, in opening the debate of the National Assembly on the 29<sup>th</sup> of May 1998, called for the abolition of disparities in the quality of life based on the racial, gender and geographic inequalities inherited from the past (Mbeki 1998). To date, not much has been achieved for the women of iLembe district. In most cases, the interviewees could not rely on the fathers of their unborn children to share the responsibilities of child care. They thus faced the additional challenges of financial hardships. As only three were employed in low waged jobs, it seemed unlikely that their financial circumstances would change in the future. In all ten cases, a clear structural basis for the reproductive risk status of the women could be seen.

#### **4.4 REPRODUCTIVE HEALTH STATUS OF THE WOMEN 'AT RISK'**

In this section, reproductive health matters such as the age at first pregnancy, birth intervals, pregnancy and delivery management, the use of contraception and HIV status are discussed.

##### **4.4.1 Age at first pregnancy**

Marriage signals the start of exposure to childbearing via its relation to the onset of cohabitation with a male partner or spouse. However, for the ten interviewees, most were not married or living with a male partner, although they were pregnant. Similarly, when the initiation of childbearing among these interviewees was examined, it was revealed that eight women had their first pregnancy at young ages (under 21 years of age), while only two women had their first pregnancy between the ages of 21 and 25 years (see Table 4.5 below). The mean age at first pregnancy was found to be about 19 years for the women at risk. In addition, all births resulted from premarital conception.

Hayford and Guzzo (2010) point to a relationship between a young mean age at first pregnancy, unplanned pregnancies and negative health outcomes for mothers and

babies. Accordingly this study showed an association between unplanned, early pregnancies, closely spaced births and non-use of contraception for the ten interviewees, which could potentially lead to poor reproductive health outcomes.

**Table 4.5: Women at risk disaggregated by age at first pregnancy (N = 10)**

Pseudonym and at-risk status	Age group at first pregnancy	
	15-20 years	21-25 years
Ntombi (teenager)	✓	
Zodwa (teenager)	✓	
Thandeka (> 35 years)		✓
Busi (> 35 years)	✓	
Thuli (closely spaced births)	✓	
Boni (closely spaced births)	✓	
Masesi (high parity)		✓
Zanele (high parity)	✓	
Lolo (HIV+)	✓	
S'mangele (HIV+)	✓	
Total (N = 10 women 'at risk')	8	2

What was striking from the findings is that the two teenagers in the at-risk group were 16 and 15 years old, revealing that girls in the rural iLembe district engage in early sex, unprotected against pregnancy, and the possibility of early childbearing and potentially difficult labour and motherhood. Unprotected sex also exposes girls to contracting sexually transmitted infections, including HIV. These factors subject women to the risk of reproductive ill health and mortality. Further analysis showed that the level of education of the risk group, geographical location and poverty played a role in influencing childbearing and demographic behaviour; for example, while half (five) had Grade 9 -12 level of education and another five had below Grade 8 or no education, the findings showed that no one amongst the women in the risk group had tertiary education. All the women lived in the rural iLembe and were generally poor.

Early childbearing might have serious consequences such as dropping out of school, restricted skills for gainful employment, capacity to support own children and poor quality of life generally.

#### **4.4.2 Birth intervals, pregnancy and delivery management**

Eight of the women had two or more children, with the mean number of live births (with all previous pregnancies included but the current pregnancies excluded) of three. The mean number of children surviving was 2.5. Among the ten interviewees 'at risk', two were teenagers, who were pregnant for the first time with their current pregnancies.

The pace of childbearing and the spacing of births are important factors in women's fertility behaviour and also help researchers to understand the likely influences of such behaviour on the health of the mother and the child. For example, some studies have shown that children born too close to previous births are at an increased risk of dying, especially if the interval between births is less than 24 months (Hobcraft 1998; Hobcraft, McDonald & Rutstein 1985). Similarly, the chances of the mother suffering from maternal morbidity and related reproductive health problems increase if pregnancies occur in quick succession (Hobcraft 1998).

Of the eight women 'at risk' who had had two or more live births:

- two were pregnant within 18 months of a previous birth;
- one had a birth interval of 18 to 23 months between the current pregnancy and the youngest child;
- four women had a birth interval of 24 to 35 months between the current pregnancy and the youngest child; and
- one had a birth interval of 36 months or more between the current pregnancy and the youngest child.

From the data above it can be argued that the ten women entered the demographically-defined reproductive period in already weaker positions in respect

of their vulnerability to poor health outcomes. In addition, structural factors such as low levels of education, as well as the unemployment and poverty make it difficult for them to avoid such outcomes, unless targeted social interventions are implemented to promote development and break the cycle of early childbearing and poverty.

The management of health problems during pregnancy and after delivery is important to maintain the health of the mother (and by extension the health of the new-born) (Bhutta 2011; UNICEF 2009; WHO 2010a). The respondents were therefore asked to report any health problems they had experienced during their current and their last pregnancy that caused them to be hospitalised. Six of the women reported not to have experienced any health problems that required hospitalisation. Four of the women (Thuli, Busi, Masesi and S'mangele) were hospitalised during their pregnancies and/or confinements or deliveries.

Thuli shared her experiences with regard to hospitalisation while pregnant:

With the previous pregnancies of my other two children, I was hospitalised for shortage of blood and received blood. However, for this current pregnancy I was hospitalised for stomach cramps. I also had high blood pressure. I actually slept at the hospital before delivery of my two other children and after delivery, as I always deliver through Caesarean sections.

Busi was hospitalised previously for the delivery of her first child in 1990. She was admitted again with her current pregnancy because she was considered a high risk due to her age. Much of Busi's narrative reflected a distrust of Western bio-medicine, but should also be seen as in part informed by the little information about her own health problems given to her by the staff on the one hand and comprehended by her on the other hand. She self-medicated by using traditional herbs (indigenous medication), but admitted that she was not knowledgeable about its benefits or side effects. She commented:

I am not a person who frequently visits the hospital because I stay healthy. I take herbal pots/herbal potions (*referring here to herbal remedies*) because I believe they make me healthy, although I do



not know if taking ihlambizo (*an herb*) is right or wrong. My strong belief is that the tablets make us weak, they weaken our blood.

Masesi was admitted for persistently high blood pressure during the last pregnancy, hence she has been advised to deliver at the hospital again for management of her labour and high blood pressure. S'mangele was admitted in 2007 with premature rupture of the membranes.

In terms of immediate health threats at the time of the interviews, Thuli appeared to be most at risk of reproductive ill health and mortality should she not be managed properly. She reported to have suffered from high blood pressure, swollen feet and anaemia with previous pregnancies. She had already been admitted to the hospital with her current pregnancy, again suffering from high blood pressure, anaemia, obstetrical haemorrhage and abdominal pain. As with Busi (discussed above), Thuli found the little information she had about her own health baffling and struggled to use bio-medical terms to describe to the researcher what she experienced. She said:

The doctor says I have a heart problem, hence he took it upon himself to book me for the clinic. I think I have all these problems because of blood. I had blood pressure when I was 16 years old in 2007 with my child number 1.

Masesi, with a history of high blood pressure, obstetrical haemorrhage and a previous Caesarean section, also presented as a high risk case. Her re-telling of the treatment of these problems reflects the same lack of clear information about her pregnancy-related and obstetric health problems, as reported for Busi and Thuli above. Yet, as was the case for Busi and Thuli, she saw value in accepting bio-medical interventions to avoid poor health outcomes. She shared her story:

I had high blood pressure with all my previous pregnancies. Then I would always be given tablets and attend my clinics at Stanger Hospital. I've been requested to be managed at the hospital and not the nearby clinics like other women. Even before I went for my booking, on the 10<sup>th</sup> of January 2011, I went to the doctor first so that he could tell me how many months pregnant I was. Then I went for my first booking at the clinic but was then referred to the

hospital. All the tests were done. ... I was then advised to go for an ultrasound on the 14<sup>th</sup> of January so that I can know exactly how far pregnant I am. I will be given dates for attending check-ups before I go for delivery at Stanger Hospital ... I delivered child number 4 through Caesarean section at Stanger Hospital, because I was bleeding vaginally. I really do not know why I was bleeding; hence I am so scared about what will happen with me or my baby during the time of delivery.

Although six of the ten women reported that they did not suffer from health problems that might require hospital admission during their current pregnancies, all ten reported some pregnancy-related health problems. In particular, they reported the following minor 'pregnancy' ailments:

- two reported light-headedness during physical strain;
- two suffered backache;
- two experienced abdominal pain;
- one reported obstetrical bleeding;
- two reported a white discharge;
- two suffered oedema of the feet; and
- five reported pregnancy-related nausea and vomiting.

These ailments were not generally discussed with medical staff during antenatal care visits, revealing again the limited communication between the pregnant women and the health care practitioners. The interviews revealed that all of the ten interviewees made arrangements to be medically assisted for their deliveries. Four women reported previous home deliveries with their second youngest children, with all the home deliveries attended to by untrained persons. However, as all ten women were booked for medically assisted delivery with their current pregnancies, the problems related to home delivery seem to be less prominent for the interviewees.

#### **4.4.3 Use of contraception**

According to Table 4.6 below, five of the ten interviewees had used contraception before, whereas five had never used methods of birth control for reasons ranging from a lack of knowledge to never considering adoption of such methods. These five never-users included the two teenagers, two women with closely spaced births and one with a high number of births. One of the closely spaced birth interviewees underestimated her risk of falling pregnant with all three of her pregnancies.

The five previous users of contraceptives included three who have stopped due to unpleasant side effects, one due to the distance to a clinic, and one previous user fell pregnant as she underestimated the risk of conception. Ambivalence, lack of information on contraception coupled with poor knowledge of conception and lack of access to family planning services have been identified in this study as major factors subjecting women to the risk of reproductive ill health. Discontinuation of contraception associated with perceived risks of side effects and real side effects (which were at times discussed or not discussed with health professionals) added to the reasons for some of the women's failure to prevent pregnancies or to mistime their pregnancies.

A lack of active pregnancy planning and ambivalence about the consequences were evident in all the narrations. There thus seems to have been a passive romanticisation of pregnancy with some of the women neither actively planning nor actively avoiding pregnancy. The women who confessed that they lacked information about birth control did not indicate that they were actively pursuing obtaining such reproductive health information in the near future. These issues are discussed in greater detail below, starting with the non-users.

**Table 4.6: Women at risk disaggregated by ‘ever used’ contraception (N = 10)**

<b>Pseudonym and at-risk status</b>	<b>Ever used contraception?</b>	<b>Comment</b>
Ntombi (Teenager)	No	No knowledge of contraceptive methods
Zodwa (Teenager)	No	No knowledge of contraceptive methods
Thandeka (> 35 years)	Yes	Stopped due to clinic inaccessibility – long distance to a facility
Busi (> 35 years)	Yes	Stopped, parted with boyfriend in 1995
Thuli (Closely spaced births)	No	Went to clinic to fetch them, found that she was pregnant already
Boni (Closely spaced births)	No	Never considered it
Masesi (High parity)	Yes	Stopped due to bleeding problems
Zanele (High parity)	No	Just didn’t think of using it
Lolo(HIV+)	Yes	Bleeding problems due to contraception
S’mangele(HIV+)	Yes	General swelling due to contraception, fluid retention and bleeding problems.

**4.4.3.1 Reasons for the non-use of contraception by five at-risk interviewees**

The reasons for non-use included poor knowledge of contraception, poor tolerance of the side effects of hormonal contraceptive methods, a wish to prove own fecundity, and a reliance on extended breastfeeding as a method of birth control. When the researcher asked Ntombi why she did not use contraceptives, she responded that she had no knowledge of family planning, contraception, sex or reproduction, and that she had never discussed such matters with her mother or other older females. The other teenaged interviewee, Zodwa, also indicated that she lacked knowledge about reproductive health and that she was pressured into having unprotected intercourse by her boyfriend (in her own words, he asked her to ‘*play husband and wife*’). She reported that before having intercourse with this boyfriend, she had only had one menstrual cycle.

The researcher found it shocking to hear from the two teenaged interviewees that they had never been exposed to sex education – not even when they were at school.

This lack of knowledge rendered the two young women extremely vulnerable, not only to unplanned pregnancies but also to the risk of HIV infection or other STIs.

Although she knew about contraception, Thuli never practised it because she thought she would cope with sexual abstinence. She drifted from one sexual relationship to another and only considered using birth control after suspecting that she might be pregnant again. Even after having had two previous births from two previous relationships, she claimed that her third pregnancy caught her off guard as it occurred so quickly after meeting her latest partner. The reasons for this lack of planning on Thuli's part are difficult to fathom. She appeared to be fully cognisant of the health implications of closely spaced pregnancies, and of the hypertensive eclampsia that she was experiencing at the time of her pregnancy. However, she appeared to be ignorant of the fact that pregnancy can result from unprotected intercourse. She reported that she was considering asking for a tubal ligation following the delivery of her current baby.

Boni, another woman who has never considered using contraception, was pregnant for the second time, 16 months after delivering her first child. She confided in the researcher that she deliberately fell pregnant at the age of 19 years because she wanted to see whether she could have a child. She also reported that the second pregnancy was unplanned. When asked why she did not use contraceptives when she did not want to fall pregnant again, she replied:

It's not that I do not want the child to be born; it's just that I did not plan to be pregnant. It's a mistake. I cried when I learned that I was pregnant. I have since accepted that I will have the child. My mom shouted at me for being pregnant again when my first child is still very small.

Zanele, the 40-years-old interviewee who had been pregnant nine times, was HIV-positive and 7 months pregnant at the time of the interview, never used contraception because she apparently did not like hormonal contraception. She reported that she preferred using breastfeeding to keep ovulation away. As Zanele is not new to antenatal care, it can be argued that there were many missed

opportunities to educate her on the poor contraceptive efficacy of extended breastfeeding. In addition, Zanele's HIV-positive status is a concern.

#### **4.4.3.2 *Reasons for discontinued contraceptive use by five at-risk interviewees***

All of the previous contraceptive users who discontinued use relied on hormonal methods offered by clinics. The reasons for discontinued and intermittent use ranged from poor access to clinics, to underestimating the need for protection and poor tolerance for the side effects of hormonal contraceptive methods. Thandeka, the interviewee in the over 35 age group, used the contraceptive pill before changing to Depo Provera, but found the distance to the nearest clinic too far, and thus stopped using. The other previous user of contraception in the over-35 group, Busi, reportedly used a long acting hormonal contraceptive injection, Depo Provera, for five years until 1995, when she discontinued use because her relationship broke up. On probing why she did not resume contraceptive use after commencing another sexual relationship, she asserted that:

I never thought I would be pregnant again because for 15 years I did not use any contraception even during the times when there was a man in my life. Then all of a sudden I realised that I missed a period ... I did not think about pregnancy, I thought I am getting into menopause. I was disappointed ... scared because of my age ... and thought my partner will be angry with me because we did not plan the pregnancy together. When I disclosed to him, he told me that I shouldn't worry, the pregnancy is very much welcome. Since then he is even more supportive and very loving. It is for this reason that I accepted the pregnancy too, although it was not planned.

Busi's story shows how little personal agency forms part of her reproductive decision-making. Although she used contraception before, she stopped and did not use it again as casual sexual encounters did not result in a pregnancy.

Masesi stopped using a long acting hormonal contraceptive injection, Depo Provera because of the side effects she experienced. At the age of 35, she was expecting

her sixth child and suffered from pregnancy-related hypertension. On probing for the reasons why she was not practising family planning, Masesi responded as follows:

To be honest with you, I did not want to have so many children, but when I think back to where my problems started with this blood pressure, my observation is that it happened when I started using contraception after my second child. I was switching methods from the pill to the injection, then back to the pill. But they were all the same with giving me health problems. I never used to have a body as big as this. In the process of changing, then I would fall pregnant. Before the current pregnancy, I used an injection again. I chose it because it lasts for three months and I thought that it was also economical because I wouldn't have to waste money on transport to go to the clinic. I started bleeding profusely. When I went to report this at the clinic, I was told that the bleeding would stop and was given tablets. The nurse said after a full month cycle, they will control my menstruation. Now with a double dose of contraception (*meaning the injection and the pill*), I experienced headaches. I got fed-up with this contraception thing, discontinued everything with the hope of going for sterilisation. When the doctor confirmed that I was pregnant and my blood pressure was high, I became so scared. I am so scared and worried. I have asked for sterilisation after delivering this baby.

It seems that in Masesi's case, missed opportunities for advice on a more permanent form of contraception such as female sterilisation, put her life at risk. She is not against using contraception and is considering tubal ligation. Thus inattention to Masesi's reproductive needs by health care professionals has contributed to her ill health.

Lolo, a previous hormonal contraception user, started experiencing bleeding problems. Her first use commenced after the birth of her third child. She shared her story:

I went for an injection at the clinic. I was given Depo Provera ( a long acting hormonal contraceptive injection) but since then I have been spotting and bleeding. I went back to report it, but I was told that it is normal for a woman to experience bleeding when on the

injection. The bleeding interfered with my life and my partner too did not like it. When I stopped, I fell pregnant. I was never informed that this could happen. I only heard from other women who also used an injection and experienced bleeding problems. Some of them were told by the nurses that it is normal. I do not agree with this story. Naturally a woman has to bleed and stop. I do not think it is right to bleed forever.

Lolo's story seems to hint at poor acceptance of contraception in iLembe, due to the unpleasant side effects of the hormonal injection. In the absence of proper counselling by the health care professionals and proper screening for an appropriate method, women will share lay information among themselves - which in turn may increase non-acceptance of modern contraception.

S'mangele used the contraceptive pill for some time, but when she experienced side effects, she switched to an injection. This caused more severe side effects such as fluid retention, swelling and bleeding, and she decided to discontinue contraceptive use altogether – which soon resulted in a pregnancy. She reported that she and her partner were currently using condoms because of their HIV status. They do however wish to have another child in future in line with familial expectations upon the recently married couple to produce offspring.

Although the ten women at risk were pregnant, all of them alleged that their pregnancies were unintended and mistimed, pointing to an unmet need. Casterline and Sinding (2000) note that women have an unmet need for contraception if they are not using a contraceptive method but are capable of conceiving, are exposed to the risk of pregnancy, and wish to avoid or to postpone pregnancy.

Dixon-Mueller and Germain (1992) identify an unmet need in the following categories:

- (a) women who definitely want to avoid or postpone pregnancy but use an ineffective method;
- (b) women who definitely want to avoid or postpone pregnancy but use a theoretically effective method incorrectly or sporadically; and



- (c) women who, regardless of their reproductive intentions, use a method that is unsafe or unsuitable.

From the five previous users of contraception, Thandeka belonged to category (b) of the classification, while Masesi, Lolo and S'mangele belonged to category (c). Busi just underestimated the risk of pregnancy and thus it is not easy to fit her within the classification of Dixon-Mueller and Germain (1992). From the perspective of the non-users, only Zanele used the Lactational Amenorrhoea Method (LAM), which was unsafe and ineffective, and places her in category (c).

#### **4.4.4 HIV status**

Among the ten interviewees, three women had a known HIV-positive diagnosis. They were the two women who were deliberately chosen to be in the category of HIV-positive women and one who was in the category of high parity. These three women, Zanele, Lolo and S'mangele, all indicated that they only discovered during the antenatal care visits for their current pregnancies that they were HIV-positive. It should be noted that all ten women had unprotected sex and, whereas it resulted in unplanned pregnancies for all of them, it also resulted in infection with the HI-virus for three of them.

S'mangele was 21 years old, just married and expecting her second child. She declared, *'Irrespective of my status, I will still have other children. My partner and I will decide how we deal with the issue later because the nurses have advised that we should use condoms'*. She revealed that her husband had confessed that he was the one who had transmitted the virus to her. S'mangele has decided to stay in the PMTCT programme until her baby was born. In follow-up interviews with S'mangele, the researcher probed the reasons for her determination to have more children despite her status. It seemed that she had interpreted the advice of the nurse that PMTCT can assist HIV-positive women to have healthy babies as an instruction to fall pregnant again in future. Moreover, this was also influenced by S'mangele's interpretation of cultural and familial pressure on her to produce offspring.

Lolo, interviewed as part of the HIV risk group, was pregnant for the fifth time. It seemed to the researcher that Lolo's concerns about the latest pregnancy were greater than her concerns about her HIV-positive status. Lolo might not have discovered her status had she not been pregnant and been tested at the antenatal care clinic. This points to the possibility that the true prevalence of HIV/AIDS in South Africa is possibly being underestimated as not all people at risk are routinely tested. S'mangele's and Lolo's attitude towards their HIV status also demonstrates that the women's lived experiences of their own risk status in terms of maternal morbidity and maternal mortality differed from any biomedical or demographic classification system.

#### **4.5 PERCEPTIONS OF THE AT-RISK INTERVIEWEES ABOUT RISK FACTORS FOR HIGH MATERNAL MORTALITY IN SOUTH AFRICA**

Through talking to the pregnant women in the rural iLembe district and getting their perspectives, it became clear that nutrition (mentioned by five women), male partners absconding and shirking their responsibilities (mentioned by three interviewees), pregnancy itself (mentioned by three women), and prior illnesses such as HIV/AIDS and TB (mentioned by three women), were regarded as the major causes of maternal morbidity and mortality in the area. These ideas are summarised in Table 4.7 (below). Two socio-economic factors, namely poor nutritional status and neglect by male partners, were singled out as the major concerns for the at-risk interviewees.

Nutrition (poor nutritional status due to poverty) ranked high as a perceived cause of death among women of reproductive age. In addition, social, economic and emotional neglect by male partners were perceived as a second important cause for poor health outcomes for women in South Africa. The two biomedical factors mentioned were the risks posed by pregnancy itself and illness prior to pregnancy such as TB or HIV. Another reason mentioned by two interviewees as causing maternal morbidity and mortality was teenage pregnancy. This was linked to problems caused by young women's physical immaturity (e.g. '*a weak bone structure*'). Two interviewees could not mention possible causes for maternal mortality. For example, Busi mentioned:

I really do not know what kill women these days. We never used to have so many deaths ... We learn that women are killed by diseases such HIV/AIDS. Nowadays AIDS kill people and mostly women. We are concerned about our kids. Things have changed. People suffer from (high) blood pressure, sugar diabetes and other illnesses which we do not understand and yet kill women. We are dying, it hurts and it is scary. Women used to deliver safely by traditional birth attendants (TBAs) at home, but now things have changed. I think it is because our health system tends to be weak in accepting traditional ways of preventing illnesses.

**Table 4.7: Views of women at risk of the causes of ill health and mortality of women during pregnancy/during or after delivery (N = 10)**

Pseudonym and at-risk status	Poor nutrition	Partner disappearing	Pregnancy itself	Prior illnesses e.g. HIV, TB	Teenage pregnancy	No idea why	Other
Ntombi (Teenager)	X	X					No support from family
Zodwa (Teenager)						X	
Thandeka (>35 years)		X		X			
Busi (>35 years)	X			X		X	Traditional birth practices are ignored
Thuli (Closely spaced births)		X			X		Closely spaced births
Boni (Closely spaced births)				X	X		
Masesi (High parity)			X				
Zanele (High parity)	X		X				
Lolo (HIV+)	X						
S'mangele (HIV+)	X		X				Smoking, alcoholism
Total number of responses	5	3	3	3	2	2	

Upon further probing by the researcher, Busi mentioned that many women suffer poor health outcomes due to poverty and starvation, and that the state is only able to

offer tangible assistance in such matters when a woman has a known HIV-positive diagnosis. She elaborated:

For example, one has to be HIV-positive to receive assistance from the government; otherwise no one cares for women if they are not HIV-positive, regardless of how poor they may be ... The health professionals advise us that we should eat healthy; they have no idea if we have the food that they tell us to eat. They do not even ask if we will be able to afford the very food they are telling us to eat. Women and their children have no food; hence the nutrition is not right. One just eats to fill up the stomach. We are taught that to eat starch with starch is bad eating ... but if it's only pap and potatoes that we can afford and it is available, what shall we do? We will eat so that we do not die from starvation. The government needs to assist us based on our situation at home, not only based on our HIV/AIDS status. I agree that women with HIV/AIDS have to be assisted, but HIV is not the only illness that kills; starvation kills women because if a woman is pregnant, there are two people to be fed there, a woman and the one to be born.

Of interest from Busi's interview are her insights into a wider net of causal factors in maternal mortality. Beyond her utterances about poverty and poor nutrition, she also held firm views concerning an integration of modern biomedical assistance with traditional antenatal and delivery care. Although she actively sought modern biomedical attendance at a health facility, she was still doubtful about the adequacy of this service. She expressed views in favour of integration of modern and traditional methods of health care.

#### **4.5.1 Nutritional inadequacies as a cause of maternal morbidity and mortality**

Half of the interviewees spontaneously listed malnutrition as a major cause of maternal mortality in South Africa. Problems related to inadequate nutrition were also mentioned by the interviewees when asked what the government can do to assist women to survive. However, a focus on inadequate nutrition as a cause of death obscures the full character of social problems suffered by black, poor, rural women.

While malnutrition can be regarded as a cause of death and thus as a health issue, it is also a symptom of deprivation at the level of household and community, and is thus related to poverty and norms regarding food distribution in the family or community. The researcher found that at the household level, all ten women reported a lack of food and a lack of nutritious foodstuffs. For example, although starchy foodstuffs were available (albeit in inadequate quantities), protein-rich foodstuffs were reported as being scarce and unaffordable.

Thus the study found that malnutrition stood out as a social root cause of morbidity and increased mortality of women in the iLembe district. In this regard, addressing poverty seems a priority, as countries with greater income equity show better health outcomes and lower levels of violence, better educational performance of school children, lower teenage birth rates and reduced mortality rates (Sen, quoted in Wuyts, Mackintosh & Hewitt 1997).

#### **4.5.2 Neglect by male partners as a cause of maternal morbidity and mortality**

Three of the 'at-risk' interviewees reported the absence of a male partner and lack of support by male partners during pregnancy or post-delivery as a cause of maternal and new-born deaths. Abandonment or neglect by male partners was narrated as a deeply degrading and humiliating experience for women, causing serious ill health. Thuli, for example, said:

To tell the honest truth, men do not love us. All they want is to sleep with us; when we fall pregnant, then they run away. One becomes a laughing stock in the community and one feels so dirty. This too causes such an embarrassment to our parents. One neighbour commented sarcastically that some girls are just objects that men relieve themselves with sexually when they have lust ... I have come to realise that we – the young ones – fall in love with older men who are already married. They manipulate us so that we can have sex with them and when we fall pregnant they run away. Men also do not want to carry the responsibility of looking after their offspring. What I mean is that they do not want to maintain their offspring.

People engage in unprotected heterosexual sexual intercourse for different reasons, one possible result of which could be a risk to the woman's health in the form of a sexually transmitted infection or pregnancy. Thuli hid her pregnancy from her mother and neighbours, because she felt judged by the remarks they made about her. Reproductive health rights imply that men and women can engage in sexual intercourse and plan the number and spacing of children freely without discrimination, violence or coercion. Yet Thuli, who felt embarrassed about her latest unplanned pregnancy, clearly could not exercise these rights. Not only did the short intervals between her pregnancies pose a threat to her health, but her fears about making her current pregnancy known posed emotional and physical health threats to her.

Thuli continued:

The father of my second child deserted me when I was 9 months pregnant. He has never seen his child and the child is already 2 years old. Throughout pregnancy he beat me, forcing me to sleep at his place so that he can have sex with me, when he knew that he didn't love me. He was just using me.

The panel on reproductive health in developing countries at the 1994 International Conference on Population and Development, concluded that a reproductive health policy should aim at achieving the following goals, namely that:

- every sex act should be free of coercion and infection;
- every pregnancy should be intended; and that
- every birth should be healthy (Tsui, Wasserheit & Haaga 1997:1).

Following the ICPD, the World Health Organization (WHO) promoted the concept of reproductive health care in the context of Primary Health Care at its workshop in Southern Africa (WHO 1998). Among others, the recommendations of the workshop were that countries should embrace a gendered perspective as a fundamental underlying aspect of a reproductive health care approach. If Thuli's narrations are viewed against such a background, a wide gap between policy directives and the

lived realities of women at risk of reproductive ill health in rural South Africa can be seen. Reproductive health care delivery in iLembe seems stuck in the implementation of the same MCH package delivered by health professionals who focus on 'the pregnant woman' and the 'presence of a foetal heartbeat' at an antenatal clinic. Gaps remain in the implementation of reproductive health policies which align themselves with international agreements reached and signed.

According to the UNFPA (2007), having children is a partnership issue, and '*women have a right to health, but protecting that right often depends on a partner's support*'. The question which arises is: why do the men impregnate women and then disappear? Moreover, why is the apparent absence of responsible fatherhood so easily tolerated by the women? A possible explanation is that in a patriarchal society like that of the iLembe district, women's sexuality is shaped in service of men's needs and defined according to male norms.

An emphasis on men's involvement in maternal health seems to become a focal point in interventions suggested for the 15-year period for achieving the Millennium Development Goals. It is now clear that the target of reducing maternal deaths by 75% by 2015 will not be met without the concerted efforts of all involved. Men as partners, fathers, husbands, brothers, policy makers and community and religious leaders have a critical role to play in safeguarding the maternal health of women (UNFPA 2007).

#### **4.5.3 Pregnancy as a cause of maternal morbidity and mortality**

The study established that the interviewees perceived pregnancy itself as one of the main causes of ill health and death. Busi said:

Pregnancy used to be something that our ancestors used to be pleased about, but now things have changed. Once a woman gets pregnant, the community and the family worries whether a woman will come back home when she goes to the hospital to have a baby. The family worries whether one will go through delivery safely. Pregnancy has become a cause of death. Even here in the ward (*meaning the labour ward*), we have been talking among ourselves

if we will come out alive with our children ... At times it is the hospital that is not managing us well. At times it is because our bodies are already weak from the kind of food we eat which is not good for a pregnant woman.

The researcher aligns herself with UNICEF's (2009) contention that a woman's health and nutritional status, including HIV and anaemia, underlie maternal mortality and morbidity, along with societal factors such as poverty, inequity, women's low status and attitudes towards women and their needs. Such conditions are at the root of women being exposed to high risks of reproductive morbidity and mortality. From the above narration, it seems that the women themselves experience poverty on the one hand and inadequate health care on the other hand as major causes in making pregnancies major health concerns for women.

In addition to poverty and inadequate health care services, some of the interviewees were able to locate the causes of maternal morbidity and mortality as belonging to the sphere of actual reproductive choices and behaviour of women. In this regard, Thuli suggested that closely spaced births are dangerous and used her own experiences to report:

You see (*addressing the researcher*), right now I am pregnant and all my children are just a few months apart. I am so ill from this pregnancy. Even with my previous, other pregnancies I was ill and was admitted to the hospital with anaemia, swelling and high blood pressure. Now this time I am bleeding. The doctor strongly warned me against another pregnancy because he told me that several pregnancies in close succession would affect my whole body. I am now suffering from a heart (*problem*). The doctor advised me that I should close (*referring here to female sterilisation via tubal ligation*), because I will die if I dare fall pregnant again. Even now I am scared that I will die and leave my children.

When the researcher asked her why she did not use contraceptives to prevent a mistimed and unwanted pregnancy, Busi answered: '*The clinic is very far from home. When I finally got money to get to the family planning clinic, I was already pregnant*'.



Thus taking this narration as an example, poverty (no money for transport) and the inaccessibility of a family planning service (too far to access by foot) were the underlying causes that led to the closely spaced births.

The interviewees also mentioned other problems such as inadequate support from the family, alcoholism and smoking as other causes of maternal morbidity and mortality. (Glasier, Gulmezoglu, Schmid, Moreno, & Van Look 2006) suggest that the absence of sexual and reproductive health in developing countries undermines the ICPD PoA to the detriment of women's health. The authors advise that sexual and reproductive health (SRH) were identified and recognised as cornerstones of population- and development-related programmes due to the recognition that, if they (SRH) embrace the advancement of gender equality, empowerment of women, and elimination of the violence against women, as well as enabling women to control their fertility, they could reduce women's risk of ill health.

#### **4.5.4 Financial, physical and emotional abuse by men**

The researcher found it surprising that none of the women mentioned outright that ill treatment at the hand of male partners was a cause of maternal morbidity and mortality, despite the fact that stories about abusive or negligent partners (and other significant men) were central motifs in all the narrations. From the ten women 'at risk' who were interviewed, three reported to have been physically abused and four women reported to have been emotionally abused by their male partners. A further two women had been physically and emotionally abused by men.

Among the five women who were allegedly physically abused, four were abused by boyfriends, and one woman, Boni, had been beaten up by her brother. This alleged attack was instigated by Boni's mother, who instructed the brother to beat his sister because of her pregnancy. Boni regarded this attack as a deep betrayal of expected support, and reported:

It's my mom; it's my mom who instructed my brother to beat me up because I am pregnant. She said I am a disgrace to the family and she does not have money to be feeding my babies. She is accusing me of increasing her family and adding to her burdens.

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A study conducted in informal settlements in KwaZulu-Natal found that violence in intimate relationships was a barrier to practising safer sex and subjected women to the risk of reproductive ill health (Abdool-Karim 2001, quoted in (Garbharran, Edwards, Smith, Lutcmiah & Mkhize 2003). From the women's narrations, the researcher concluded that emotional, physical and sexual violence form an integral part of intimate relations in the study site. Abuse of women appears to be normalised and to be proliferating under the harsh and desperate economic conditions prevailing in the area. Amina Mama (Mama 2001) provides an interesting feminist view on violence against women and suggests that tolerance for violence characterises African social and political life before and after colonisation.

Material dependency, the craving for emotional affection, lack of alternative opportunities and culturally sanctioned female subordination to the socially constructed values and norms leave very few options for a poor woman other than the physical and material protection from a man as a last resort. Almost all of the women interviewed came from and still live under circumstances that could be described as destitution. Their biographical backgrounds fit well with the stories that have been told across the developing world: single mothers, widows, divorcees dependent on their own resources. They tended to be the poorest of the poor and perceptibly vulnerable by virtue of their social status.

Adding to their economic deprivation, most of the interviewees reported a gender bias in the sexual division of labour (SDL), which dictates that mothers, daughters, sisters and pregnant women were the ones performing domestic chores during pregnancy and in the post-partum period. Of the ten interviewees at risk, five reported that they were receiving support in sharing household duties from their mothers, four from their daughters, one reported to be receiving support from a partner and one from a son.

Of the three women who reported that they would themselves do all of the household work during pregnancy and during the post-partum period, only one hoped to receive help from a partner. Patriarchal traditions expose South African, poor, rural, black women to subordinate positions and subject them to the risk of ill health. For

example, in a study conducted by Klugman and Weiner (1992) in the rural areas of South Africa, reproductive morbidity and mortality were found to be associated with excessive manual work and lack of rest. Rural black women compared to their urban counterparts worked strenuously for longer periods and were continuously overburdened with domestic chores such as collecting heavy water pots from wells and firewood for fuel.

#### **4.5.5 Conclusion**

In this thesis the causal determinants of reproductive health were examined by means of interviews with the women who were seen as 'at risk'. The age at first pregnancy, birth intervals, pregnancy and delivery management and use of contraception were associated with reproductive health status.

The study found that the mean age of first childbearing was 19 years, indicating that women at iLembe initiate sex and childbearing at a young age. The relatively low mean age at first pregnancy further indicated that many women have children before they are physically and psychologically ready for pregnancy and childbearing, thus making them more susceptible to the risk of maternal ill health and mortality.

Through interviewing the women-at-risk, the study established that most pregnancies (for all ten of the women interviewed) were unplanned; however, women tended to accept them. The study further established that the economically and socially underprivileged black rural women are the most vulnerable and disempowered groups in protecting themselves against unplanned pregnancies and HIV and AIDS due to inaccessible services, limited education and inadequate access to accurate information on sexuality and reproduction.

Reproductive ill health was further associated with closely spaced births and poor contraceptive usage, which were both attributable to ignorance of reproductive health and poverty. Reasons for termination of or poor use of contraception included long distances to the service, misperceptions about contraception and poor tolerance of side effects. The non-use of contraception was further associated with underestimation of the risk to fall pregnant during lactation.

Early childbearing, close birth intervals and non-use of contraception have a number of social and health implications for young women and their offspring, such as leaving school and the likelihood of having more children by the end of their reproductive years. They are thus trapped in the poverty cycle.

The interviews included investigating the perceptions regarding what makes the women ill, their desires, felt needs and demands that would require appropriate state intervention.

Women cited nutrition as the main factor exposing their health to risk, followed by social, financial and emotional abuse as well as neglect by male partners. These intermediary social determinants of reproductive ill health demonstrate that health is not only affected by the commonly known causative factors to maternal mortality, including infection, but also other underlying social and economic factors (that is, upstream factors). Some contradictions were also noticed during the period of data collection, e.g. the study established that women perceived pregnancy itself as a cause of mortality; however, almost all the women were found to be doing very little to prevent unplanned pregnancies.

Interviews with women at risk highlighted an inability to adhere to advice from health promotion due to its ill-affordability. For example, pregnant mothers have often been advised to take a well-balanced diet. The women at risk noted that poor rural women do not have the means to purchase such a diet and yet health care professionals do not take such factors into consideration when issues affecting women are attended to. The women at risk suggested that it may be better if the government were to provide a nutritious diet to pregnant mothers so as to prevent morbidity and mortality from maternal malnutrition and anaemia.

The women at risk voiced that serious health problems have been experienced from using contraception, and yet their health problems were not treated satisfactorily, hence they defaulted or terminated their use of contraception and fell pregnant. In this study, women demanded that safer contraceptives be provided.

## **4.6 RESULTS FROM VERBAL AUTOPSIES OF THE CIRCUMSTANCES LEADING UP TO MATERNAL AND NEONATAL DEATHS**

The researcher made use of verbal autopsies as part of gathering qualitative data from communities in the ILembe district, with the main objective of:

- Identifying deaths that have occurred in pregnant or recently delivered women;
- Identifying deaths that have occurred in the neonates;
- Providing broad categories of causes of maternal death;
- Understanding the circumstances that may have contributed to the deaths; and
- Describing the background characteristics of the women who died, including age, parity, education, and other health and social variables that may have influenced maternal mortality in the area.

Following discussions with staff members at the clinics in iLembe, the researcher was able to identify recent maternal and neonatal deaths and obtain contact details for family members of the deceased. The researcher contacted the identified individuals telephonically with the help of a member of a local NGO. The researcher was able to trace, find and interview five persons, of which three were able to offer verbal autopsies for maternal deaths and two were able to give verbal autopsies concerning deceased neonates. As will be demonstrated below, the interviewees for the verbal autopsies could not identify the specific medical causes of the maternal or neonatal deaths, but they all spoke about social and economic exclusion, limited knowledge about reproductive health matters, limited access to emergency obstetric care and negligence attributable to poor quality of care in the reproductive health care units.

### **4.6.1 Verbal autopsies about the causes of maternal deaths: Nontu's story**

The mother and uncle of Nontu (pseudonym) reported on the events that led to this teenager dying following a Caesarean section delivery. Nontu was 16 years old, unemployed and still at school in Grade 11, when she fell pregnant. This was her

first pregnancy and the family never discovered the identity of the man who had made Nontu pregnant. She lived with her mother and younger brother in the same dwelling – a traditional clay hut without running water and electricity, located in a deep rural area in iLembe. Her father, a migrant worker, was often absent from home. The researcher was told that Nontu's family hardly had money to cover the funeral costs. The hospital staff contributed to groceries for the funeral and donated tins of formula milk so that the family could bottle-feed Nontu's baby.

Nontu's uncle related:

Nontu attended the antenatal clinic after her mother discovered that she was pregnant. She was 6 months pregnant when she started attending the antenatal care and she never failed an appointment. She was healthy until she came to the hospital. She shouldn't have died. We got the story that her blood pressure (BP) went down. We then asked the nursing staff if the BP was monitored or not. From what we discovered, the BP was not monitored ... The government should in each case do a close follow-up to the admitted patients and keep a close watch on the nurses.

When probing further about possible symptoms that caused Nontu to seek help at the hospital, her mother recalled that she had complained about a pain in her leg on the 29th of November 2010. She went to the hospital on the 30th of November 2010 and was admitted to a ward at 13h00. Nontu's mother paid her a visit on the 1st of December at which time she was informed that Nontu's membranes had been ruptured to induce labour. The reasons behind this intervention as well as instructions by the nursing staff that Nontu must walk around to further encourage labour were not explained to the patient or her mother.

By the evening of the 1<sup>st</sup> of December 2010, Nontu had not yet delivered. She was then moved to the theatre for a Caesarean section. Nontu recovered sufficiently from the Caesarean delivery to be able to talk to her mother over the telephone. Nontu reported that she was doing well and that she had delivered a healthy baby boy.

Nontu's mother related the story of her daughter's death:

Then I do not know what happened sisi, (*crying*). These nurses neglect them, especially if the girl is young ... They killed her, the nurses killed my child. I still want to see those nurses who were on duty. I asked to see them so that they can just tell me how they feel after killing my child. I want them to tell me how they will feel if someone did the same to their children ... I don't know how things operate in these hospitals, especially Stanger. I've never heard that after the water has been broken, then a woman is still expected to walk. I've never heard of such a thing. What they did is unfair because the matron told us straight that they were sleeping. The sister in charge went on lunch for two hours; I really don't understand. We asked how many times they checked on her after the operation. The sister in charge said they should have checked her every hour but that was not done. She was not checked hourly, she was never checked during the night. If the patient was cared for, she would not have died. Now the nurses never told the doctor that my daughter experienced difficulties. The doctor also heard in the morning. The nurses never checked my daughter throughout the night. She died alone, in difficulties. No one knows what happened and yet she was brought to the hospital to get professional help (*crying*). Before the operation she called and said that they were taking her to theatre because the labour was delaying and I agreed that she had to go to theatre. She said we should not call her cell phone because she was about to take off for theatre and her cell phone will be off. Then she went and at home we prayed because that's what we normally do before going to bed. In the morning, at around 4 a.m. my mother woke me to say we are now happy that Nontu has given birth to a baby boy. By then my mom had already called my brother who works in the hospital to find out if the child has been delivered. We have a connection at the hospital, a guy we know that works at theatre ... he is the one that allowed Nontu to call us. She was okay because even that guy who

works at the theatre indicated to my brother that Nontu was okay, the operation was successful. ... I'm really failing to understand. I honestly want to understand what really happened because everyone doesn't know what happened. At first they lied that they were checking on her until around 5 a.m. When we got to the hospital, we then heard the truth. We were then told that her labour delayed and doctor made a decision to operate her. When she came out of theatre she was never checked until in the morning. I got to hear that when we asked where the file was so that we could see ourselves the number of times she was checked. I further asked the matron exactly how many times she was supposed to be checked. She indicated that there was a problem because she should have been checked hourly – which was never done. I reached the conclusion that my daughter was neglected deliberately.

The deceased's infant son is cared for by Nontu's maternal grandmother. Nontu's mother explained the difficulty of asking her mother to care for the infant while she herself was away at work as a cleaner:

My mom is looking after the child, although she is also very old. I leave the child with her in the morning because I have to work and provide for the family and the baby. I take over from her to look after the baby when I get home late in the afternoon. I have become a mother of a baby at my age. I have started washing nappies because I cannot afford the disposable ones. I have started to buy tin milk and baby clothes with the very little money I earn from domestic work. The baby does not have a father; we did not know the boyfriend. When the baby is not well I have to be absent at work ... It is just difficult, very difficult! It really hurts, it would have been better if she was sick like having diseases like HIV/AIDS which kill women nowadays. Maybe I would have accepted her death because I would have understood that she was ill. But now she was completely well and healthy. I called the hospital and asked what her BP was. I was told that it was normal. My thinking is that, what



really happened was that they all decided to neglect her, I really don't know. Or maybe that's the way they operate, that they just neglect women who have come to give birth and forget about them.

The researcher adopted a pathway analysis to track the pathway of the events that led to Nontu's death. According to Kalter, Salgado, Babilie, Koffi and Black (2011), the pathway analysis social autopsy model was developed by the Child Health Epidemiology Reference Group (CHERG) with the support of the WHO and UNICEF, with the aim of tracking the social, cultural and health care factors that contribute to biological factors identified by the verbal autopsy (Kalter *et al.* 2011). By using the pathway analysis, the researcher was unable to ascertain the actual cause or underlying causes of Nontu's death. However, considering that the type of medical assistance provided to a woman in labour impacts on her reproductive health and hence on maternal mortality (United Nations Millennium Project 2005), it can be concluded that poor quality of care contributed to Nontu's death. It is clear that her death had a significant emotional impact on her family. Moreover, it placed a great strain on the family's already meagre resources and on the care burden of two elderly women.

#### **4.6.2 Verbal autopsies about the causes of maternal deaths: Zola's story**

The interview about the maternal death of Zola (pseudonym) was held with the deceased's sister. The researcher was told that Zola had delivered her baby at home in the toilet and was taken to the hospital soon after. Zola had gone into premature labour, since she was only 7 months pregnant when she delivered. Before her death, Zola worked on a farm in the ILembe district. She was not married, but she lived with a boyfriend. She already had one child, who now stays with his grandmother in a rural area in the Eastern Cape. Zola's sister recounted:

It was the 27<sup>th</sup> of July 2010 when she delivered and was taken to the hospital. Some girls in the neighbourhood took her and the baby to the clinic first, because of her bad condition; but she was then transferred to the hospital. She was still bleeding profusely at the hospital. She stayed at the hospital from the 27<sup>th</sup> of July to the 3<sup>rd</sup> of August 2010, when she died. I was visiting her regularly at the

hospital. I continued visiting her, she was talking to me but her teeth were closed. She appeared to be mentally disturbed. I was informed that she was refusing to eat. The nurses asked me to urge her to eat because she was becoming weak from hunger. They said if she did not eat she would not make it. I tried but she was not eating. She was complaining that her baby has been taken away from her. She said that she was never shown the baby and really wished to see her. When I enquired from the nurses as to why she was not allowed to see her baby, they said the baby cannot go into that room since Zola was being isolated. The nurses said Zola was kept in an isolation room, but they never disclosed why she was being isolated. I do not know why she was isolated, perhaps because she was HIV-positive. She was always hiding it from me that she was HIV-positive. She was actually keeping it as a secret that she was taking ARVs. Her friends told me in confidence that she was on ARVs. She was taking ARVs privately. On the 2<sup>nd</sup> of August 2010 I paid her a visit. She asked for juice that I had brought for her. She drank it. I had also brought her apples. She took just a few bites from an apple. That was the last time I saw her alive. She died on the 3<sup>rd</sup> of August 2010.

Zola's sister thought that HIV infection was the underlying cause of her death. Moreover, she indicated to the researcher that Zola might have defaulted on her treatments because she was so secretive about her status. (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk *et al.* 2009b) suggests that HIV/AIDS is a major, if not the principal, factor in the overall rising number of maternal deaths in South Africa. However, the researcher cannot verify whether HIV infections or AIDS-related causes led to Zola's death. By applying the pathway analysis to this verbal autopsy, it would seem that Zola's HIV status, possible poor adherence to treatment, premature labour and heavy post-partum bleeding presented a chain of causes that led to her death.

#### 4.6.3 Verbal autopsies about the causes of neonatal deaths: Mary's story

Mary (pseudonym), the mother of a neonate that had recently died, was interviewed telephonically as she declined the researcher's request to interview her at her home. She informed the researcher that the support she had received from the hospital was inadequate. Mary said that she was left alone before and after labour as the nurses simply did not have the time to attend to her. She claimed to have delivered the baby on her own in her hospital bed and to have sustained vaginal tearing. This had been Mary's second neonatal death. She had no living children. She reported that the hospital staff was cruel, unsympathetic, inhuman and insensitive. Mary said:

When the black stuff started coming out of the baby' nose I could feel fear overwhelming me. I think the nurses had not sucked the baby properly (meaning clearing the baby's airway) after it was born. Before I was discharged, I realised that I had sustained a tear. I reported it to the nurse. The nurse examined me, and confirmed that I had sustained a tear. She said she cannot suture me as it was already late for suturing. She advised me to wash with salt at home. I was discharged at 12h00 on the 8<sup>th</sup> of January 2010. After two days at home, the baby developed fast breathing. The chest began to be hard. At around 2 o'clock the baby started frothing a black stuff from the nose. I hired a taxi and took the baby back to the hospital. The baby was sucked to clear the nose and given oxygen. We were re-admitted but the baby died a day later at the hospital. The baby was four days old when it died and was buried yesterday. I am very hurt (*crying*).

Mary's story recounts a loss of trust in the quality of care and technical competence at Stanger Hospital. At the heart of programme performance are the skills and competencies of staff. The quality of care is affected by, among others, the interaction between the service provider and the client. The relations between the provider and the client are strongly influenced by a programme's mission and ideology, management style, resource allocation and the ratio of workers to clients.

When applied to Mary's story, the pathway analysis shows that the public health care system failed in delivering a service that was responsive to the needs of the mother and her baby. The care accorded to the mother-baby pair during their most vulnerable days was inadequate. For example, during post-delivery the mother reported a vaginal tear, a sign of a difficult delivery; however, this was taken very lightly by the health professional, who just advised the mother to wash with salty water at home. The mother alleged that the baby was not examined by a medical professional, despite the fact that she was not attended to during delivery. Both the mother-baby pair were discharged a day after delivery.

When recognising that her baby's health was in danger due to its rapid breathing, the mother took appropriate action by taking the baby back to the hospital. Very basic care, such as sucking the baby's airways and giving it oxygen, was applied. No further care was given, although the baby and the mother were readmitted.

#### **4.6.4 Verbal autopsies about the causes of neonatal deaths: Liz's story**

Liz (pseudonym) is a site coordinator at a local NGO called Mothers-to-Mothers (m2m), who volunteered to be interviewed about a recent neonatal death of a baby born to a young mother who had been a client of m2m during her pregnancy because of her HIV-positive status. The mother died soon after giving birth due to complications related to HIV infection. Liz became the unofficial guardian of the baby on the 18<sup>th</sup> of December 2010, but the infant died on the 20<sup>th</sup> of December 2010, aged only five days. Liz was unable to establish the baby's HIV status, but reported that the child refused feeding from birth and did not react to treatment. This was despite the fact that the mother had been part of the PMTCT programme.

She said:

I learnt that the mother was in labour in December 2010 and subsequently delivered at Stanger Hospital on the 15<sup>th</sup> and died on the 16<sup>th</sup> December 2010. Apparently the woman had told her boyfriend that if she were to die, I should be given the baby; hence the baby was brought to me. The mother was a Zimbabwean and had no family around here except this boyfriend that she stayed

with. The boyfriend was Zulu-speaking and I think he was using this woman. I was aware of instances where he beat her up. I think this woman did not trust this man, hence she thought I should look after her child.

The deceased mother lived in a shack in Shakaskraal prior to the delivery and was part of the PMTCT programme due to her affiliation to m2m. According to the information provided to Liz, the deceased mother had two other children who lived with their grandmother in Zimbabwe. Liz's story revealed the deaths of two people, a mother and a baby. By applying the pathway analysis to this verbal autopsy, it would seem that, although the immediate causes of the deaths of the mother and baby remained elusive, the narration pointed to a chain of events that included HIV infection, social exclusion, violence and deprivation.

#### **4.6.5 Conclusion**

Although the discussions in the verbal autopsies (VA) did not identify the direct causes of mortality of the deceased, they (the VA discussions) revealed the depth of underlying circumstances that subjected women and the neonates to death, both at health facilities and community levels. The VA highlighted that poor rural women who do manage to seek care at the public health facilities do not always receive quality care, and may die in the hands of health professionals (Nontu and Mary's stories). Therefore, health facilities can be determinants of maternal and neonatal deaths as they may not always be sensitive and responsive to the patients' reproductive health needs.

Among the most prevalent aspects of poor quality of care cited were: negligence and a lack of commitment and accountability on the part of the health professionals; the apparent declining standards in health facilities; attitudinal issues and the absence of the caring culture which used to define health professionals' approach to patients in the past. The professional nurses' attitude to the poor rural pregnant women in the current times subjected women to ill health and mortality in their most vulnerable phases of life. Women were not treated with respect because of their defenceless and weak social position (this also includes Zola's story, who allegedly died without

even having seen her baby – despite the number of times she requested to see her baby but was denied by health professionals on duty).

The emerging picture is that women would receive respect and better quality care as informed by a more favourable position and status in the society. Problems of distance and delays in seeing a health provider also emerged from the interviews.

The discussions based on the verbal autopsies highlighted the importance of social diagnosis of the most common but important social behavioural and biological determinants of maternal and neonatal deaths. The discussion also provided an important learning opportunity for the development of effective interventions by involving communities.

#### **4.7 RESULTS OF FACE-TO-FACE INTERVIEWS WITH EXPERTS IN THE FIELD OF FEMALE REPRODUCTIVE AND NEONATAL MORTALITY IN SOUTH AFRICA**

It should be noted that that the abbreviations such as SP: WH; SP: CH; CP: SBC; D: KZN; PM: C&YH; CM: DOH have been used to protect the true identity of the national experts who were interviewed in this study. Most of the national experts were based in Gauteng province.

Six experts were interviewed in this study to determine what – in their views – caused reproductive ill health and maternal mortality in South Africa. All the six interviewees immediately mentioned HIV and AIDS as the most important causes of maternal mortality. Five experts further mentioned obstetric causes including post-partum haemorrhage (PPH) and hypertension as second and third leading causes of death of women respectively, and other pre-existing non-obstetric conditions such as anaemia and other infections. Other leading causes of maternal mortality mentioned by the experts were the poor quality of care at public health care facilities, the short operating times at primary health care facilities, problems with anaesthesia and poor infection control.

The National Committee for Confidential Enquiries into Maternal Deaths (2008)

indicates that many South African mothers died unnecessarily between 2005 and 2007 from:

- haemorrhage (25,3% of all maternal deaths);
- hypertension (20,0%);
- non-pregnancy-related infections (23,4%);
- sepsis (8,4%);
- pre-existing maternal disease (4,3%); and
- other, ill-defined causes (18,6%).

The Report further highlights that during 2005 to 2007, there were 3,959 maternal deaths, of which 1,519 could have been avoided. To achieve the Millennium Development Goals (MDGs), the MMR will need to be reduced by three-quarters (75%) and the child mortality rate by two-thirds (66%). However, indications are that the MMR remains high. The Human Rights Watch (2011) suggests that health care professionals are providing poor quality maternity care in South African public hospitals and that this contributes to the inability of the country to achieve MDG5. The poor treatment afforded to women in public hospitals serves as one of the primary factors at the root of maternal and new-born deaths.

When asked what the leading causes of neonatal deaths were, the experts listed HIV (all six of the experts); premature birth (four experts) and birth asphyxia (five experts). Other factors mentioned were problems in anaesthesia and congenital abnormalities. It should be noted that most of the experts were clinicians, hence their perspectives on the causes of maternal and neonatal deaths tended to favour biomedical causes.

Upon analysing the transcriptions of the interviews with the six experts, the following themes in connection with maternal mortality emerged:

- Theme 1: Maternal mortality due to neglect of a dedicated focus on reproductive health care. This includes poor family planning services, poor knowledge of and violation of patient rights generally and reproductive rights specifically.

- Theme 2: Maternal mortality due to HIV infection and poor conceptualisation and contextualisation of HIV/AIDS.
- Theme 3: Social causes of maternal mortality linked to marginalisation of women on the basis of income, social class, racism and rural place of residence.
- Theme 4: Institutional and systems-related factors, including the actions of health care professionals, their attitudes and technical incompetence in reproductive health care matters, and poor availability of equipment and resources at reproductive health care units.

Table 4.8 (below) shows the four themes according to the six experts. The abbreviations in the first column of the table are the codes for the experts. Themes 1, 2 and 3 emerged in all the interviews, whereas theme 4 was mentioned by only three interviewees.

**Table 4.8: A summary of the themes that emerged from interviews with expert interviewees about the causes of maternal mortality (N = 6)**

<b>CODES FOR THE EXPERTS</b>	<b>Theme 1</b>	<b>Theme 2</b>	<b>Theme 3</b>	<b>Theme 4</b>
(CM: DOH)	x	x	x	
(D: KZN)	x	x	x	x
(SP: WH)	x	x	x	x
(PM: CH)	x	x	x	
(SP: CH)	x	x	x	
(CP: SBC)	x	x	x	x

#### **4.7.1 Maternal mortality due to the neglect of a focus on reproductive health care delivery**

This thesis considers maternal and neonatal morbidity and mortality as reproductive outcomes. The Inter-American Parliamentary Group (IAPG) on Population and Development (2011) holds that *‘one of the main causes of maternal and infant mortality and health complications for women of reproductive age around the world and particularly the poor women in developing countries are problems related to sexual and reproductive health’*. From the interviews emerged a commonly shared



insight that reproductive health care needs to break away from a focus on the clinical management thereof to a broader approach that is not limited to attending to women antenatally, during delivery/intra-partum and post-partum only. Reproductive health care that is provided along a continuum of care, throughout the life cycle, including the adolescence stage, pregnancy, childbirth, the post-natal period and childhood should be the focus (Kerber, De Graft-Johnson, Bhutta, Okong, Starrs & Lawn 2007). Problems start long before pregnancy occurs, and if left unattended or if inappropriately attended to, will persist and get worse. One of the interviewees regarded the persistently high rates of female deaths as indicative of the neglect of reproductive health needs. She commented:

Ever since this country has neglected reproductive health, women are dying. The things that are making women unhealthy and that subject them to the risk of dying are poor health education and poor reproductive health care, poverty, gender inequality or poor levels of gender equality. These are directly related to reproductive health. The social norms are not empowering to women. If these things are addressed, we will get somewhere with reducing our maternal mortality and child mortality. There is much too much attention on technical matters without attending to the root of the problem. The context within which we operate does not provide an easy environment to negotiate sexual health. This brings about a vicious cycle whereby women will be even poorer. If they are poor, they will get sick and they will die. It's poor women who die. There is very little discussion of sexual rights and much too much focus on technical information. [SP: WH]

The other five experts made similar points. Aitken and Reichenbach (1994) state that reproductive and sexual health and rights go beyond simply preventing or treating diseases, and should be viewed as part of equity-oriented human development.

Adding to this, Keyzers (1997) argues that reproductive rights or choices are meaningless if the poor and disenfranchised are not supported by enabling conditions through which such rights can be realised. The view that most women are unaware of their rights was confirmed by one of the experts when she commented:

The women and the people of South Africa are not aware of how poor the services are ... They tend to judge the quality of health services they receive in terms of how long they have to wait and how they get to be treated. Although these are important, people often complain about those things. They often don't have the knowledge of whether the technical quality of care they receive is good or not. For example, say a woman had a 1,5 kg baby and the baby dies. The hospital staff would say that the baby died because it was too small. They will not know that if the 1,5 kg baby had received good care, it could have survived. They don't have the knowledge. Women do not know that they have rights and what their rights are. [SP: CH]

Another interviewee added further insights to the issue of women's lack of awareness of their rights:

There is no way we can be on track to achieving MDG4 and 5 for as long as our women are still disempowered. They do not know their rights. They are illiterate and generally poverty-stricken. Women should know that they have rights and should be able to claim them. But women in this country don't even know that they have rights; thus they will not be able to claim them. [PM: C&YH]

A third interviewee held the view that, because South African women are not aware of their rights, the services are not responsive to their needs; adding:

If you don't know what you could have, you cannot demand it. Mothers might be pregnant and not know their rights. If you are poor you are likely not to receive the services that you are entitled to. [CP: SBC]

This study has established that impoverished women, especially those living in the rural areas, are continuously exposed to undue suffering from unintended pregnancies, sexually transmitted infections (including HIV), gender-based violence and other problems related to reproductive and sexual behaviour. Historically speaking, reproductive health care in South Africa was delivered through family

planning units, although the emphasis was on the provision of contraception for reducing fertility. Several experts confirmed that family planning services have been neglected in South Africa, for example:

The country left family planning services behind to concentrate on HIV and AIDS. Now they are trying to revert back to family planning services. [CM: DOH].

The contraceptive methods that were there 10 years ago are no longer available. The family planning units now hold a smaller range of contraceptive methods compared to 10 years ago. Female condoms are rarely available. The IUD is no longer provided. There is no low dosage hormonal pill. What is available is high dosage hormonal contraception that people might not use because of the side effects they bring about. Women's health might certainly suffer if they end up with the pregnancies that they did not plan. For example, we hear of many young girls who have died because of unsafe abortions. Older women also become ill or die due to complications from pregnancies they never planned. Why deny people a service? Why? The country is violating women's rights. The country must take responsibility for failing its women. [SP: WH]

If women were to avoid pregnancy through contraception, that would make an impact on the national maternal mortality ratio. Therefore, mothers need to plan their pregnancies with the help of public family planning services to reverse the upward trend of MMR in this country. Now the question is, is it offered in the country? Yes, it is offered in the country and it is a free service. How widely? Not sure. It should be offered at all the clinics and hospitals after delivery. It used to be offered after delivery, and that used to boost coverage. Where are we with coverage at the moment? It's a question still to be answered. [CP: SBC]

The contributory factors to the problem of HIV are poor access to contraception. This is a reproductive health care provision issue.

[SP: CH]

A gross neglect of reproductive health needs, reproductive rights and sexual rights has contributed to a lag in decreasing maternal deaths and the accompanying neonatal deaths in South Africa, according to the expert interviewees. The provision of contraception when it is needed is a reproductive right and a human right for every woman. However, the six experts interviewed highlighted the apparent contravention of some of the international recommendations and 'tools' that could have prevented maternal mortality. As demonstrated in some of the data vignettes quoted above, they expressed the view that, if the democratic South African government had recognised and enforced the realisation of these reproductive rights, the country could have been closer to reaching MDGs 4 and 5 targets.

#### **4.7.2 HIV and AIDS as leading causes of maternal mortality: the views of the expert panel**

Several commentators suggest that continued socio-economic and geographical divisions have worsened the spread of HIV in South Africa. Hunter (2006b), for example, suggests that informal settlements in South Africa show high HIV prevalence rates. Hoogeveen and Ozler (2006) add that the spread of HIV/AIDS in South Africa can be attributed to the residuals of the apartheid system, which denied health opportunities to blacks.

In South Africa, women represent 55% of those infected with the HI-virus. Women are more vulnerable to HIV infection than men due to their poor economic and social status and because of inadequate access to care (Ackermann & De Klerk 2002). All of the experts interviewed indicated that HIV infection and AIDS-related causes are responsible for most of the national maternal deaths.

If women were not dying from HIV/AIDS, South Africa could have managed to reduce its maternal mortality. If we look at the trends in our maternal mortality, the MMR was declining till around 1998. Then it started increasing, mainly due to HIV. The single largest

cause of MMR is HIV. HIV contributes to pregnancy-related deaths. The reason why women die of HIV is mainly due to lack of access to health care. The contributory factors to high rates of HIV are poor access to contraception, women's inability to negotiate for contraception, sexual abuse and domestic violence, and young women having sex with older men. If HIV and AIDS were out of the way, we would manage the MMR in this country. [SP: CH].

At least three of the interviewees felt that the almost exclusive focus on HIV and AIDS has left reproductive health care services for women in dire straits, for example:

HIV/AIDS has been taken out of reproductive health, where it needs to be dealt with. In the mind of the activists of reproductive health, there has been a problem regarding talking about HIV separately from reproductive rights, and yet the two shouldn't be separated. The country needs to talk about AIDS and reproductive health and reproductive rights as a combined issue; there is an exclusive focus on AIDS without talking about reproductive health. While it's fantastic that this government is finally taking AIDS seriously, what we see now is an exclusive focus on AIDS and condoms, without any mention of reproductive health. All of these add to the problem of poor health services. [SP: WH].

The HIV/AIDS problem is used by the AIDS activists to gain political scores and media publicity. There is more activism around HIV and less activism around maternal and child health. This shows that the issues of maternal and child health and reproductive health are regarded as less important. Activism around HIV is used for the wrong reasons. [SP: CH].

All the resources are channelled to HIV issues. If we can have the same energy and resources as we have for HIV and be able to channel the same energy and support to reproductive health, and maternal and child health care, then we could go somewhere. We

have the NSP for HIV/AIDS. This strategy is integrated, but not integrated with maternal and child health care. [PM: C&YH].

Another gender-related issue highlighted in the interviews as a prominent factor in women's vulnerability to HIV infection was their relative financial dependence on men and the normalisation of transactional sex. Hunter (2006a) sees women's use of transactional sex as intricately linked to gendered economic inequalities. Some interviewees argued that women are vulnerable to reproductive ill health because they engage in risky sexual relationships with older men, purely for material survival, for example:

An urban girl might not be poor, but will still have sex with sugar daddies for material gain. Many women and girls are engaging in sex for money and this makes them vulnerable, especially if coupled with a decline in health services. Unprotected sex for some youth, especially girls, is for some by choice and for others not by choice. You might have seen media reports about 57 girls at one certain school being pregnant. The media tends to put the blame on these girls, but they were all very young. This is victim blaming. No one else is taking accountability. No one is looking at the conditions under which these girls become pregnant. The teachers must be held accountable for their actions. Something has to be done in schools. The government has to hold schools accountable when a young girl falls pregnant, especially by a teacher. The young women are so at risk! [SP: WH].

#### **4.7.3 Social causes of maternal mortality linked to marginalisation of women on the basis of income, social class, racism and rural place of residence**

The expert interviewees regarded maternal mortality as indicative of a lack of the empowerment of women. This is linked to high unemployment rates for women, low levels of female literacy, patriarchal norms that subjugate women, gender inequality, sexual domination and transactional sex. The legacy of apartheid through economic marginalisation and the complex interactions between race, class, gender and geographical location render many rural South African households vulnerable to poor

health. This insight into the social-structural basis of reproductive ill health was affirmed by five interviewees, as follows:

From a public health perspective, health including women's health exists within the social context. Problems in meeting MDGs 1, 2, 3, and 6 will always hamper the efforts to achieve MDGs 4 and 5. They are the result and products of the social context and will always influence MDGs 4 and 5 negatively. The positive results on these goals, 1, 2, 3, and 6 will impact positively on MDGs 4 and 5. The key determinants are poverty, unemployment, illiteracy, lack of the empowerment of women, women still having no rights and people taking advantage of women who do not even know that they have rights. For example, women have been turned away from health facilities and have died as a result. In a nutshell, if poverty, illiteracy and women's empowerment are not addressed, it will be difficult to meet MDGs 4 and 5. The majority of the South African women are vulnerable to illness mainly because they are poor, unemployed, illiterate and therefore powerless. The country is trying to empower women but it is still lagging behind. [PM: C& YH]

If we need to make an impact, we need to look beyond health. The root of ill health and mortality of women is not clinical. It starts in the household, in the community. For example, take the issue of poverty. Poverty is rife in KZN. The literacy of mothers is low, and hence HIV/AIDS is the number 1 killer of women in KZN, like in the rest of South Africa. HIV/AIDS is linked to poverty, unemployment and low literacy levels. The total fertility rate is still high because women do not even use contraceptives. Poverty, social exclusion and its link to reproductive health should be understood in order to address South Africa's high MMR. [D: KZN]

Women die because of prolonged malnutrition and patriarchy that endorses men's superiority. [CM: DOH]

The things that are making women unhealthy are poverty and gender inequality. These are directly related to reproductive health and the social norms are not empowering to women. [SP: WH]

A person's own sense of agency can be greatly undermined if she is not treated as equal to others. Research shows that gender matters operate at the level of health care facilities when, for example, men decide on who gets transport in cases of emergencies, even when a woman is in labour, or if a road accident had occurred. [SP: WH].

Landman, Borat, Van der Berg and Van Aardt (2003:1) write: '*There is a consensus amongst most economic and political analysts that approximately 40% of South Africans are living in poverty – with the poorest 15% in a desperate struggle to survive*'. The insights gauged from the expert interviews, when juxtaposed against the data gathered from the interviews with the women at risk, underscore the importance of addressing the socio-structural factors that influence health. The experts alluded to the fact that it would be difficult to achieve MDGs 4 and 5 as long as the majority of black, poor, rural women still live in abject poverty. When the researcher enquired about what they meant by poverty, the experts explained that it refers to inadequate shelter due to poor housing, poor educational resources coupled with low levels of literacy, high levels of unemployment and local governmental structures not coping with the needs of communities.

Another co-factor in poor socio-economic circumstances mentioned in the interviews is under- and malnutrition due to poverty. Malnutrition predisposes menstruating and lactating women to prolonged morbidity and anaemia. Anaemia increases the mortality risk of women, both directly and indirectly through post-partum haemorrhage (WHO 1990).

One of the interviewees linked poverty to social exclusion in health care service provision as follows:

If you are poor you are likely not to receive services properly. It also depends on the support around you. If the system does not provide,



you need to depend on your pocket. If you do not have the money, then you are gone. It's about the financial muscle. Education and some economic background put one in a better standing. It determines the quality of health care. If the hospital does not treat them (women) well, there will be no progress and improvement in the health status. [CP: SBC].

Available models of factors leading to maternal mortality tend to ignore the role played by powerlessness that results from many years of oppression in which the oppressed themselves have become complicit in their own subjugation by blaming their poor health conditions on themselves.

#### **4.7.4 Institutional and systems-related factors**

Limited access or poor use of health care services and consequent reproductive morbidity and mortality has also been associated with poor interpersonal relations and attitudes of the health care workers (Tint *et al.* quoted in Budlender 1997). When dispossessed women come into contact with unsympathetic or insensitive health care providers, they may become reluctant to ask for more information or better care, or to return for follow-up consultations. Two of the interviewees narrated the role of the public health care system in maternal deaths as follows:

Within the health care system, there are many times which – if things were only done differently – the outcome could have been different; for example, my impression is that women are not monitored properly, sometimes due to lack of knowledge or due to the poor attitudes of staff. [SP: CH].

If we can deal with the attitudes of the health care professionals, then we would have done well for the women of this country. There is a lack of technical skills at the DoH and this impacts on leadership. Although the provision of facilities has been attended to, we have not yet addressed the issue of how we attract good staff to work in the rural areas. Most facilities in the rural areas are not

commissioned yet. Other problems exist, such as making sure that every place where deliveries are assisted gets blood for transfusions. There are problems with emergency deliveries where facilities do not have the proper equipment. Intrapartum care is neglected. Maternity waiting homes should be improved. There should be a complete re-engineering of the PHC approach where teams can be made responsible for a certain number of households. There should be better supervised on-the-job training of health care workers at bedsides. We need to find out why people with equal resources respond differently to available health care services – that is, one might actively seek out health care and another would not. Manpower-related issues contribute to the problem such as a shortage of staff. [CP: SBC].

#### **4.7.5 Conclusion**

The interviews with the six experts for this study cited HIV/AIDS as the main cause and determinant of maternal and neonatal deaths. The experts are further of the opinion that other causes of high maternal deaths in South Africa continue to reflect the same pattern of women dying from hypertension disorders, obstetric bleeding and infection. Malnutrition continues to be an underlying factor to most maternal and neonatal deaths. The latter view resonates with the findings of the National Committee for Confidential Enquiries into Maternal Deaths (2008).

The interview with the experts suggested that, while there is a realisation that HIV/AIDS does not attack men and women equally in this country, the approach to dealing with the HIV/AIDS problem lacks a gender analysis which could be a contributory bottleneck to effectively reduce maternal and neonatal mortality attributable to HIV/AIDS. In addition, the expert view expressed is that HIV/AIDS is a reproductive health issue; however, it has been blown out of context by some activists who have other interests than caring for women.

The analysis of the interviews of the experts indicated a variety of social factors as determinants of poor reproductive outcomes in South Africa. For example, that the

structural determinants of maternal ill health and mortality during their reproductive ages are powerlessness due to low levels of literacy, being unemployed, deprived, ignorant and destitute. The high level of poverty in the country adds to the problem, as pregnant women may not seek quality antenatal and delivery care in the so-called 'good' health institutions, because they cannot afford private quality health services.

In addition, the respondents reported that maternal mortality is associated with high rates of unplanned pregnancies due to the weakened family planning services. The interviewees are of the opinion that the lower the rate of pregnancy, the lower would be the incidence of maternal illnesses and deaths; hence, women need to be supported with provision of safe contraception and enhanced coverage of family planning services.

The analysis of the views of experts also reflect that women's health is at risk in the inadequately equipped public reproductive health delivery services in the public health facilities, especially in the rural areas. The situation is aggravated by the consistent lack of infrastructure and the concentration of health facilities in urban areas, delays in women getting to hospitals for emergency care, lack of medical facilities and manpower, poor relationships between the providers and the recipients of reproductive health, and inattention to women's reproductive health needs.

The views from the experts pointed to policies that have to address maternal mortality as a determinant of poor reproductive outcomes. For example, women's health experts noted that the MC&WH package reduces reproductive health to services for prenatal care and childbirth, showing that women are valued only for their reproductive role. The beneficiaries of this package are children. Moreover, reproductive health has not been well contextualised and conceptualised. The implication is that the MC&WH package does not address all reproductive health care needs, hence the high rates of female reproductive ill health and mortality.

The findings from the analysis of the views of the experts further reveal that:

- Reproductive health care is still provided through narrow, vertical programs.

- There is little participation and involvement of women in developing policies and in planning, monitoring and evaluation of health services, resulting in low demand for quality services and contributing to poor reproductive outcomes.
- The national reproductive health policy is conspicuously absent in informing the provision of services that would address all the reproductive needs of women. Other policies which have been developed are not being implemented.

#### **4.8 RESULTS OF FACE-TO-FACE INTERVIEWS WITH INDIVIDUALS WORKING FOR NGOs IN THE FIELD OF REPRODUCTIVE HEALTH IN STANGER**

Three representatives from three NGOs working in the field of reproductive health in Stanger were interviewed. These representatives are identified by their organisations as MDCI, m2m and Kheth'impilo in the data vignettes quoted in this section. Three major themes emerged from their transcribed interviews as important factors in maternal mortality in the area. These were gender and cultural norms, socio-political issues and health care issues. These themes are addressed in greater detail below.

##### **4.8.1 Gendered and cultural norms influencing maternal mortality**

Issues mentioned under this theme were the subjugation of women under polygamy and patriarchal domination, the abuse and violence against women, and men having several sexual partners. Cultural traditions were mentioned such as forbidding women from eating dairy products and eggs, because it is believed that it would increase her libido. Other problems mentioned were transactional intercourse for monetary returns and parents forcing young girls into early marriages to gain lobola. Finally, the problem of women needing their husbands' consent to seek health care was mentioned.

The MCDI representative explained:

The rural women in iLembe are exposed to poor social conditions, for example, polygamy and several sexual partners put women at risk of morbidity and mortality. All these are due to the economic

situation of women. They are in a trap. They agree to polygamy, which puts them at the mercy of their husbands. They have multiple sexual partners for financial gains. Women have to be empowered to stand up on their own. If they are independent, they would not be continuously exposed to the risk of reproductive ill health. Policies that encourage women's economic empowerment would encourage the survival of women themselves, their babies and the nation.

#### **4.8.2 Socio-political issues influencing maternal mortality**

Issues mentioned in this theme included the lack of social policies that could lead to women's economic empowerment, and poor roads that hamper women's ability to access health care. All three interviewees expressed the view that a woman's health status is inseparable from her living conditions and her cultural, political and economic setting. The three representatives from the NGOs commented that their organisations often dealt with women who live in substandard living conditions, for example:

The living conditions are related to cultural, political and economic issues and to overall well-being. Even if these factors are social, they are health determinants for women and everybody. For example: I came across a woman living with five children in a house with one room and one window. This represented a risk to her health and that of her children. She came to us so many times due to ill health. I had to visit her home to see for myself what her day-to-day life was like. This woman had a boyfriend who was visiting her regularly and the two of them would have sex in the presence of her children. We should not forget that children live what they learn and learn what they live. Thus they might repeat what they have seen. [m2m representative]

Poverty explains a lot. It leads to malnutrition. Mothers are not gainfully employed and have no means to support their babies and themselves. [representative of Kheth'impilo]

### **4.8.3 Health care issues influencing maternal mortality**

Under this theme, the three representatives spoke about the poor level of antenatal care available at local health care facilities. This was exacerbated by poor resources, lack of skills and staff not motivated to follow the correct procedures.

### **4.8.4 Conclusion**

The interviews with the representative of the three NGOs working in the iLembe district reflected that poor reproductive outcomes were associated with certain cultural beliefs and practices, including early marriage, polygamy, men having several sexual partners, and patriarchal domination. Women are still undervalued and could be exchanged for monetary gains or inherited like resources.

Other social factors included practices that undermine women. Women are disempowered, for example the majority of women lack self-confidence in participation and decision-making at all levels, for instance from family level to village level. The NGO's representatives laid bare the extreme poverty conditions which make it very hard for women to survive, for example, they live in degrading home circumstances, they do not eat well and remain poor, because they contribute to unpaid labour to maintain a livelihood for themselves and other family members.

Lack of skilled health professionals, and poor attitudes toward health by professionals emerged from the discussions with the NGOs as contributing to poor reproductive health outcomes. Section 4.9 below discusses the findings on the study of documents related to female reproductive health in South Africa.

## **4.9 DOCUMENT STUDY: TRACKING REPRODUCTIVE HEALTH IN SOUTH AFRICA**

This section discusses the findings from the analysis of the documents on the organisation of reproductive health care services, models, policies, strategies and interventions in South Africa from the past to the present. The discussion from the interviews with experts on their experiences on the current models, policies, strategies and interventions, complements the section further.

### **4.9.1 A brief account of history**

An understanding of the South African high rates of reproductive morbidity and mortality requires a brief mention of South African history. To recap, South Africa was marked by an apartheid system characterised by discriminatory allocation of resources, including health care. Numerous laws such as the Native (black) Urban Areas Act (Act No. 21 of 1923) and the 1950s and 1960s Group Areas Acts were passed, requiring that all economically inactive blacks live in poverty-ridden and degraded homelands which comprised 13% of South African land (South African Department of Communication and Information System 2011). The remaining fertile land (87%) was reserved for exclusive access and control by the whites (South African Department of Communication and Information System. 2011). This led to differential health status of the people within South Africa, with the black, rural women becoming poorer and the most vulnerable (Treiman 2005; Doyal & Pennel 1979; Klugman 1994; Meer 1985).

High rates of reproductive morbidity and mortality are also a response to the migrant labour system. With the discovery of diamonds in Kimberly in 1867 and gold in the Witwatersrand in 1886, the demand for cheap, black male labour became insatiable, with ever-ruthless methods used to procure it – resulting in profound changes in society including determining the disease patterns of South Africans (Coovadia *et al.* 2009). The authors further observed that the migrant labour system undermined the rural black agricultural economy, which was a source of survival for the black population (Coovadia *et al.* 2009).

In addition to the discriminatory laws referred to earlier and the system of migrant labour, the homeland system and forced removals added to the destruction of the health situation of the black population, particularly the African family structure. Meer (1985) highlights the fact that health facilities broke down completely with forced removals and resettlement. The homelands were a dumping place used to keep the blacks away from the whites, except in cases where the former were to serve the interests of the latter (South African Department of Communication and Information System 2011).

While men suffered discrimination under apartheid based on the colour of their skin, women suffered double discrimination, that is, both gender and racial discrimination (Meer 1985). Black women had very few legal rights, no access to education and no rights to own property. Meer (1985) alludes to the fact that women had poorer access to property than men, thus finding themselves in an immediate disadvantage. Most jobs for women were in either the agricultural or domestic sectors and those who managed to be employed were paid very low wages (Meer 1985). Malnutrition and sanitary problems became the order of the day (Meer 1985). Motherhood, often without adequate financial or emotional support, continued to be a source of great pain for most black South African mothers (Meer 1985). Mhlanga (2003:115-126) highlights that the poor, under-educated and unskilled South African women became vulnerable to a range of sexual exploitations, including high rates of rape. The law operated to protect the male in cases of both paternity and rape claims; for example, women would have to undergo humiliating cross-examinations in court and often required to establish impossible evidence (Meer 1985). It was for this reason that women were often discouraged to report rape cases, and chose to suffer in silence (Meer 1985).

The post-1994 democratic South African government committed to a 'better life for all' through among others, delivering comprehensive health services equally to all South Africans. Having realised that most of the health problems were by and large a result of apartheid dispossession and all its ill attendants, the point of departure for a South African government of post-1994 was to transform the public health system into a unitary, comprehensive, equitable and integrated National Health System



(NHS) in order to redress the injustices of the past (Chetty 2007). The implication was a complete overhaul of the pre-1994 National Health System and all the relevant legislation and institutions, thus paving the way for a proposed equitable system that would inform policies, programmes, models and interventions representing the new order (ANC 1994a; Chetty 2007). An enabling policy development process, followed by the transformation of the health system was to be instituted (ANC 1994a). The proposed transformation of the health system called for the following:

- allocation of resources,
- restructuring the health system according to the South African Demographic and Health Survey (SADHS), and
- delivering health care through the Primary Health Care (PHC) approach (ANC 1994a).

The section below tracks and examines relevant health care policy issues in South Africa, followed by an analysis and discussion of the relevant policies, programmes, strategies and interventions in the field of reproductive health.

#### **4.9.2 Health system in South Africa**

Historically, health care within South Africa was delivered through two parallel systems, public and private. After World War 2, between 1945 and 1960, the private sector, serving only 20% of the wealthiest population, the majority being whites, was mostly covered by health insurance (Chetty 2007; Soderlund, Schierhout & Van den Heever 1998). These authors add that membership of health insurance and private care was made compulsory for all white South Africans (Soderlund *et al.* 1998). The black population had to rely on the under- resourced and overcrowded public sector for their health needs. Of the 5.8% of the GDP allocated for health, 44% was spent on private health which catered for 20% of the mainly white population, while 56% catered for 80% of the black population (Chetty 2007). To date, the public sector still serves the majority of the black population of South Africa and not much has changed since 1994 in terms of resource allocations and improvements in quality of care (Botha & Hendricks 2008). The private sector, known to be well resourced and under-utilised, is currently allocated more than 55% of the health care budget, mostly

from the middle and high income earners, while the budgetary allocations for the public sector are less than 44% (Botha & Hendricks 2008).

The public health system was reformed in line with the provisions of the new South African Constitution (Act No. 108, 1996) as follows:

**Administratively:** South Africa established nine provincial Departments of Health, responsible for delivery of comprehensive Primary Health Care (PHC) services through the District Health System (DHS) (SA DoH 1997). The services were to include community-based health services, made available through mobile/fixed clinics and community health centres (SA DoH 1997). District hospitals also form part of the DHS in the new policy (SA DoH 2007). The provincial Departments of Health share part of their budgets with local authorities, who also render PHC (Botha & Hendricks 2008).

**Policy development:** The overall responsibility for health policy resides with the National Minister of Health, supported by the National Department of Health (NDoH).

**Finances:** Policy implementation should be backed by resources; however, since 1994, the financial arrangements of the government had implications for the provisioning of health care, the major one being introduction of a fiscal federal system (FFS). Under the FFS, the public sector budget for health is determined by provincial legislatures and not advised by the national policy. The provinces receive budget allocations from the national budget through equitable share or unconditional grant.

Notwithstanding the fact that the public health system was reformed along the lines of the new South African Constitution (Act No. 108, 1996), it remains chronically underfunded and understaffed. For example, the decline in budget allocations to the provinces attributable to the introduction of the FFS stalls implementation of policy in the provinces (Thomas & Muirhead 2000). Some of the challenges impacting on delivery of health include:

- Poor implementation, monitoring and evaluation of policy decisions due to poor resource allocation at provincial level, resulting in undermining the fundamental public principle of equity.

- Budget allocations declining in real terms and not matching the emerging or growing needs, for example, there were no specific measures to deal with a growing service-related impact of HIV-AIDS, affecting mostly women..

#### **4.9.3 Policies for reproductive health under Apartheid South Africa**

Reproductive health needs are crucial to women's overall health and well-being; however, health policies under the apartheid government did not address the health needs of black, poor, rural people, specifically the conditions under which black, poor, rural women performed their reproductive functions. Reproductive health delivery was a ground of contestation between the field of population development and maternal and child health, each with different goals, strategies and interventions. Under these circumstances, the black, poor, rural women became the most vulnerable (Meer 1985; Klugman 1994; Cooper, Morroni, Orner, Moodley, Harries, Cullingworth *et al.* 2004).

Prior to 1994, there were no comprehensive reproductive health policies in South Africa (Cooper *et al.* 2004). Reproductive health care was provided through the conventional Maternal and Child Health package and the National Family Planning Programme, which was later replaced by the Population Development Programme (PDP) (Cooper *et al.* 2004; Du Plessis 2008). Family planning services were provided to regulate fertility within South Africa since the 1930s (Kaufman 1997). The clinics were launched with the main intention of providing the means to control births and to advise the poor white women who needed such a service (Kaufman 1997). The National Party government's intention and focus later changed to controlling the growing numbers of the black population with the fear that the latter would soon outnumber the white population (Cooper *et al.* 2004; Du Plessis 2008; Kaufman 1997). This led to the official establishment of the controversial state-sponsored National Family Planning Programme (NFPP) in 1974, through which contraception was provided abundantly with a clear aim of reducing black fertility (Kaufman 1997).

The family planning (FP) services were then made available to all races, however, in a segregated fashion (Kaufman 1997). In the municipal clinics, contraception was offered as an integral part of the Maternal and Child Health (MCH) programme, but

elsewhere in the country, it was a state-run service through the national and provincial health departments which developed strong vertical family planning structures (Cooper *et al.* 2004). Although the FP service was freely available and accessible country wide, it operated independently of other complementary reproductive health services (Cooper *et al.* 2004). The SA DoH (2001b) points to the extreme violation of the reproductive rights of family planning clients under the apartheid Government, with no regard of meeting black female reproductive health needs.

The NFPP was followed by the establishment of the Population Development Programme (PDP) in 1984, through which the Government implemented an explicit policy decision to lower the national population growth (South African Department of Welfare 1998; Du Plessis 2008). The establishment of the PDP was a response to the 1983 proposal by the Science Committee of the President's Council into Demographic Trends in South Africa (Du Plessis 2008). The PDP was largely informed by the Malthusian theory of population and restriction of family size (Klugman 1991).

The thrust of the PDP was therefore fertility reduction through a family planning programme; however, it was to be supported by other interventions that would influence fertility levels such as education, PHC and economic upliftment (South African Department of Welfare 1998). The PDP had set a clear demographic target of a national total fertility rate of 2,1 children per couple, and stabilising the population at 80 million by the year 2100 (South African Department of Welfare 1998). According to Du Plessis (2008), the PDP could not be sustained due to a lack of funding, and it shifted to information, education and communication (IEC) which basically promoted the concept of small family as the norm. The aim was to influence the reproductive behaviour of blacks so that they would prefer reduced family sizes, resulting in reorganising the demographic profile of South Africa (South African Department of Welfare 1998).

Contraception was provided in a manner that showed no regard for the reproductive health of women, especially in the rural areas; for example, the long-acting injectable contraceptives such as Depo Provera, were strongly promoted, while barrier

methods and the Lactational Amenorrhoea Method (LAM) were highly discouraged (Klugman 1994). The long-acting hormonal contraception was provided even immediately after delivery of a baby, before the mother-baby pair was discharged, so that women would not go home 'unprotected from pregnancy'. Many women complained unsuccessfully that they did not want hormonal contraception, especially the injection because it dried up the breast-milk. Contraceptives were provided by inadequately trained personnel in most community-based health services (Klugman 1994; Cooper *et al.* 2004). Essential services such as screening for and treating sexually transmitted diseases were not performed (Cooper *et al.* 2004). Screening tests for cancer of the cervix and breasts were also not done. Information about the relative risks and benefits of contraception was not given. Women could not make a choice on the suitable contraceptive method as there was a very limited range from which they could choose (Klugman 1994; Kaufman 1997; Cooper *et al.* 2004). Even young girls who had not proven their fertility were provided with the most widely available and promoted long-acting hormonal injection. Infertility problems emerged, while infertility services were not offered to black women (Klugman 1994). Men's responsibility for their own sexuality and reproduction was side-lined. In keeping with Malthus' theory that only misery would keep the poor from breeding excessively, the programme did not address the problems of poverty and powerlessness (Klugman 1994; Kaufman 2000). It rarely specified means to reduce mortality.

The maternal and child health (MCH) policy guided the provision of women's health services through its popular MCH package (Cooper *et al.* 2004). The maternal and child services consisted of antenatal clinics, labour wards and post-natal wards. These facilities, mostly in townships and hardly available in rural areas were often overcrowded, understaffed and lacked privacy (Cooper *et al.* 2004). The conventional Maternal and Child Health package was limited to providing the health needs of a pregnant mother, a woman in labour and care of the mother-baby pair post-delivery, and 6 weeks post-natal visits and child welfare, which were mostly EPI services. Cooper *et al.* (2004) point to the underestimation of maternal mortality prior to 1994, due to the fact that data was typically collected from the urban areas where women were giving birth in the maternity homes. Indications are that maternal mortality rates could have been higher than the reported figures.

The termination of pregnancy services were not liberalised until 1996, with the passing of Choice of Termination of Pregnancy (Act No. 92 of 1996) under the new democratically elected government (Cooper *et al.* 2004). The Act was passed after much debate and a call for legislative reform from research and academic institutions, showing the burden of ill health and deaths from septic abortions, mostly from the blacks (Mhlanga 2003). The ‘back-street’ or illegal abortions claimed the lives of many South African black women, estimated to have been around 200,000 annually, against 1,000-1,500 legal abortions that were performed for the white women during the same period (Cooper *et al.* 2004). Mhlanga (2003:115-126) notes that a septic abortion was a major contributor to maternal deaths; however, ‘under the Hippocratic Oath, an abortion upon request or demand was prohibited’. Meer (1985), illustrating this issue, mentions that as far back as 1982, social welfare workers estimated that at least 75,000 illegal abortions were performed on blacks. The South African Medical Research Council (in Meer 1985) reported that 33,421 abortions ended as incomplete and septic miscarriages in the same year. Termination of pregnancy services were later made available through the passing of the Abortion and Sterilisation (Act No. 2 of 1975), however, under very strict conditions or grounds, and were almost inaccessible for the black rural women. The reproductive health status remained at risk of illegal abortions, should a pregnancy not be desired (Mhlanga 2003).

#### **4.9.4 Health and reproductive health legislation and policies: Transformation of the health system**

The 1994 democratic elections led to a change in laws and policies that aimed at providing an enabling environment for reproductive health reforms, e.g. the new South African Constitution (Act No. 108, 1996) and the Bill of Rights outlawed discrimination on the basis of colour, sex, gender or sexual orientation, and explicitly provided for a right to reproductive health. The ANC Health Plan of 1994, The adoption of Primary Health Care Approach, the White paper for the transformation of the health system in South Africa, and international tools and conventions such as the International Planned Parenthood Federation (IPPF), the Beijing and Cairo conferences and the CEDAW all facilitated transformative policy changes to make South Africa a better place for women to live in – irrespective of colour, race or

geographical location or social position (Cooper *et al.* 2004). The proposed changes in law and policy were accompanied by restructuring of health programmes and administration.

#### **4.9.4.1 The National Health Plan (ANC 1994a)**

The new democratic government had inherited a deeply divided, fragmented and inequitable health system (Chetty 2007). In 1994 the ANC through the National Health Plan for South Africa proposed an alignment of government activities to the new human rights based political and social approach, the national priorities and international conventions (ANC 1994a). The 1994 ANC Health Plan was developed by the ANC technical team, the WHO and the UNICEF, through a broad consultative process. The 1994 National Health Plan was heralded as comprehensive and firmly entrenching the principles of social justice and equity (Chetty 2007). The National Health Plan of 1994 argued for a National Health System that laid emphasis on:

- health, and not only medical care, and that health should be viewed from a development perspective and as being integral to the socio-economic development plans and programmes of South Africa;
- development of comprehensive health care practices that are in line with international norms, ethics and standards; and
- an adoption of PHC as the underlying philosophy for restructuring the health system and that PHC should form an integral part of the country's national health system (ANC 1994a).

The PHC proposed by the ANC (1994a), was to be a central focus guiding overall social and economic development of the community. The 1994 National Health Plan for South Africa further warned that PHC should not be regarded as a cheaper and simpler basic health intervention. The ANC Health plan (1994a) argued that PHC should be viewed as an approach that should change the medical culture whereby the communities and patients are not just passive observers and recipients of health services, while the doctors and other health professionals are dispensers of health care (ANC 1994a). Within the PHC approach, the communities should participate alongside the government and health professionals to determine their health needs and accordingly plan a manner in which such needs should be met (ANC 1994a).

The 1994 National Health Plan held the view that health problems have many and complex causes whose solutions demands not only the attention of the health sector, but an inter-sectorial approach.

In the proposed South African National Health System of post-1994 multi-racial democratic elections, special attention was to be given to the vulnerable groups and development programmes would be established to address women's health. The health of women and children was not to be compromised as a result of foreign debt and structural adjustment programmes (ANC 1994a).

With regard to childbearing decisions and contraception, the 1994 ANC National Health plan highlighted that contraception is a factor which is necessary, however, not sufficient in promoting fertility decline (ANC 1994a). The plan further suggested that a choice of contraception should be provided within a broader framework of reproductive health and within a comprehensive health care approach.

In preparation for democracy, the civil society organisations active in gender and women's health research and programmes lobbied for the creation of locally appropriate reproductive health policies which would embrace a human rights and gender equity approach (SA DoH 1997). Taking the tune from the International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women (FWCW) in 1995, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1995, the women's health and gender activists in South Africa made links between women's reproductive health and women's rights and socio-economic development, and explicitly emphasised and called for a broadened definition of reproductive health (United Nations 1994).

Empowerment of women in South Africa was debated before and after the 1994 democratic elections. The point that poverty has a black rural women face in South Africa was well expressed by Sadie and Loots (1998) in a report that reflected that unemployment of black/African women was 47% and exceeded the national average of 29% by far. Sadie and Loots (1998) added that empowerment is central to a gender perspective and to empowerment and development of women. The ANC,



through its Reconstruction and Development Programme (RDP) policy document explicitly committed the government to empower and develop the women of South Africa (ANC 1994b). This position of the ruling party was reiterated in the first State of the Nation Address of the 24 May 1994 by the first president of the democratic Republic of South Africa, President Nelson Mandela who stated that, 'freedom cannot be achieved unless the women have been emancipated from all forms of oppression' (Mandela, quoted in Baden, Hassim & Meintjies 1999:4). Mandela added, 'the objectives of the Reconstruction and Development Programme will not have been realised unless we see in visible practical terms that the conditions of women in our country have radically changed for the better, and that they have been empowered to intervene in all aspects of life as equals with any other member of society' (Mandela, quoted in Baden *et al.* 1999).

#### **4.9.4.2 Primary Health Care Approach**

The ANC Health Plan had proposed the creation of comprehensive, community-based health care accessible to all South Africans through the establishment of PHC centres as the foundation of the National Health System (ANC 1994a). Accordingly, in 1994, the South African Department of Health adopted a Primary Health Care (PHC) approach as a guideline for improving the quality of services at all levels and a way of reaching out to the poor, the aged, the women and children, as they were the most vulnerable. The approach emphasised health as a human right, equity in resource distribution and expanded access through decentralised services and the district health system (HST 2000, in Cooper *et al.* 2004). The preventive and promotive health care was to be strengthened to meet the local health needs (HST 2000, in Cooper *et al.* 2004).

#### **4.9.4.3 The White Paper on the Transformation of the Health System**

The White Paper on the Transformation of the Health System was formally endorsed in 1997 (SA DoH 1997). It presented a set of policy objectives and principles upon which the unified National Health System of South Africa would be based. The 1997 White Paper on the Transformation of the Health System reaffirmed:



- that the National Health System would be guided by a comprehensive health system;
- the state's commitment to foster empowerment for all the citizens and promote gender equality; and
- the state's commitment to attack poverty through RDP, thus building and developing the economy (SA DoH 1997).

The 1997 White Paper on Transformation of the Health System further stated the four aims of restructuring, among which was to prioritise maternal, child and women's health (SA DoH 1997). The maternal, child and women's health was to be restructured from a curative-based model to a more community-oriented service, based on the PHC principles of universal access to infants, children under 5, adolescents and women (SA DoH 1997). The 1997 White Paper on Transformation of the Health System further stated that women and men would be provided with services which would enable them to achieve optimal reproductive and sexual health (SA DoH 1997).

HIV/AIDS was identified as one of the key health issues affecting the South African population as far back as 1997 (SA DoH 1997). The Government established a National AIDS Control programme which was based on the National AIDS plan of South Africa. The programme aimed at reducing the transmission of sexually transmitted infections including HIV, provision of appropriate care, treatment and support for the infected, and coordination of efforts of the role players to use the resources (SA DoH 1997).

The SA DoH (1997) added that HIV/AIDS is a problem which:

- is rooted in society's fabric, therefore civil society and the government will be mutually involved in containing its spread and impact, and it
- expands beyond health, thus requires a multidisciplinary and multi-response from other stakeholders.

The 1997 White Paper for Transformation of Health Services called for non-discrimination and equity of the HIV/AIDS-affected individuals. The National

HIV/AIDS control programme recognised the vulnerability of women to the epidemic and suggested that all the projects should be gender-sensitive (DoH 1997).

It is the 1997 White Paper on the Transformation of the Health System which established a cluster of Maternal, Child and Women's Health (MC&WH) within the National Department of Health. The objectives of the (MC&WH) were to increase the accessibility of women and children to appropriate health services and to ensure that approaches to health service delivery are consistent with the goal of increasing gender equality.

Kautzky and Tollman (2008) note that other achievements which resulted from changes in National policies after the establishment of the Government of National Unity in 1994 included the following:

- the introduction of free health care for pregnant mothers and children under 6 years with the main goal of redressing the past neglect of the health needs of poor, black women; it was later extended to include free PHC for all who were using the public sector;
- infrastructural development to enhance increased access to water and electrification;
- comprehensive extension of social welfare grants to the previously disadvantaged populations;
- a national school building programme, a clinic building and upgrading programme and the RDP housing programme; and
- a national school nutrition programme.

The section below summarises and assesses the current reproductive health policies, models, strategies, interventions and activities in order to find out how the South African government addresses reproductive health issues, with particular reference to the Strategic Plan for Maternal, Neonatal, Child and Women's Health (MNCWH) and Nutrition (N), in South Africa 2010-2015.

#### **4.9.5 Analysis of the current reproductive health policies and strategies**

The section begins by briefly discussing the Maternal, Child and Women's Health (MC&WH) policy that was developed in 1995, as it laid the foundation for the current Strategic Plan for Maternal, Neonatal, Child and Women's Health (MNCWH) and Nutrition (N) in South Africa. The WHO's Commission on Social Determinants of Health (CSDH) framework and Mosley and Chen's (1984) framework on the determinants of infant mortality are used for the analysis. The key aspects on reproductive health from the Strategic Plan for MNCWH & N 2010-2015 are further examined against the Constitution of the Republic of South Africa (Act 108 of 1996), the RDP, the PHC framework, the 1994 National Health Plan, the 1997 White Paper on the Transformation of the Health System, and the recommendations from international conferences such as ICPD in 1994, FWCW in 1995 and the CEDAW in 1995 as reference policy documents.

##### **4.9.5.1 The Maternal, Child and Women's Health (MC&WH) Policy of South Africa**

In 1995 the South African Department of Health developed the Maternal, Child and Women's Health (MC&WH) policy (SA DoH 1995). The MC&WH policy of South Africa, within which reproductive health service delivery was located, was formulated within the Primary Health Care framework (SA DoH 1997). The Draft MC&WH policy of South Africa was informed by the 1994 ANC Health Plan (1994) which gave overall health policy direction, the 1994 RDP, and the 1997 White Paper on the Transformation of the Health System. Reproductive health issues including contraceptive provision were shifted from the Population Development to Primary Health Care as a result of the influence of women movements who argued for quality of health care for women, rather than striving to achieve demographic goals and targets through the family planning units.

Through the MC&WH policy, the South African DoH committed itself to achieving universal access to health services for infants, children under 5, adolescents and women (SA DoH 1995; SA DoH 1997). According to SA DoH (1995), the draft policy

on MC&WH had the following stated goals, objectives and indicators for the year 2000:

- to reduce maternal morbidity and mortality rates by 50%;
- to ensure that 75% of all maternity facilities were mother- and baby-friendly; and
- to increase the proportion of deliveries with trained birth attendants to 90%.

The policy called for an increase in the proportion of pregnant women who received antenatal care to 90%, and to increase contraceptive provision services so that it would be provided to those in need (SA DoH 1995). Amongst other principles, the policy suggested provision of adequate health resources especially to the rural areas, highly dense peri-urban areas, and informal settlements, as well as for the workers in the farming communities. The draft MC&WH policy proposed integration of the MC&WH services, especially at the clinic and community health centre levels, so that these services could be provided on a 'one-stop supermarket' basis. The policy recommended that individuals and communities be equipped with adequate knowledge and skills that promoted positive behaviour related to maternal, child and reproductive health. In addition, the MC&WH policy stated that quality care should be enhanced while the services were provided efficiently and cost effectively (SA DoH 1995).

Informed by the MC&WH policy, women and men were to be provided with services that enabled them to achieve optimal reproductive and sexual health. This was to be achieved through providing communities with information on sexuality and reproduction; providing services on HIV/AIDS and STDs in all health centres; and making family planning services available to all men and women, while enforcing confidentiality in accordance with individual preferences. Pap smears and breast examinations would be conducted at scheduled intervals (SA DoH 1995). Like the conventional MCH policies, considerable focus was placed on pregnancy and childbirth, and little on the reproductive health of non-pregnant women and women empowerment aspects.

The literature at the disposal of the researcher reflects that the policy has been in a draft form since 1995. The available records do not show whether monitoring or evaluation was ever done on the achievement of the stated goals, objectives, indicators and the targets of the policy. In 2008 the South African Department of Health developed a Strategic Plan for Maternal, Neonatal, Child and Women's Health (MNCWH) and Nutrition (N) in South Africa 2010-2015. The following subsection presents a critical analysis of the Strategic Plan for MNCWH & N in South Africa 2010-2015.

#### **4.9.5.2 Strategic Plan for MNCWH & N in South Africa, 2010-2015: a critical analysis.**

##### **i. Vision, mission, goal and objectives of the strategic plan for MNCWH & N in South Africa 2010-2015**

An examination of the Vision and Mission stated in the Strategic Plan for MNCWH & N 2010-2015 reflects that the South African NDoH aims to provide accessible, caring, high quality health and nutrition services for women, mothers, new-borns and children. The MNCWH & N strategic plan 2010-2015 further aims at outlining and guiding efforts to reach the country's targets for MDG 4 and 5. Like the MC&WH policy, the Strategic Plan for MNCWH & N 2010-2015 embraces reproductive health service delivery and has been formulated within the Primary Health Care framework.

The Strategic Plan for MNCWH & N 2010-2015 has stated goals, objectives and indicators to reduce maternal, neonatal and child morbidity and mortality in line with the MDGs. The Strategic Plan for MNCWH & N 2010-2015 intends to reduce child mortality from the current levels to 20/1,000 by 2015. The MNCWH & N strategic plan holds that the neonatal mortality rate accounts for approximately one-third of all deaths in children under 5 years, implying that an effective and focused effort on neonatal mortality would make a difference in reducing child mortality.

The Strategic Plan for MNCWH & N 2010-2015 further intends to reduce the maternal mortality ratio from the current levels to 38/100,000 by 2015, and accordingly to ensure universal access to reproductive health care. The MNCWH &

N strategic plan 2010-2015 intends to achieve its goals through ensuring access to high quality antenatal, delivery and post-delivery care to mothers; to achieve optimal reproductive and sexual health for all women and men across their reproductive lifespans; and to find means for reducing the maternal mortality rate and abortion-related problems.

Strategic Plan for MNCWH & N 2010-2015 further alludes to have aligned its approach to that of the African Union (AU) Strategic Framework for reaching the MDGs on child survival in Africa, which calls for embracing gender equity and reproductive health. The national MC&WH directorate intends collaborating with the Nutrition directorate in formulating and coordinating policy as well as monitoring and evaluating the MNCWH and N services.

With regard to its implementation, the Strategic Plan for MNCWH & N in South Africa 2010-2015 suggests that there will be a range of cadres in the health profession, including the CHWs who will be expected to deliver a set of priority cost-effective MNCWH & N interventions for the services, from the hospital to the household levels. Likewise, the MNCWH & N directorates have been deployed in the nine provinces. The provinces are expected to deliver a comprehensive MNCWH and N package through the District Health System (DHS) within the PHC context, thus reaching every mother, neonate and child in every district.

Good intentions, however vague, are expressed in the vision of the Strategic Plan for MNCWH & N in South Africa 2010-2015, to the extent that accessible, caring and high quality care in this sense reaches only the conditions in the clinic and do not extend to the local communities and the larger society. In addition, of the four principles of PHC, which can be summarised as equity, accessibility, affordability and sustainability, the vision statement refers to accessibility only.

Furthermore, the 1997 White Paper on Transformation of the Health System called for services that are comprehensive and integrated; however, these two elements are missing from the MNCWH & N strategy 2010- 2015. The vision statement does not incorporate the proposal of the 1997 White Paper on Transformation of the Health System to move from the curative-based to a

more community-oriented care, based on PHC, which emphasises preventive, promotive and curative services for women and ensuing universal access and reduction of mortality, in keeping with the RDP prescriptions.

When asked about their opinion on the Strategic Plan for MNCWH & N in South Africa 2010-2015, some experts expressed concerns that:

the MNCWH & N strategic plan was vague; it lacked clarity regarding what it was based on, because it did not state the problem which should be the basis for the vision, mission, goals and objectives of the MNCWH & N strategy, and there was no reliable and up-to-date data to inform it [D: KZN].

The researcher's observation is that, there is a general stalemate in implementing the Strategic Plan for MNCWH & N 2010-2015. Of the six (6) experts interviewed in this study, only four (4) knew about the existence of the Strategic Plan for MNCWH & N 2010-2015. The four (4) experts who knew about the existence of the Strategic Plan for MNCWH & N 2010-2015, worked for the National and Provincial DoH, while the other two experts interviewed for the study, not employed by the DoH, did not know about its existence. Like the MC&WH policy, the Strategic Plan for MNCWH & N 2010-2015 still has a stamp 'Draft, not for circulation', although it has been posted on the Internet.

The MC&WH cluster needs to bridge the gap between the rhetoric about women's health and the harsh realities most women face. In light of the above, a model or strategy aiming at improving women's health should have a broader vision

## **ii. Primary Health Care approach to maternal, neonatal, women and child health**

PHC was developed as a strategy to achieve the goal 'Health for all' at a conference held in 1978 in Alma-Ata in the former Soviet Union (Wass 2000; Martens 2009; WHO 2008a). The emphasis of the PHC approach was on prevention rather than cure, while relying on:



- home self-help, community participation and technology that the people can afford, find acceptable and appropriate;
- combining modern medicine, scientific knowledge, feasible technology with acceptable and effective traditional healing practices; and
- the curative approach taking second place to prevention.

Framed by the Alma-Ata declaration, and with the technical support of WHO and UNICEF, the ANC declared the PHC approach as the underlying philosophy for redressing and reducing disparities in accessing health services, especially in the rural areas and deprived communities. PHC in this context was defined as embodying the concept of community development that is based on full community participation in the planning, control and monitoring of services.

Although the services are provided in the context of PHC as the Strategic Plan for MNCWH & N 2010-2015 holds, women who lived in the rural areas did not always receive quality service from some of the public hospitals, hence they were increasingly at risk of morbidity and mortality – as the verbal autopsies in this study have established.

### **iii. Empowerment of women**

The policy rhetorically places emphasis on addressing social factors that are related to reproductive morbidity and mortality in terms of the physical infrastructure; this includes health care and education facilities, transportation, housing, water supply, sanitation, and the social aspects which include education, health status, health perceptions and behaviours. The Strategic Plan for MNCWH & N 2010-2015 is silent on how it will achieve that. Not much is mentioned about empowerment of women in terms of improving the socio-economic position of the majority of women such as addressing employment issues, education of the girl child, measures to improve their nutritional status and increase their self-esteem, autonomy and self-determination.

The Strategic Plan for MNCWH & N 2010-2015 is silent about coordinating with other departments such as Education, Welfare, Transport, Population Development,

Labour and Works, as well as the NGOs and the private sector for addressing the empowerment position of women so that high rates of reproductive morbidity and mortality could decline. The PM: C&YH pointed to the absence of inter-sectorial collaboration between the cluster MC&WH and other organisations or institutions outside health, in addressing the problem of high maternal and child mortality. When asked about the interventions on maternal and neonatal mortality, the experts, notably the D: KZN and the PM: C&YH confirmed that the services remain vertical and not integrated, hence maternal mortality remains high. The two experts narrated their impressions of the policies and interventions as follows:

‘The interventions are only in health, if we need to make an impact, we need to look beyond health. The root causes of mortality are outside health’. [D: KZN]

PM: Y & CH added:

‘As long as the levels of poverty, illiteracy and education are still high on women, we will not be making any impact on MDG 4 and 5. Poverty, illiteracy and women empowerment are key to achieving goals 4 and 5, hence we are not on track as a country to meeting the commitments of goals 4 and 5’.

Giving guidance on empowering women, Garcia-Moreno and Claro (1994) indicate that programmes should provide equal opportunities for women in all aspects of social, economic and political life, not simply as a means to reduce fertility. Such policies should pursue sustainable approaches to development that invests directly in women’s well-being (Garcia-Moreno & Claro 1994; Kabeer 1994). The approaches, policies and process that aim at changing the nature and direction of systemic forces which marginalise women have been referred to as empowerment (Batliwala 1993). The outcome would be redistribution of power, transformation of all the structures, systems and institutions which support inequality. In this regard, women themselves should be agents of change and facilitate processes in which they can exercise informed choices within an expanding framework of information, knowledge and an analysis of options available (Moser 1993).

#### **iv. Inequality in terms of race and class**

The Strategic Plan for MNCWH & N in South Africa 2010-2015, like its predecessors, remains silent about addressing the unequal relations between women on the basis of race, class and gender. Data revealed that the black, rural and poor women who are in the majority still utilise the un-resourced public services, compared to the black elite and white women who benefit from the well-resourced private sectors (McIntyre & Gilson 2002). The data further revealed extreme violation of reproductive rights of the black, rural and poor women who suffered and died in the hands of health professionals in public hospitals like Stanger Hospital.

#### **v. Gender-sensitive, gender-aware and gender-responsive policies, strategies and models**

The policy is presented in gender-neutral terms. It does not question the unequal relations between men and women and the subordinate position of women as responsible for reproductive outcomes. The Strategic Plan for MNCWH & N 2010-2015 concentrates only on the biological dimension of women's needs. The focus is on women in their gendered roles as mothers. Men's responsibility role in reproductive matters is neglected, for example, the Strategic Plan for MNCWH & N 2010-2015 mentions vaguely that men have to play a role in reproductive matters by assisting their wives. In most socio-economic settings, men are ruling, dictating and making reproductive decisions without providing a caring and sharing responsibility. The lack of a gender approach in the Strategic Plan for MNCWH & N 2010-2015 places an unequal burden on women. Health and social programmes should promote increased responsibility among men for their own reproductive behaviour, for the prevention of sexually transmitted diseases and for the health and well-being of their partners and the children they father.

#### **vi. Quality care in service delivery**

The elements that constitute quality care are not stated in the Strategic Plan for MNCWH & N 2010-2015. The policy mentions vaguely that high quality care services will be provided in the health delivery units but does not state how.

The CM: DOH corroborates this fact:

‘The confidential inquiry into maternal deaths only looks at what could have been prevented. It looks at the reasons rather than the quality’.

It is also remarkable that the quality of care in family planning services is rarely stated as a policy goal in policy documents. The national Strategic Plan for MNCWH & N 2010-2015 points to the importance of having integrated services. This is still rhetoric because HIV/STD services are handled elsewhere and not within the MNCWH directorates nor within family planning services. Services are still vertically organised, with different services being offered at different times.

#### **vii. Women participation in the formulation of the MNCWH & N strategy**

The ANC Health Plan of 1994 called for recognising the community as the most important partner in health care delivery and emphasised community participation and involvement in defining health care needs. While the participation of women organisations and gender activists who lobbied for the creation of locally appropriate reproductive health policies was evident prior to 1994 when the country was preparing for democracy, the same level of participation was missing in the development of the Strategic Plan for MNCWH & N in South Africa 2010-2015. A strategy that aims at reducing reproductive morbidity and mortality adopts a process that has involved women in the definition of their needs. Such a process has the potential to change women’s understanding in respect of their conception of issues around reproduction.

Garcia-Moreno and Claro (1994) argue that involving women gives professionals a chance to assess the client’s path to a desired outcome rather than the service delivery procedures or a given methodology. The authors further suggest that models, policies and programmes should invite women’s representatives at all levels of decision-making. Lessons from countries, notably Kerala state in India, highlight that women have participated alongside the health professionals in successfully voicing and demanding attention to their needs and advancing primary health care for improvement of their health. Sen (quoted in Wuyts *et al.* 1997) notes that a combination of a responsive state, public awareness and women participation in

defining their own needs as well as enforcing accountability, all contributed to the reduction of women and child mortality and contributed to the success of the Kerala model of social development (Sen, quoted in Wuyts *et al.* 1997).

#### **viii. Emphasis on health and not only on medical care**

On assessing the Strategic Plan for MNCWH & N in South Africa 2010-2015, the researcher's observation is that the strategic plan still adopts a top-down approach and focuses on the health systems to an extent that it views and reduces health to health care; hence, health professionals, mainly doctors and nurses, are assumed to be the providers, and the community, the recipient. In the same vein, it views ill health as a transient state, caused by the presence of disease, which would be ended by appropriate application of medical technology. The curative medical approach assumes that it is the individuals who become sick rather than the social, economic or environmental factors which cause illness. This view obscures the social and economic causes of ill health.

The curative medical approach that is informing the Strategic Plan for MNCWH & N in South Africa 2010-2015 is based on the framework that has been set down by modern medicine, which views the broader ideas and context of social determinants as largely irrelevant. Bambara, Fox and Scott-Samuel (2005) and Doyal and Pennel (1979) share the view that the neglect of health as a social or political phenomenon is in part due to 'medicalization' of the root causes of health or ill health. It is the transfer of power and responsibility for health away from individuals, the public and therefore the social, economic and political life, to the powerful elite such as medical and other professionals including multinational pharmaceutical companies (Doyal & Pennel 1979).

The MNCWH & N focuses on the provision of reproductive health through the health facilities as representing the 'health system'. Although the Strategic Plan for MNCWH & N in South Africa 2010-2015 recognises a relationship between poverty and ill health to an extent that it intends to address inequity and social determinants of health, the strategy provides no tools for effective implementation of integrated social and health interventions for reducing maternal and child mortality. The

underlying common view of health care that is apparent in the Strategic Plan for MNCWH & N in South Africa 2010-2015 is a non-consideration of the relationship between medicine, health and society and the belief that scientific medicine is the only viable means to resolving health issues of women, without minimising the risky situations to which they are exposed.

Much maternal ill health is not accidental; however, MNCWH & N in South Africa 2010-2015 does not question what makes women ill in the first place, and how that can be avoided or how much is avoidable. This translates to a rhetorical commitment which might never be translated into practical strategies. Doyal and Pennel (1979) highlighted that curative medicine is ineffective to diseases of poverty or diseases of affluence.

The WHO's director-general's message in the World Health Report of 2008 reaffirmed WHO's commitment to PHC and condemned the current health systems for being organised around hospitals, commercialised and supply-driven, while excluding those who cannot afford such care (WHO 2008a). The WHO's director-general warned the policy makers against being driven by self-interest and against having goals that are disconnected from people's expectations (WHO 2008a). The WHO's director-general called for a change in the culture and values of the provision of health and health care that deals with people as individuals with rights and not as mere targets for the programmes (WHO 2008a). In the WHO's director-general's words, 'the health care systems in developing countries suffer hospital-centrism that carries with it unnecessary medicalization, thus compromising the human and the social dimensions of health' (WHO 2008a:14).

According to the WHO (2008a), the health systems are subject to powerful forces that often override priorities and have the following characteristics:

- a disproportionate focus on specialist and tertiary care; and
- fragmentation as a result of the multiplication of programmes and projects and the pervasive commercialisation of health care in an unregulated health system.

CM: DOH observed with concern that:

“...the problem of non-performance in our health systems is that most of the specialists act in self-interest, with little concern for the people. Our health system is crowded with doctors who want to be specialists, driven by self-interest vs. broader issues.

They do not even know that the broader issues are real issues. For as long as this status remains, the country will do very little to meet the MDGs. Perhaps we will go somewhere with the Minister focusing on PHC. The problem is the people with vested interests’. [CM: DoH]

There has to be recognition that health problems have complex causes whose solutions demand an inter-sectorial approach as was suggested by the 1994 National Health Plan (ANC 1994). In 1997, the SA DoH had suggested that inter-sectorial collaboration should be encouraged, as the health status of women and children will benefit from interventions in other sectors (SA DoH 1997). However, the analysis reveals that reproductive health issues remain in the hands of the health sector only and losing out from the activities of sectors.

**xv. Enforcement mechanisms and public accountability for non-performance in the reproductive health units, including violation of reproductive rights**

Further analysis of the Strategic Plan for MNCWH & N in South Africa 2010-2015 reflected that there was no provision for enforcement mechanisms and accountability for non-performance –neither from the directorates nor the cluster – or violation of reproductive rights in the reproductive health units. Perpetrators of violations of women’s rights in the reproductive units of Stanger Hospital, as in the case of a teenager who died at the hands of health professionals post-Caesarean section (Nontu’s story), and the neonate dying because the mother was unattended and delivered herself (Mary’s story), would have been brought to book if the Strategic Plan for MNCWH & N in South Africa 2010-2015 had embraced accountability measures for such occurrences.

#### **4.9.5.3 The Population Policy for South Africa (South African Department of Welfare 1998)**

The Population Unit within the Department of Welfare developed a Population Policy in July 1998, which replaced the previous population policy of the Apartheid Government, whose aim was to reduce the fertility rate of the black population. The current population policy for South Africa incorporated the principles and recommendations proposed by the United Nations International Conference on Population and Development held in September 1994 in Cairo (South African Department of Welfare 1998:38). The vision as stated in the policy is to attain high and equitable quality of life for all South Africans programmes (South African Department of Welfare 1998). Its goal and objectives are to focus on changing the determinants of the country's population trends, so that these trends are consistent with the achievements of sustainable human development.

The strategies identified for achieving the objectives of the policy are to promote gender equality and improve PHC, including reproductive health and family planning services. This will be spread to the entire population in order to reduce mortality and unwanted pregnancies, while focusing on disadvantaged groups including adolescents. Disparities in service provision based on gender will be eliminated. Sexual and reproductive health and rights will also be promoted in achieving the goals of the policy. The information, education and communication activities will be integrated into all relevant programmes (South African Department of Welfare 1998:38).

An assessment of the Population Policy for South Africa reflects the aim to provide equal opportunities for women in all social, economic and political aspects of life, in order to reduce fertility. An analysis of the Progress review of the implementation of the White Paper on Population Policy for South Africa (1998) and the ICPD Programme of Action (1994) shows the measures that have been recommended in response to the challenges to implementing the 1998 population policy of South Africa. The recommendation includes, among others, the following:

- Improving women's access, especially those residing at the underserved areas, to effective contraception.



- Removing barriers to adolescents' access to contraception
- Increasing men's responsibility in reproductive matters ; and
- Improving accessibility to PHC facilities for childcare which should include nutritional supplements.

Such statements were said many times in the past but remained at the level of verbal and written acknowledgement. The review referred to in-here further recommended integration and management of HIV & AIDS into sexual and reproductive health and PMTCT services and vaguely called for increased recognition of gender specific vulnerability and risk that facilitate HIV transmission, the management of AIDS-related illness and the health seeking behaviour of HIV-infected individuals (DSD 2010a). However, the recommendations have not been supported with the processes that should unfold to ensure their realisation. In addition, The HIV/AIDS programmes including PMTCT services are currently run by the South African Department of Health and yet not supported by any integration mechanisms between the two departments.

Further, while the 1998 Population Policy for South Africa sounds good, its underlying mission is to reduce population growth. Hartman (1995) notes that the World Bank's interest is to speed up the fertility transition rather than to implement quality care in reproductive health care services in poor countries, through multilateral institutions such as UNFPA. Women empowerment as mentioned in the Population Policy for South Africa could remain purely rhetoric and instrumental if the main aim of the policy is to reduce fertility rather than to provide women with capabilities.

Like the MC&WH policies, some policy statements in the Population Policy for South Africa are unclear, ambiguous and general. The policy acknowledges the importance of gender-specific planning and its link to reducing women's poverty; it also mentions that gender equity will be promoted, but it is silent on how to achieve that.

The policy aims to improve primary health care and reproductive health care services by making these services accessible and affordable to the majority of the

population. This shows some discrepancy, because in practice provision of reproductive health care lies with the Department of Health. It would appear that the poor, black, rural women are still targets for fertility reduction programmes, in which case quality health care will be neglected.

The researcher concurs with the view that the population development policy should pay more attention to redistribution of resources, reduce class, race and gender inequalities and minimise its role in fertility control, if reproductive morbidity and mortality is to decline. The researcher further supports that the population unit should drive integration of population factors into development planning efforts within South Africa and make available reliable and up-to-date information on population and human development situation to inform policy-making and programme development as embraced by the 2008 Population Policy + 10-year Review (DSD 2009; DSD 2010a).

A model that embraces inter-sectorial collaboration of the Health and Social Development departments to address the structural and the social determinants of health, as well as the direct factors which affect female reproductive morbidity and mortality rates, would be more ideal.

#### **4.9.6 Gaps in public policies, strategies, approaches, interventions and models aimed at reducing the risk of reproductive morbidity and mortality**

The analysis of policies confirmed the finding from the interviews with the experts that some good policies and legislation have been developed such as the choice of termination of pregnancy, the policy on sterilisation, the policy on free health care to women during pregnancy and delivery, and the 10-point plan for maternal issues, although there are still gaps – hence the rates of maternal and neonatal deaths are still high. On studying the Population Policy + 10 Review, the MC&WH policies and the Strategic Plan for MNCWH & N in South Africa 2010-2015, the following gaps have been identified:

**Access not addressed:** Access is vital for ensuring that mothers and children enjoy other policies such as free health care for pregnant mothers and children under the age of 6 years. For example, the policy does not address distance, community engagement and social determinants of health.

**Implementation of policies:** The MNCWH & N strategy shows that this strategy has been only a draft, suggesting that the strategy has never been implemented thus hampering effective delivery of reproductive health care. Some experts (five) mentioned that the policies were good; however, the challenge lies in the implementation, as it was narrated by SP: CH:

‘Policies are developed but they are not being implemented. We have good policies. If we were implementing them, we would be doing very well. Some policies cannot be implemented due to the fact that they are developed in definite terms and at times suffer lack of clarity. Implementation is further constrained by unclear, vague and ambiguous statements in policies, e.g. a policy statement such as increase access to contraception is vague and meaningless. There is expertise in the country about what needs to be done; however, that cannot be translated into implementation’.  
[SP: CH]

The SP: WH further added:

‘There is expertise in the country about what needs to be done; however, that cannot be translated into implementation. There is a mismatch between the country’s good policies and implementation’.

**Community participation:** The experts alluded to non-involvement of the community in the policies which affect their lives, including the Strategic Plan for MNCWH & N in South Africa 2010-2015, in spite of the fact that community participation is one of the pillars of PHC. CM: DOH was concerned about the lack of community participation, poor recognition of the social determinants of health, poverty, malnutrition, power relations, urban/rural divide, lack of access to health care.

**Integration of services:** Although the need for integration was mentioned in the Strategic Plan for MNCWH & N in South Africa 2010-2015, the mechanisms for ensuring the proposed integration were not stated. The interviews with the experts in this study confirmed that, in practice, the services were not integrated. The experts identified lack of skills in integration as a bottleneck to non-integration of services.

The services are still organised vertically and the programmes are not integrated, hence implementation is a challenge. The strategy was developed by Health for Health'. [D: KZN]

**Inadequate policies:** The assessment of the Strategic Plan for MNCWH & N in South Africa 2010-2015 reflected that reproductive health, including 'family planning', has been scantily packed under promoting a healthy lifestyle for a pregnant mother during pregnancy, along with the advice on nutrition, promoting healthy safe sex, avoiding smoking and alcohol intake during pregnancy and the genetic services. Further analysis of the MNCWH & N strategy revealed that reproductive health and neonatal health were not given due attention. The concern was further raised during the interviews with the experts, who said that:

'The MNCWH & N cluster does not have certain very important policies. There is no policy to reduce the deaths of new born babies; there is no policy on reproductive health'. [SP: CH]

#### **4.9.7 Conclusion**

This section tracked the root causes of the persistent ill health and mortality from the policies of the past to the present. The analysis established that there is a missing link between the empowerment of women, quality care in reproductive health care services, and reproductive morbidity and mortality. In order to reduce the risks of reproductive morbidity and mortality, the empowerment of women has to be addressed and quality care in the reproductive health care services has to be enhanced in line with the Constitution, the 1994 National Health plan that gave policy direction, the WHO's framework on Social Determinants of Health, as well as Mosley and Chen's (1984) framework on determinants of child mortality.

The South African Government has made some policy initiatives to address the vulnerability of women. For example, the findings revealed the government's intention to empower women through the Population Policy, while the MC&WH policy and the Strategic Plan for MNCWH & N in South Africa 2010-2015 aim at lowering high rates of maternal mortality rates through eight strategies to meet MDG 4 & 5. However, the Government is still faced with some obstacles in addressing the conditions that put women's health at risk of increased rates of reproductive morbidity and mortality. These are among others, women's poor socio-economic position; lack of specific data about women's living conditions, reproductive health status and needs as described by women; and the reorganisation of reproductive health care services. The government is also faced with the challenge of redistribution of national resources, from macro-level to the operational level of service delivery, such as redistribution of health facilities, equipment and services, which are concentrated in the private sectors as compared to the public services. These factors determine access and equity to quality reproductive health care. Therefore, the Department of Health and that of Social Development in South Africa still have to design strategies and practical action plans in a manner that recognises the daily realities of women's lives and have to ensure that what has been planned is implemented.

The experts problematised that the absence of policies for reproductive health and new-born care is largely contributing to the persistently high levels of maternal and neonatal deaths. The study further established that PHC, integration of services and inter-sectorial partnerships as well as addressing health issues from a development perspective are but paper policies. The country still needs to ensure practical implementation of PHC, which will be made possible by a model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa.

#### 4.10 OVERALL CONCLUSION

Data was collected through face-to-face interviews during January and February 2011 at iLembe district, KwaZulu-Natal Province. The interviewees were grouped into four (4) subgroups:

- 'women at risk',
- the significant others of the women and the neonates who had died from reproductive activities recently (the verbal autopsies),
- experts working in the area of reproductive health at a national level, and
- the NGOs working in the area of reproductive health in KwaZulu-Natal, iLembe district.

The risk group for this thesis were black, poor, rural women who were characterised by their encounter with adverse reproductive conditions such as early pregnancy/teenage pregnancy, excess fertility, closely-spaced births, childbearing above age 35 years, and HIV/AIDS infection. The thesis established that the risk group was also associated with unintended pregnancies, late booking in pregnancy and poorly managed obstetric complications. All these demographic factors presented in a chain of events, demonstrating causal linkages between poverty at the level of the household and poor reproductive outcomes.

The study further found that reproductive health outcomes, poverty and household level explanatory variables influenced each other and produced certain values, culture and attitude to life, and interplay of risk variables during reproductive phases. For example, the age group at first pregnancy for eight of the ten women at risk was between 15-20 years, indicating that eight of the ten women had been teenage mothers. Furthermore, the women at risk who fitted into each of the defined criteria of the five subgroups (the teenagers; women at the lower end of the reproductive age group who were pregnant – 35 years or older; women with closely spaced births; high parity women; and HIV-infected women in their reproductive age) were found to be fit well in other subgroups, for example, a woman recruited for high parity would also be HIV-positive.

The evidence revealed that the risk group in this study began their motherhood early in their lives, exposing them to the risk of additional vulnerability associated with poor developmental status, subservient position in society and social exclusion. The social factors just mentioned subjected the women at risk to an inability to secure adequate and quality prenatal and obstetrical services when they needed them. By encountering the above, the repercussions they would have to endure would last over a longer period of time, to the extent that they would be unable to get out of the so-called 'poverty trap'.

The analysed data revealed the following as the determinants of poor reproductive outcomes as voiced by women themselves:

- nutritional inadequacies;
- neglect by male partners;
- pregnancy and financial, physical and emotional abuse by men; and
- health system issues such as poor quality and incompetent health care.

Data from the verbal autopsies pointed to the following as associated with poor reproductive outcomes:

- HIV/AIDS,
- poverty judged by poor socio-economic background, and
- health system issues such as poor quality and incompetent health staff as the determinants of female reproductive ill health and mortality.

The experts cited the following as determinants of reproductive ill health and mortality:

- poverty,
- HIV/AIDS,
- inattention to reproductive health and violation of reproductive rights,
- powerlessness of women,
- absence of policies that should guide action, and non-implementation of the policies that have been developed, and

- Health System issues such as incompetence, bad attitude and poor interpersonal relationships of health professionals in the reproductive health units, as well as a lack of equipment.

Confirming the determinants of maternal ill health and mortality, the NGOs pointed to:

- HIV/AIDS,
- poverty as the underlying cause of female reproductive mortality and providing a fertile climate for the spread of HIV/AIDS, and
- the practice of polygamy as a factor that was increasing contraction of infections and adding to the HIV/AIDS pandemic in KwaZulu-Natal.

Many women were found to be at nutritional risk during pregnancy because of their deprived nutritional growth and development in early childhood and adolescent years. Malnutrition is primarily due to a general lack of basic sustenance; people simply do not have enough to eat to be healthy. The effects are then perpetuated through succeeding generations, since mothers themselves are stunted by childhood malnutrition and deprived of adequate food during pregnancy, leading to maternal anaemia, which increases the risk of mortality both directly and through post-partum haemorrhage. Undernourished mothers also tend to give birth to underweight babies. Under such circumstances, the risk of neonatal mortality also increases.

The prevalence of HIV/AIDS in South Africa is disproportionately affecting the women. The data in this study suggested a correlation between structural factors such as poverty and gender as an underlying factor to the vulnerability of women to HIV/AIDS. Sen and Ostlin (2007) note that HIV/AIDS suppresses the immune system; immune system suppression results from poverty, yet prevention strategies do not focus sufficiently on these, but rather address individual risk behaviours related to sexuality and drug use, and teach women to refuse sex or initiate condom use (Sen & Ostlin 2007). Cognisance should be taken to the fact that, while abstinence and condom use function as core pillars of HIV prevention efforts, within the context of unequal gender power relations, these may serve as triggers for violence against women (Sen & Ostlin 2007). In addition, the data revealed that



young girls engage in sex for the wrong reasons, such as receiving money and gifts, especially if they come from a poor background (poverty stricken home background).

Poor quality of care in public hospitals contributes significantly to maternal deaths. Similarly, family planning services are poor, erratic and inaccessible, contributing to a lack of interest among potential clients, leading to unwanted babies or illegal abortions and poor reproductive outcomes.

Reproductive health policies as part of this study showed that, irrespective of the recognition of the issues, mothers and babies continue to die. South Africa continues to adopt the same MCH/FP package which does not address contextual issues and therefore is a determinant of risk to women's health. The current policies do not address the following factors that are linked to women's health and their social position, thus subjecting women to being vulnerable to ill health:

- poor socio-economic position of women;
- lack of specific data about women's living conditions;
- women's lack of control over financial resources;
- discrimination against girls;
- the inaccessibility of food and health care to women;
- gender-related issues at the level of the household, including:
  - ✓ male dominance in sexual relations;
  - ✓ irresponsibility of men in reproductive matters;
  - ✓ women's lack of control over their sexuality;
  - ✓ gender division of labour.
- violation of women's right to determine the number of children they want;
- factors responsible for quality of health, such as:
  - ✓ reproductive health status and needs as described by women;
  - ✓ re-organisation of reproductive health care services.

The government is also faced with the challenge of redistributing health facilities, equipment and services that are concentrated in private sectors to public services. These factors determine access and equity to quality reproductive health care which would incorporate differences in exposure and vulnerability. In this sense, the health system is a determinant of reproductive ill health.

Poverty among the women at risk was found to be the underlying determinant and common denominator for all the medical, social and political factors. The gap between the rich and the poor has increased in South Africa, as highlighted by the Minister of Finance, Gordhan, in his 2011 budget speech. The Minister added that the 'Gini' coefficient in South Africa is 0,68, exposing South Africa as one of the countries in the world with the widest gap between the rich and the poor, with women being the most affected, a point that clearly emerged from this study (Sanders & Maler 2011)

The analysis of policies and other documents showed that poverty of women is historically determined, closely related to gender and hinges on the women's economic and social position. For example, the study provided insights into the historical changes which affected black rural women, invariably making them poorer and exposing them to prolonged deprivation which they transmitted to their children. Feminisation of poverty in South Africa is a result of a long history of exploitation of black women which in many cases was intensified by colonialism, apartheid, the migrant labour system and patriarchy.

From studying the policies, the study established that the vertical interventions to address the vulnerability of the poor South African women are still embedded in the current reproductive policies. For example, the population policy pointed to the importance of addressing the empowerment of women, while the MC&WH policy aimed at lowering the high rates of maternal mortality through improving the quality of prenatal care. The two policies do not show how integration to address the vulnerability of some women for better reproductive outcomes will be effected. Conceptually and rhetorically, integration has been supported by the population policies, namely the 1998 Population Policy for South, the 2009 Population Policy + 10 Review (1998-2008) as well as the MC&WH policies and the Strategic Plan for MNCWH & N in South Africa 2010-2015; however, it is infrequently tried and ineffective. Developing and implementing a model and policies for inter-sectorial collaboration is fundamental, not only for enabling a multi-sectorial approach but also for introducing a life cycle approach to coordinating the empowerment and management of girls before entering menarche, through contraception for delaying

pregnancy and childbearing, during pregnancy, prenatal and childbearing phases, to post-natal care and child care. Further, development of a comprehensive model that embraces efforts from both the social and the health systems and that would not only empower women but would impact broadly on the rural people, is long overdue as the root of the vulnerability of black, rural, poor women in South Africa is rural poverty.

This study and the literature on poverty and empowerment pointed to the extensive and devastating disempowering effects that poverty can have on women's lives. Literature associates empowerment with control to enhance the possibilities control to control one's life (Batliwala 1993). The study has proved that the people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. In order to take power, women need to gain information about themselves and their environment and be assisted to participate and work with others for change. Drawing on the findings, this study adopts empowerment theories as they explicitly focus on structural barriers that prevent people from accessing resources necessary for health and well-being including unequal distribution of power.

The next chapter (Chapter 5) presents the model for integrating the social determinants of health and primary health care to address the inadequate attention to reproductive health needs and the deprivation and inability to cope with the health problems posed by pregnancy and childbirth.

## CHAPTER FIVE

### **SUGGESTING A MODEL FOR INTEGRATING SOCIAL INTERVENTIONS INTO PRIMARY HEALTH CARE IN ORDER TO REDUCE MATERNAL AND CHILD MORTALITY IN SOUTH AFRICA**

*'Action should focus on reducing the social gradient in health.'*

(Marmot *et al.* 2010:9)

#### **5.1 INTRODUCTION**

In this final chapter, the research findings are summarised with a focus on key issues. The researcher suggests an alternative model for reducing maternal and child mortality in South Africa as based on her findings. The study revealed the lived experiences of black, poor, rural women and the social injustices that underlie the persistent female reproductive ill health and mortality in South Africa. The findings clearly showed that, while a small minority of black women in the cities benefited from democracy, the lives of their rural sisters hardly improved. For example, of the 10 women at risk who were interviewed, 9 were heads of households, responsible for meagre household incomes and the subsistence of their families. The study showed linkages between ill health during reproductive phases and female poverty, female-headship, deprivation, voicelessness and poor health care.

Throughout the thesis the researcher has recognised and acknowledged that the South African government has developed policy initiatives to address the vulnerable situation of women. Progress in the implementation of such strategies is questionable as obstacles remain, such as addressing the conditions that subject women to the vulnerability of ill health, in particular the general and worsening poverty in rural areas. The findings revealed that the government's effort to improve the health of South African women has been undermined by the HIV and AIDS epidemic, which has gripped the country and has disproportionately affected women. Moreover, the government is faced with the challenge of unequal distribution of the country's resources, including income, which affects mostly the rural parts of South Africa, and especially black rural women. These factors determine access to quality reproductive health care. This thesis contends that, while improving access to health

is a crucial part of tackling inequality, the key task for the National Health System, the National Social Welfare and Development Systems and other partners is to help stop women falling prey to and continuing in preventable ill health, rather than picking up the pieces when this has happened.

A different approach is required that would make an impact on the lives of women in South Africa and ultimately reduce the deaths associated with reproductive health. The challenge for South Africa is to design models, policies, strategies and practical action plans in a manner that recognises the daily realities of women's lives and ensures their implementation.

## **5.2 MAIN FINDINGS**

The researcher found that the women in the risk group entered their reproductive years already disadvantaged. This was exacerbated by their early childbearing, their poverty, their static view of life and apparent acceptance of their circumstances. The economic subordination of women exposes them to high birth rates since their poverty increases their need for children and impedes their ability to practise birth control. Other variables such as ignorance, poor educational background and distance to the health services were found to contribute to problems in this regard.

The study established that poverty was for women the root of ill health, manifesting itself in low levels of education and health that was often accompanied by material lack. The study further established the following categories of structural poverty among the risk group: they were born into poor families, had low levels of education and had no saleable skills, thus could not be gainfully employed. Their social capital remained under-utilised because they were not participating in any meaningful economic activity. The risk group had no investments nor commanded any entitlements.

In addition to poverty, the thesis has established that the quality of care in reproductive health care services is of vital importance in reproductive morbidity and mortality. In order to reduce the risks to female reproductive illness and mortality,

any model proposing policy measures should address the empowerment of women and the enhancement of the quality of care in reproductive health care services.

Gender disparities as a contributor to reproductive ill health are still prominent in South Africa. In this study, neglect and abuse by male partners were discussed in relation to maternal mortality. This needs to be addressed for any development strategy or model to succeed, and warrants urgent attention from policy makers. Sen and Ostlin (2007) remind us that gender and society interact to determine who is well, ill, treated or not treated, and who is exposed or vulnerable to ill health, whose health needs are acknowledged and met, or simply dismissed. Thus, the model to be developed should propose policy initiatives for tackling gender biases so that South Africa can move towards more democratic and more equitable development for all. Sen and Ostlin (2007) further suggest that addressing women's vulnerability to HIV and AIDS requires significant, sustained policy and programmes backed by investment to address the social determinants of vulnerability.

Subsection 4.9 in the thesis established the policy guidelines that give direction to the provision of reproductive health care in South Africa. To recap, the ANC Health Plan (ANC 1994a) provides that:

- Health (including reproductive health) should be viewed from a development perspective and be integral to the socio-economic plans of South Africa.
- PHC should be an underlying philosophy whereby communities participate alongside the government and health professionals in determining their reproductive health needs and how such needs should be met.
- Health and not medical care should be an underlying principle to health and the PHC should change the established culture of medicalising all health problems.
- Within the PHC approach, it should be recognised that health problems have complex origins whose solutions demand attention not only of the health sector, but of other sectors as well, through inter-sectorial collaboration.
- The choice of contraception should be provided within a comprehensive approach and the health of women should not be allowed to suffer as a result of foreign debt and structural adjustment programmes (ANC 1994a).

In 1994 the government of South Africa adopted PHC as a guideline for reaching out to the vulnerable groups and the under-served, including the women and children. The government committed to empowering and developing the women and ensuring visible improvements in the conditions of women (ANC 1994b). The PHC approach emphasised that health, including reproductive health, is a human right. The constitution of South Africa (Act 108, 1996) and the Bill of Rights supported the right to reproductive health in 1996 (Constitution of the Republic of South Africa 1996).

Subsection 4.9 of the thesis provides the basis for the argument that the women's health movements and gender activists in South Africa have linked women's health directly to reproductive health, and have called for a broadened definition of reproductive health as informed by international thinking (SA DoH 1997). In addition, the gender and women's health activists lobbied for the creation of locally appropriate reproductive health policies which would embrace a human rights and gender equity approach (SA DoH 1997).

On critically analysing the Strategic Plan for MNCWH & N in South Africa 2010-2015, the researcher established that in many respects the design thereof did not follow the policy direction provided by the national documents above, neither was it informed by international thought concerning reproductive health. Furthermore, the Strategic Plan for MNCWH & N in South Africa 2010-2015 was not data-driven, thus lacks evidence to support it. A critical analysis of the Strategic Plan for MNCWH & N in South Africa 2010-2015 demonstrated that the vision as stated therein does not involve elements to ensure comprehensive, preventive, promotive and curative services for the women and a reduction of maternal mortality, in keeping with the PHC approach. Moreover, the vision as stated in the Strategic Plan for MNCWH & N in South Africa 2010-2015 is vague and lacks clarity on how it will ensure universal access to the vulnerable black rural women. Further analysis of the Strategic Plan for MNCWH & N in South Africa 2010-2015 could not establish the involvement of other sectors or the participation of women in its development. The Strategic Plan for MNCWH & N in South Africa 2010-2015 is silent on how it will address the conditions which subject women's health to the risk of reproductive ill health and mortality.

Evidence points to the government's intention to empower women through the Population Policy for South Africa; however, the lack of specific data about women's living conditions, reproductive health status, their reproductive health needs as described by women themselves, and the reorganisation of reproductive health care services remain a challenge. The proposed empowerment strategies have seemingly not been put in place irrespective of being mentioned in several public policies. Both the Strategic Plan for MNCWH & N in South Africa 2010-2015 and the Population Policy for South Africa are silent on addressing the racial, class and geographical differentials which determine who and under what conditions a woman will receive quality reproductive health – or not. The study could not establish any collaborative functional relationship or integration between the two departments that are custodians of the Population Policy for South Africa and the Strategic Plan for MNCWH & N in South Africa 2010-2015, namely, the Department of Social Development and the Department of Health respectively.

It is the view of the researcher that the formulation of the Strategic Plan for MNCWH & N in South Africa 2010-2015 follows a narrow historic approach of regarding reproductive health as a condition affected by biological factors, and disregarding the social context under which reproduction takes place. It is also the researcher's view that the Strategic Plan for MNCWH & N in South Africa 2010-2015 does not follow the development and empowerment route to improve the living conditions of women and subsequently reduce risk to female reproductive ill health.

In the light of the above analysis, a model that will tackle general poverty, the structural forces and other social biases such as social class, race and geographical location that generate differentials in health-related risks and outcomes is proposed below. The model emphasises social and economic rights, including rights to housing, social security, and education. The proposed model embraces the principles of PHC within which the Reproductive Health Care service delivery is located. Within the Primary Health Care approach, the Alma-Ata Declaration fully recognises that, in order to address the reproductive health problems effectively, basic changes are needed in the social and economic situation of the poor majority, including women (CSDH 2007). By implication, the Alma-Ata recognises the integration of PHC and the SDH.



The proposed model addresses the structural reasons for high risk behaviour. In the absence of attention to the structural forces in which poor reproductive outcomes are embedded, a focus on the health system and the medicalization of maternal and neonatal morbidity and mortality can continue to lead to an emphasis on behavioural change at the individual level rather than on policy at the social level. Therefore, the model addresses the socio-economic and political context as the root of female ill health and mortality, and proposes intervention on the structural determinants, the socio-economic position of women, the intermediary determinants and the direct determinants of reproductive health through active policies and action plans.

### **5.3 A MODEL FOR INTEGRATING SOCIAL INTERVENTIONS INTO THE PRIMARY HEALTH CARE SYSTEM IN ORDER TO REDUCE MATERNAL AND CHILD MORTALITY IN SOUTH AFRICA**

Figure 5.1 below depicts an alternative model that integrates social interventions into primary health care that would reduce the risks of reproductive ill health, thus reducing reproductive mortality and improving reproductive outcomes.

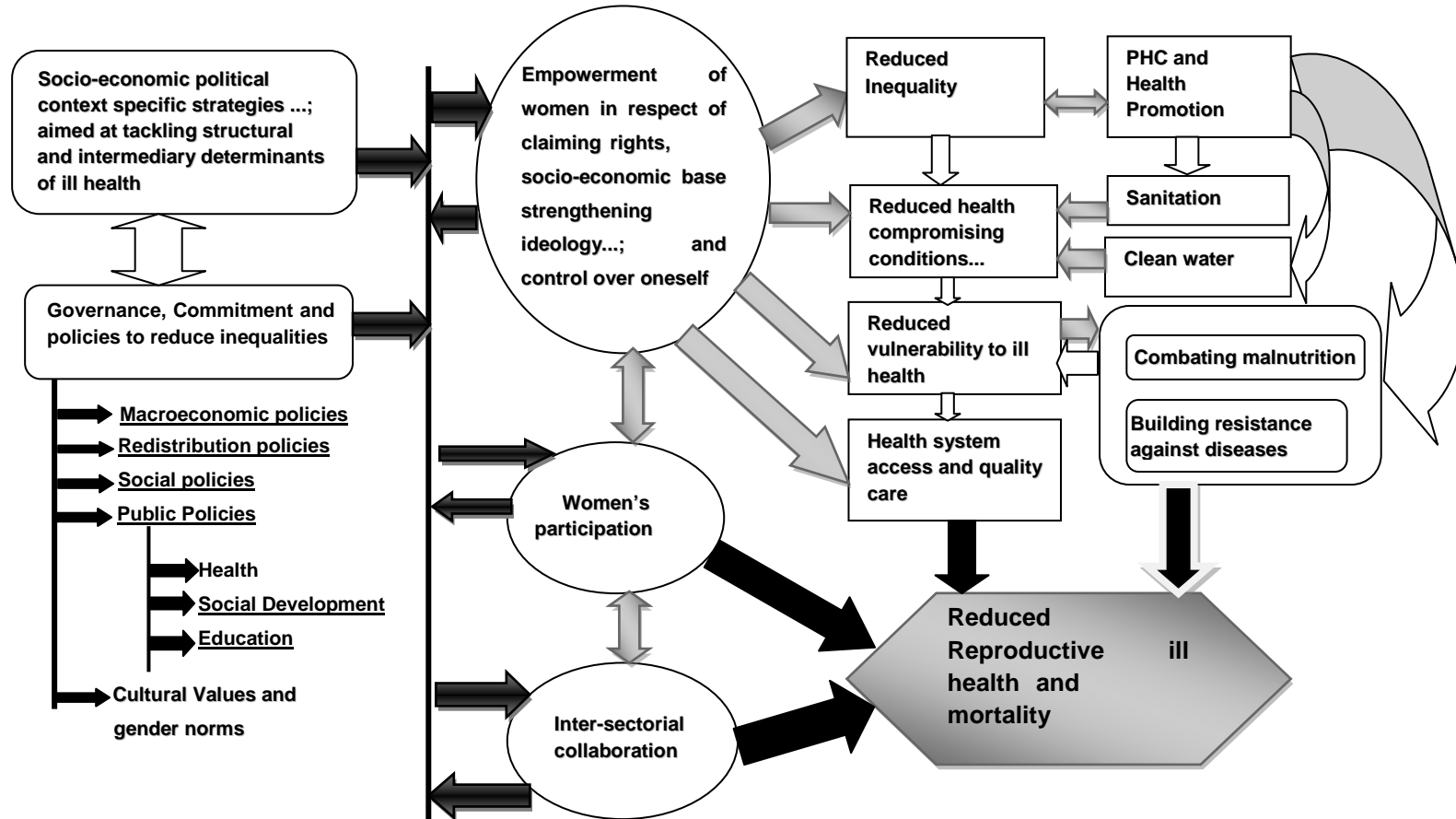
The model rests on three pillars. Firstly, a coordinated, multi-sectorial, interdisciplinary and integrated approach that could impact on the structural and intermediate of reproductive health, that is, those factors that affect the health status of a girl before entering her reproductive age, a woman during all her reproductive life phases, and preventing illness and premature deaths.

Secondly, the model emphasises empowerment and social participation of women to influence policy. Sen (1994) suggests that, where women do not organise in their own interest, policies and politics will marginalise or ignore their needs and concerns or even blame them for reproductive failures or problems which would have been a result of social inequalities or poor policies.

Thirdly, access to quality care in cases of pregnancy, delivery and post-natal period in the Primary Health Care centres should be provided basically by the South African Department of Health, to prevent the onset of obstetric complications and to allow

the necessary treatment in emergency situations thus protecting the women and their neonates from dying. This level pillar could impact on the direct determinants of maternal and neonatal mortality.

Figure 5.1: An alternative model



Underpinning these three pillars is a need for reliable up-to-date information on women's health status, maternal mortality ratios and maternal and neonatal mortality rates to inform policy and programme design.

### **5.3.1 Prerequisites and background**

Policy makers should appreciate that the female reproductive health status of a nation is a consequence of different and interrelated activities of women and a response to actions and failures of government policies and services. If this is realised, it will be possible to identify constraints to achieving the desired state of reproductive health for the majority of women in the provinces of South Africa.

#### **5.3.1.1 *The vision***

The notion of reproductive morbidity and mortality including maternal and neonatal ill health and mortality has to change from the view that this phenomena is disease-specific, thus warranting narrow curative interventions only, to the one that poor reproductive outcomes are a result of the social, economic and cultural factors, deemed structural factors in this study, working through intermediate factors to trigger the direct factors causing ill health, complications and deaths of women, before, during and after pregnancy. It is hence required that, as a matter of priority, interventions have to start by addressing the socio-economic level, that is, poverty and other structural determinants that subject women to the risk of reproductive morbidity and mortality. Accordingly, intervention should empower women and minimise their vulnerability to overall women ill health. This will make an impact in reducing high rates of reproductive morbidity and mortality.

#### **5.3.1.2 *The goal of the model***

The primary goal of the model is to reduce poverty and inequality, empower women and propose policy that guides action to reduce health differences among women and ultimately the levels of illness and death of women in all the reproductive phases. Meeting this goal requires multiple interventions. The guiding principle is health equity.

### **5.3.1.3      *The role of political will***

There has to be adequate political will and commitment at the national and provincial political levels to acknowledge and support efforts to address the factors responsible for the high rates of reproductive mortality and mortality. Consideration must be given by the national government to fairly allocate and share the resources between the provinces, with preference given to the previously under-served provinces like KwaZulu-Natal. In turn, the province needs to distribute its allocation of resources fairly to the districts and between the departments, with particular emphasis on the Departments of Health and of Social Development to enable these departments to attend to the reproductive health needs in a coordinated fashion, especially those of the marginalised poor women. Several laws could be used to seek support not only from the politicians, but also from the bureaucrats and other related parties in prompting policy changes.

### **5.3.1.4      *The role of legislation***

The model should state, promote, protect and defend reproductive health rights. Instruments that could be used at the international level include the International Human Rights Framework as the appropriate conceptual and legal framework through which to advance towards health equity through action on the social determinants of health. Sen, Germain and Chen (1994:5) see reproductive health, empowerment and rights as central objectives of a human development approach. Other international level legislative tools include the Millennium Declaration; the International Conference on Population and Development Plan of Action on Reproductive Health and Rights; the Fourth World Conference on Women and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The South African Constitution, as amended in 1996, could be used at the national level.

### **5.3.1.5      *Indicators of progress***

These should be clearly stated in respect of the budget allocation for reproductive health care services. They should include:

- Equal and fair allocation and distribution of resources, so that the per capita expenditure and staff that are devoted to reproductive health care service delivery are equal and fair for the various population groups as well as between urban and rural areas;
- Representation of women in the budget and other resource allocation national structures;
- Available policy on reproductive health; and
- Trained personnel on reproductive and sexual health and rights; technically competent personnel need to be made available for attending and supervising pregnancy and childbirth, be it at home or at a hospital. This should also include training so that personnel are knowledgeable concerning patient rights and sensitised to support the implementation, monitoring and evaluation of such rights in the field of reproductive health care service provision.

#### **5.3.1.6      *Mobilisation of human potential***

Political representation by women who are competent in reproductive health issues could give women a power base from which to organise and solve reproductive health problems. The support could be sought from the national women machinery. Resistance to reductions in medical care, coupled with demands for increased state expenditure on health and a more equal social distribution of medical resources in securing reproductive health rights, could ensure quality reproductive health care services and contribute to positive outcomes. Accordingly, the health professionals and social scientists have to be trained so that their skills are aligned with the international recommendations on reproductive health.

#### **5.3.1.7      *Women's participation in reproductive health care issues***

For women's health issues to be addressed, women themselves must be responsible for identifying their own problems and participate in planning their services to overcome problems. Participation of women in health issues will change the health profile and the attitude towards health services, as both the users and

providers will influence decisions and the types of services offered as well as the priorities assigned to them.

#### **5.3.1.8      *Reorganisation of services and shifts from curative to preventive services and integration***

Current levels of reproductive morbidity and mortality cannot be reduced to medical interventions only. The government has to shift focus from curative services to prevention of the conditions that expose women to ill health and death, in line with the PHC approach. Preventive health care requires a shift both in organisation and use of resources as well as a shift in responsibility. The private sector that has been rendering curative services should be integrated with the public sector which is expected to offer preventive services. The country could experience dramatic reproductive health gains if preventive services are strengthened, especially by responding to real structural factors rather than diverting resources into the hands of the 'better off'.

### **5.4      IMPLEMENTING THE MODEL IN SOUTH AFRICA: ADDRESSING THE SOCIAL DETERMINANTS OF REPRODUCTIVE ILL HEALTH AND MORTALITY**

This model assumes that the social determinants of health constitute the structural factors which operate through the intermediary factors to determine differences in exposure and levels of vulnerability to the risk of reproductive ill health and mortality. Therefore interventions for achieving the desired reproductive goals have to address the three levels of the determinants of reproductive ill health, including the structural, the intermediary and the direct levels, as shown hereunder.

#### **5.4.1 Addressing the structural and the intermediary determinants of reproductive ill health and mortality**

##### **5.4.1.1 *Tackling female poverty as the root of reproductive ill health and mortality***

Mechanisms of the equitable redistribution and allocation of resources in health care should be put in place. Borat & Van der Westhuizen (2008) suggest that governments need to be committed to reversing the effects of decades of inequality that have left rural people in deep poverty and dying from preventable diseases. For example, the Department of Water Affairs and Forestry (DWAF) indicated that service delivery in respect of water, sanitation and electricity connectivity still lags far behind in the rural areas and impacts negatively on health (South African Department of Water Affairs and Forestry 2002).

Increasing job opportunities is a powerful tool to eradicate poverty and to reduce the intergenerational transmission thereof. This should be coupled with the elimination of the wage gap. An integrated effort is required to create opportunities and economic independence for women. However, it might be difficult to create jobs for women in the context of South Africa where unemployment and lack of skills have become a national problem. Under the circumstances, labour market policies need to secure jobs with adequate pay for women and labour-intensive growth strategies. It is also necessary to appreciate and assign value to women's work and activities. Women are over-represented in informal sectors, pointing to the need for a holistic approach to livelihood and a sectorally based strategy to increase women's economic activity rates in the formal sector.

##### **5.4.1.2 *Women's empowerment***

Here, the creation of structures that can facilitate the empowerment of women is of crucial importance. This implies finding ways by which gender interests and the voices of minority groups can be represented. At policy level, the women's structures should facilitate the development of approaches that would empower women through practically setting-up education and employment projects and strategies leading to



their increased autonomy and decision-making power. These are the underlying issues to meeting reproductive health needs.

Intervention at this level requires the integration of services and collaboration with other provincial departments to implement the identified strategies to empower women as follows:

- The design and implementation of intervention policies, strategies and plans to improve the socio-economic position of women should be undertaken by the Population Unit in the Department of Social Development and the Department of Labour. Government housing projects (RDP houses) should identify and consider provision of housing for rural women.
- The education of girls should be ensured by the Department of Education. Education for girls is an investment for themselves and for their children in the future and increases their earning potential. An emphasis on primary education for all girls is needed. However, South Africa should also make it possible that women attain higher levels of education as it would increase their representation in state institutions, and put them in a better position to defend women's reproductive health rights.
- The Department of Public Works has to ensure the availability of infrastructure such as the clinics, transport, and a communication and referral system in rural areas. The provision of free public transport for pregnant women to attend clinics should be investigated.
- A multidisciplinary body representing the above-mentioned partners, the private sector, NGOs and other women organisations that represent the interests of ordinary women, could be formulated and led by a trained reproductive health care champion or team. Partners should be involved in all the stages of designing, implementing, monitoring, and evaluating a reproductive health care policy and action plans.

#### **5.4.1.3 Tackling malnutrition**

There is a need to increase appropriate food production and to better control the prices for foodstuffs and food supplements. The provision of nutritional packs to

needy school children by the nutrition sub-directorate in the DoH should be extended to the poor women in the community. In addition, the community should be encouraged to embark on self-help projects such as food gardens. This task should be jointly carried out by the Department of Social Development.

#### **5.4.2 Addressing the direct determinants of reproductive ill health and mortality at service level**

##### **5.4.2.1 *Strengthening PCH and Health Promotion***

The South African Department of Health needs to recognise that the current MCH package provides a partial remedy for the prevailing risky conditions of women. Both the Department of Social Development and the Department of Health should mobilise women and facilitate campaigns:

- against maternal mortality and morbidity;
- for high quality primary health care including reproductive and sexual health care; and
- against disempowering, disabling and mortal conditions.

Joint commitment of the Departments of Social Development and of Health to set the objectives related to health promotion, that tackle the main determinants of reproductive ill health as informed by this thesis is of the utmost importance. Action at this level should be backed by shifts in resource allocation.

##### **5.4.2.2 *Establishing a national reproductive health team***

A reproductive health team constituted of representatives from the Departments of Social Development and the Department of Health should drive reproductive health within South Africa. The mandate of the reproductive health team should be amongst others to:

- **Develop a reproductive health policy**

The proposed reproductive health policy has to be developed in line with the recommendations of the 1994 ICPD PoA within the PHC approach (United Nations

1994). This policy should cover the following services in an integrated continuum: health promotion, services for STIs and HIV/AIDS, contraceptive provision, prenatal care, maternity care ensuring safe delivery, post-natal care, choice on termination of pregnancy, training for responsible parenthood, infertility clinics, screening for cancer of the breast and cervix, and counselling. In addition to developing a reproductive health policy, the reproductive health team should ensure implementation, monitoring and evaluation of a reproductive health policy.

- **Reconceptualise HIV and AIDS**

The persisting high rates of deaths from HIV and AIDS indicate a need to take a step back and find out how things can be done differently. Operational research to reconceptualise HIV and AIDS as well as integrate HIV and AIDS prevention strategies into reproductive health programmes at PHC level. Research into the socio-demographic implications of the HIV and AIDS epidemic could be a viable option.

- **Strengthen contraceptive provision**

Contraception should be made accessible to all who need it to make termination of pregnancy less necessary. Reproductive health care units should have a wide range of contraceptives in sufficient supply from which women could choose a suitable method. Information should be provided that would diminish reliance on industry-produced information and would promote scientifically approved methods such as LAM, IUDs and other barrier methods. The following aspects of quality care should be emphasised by the policy: choice of methods; information provided; technical competence; interpersonal relations; follow-up and continuity of care; and appropriate constellation of services.

- **Ensure accessibility of termination of pregnancy services**

These should be made available and be equally accessible and controlled for safety, even in the rural areas. Strategies to dispel the myths and misconceptions about

termination of pregnancy should be incorporated into the policy. Termination of pregnancy teams in South Africa should be put up as urgently as possible, even in the rural areas, to minimise reproductive morbidity and mortality from clandestine termination of pregnancies.

- **Strengthen information, education and communication (IEC) programmes**

The IEC programmes should not only promote contraception, but also other health measures that could be undertaken by women to prevent reproductive ill health.

#### **5.4.2.3 *Strengthening reproductive health programmes through improving quality of service and expanding coverage to reach all those in need***

What is needed at service delivery level is an approach that maintains that all problems related to the reproductive system, its functions and processes have to be addressed through provision of quality reproductive care. The proposed quality of reproductive care should ensure constellation of methods, techniques and services, thus contributing to reproductive health and well-being. This specific function has to be performed by the Department of Health, which needs to develop policies, redefine programme objectives in line with the new approach, design and operationalize concrete action plans to ensure the development of a comprehensive reproductive health programme that will facilitate provision of quality reproductive health service. The Department of Health needs to explicitly address the inadequacy of reproductive service delivery units in the rural areas.

Guided by the 1994 ICPD PoA, reproductive health care programmes in South Africa should be designed to serve the needs of all women and adolescents, even (and especially) in the rural areas (United Nations 1994). The design and implementation of the reproductive health programmes should involve women in the leadership, planning, and decision-making phases, including management, implementation, organisation and evaluation of services for support. Such programmes should be inclusive and aim to counsel, teach and 'conscientise' men to accepting their reproductive and parental responsibilities. Policies and action plans need to be

developed that would guide and educate men and boys on avoiding abuse of women and girls in any form, including physical and verbal abuse and rape. Programmes should further guide partners on taking responsibility in the daily household and child care.

#### **5.4.2.4 *Scaling up antenatal intra-partum and post-natal care***

To upscale the current services, screening for early detection and treating risky health situations during ante- and post-natal periods should be emphasised. In addition, the following should be addressed:

- The improvement of the ratio of health professionals to the population in specific localities;
- The transfer of activities that could be performed by non-professionals (including traditional birth attendants) to such individuals;
- The investigation of essential drug availability and adequacy in reproductive health care at service delivery units in the rural areas;
- The implementation of free screening for cancer of the breast and the cervix; and
- The management of sexually transmitted diseases, including HIV/AIDS, and activities for preventing the spread of infection should be performed within the reproductive health unit.

## **5.5 RECOMMENDATIONS FOR FURTHER RESEARCH**

The study has pointed to the challenges in measuring maternal deaths in South Africa as reflected by differing and diverging ratios from the different sources. The findings highlighted the fact that there is a serious under-estimation of the maternal mortality, which is compounded by under-representation of the affluent and the hard-to-reach areas. This indicates an immediate need to collect reliable data on the extent of maternal and neonatal mortality for proper planning, as well as monitoring and evaluation of the success/failure of reproductive health programmes.

The absence of baseline information about women's economic, social and political status means that there are no standards against which success could be measured.

The lack of access to information disempowers those involved in decision-making processes and also point to the need for immediate research on women's socio-economic standing. Future research and development data is needed and should include disaggregation by gender, racial divisions and geographical location to inform focused policy development and action.

The current assessment of HIV/AIDS prevalence rates in South Africa is based on women attending antenatal care. HIV/AIDS is a serious matter in this country. South Africa needs to pay particular attention in researching the trends, patterns and rate of HIV/AIDS infection, as well as monitoring and evaluating the effectiveness of the HIV/AIDS programmes that have been introduced. Research on HIV/AIDS should involve all people in the country and not a particular group only, in order to get a comprehensive picture of the extent of the problem.

The negative attitude of health professionals towards women in labour is still not understood, pointing to the need for strengthening research into the conduct of professional nurses. Future research should further include a national skills audit of reproductive health professionals for mobilisation of human resources.

The interweaving of gender with race and class in human reproduction means that equal attention must be given to all three and to the interplay between them. This requires more research.

The need for research to establish whether traditional birth attendants (TBAs) still deliver women in the community, irrespective of national policy that emphasises that women should deliver at PHC centres, is critical. The research should establish the possibility of any maternal deaths associated with TBAs in the community.

Given the social and demographic significance of unplanned pregnancies and the associated risks to maternal health as evidenced from this study, the government should endeavour to embark on more social research to discover the causes for the non-use or discontinuation of contraception, and accordingly introduce more rigorous interventions to deal with this phenomenon. Lastly, research on the effects of the

macroeconomic policies on women's health is required for focused policy development and action.

## **5.6 WEAKNESSES, STRENGTHS AND CONTRIBUTION OF THE STUDY**

### **5.6.1 Weaknesses of the study**

The small number of women at risk who participated in the study limits the generalizability of the findings to the rest of the country. Although the verbal autopsies exposed the economic, social and cultural difficulties which the black, poor women are facing in iLembe district, a small sample size of this category of data collection presents a challenge in making conclusive judgement about a myriad of factors and the social dynamics leading to maternal and neonatal deaths. In addition, the non-involvement of other stakeholders in maternal mortality and neonatal mortality such as the traditional birth attendants and other developmental partners in the field of reproductive health, whose views could have contributed to a more informed public debate on reducing maternal mortality is a limitation in this study. Interviewing more experts outside the DoH could have provided more exploration of the MMR and NMR issues from a social perspective.

The findings of the study regarding women at risk are based on the views of women in iLembe district, KwaZulu-Natal, and may not be applicable to other districts or other provinces. In addition, the study might have missed data regarding the views of women who did not attend the antenatal care unit during the period of study, precisely because of their social and economic circumstances. Conducting verbal autopsies a few months after the mother or a neonate has passed on might have introduced a recall bias on the parts of some of the significant others.

### **5.6.2 Strengths and contribution of the study**

The strength of this study lies in the development and consistent application of a social model that analysed and assessed the current health approach to identify and address the determinants of maternal and neonatal mortality and its impact on the actual delivery of reproductive health services. The presentation of the views of

women at risk of reproductive ill health in respect of the determinants of reproductive outcomes and their needs and demands, the data collected through the verbal autopsies, the interviews with the national experts, the NGOs and the analysis of documents, provided a powerful illustration in terms of the shortcomings of the current approaches and interventions and the requirements for an integrated social and health model for reducing the risk of female reproductive ill health. Below, the strengths of the study are discussed in relation to its contributions at the level of social theory, methodology and policy.

#### **5.6.2.1      *The strengths of the study in relation to its contribution at the level of social theory***

From the findings presented in Chapter 4, the study has demonstrated that reproductive health is shaped by and remarkably sensitive to the social and economic conditions that are characterised by deprivation and hardship. Economically and socially under-privileged women are the most vulnerable and disempowered groups in protecting themselves against the risk of reproductive morbidity and mortality. This vulnerability is contoured by limited education, limited access to accurate information on sexuality and reproductive health matters, and prevailing poor material circumstances. The narrations provided insights into the women's experiences with the formal medical health system and expanded an understanding of the perception of women of the formal health system to problematised, manage and regulate women's sexuality.

The key demographic themes that emerged from the study as risks to reproductive health, notably, early sexual engagement and childbearing, unplanned pregnancies, pregnancy itself, closely spaced births and non-use or discontinuation of contraception, demonstrate an inattention to women's reproductive needs in iLembe. These factors have influenced the ability of the women 'at risk' to control their reproductive behaviour and have exposed them to the risk of ill health. The study therefore provides an indication that reproductive health continues to be understudied as a social phenomenon. The study has demonstrated that female reproductive health status is not only affected by biological factors, but is also a product of social and cultural factors that are interrelated – suggesting the



importance of an application of a social analysis and models to address negative reproductive outcomes in South Africa.

As the study is located in the sociological understanding of demographic behaviour, this research reiterates the failure to realise women's sexual and reproductive rights. Reproductive health failures and problems are therefore a result of social inequalities of poor social and health policies which do not complement each other in practice. The study adds to the existing body of conceptual tools by showing the interdependence between reproductive health outcomes and social conditions. Having drawn from the 1994 ICPD PoA, and the models developed by the CSDH (2007) and Mosley and Chen (1984), evidence suggests that poverty remains the single major determinant of poor reproductive outcomes. Without a significant reduction in poverty, and improvement in the living conditions of women, coupled with having their basic needs met, the risk to maternal illness and mortality will be difficult to reduce.

#### **5.6.2.2      *The strengths of the study in relation to its contribution at the level of methodology***

At a methodological level, the multi-stage, qualitative research design made it possible to investigate the root of reproductive ill health and maternal mortality by using comprehensive frameworks on the SDH that were obtained from literature as conceptual frameworks. The research design included obtaining the perspective of the different subgroups, of their social context, and the health system, as well as the quality and availability of reproductive health services. Data gathering was complemented by the study of documents to obtain the available statistics and policy issues on reproductive health, including MMR and NMR.

The face-to-face interviews with the women at risk allowed the researcher to explore their experiences on reproductive health that subjected them to reproductive ill health and mortality. The qualitative research design further demonstrated its relevance and appropriateness for investigating core issues relating to the need for a change in policy making. The use of a multi-stage, qualitative research design also allowed different subgroups to express their opinions on the core issues. Through

the verbal autopsies, the study methodology provided an opportunity to investigate and expose real-world experiences of rural women. Although the verbal autopsies painted a blurred picture on the causes of mortality of women, they exposed a chain of events leading to the death of women and neonates.

### **5.6.2.3      *The strengths of the study in relation to its contribution at the level of policy***

Having showed the interrelatedness of female ill health and development and that empowerment of women relates to reproductive health, the study has argued for an alternative model which embraces more coordinated, multi-sectorial, interdisciplinary as well as empowering policies and approaches, to address both the structural and the intermediary determinants of women's vulnerability to reproductive ill health. The researcher is of the view that the study objectives have been met.

## **5.7      CONCLUSION**

The aim of the study was to develop a model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa. The focus was to trace the underlying conditions that expose women to risk of reproductive ill health and the associated mortality, and to recommend solutions to minimise their vulnerability as a result of their social position. The thrust of this thesis is that any strategy aiming at improving reproductive outcomes must address the underlying issues so as to effectively prevent and reduce the occurrence of the direct causes to maternal and neonatal mortality.

The study revealed that the root of the persistent reproductive ill health and premature mortality is structural poverty and unequal distribution of material and health care resources, pointing to the need for a broader approach which would move beyond addressing individual health complications in health facilities, and would rather encompass a broad spectrum of structural, cultural and functional aspects of the social system. The study has further shown the limited scope of reducing maternal and child mortality in the Strategic Plan for MNCWH & N in South Africa 2010-2015 which is embedded in the narrow curative approaches. Moreover it

showed the interrelatedness of female ill health and development and that empowerment has a relationship to reproductive ill health. Hence the thesis argued for an alternative model that would act and impact on the social determinants of reproductive ill health in addition to addressing the direct causes of maternal and neonatal deaths.

The study has further demonstrated that very pertinent issues such as non-compliance with the hospital procedures can lead to loss of life and dire consequences at the household and community level, as it was revealed by the verbal autopsies (Nontu's story). The provision of accessible, equitable, quality reproductive health care services from the Primary Health Care Centres including hospitals therefore remains one of the core pillars of the proposed model, and this task should be ensured by the Department of Health in South Africa by designing and operationalizing concrete action plans. The policy makers concerned with reducing maternal mortality should be aware that neglecting family planning programmes is a determinant of reproductive ill health, as this study has pointed out, and that both the providers and the recipients bemoan it as pointed out below:

The government has been neglecting family planning, now it wants to go back to it. [CM: DOH]

There is less range of contraceptives compared to 10 years back.

The female condoms are barely available.

The IUD is not provided anymore. There is no low-dosage pill.

What is available is high-dosage contraception, which people might leave because of the problems they bring about. [SP: WH]

Women at risk demanded that:

The government should build counselling centres at the rural areas, where in addition to addressing the reproductive health needs of the teenagers, women can be tested and informed about their status and the available methods for family planning. [Thuli]



This study would have reached its goal if it succeeds in cautioning policy makers to consider that reproductive health and reproductive outcomes are products of complicated power relations. Women need to be protected from policies of the parties that have other interests rather than caring for their health and well-being in every aspect of health provision. The insights arrived at in this study will hopefully add value in the various departments involved in the design and implementation of public policies and models which create conditions conducive to reducing the risky conditions to women's health overall, and the reduction of reproductive morbidity and mortality. This study should serve as a tool that could raise awareness with the policy makers and the people about the social determinants of reproductive ill health and mortality, including maternal mortality. Moreover, this thesis should assist the Government of South Africa to:

- be responsive to women's needs overall, including ensuring their right to reproductive health;
- address the needs of in and out of school youth and young women, strengthening advocacy programmes for the adolescents' reproductive health and responsible sexual behaviour; and
- strengthen training programmes for the providers of health care; however, this should be preceded by recruiting the right people who have a passion for the profession.

The copies of this thesis will be made available to the NDoH, the KwaZulu-Natal provincial DoH, and iLembe district health offices, in order to share the findings and facilitate the implementation of its recommendations.

The policy makers need to be made aware that the pain and difficulties which the South African health institutions can cause to people's lives are beyond any measure, as captured below in the words of Nontu's mom on the circumstances around her teenage daughter's death:

There is a guy whom we know who works in theatre. He spoke to Nontu after she woke up from a Caesarean section. He then called us at night to let us know that Nontu has given birth to a baby boy

and they are both well. Then Nontu was taken to the ward, she was okay.

At around 4 a.m. in the early hours of the morning, my mother woke me up to say we should be happy that Nontu has given birth to a baby boy.

***Then later that morning my brother who works in the hospital came with the news that Nontu has died in the ward (Nontu's mom bursting into tears) ...*** Honestly, I'm really failing to understand because no one could tell us what happened.

At first the nurses lied that they had been checking on her until around five (5 a.m.). When we insisted on the answers, the matron told us right to our faces that **Nontu should have been checked on hourly after siza (Caesarean section) of which it was never done ... The nurses killed my child, sisi, they killed my child!**

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Constitution of the Republic of South Africa (Act 108 of 1996).

## **APPENDIX A: BACKGROUND INFORMATION ON RESEARCH QUESTIONS AND DATA SOURCES**

### **1. Title**

A model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa.

### **2. MDGs relevant for this study**

While this study is specifically addressing goal 4 and 5, the following MDGs are relevant:

- Goal 1: Remove Poverty & Hunger
- Goal 4: Reduce child mortality (2/3)
- Goal 5: Improve maternal health (3/4)
- Goal 6: Combat HIV/AIDS, malaria and other diseases

### **3. Main research questions**

1. What are the current direct causes of deaths of women during their reproductive ages?

Data sources to answer this question:

1. Secondary analysis first.
2. Interviewees
  - 2.1 Experts and Health Professionals
  - 2.2 Women at risk of reproductive ill health
  - 2.3 Representatives at local NGOs that offer services to women

2. What are the structural determinants of and the socioeconomic positions of women who died from pregnancy or child birth?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Women at risk of reproductive ill health
  - 2.2 Representatives at local NGOs that offer services to women

3. What pathways lead from the root causes to the stark differences in health status observed in women during their reproductive ages?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Experts/Health professional
  - 2.2 Women at risk of reproductive ill health
  - 2.3 Representatives at local NGOs that offer services to women

4. What are women's real needs at service level (primary health care facilities) and household community level before pregnancy, during antenatal, delivery and postnatal periods? (What do women want?)

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Women at risk of reproductive ill health
  - 2.2 Representatives at local NGOs that offer services to women

5. What are experts' views on interventions which have the potential to reduce the maternal and child morbidity and mortality rates within South Africa?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Experts and Policy makers

6. What services do faith-based (FBOs), community-based (CBOs) and non-governmental organisations (NGOs) deliver to poor women and what do they perceive as possible strategies to improve services for better reproductive health outcomes for women?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Representatives at local NGOs that offer services to women

7. What have been the effects of the current models, policies and strategies on reproductive health outcomes?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Experts and Policy makers

8. What measures can make a difference in addressing the vulnerable situation of women for better reproductive health outcomes?

Data sources to answer this question:

1. Literature review
2. Interviewees
  - 2.1 Experts/Health professional
  - 2.2 Women at risk of reproductive ill health
  - 2.3 Representatives at local NGOs that offer services to women

## **APPENDIX B: INTERVIEW SCHEDULE FOR INTERVIEWS WITH THE EXPERTS**

A maternal death is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”.

A “pregnancy-related death”, on the other hand, is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death or duration and site of pregnancy”.

### **Improving the health of mothers and children requires an integrated approach.**

Appropriate interventions must be based on a well-grounded understanding of social and health determinants.

For the purpose of this study, social factors are as important as physical factors in determining health status and suggest alternative interventions.

The MDG 4 commits the global community to reducing under-five child deaths by two –thirds (66%) by 2015 from a baseline in 1990.

MDG 5 commits the countries to improving maternal health and reducing MMR by three-quarters (75%) by 2015 from a baseline in 1990.

Massive increases are required in coverage of essential interventions to reach MDG 4 and 5, thus ensuring maternal and child survival.

In the context of this research paper, maternal and child survival refers to the preventive, promotive and curative interventions that ensure survival of the mother and her child.

The maternal, neonatal or child survival interventions in the context of this paper is limited to two component areas, that is, maternal health and newborn health and nutrition interventions including breastfeeding.

### **1. Questions for the expert**

1. Data management and reporting remain challenges in South Africa, resulting in inconsistent reporting on the levels and trends in maternal and child mortality.
  - 1.1 How is maternal mortality and neonatal mortality currently measured in South Africa?
  - 1.2 What, in your opinion, is the MMR currently in South Africa?
2. What is your opinion of maternal and child survival interventions currently implemented in South Africa?
3. Is this country on track to meet its commitments of MDG 4 & MDG 5 in your opinion?



4. What are the key determinants of deaths of women during their reproductive ages?
5. What have been the major causes of the high rates of MM and neonatal mortality?
6. What are the constraints/bottlenecks to reducing maternal mortality ratio (meeting MDG 5)?
7. What are the constraints/bottlenecks to reducing the neonatal mortality rate?
8. What should be done? In other words what key measures can assist South Africa to reduce mortality?
9. Who are the main actors in efforts to reduce MMR?
10. Who are the main actors in efforts to reduce NMR?
11. To what an extent do politicians support maternal (M), neonatal (N) & child (C) survival interventions?
12. In your opinion what are the gaps in the policies for reducing maternal and newborn mortality (including Health Sector Strategic Plan 2006/2007 - 2007/2008)?
13. What measures do you recommend to be put in place for reducing maternal mortality including access to health care and emergency obstetric care and intrapartum care?

## **APPENDIX C: INTERVIEW SCHEDULE FOR INTERVIEWS WITH A WOMAN AT RISK OF REPRODUCTIVE ILL HEALTH**

### **1. Demographic background**

- 1.1 Age: How old are you? Please give me your precise date of birth.
- 1.2 Residence: Where do you live? Is this an urban, a rural or an informal area?
- 1.3 What is your marital status? (Probe for polygamy, widowhood)

### **2. Educational Background**

- 2.1 Have you attended school?
- 2.2 If yes where did you attend school?
- 2.3 What standard have you passed?

### **3. Employment Status**

- 3.1 Are you currently employed? (Probe for type of work, time unemployed)
- 3.2 If employed, how much do you earn (Rand per month)?
- 3.3 If employed, access to health care benefits/medical scheme?
- 3.4 If not, what is the source of you income? (Probe for social grant recipient)

### **4. Reproductive Health**

- 4.1 Are you currently pregnant? (Probe how many months gestation)
- 4.2 How many children do you have? (Differentiate between own children, adopted, step- or foster children)
- 4.3 How many times have you been pregnant in your life? (Probe for birth intervals, previous miscarriages or stillbirths)
- 4.3.1 I would like to have detailed information about each of your pregnancies over your life time, starting with the latest (current pregnancy or youngest child) to your first pregnancy or birth:

Current pregnancy	Months pregnant:	Not currently pregnant
Youngest child	Date of birth	Still alive?
Second youngest child	Date of birth	Still alive?
Third youngest child	Date of birth	Still alive?
Fourth	Date of birth	Still alive?
Fifth	Date of birth	Still alive?
Sixth	Date of birth	Still alive?
Seventh	Date of birth	Still alive?

- 4.4 Have you ever been hospitalised during any of your previous pregnancies for a health concern? Explain that this excludes confinement for the birth.
- 4.5 If yes, what were you suffering from?
- 4.6 If no, in your opinion what kept you healthy during your previous pregnancies?
- 4.7 Have you ever been hospitalised after any of your child births for a health concern? Explain that this excludes confinement for the birth.
- 4.8 If yes, what were you suffering from?
- 4.9 If no, in your opinion what kept you healthy during your previous child's birth?
- 4.10 Have you used contraceptives before this pregnancy? Probe for type, side-effects, etc.
- 4.11 Have you ever had a termination of pregnancy? If yes, probe for age and reasons
- 4.12 Did you plan this pregnancy?
- 4.13 If no, what are your feelings regarding this pregnancy and the child to be born?
- 4.14 If currently pregnant: How often do you go to the clinic/hospital for ANC? If not currently pregnant: At your last birth, how often did you go for ANC? Probe for types of tests and services received at ANC (including HIV-testing). (When did you start your ANC- in which month of this pregnancy? When do you usually start your ANC each time you are pregnant?)
- 4.15 Have you ever suffered from the following during pregnancy or childbirth: (explain each condition in language of the interviewee)
- 4.15.1 High blood pressure?
- 4.15.2 Diabetes?
- 4.15.3 Bacterial infection?
- 4.15.4 Obstetrical haemorrhage?
- 4.15.5 Ectopic pregnancy?

4.15.6 Puerperal sepsis (childbed fever)?

4.15.7 Amniotic fluid embolism?

4.15.8 Malaria?

4.15.9 Anaemia?

4.16 Do you suffer from illnesses associated with pregnancy currently or anytime during the time since you were pregnant? If yes, can you explain what causes that illness?

## 5 Factors leading to her vulnerability

5.1. In many homes, girls and women eat last; can you share with me what the situation is in your home?

5.2. Do you have enough food at home? (Probe for how many times in the last month the woman has gone to bed hungry. Ask to describe a typical daily diet).

5.3. Many South African women suffer from illnesses during pregnancy. In your opinion, what causes that?

5.4 Who decides what to do regarding your health at home?

5.5 How can you be assisted to have a healthy pregnancy, delivery and that you and your baby are well after delivery?

5.6 To what an extent is your husband/partner involved in ensuring that you and the baby-to-be-born are healthy?

5.7 Who carry out household duties (name them) in your home?

5.8 Who will carry out household chores when you have a baby?

5.9 Do you usually manage to go for health care when you are ill? Probe Why not.

5.10 How far is the nearest health facility from where you stay?

5.11 What kind of toilet facility do members of your household usually use? Do you share this facility with others who are not members of your household? If yes, how many families are attached to using this facility?

5.12 Does your household have:

5.12.1 Electricity?

5.12.2 Radio?

5.12.3 A television?

5.12.4 A non-mobile telephone?

5.12.5 A refrigerator?

5.12.6 Stove (For cooking, boiling water etc)

5.12.7 Clean tap water?

- 5.13 Have you ever felt harmed emotionally or psychologically by your partner or another man important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, etc.) If Yes, when did this happen? By whom? \_
- 5.14 Has your partner or another man important to you ever caused you physical harm? (Examples, hitting, burning or kicking you?) If Yes, when did this happen? By whom?
- 5.15 Were you ever forced to have sexual contact or intercourse? If Yes, when did this happen? By whom? \_

6. For The Newborn Care and Child Survival

- 6.1 Referring to your youngest child or latest pregnancy: How many days did you stay at the hospital/clinic after delivering your baby? Probe reasons for longer stay.
- 6.2 Have you ever given birth to a boy or girl who was alive but died before it was one week old?
- 6.2.1 For how many days did the baby live?
- 6.2.2 What was the cause of your baby's death?
- 6.2.3 Did your baby pass away at the hospital/clinic or at home?

7. Questions for mothers with a known HIV-positive diagnosis

- 7.1 Are you currently part of or have you been part of the Prevention of mother to child transmission of HIV programme? (Probe for details)
- 7.2 When did you first discover that you are HIV-positive?
- 7.3 Will you have another child after this pregnancy/this recent birth?
- 7.4 Have your husband/partner been tested for HIV?

8. Women's perceptions of services to women and babies

- 8.1 In your opinion, how can this country/government ensure that women and mothers do not die during pregnancy and child delivery?
- 8.2 In your opinion, how can this country/government ensure that newborns do not die during pregnancy and child delivery?

**APPENDIX D: INTERVIEW SCHEDULE FOR INTERVIEWS WITH A REPRESENTATIVE FROM an NGO**

1. What is your opinion about the following statement: “Health is not separable from a woman’s living conditions and her cultural, political, and economic setting”?
2. What are the common factors that contribute to the maternal deaths or newborn deaths in this community?
3. Which services are rendered by this NGO after any event of maternal or newborn death?
4. Does your NGO actively intervene to prevent maternal or newborn deaths? If yes How/Why if No?
5. Do you have enough resources to continue providing this service
6. How does your organization support the efforts of the government to prevent maternal and newborn deaths.
7. In your opinion, is this the ideal?
8. How can this country improve the conditions of women in such a way that their health statuses are positively affected.

**APPENDIX E: INTERVIEW SCHEDULE FOR INTERVIEWS WITH A SIGNIFICANT OTHER OF A WOMAN WHO HAS DIED**

1. What lead to the death of Mrs/Ms (name)?
2. Can you share with me the circumstances around her death?
3. Was she working and earning an income?
4. What was her educational level?
5. Was she married?
6. How many children did she have?
7. To what an extent was her husband supportive to her?
8. Did she attend clinic when she was pregnant?
9. Do you have an idea about when she booked for the first time at the clinic when she discovered that she was pregnant?
10. What do you recommend to Government and its partners to prevent such an incident happening again?

**APPENDIX F: INTERVIEW SCHEDULE FOR INTERVIEWS WITH A CAREGIVER OF A  
NEWBORN WHO HAS DIED AFTER THE MOTHER'S DEATH**

1. What lead to the death of baby (name)?
2. Can you share with me the circumstances around the baby's death?
3. Did the baby die at home or at the hospital/clinic?
4. How old was the baby at the time of death?



## REQUEST FOR CONSENT: AN EXPERT



My name is Rose Phetoe. I am a Doctoral student at the University of South Africa (UNISA). As part of the requirements of this degree, students must undertake an empirical study.

My study focuses on reducing maternal and newborn mortality in South Africa. Maternal and child mortality remain significantly high in this country. My study aims at identifying the causes of illness during pregnancy and after birth and eventually death from pregnancy and birth related circumstances. The study assumes that if the real causes are identified, appropriate solutions to reducing the number of women and children who die from pregnancy, while giving birth or after giving birth will accordingly be identified.

You were purposefully selected for participation in the study due to your expertise in the field of maternal and/or child mortality. However **your participation is voluntary**. You may choose whether you would like to have your name revealed in the study as part of the expert panel or if you would prefer to remain anonymous.

The interview will last approximately 15 to 20 minutes. I will be asking you a few questions and tape-record your responses.

My promoter for this study is Dr G. du Plessis and can be reached during office hours at telephone number 012 4296507

### **Do you consent to participate?**

Please sign here \_\_\_\_\_  
if you consent to the interview and agree to the audio-taping of the interview. You will be given a copy of this form.

I shall also ask you to confirm your consent on tape when we start with the interview.

Regards

Full names: Rose Maureen Makapi Phetoe

Student no: 0622 061-4

Date:

## REQUEST FOR CONSENT: MOTHERS, CARE GIVERS, SIGNIFICANT OTHERS



Date

Dear research participant

I am a doctoral student at the University of South Africa. As part of the requirements for my Doctoral Degree I have to complete a research dissertation. I wish to study the causes of maternal and child mortality and propose solutions for saving South African mothers and babies from dying.

If you agree to participate in this study, you would be involved in the in the interview. Please understand that **your participation is voluntary**. This means that you will not be forced to take part in this study. The choice of whether to participate, is yours alone. However without your kind co-operation, I will not be able to find information about the health of mothers and babies that I need for this project.

The interview will be conducted face-to-face where I will be asking you a few questions and request you to be as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. You may choose not to answer these questions. I will also be asking some questions that you may not have thought about before and which also involves thinking about your involvement in certain situations. Even if you have never being involved with these issues, please complete the questions on how you would feel about each statement. When it comes to answering these questions, there are no right and wrong answers.

An audiotape will be used to record the interview so as to capture accurately all the required information. At all times, I shall keep your details and the tape safe and treat all information given to me as confidential. Your actual name or identity will not be known to anyone else related to the research. The recordings as well as the transcripts of the actual interview will not be released.

The interview will last approximately 15 to 20 minutes. I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. There are no anticipated risks, compensation or other direct benefits to you as a participant in this interview. If you have any questions about this research protocol, please contact me at 082 4540 553.

Yours sincerely

Rose Phetoe

Please sign and return this copy of the letter in the enclosed envelope. A second copy is provided for your records. By signing this letter, you give me permission to report your responses anonymously in the final manuscript to be submitted to my supervisors.

[Name] \_\_\_\_\_

I have read the procedure described above for the proposed research study. I voluntarily agree to participate in the research and I have received a copy of this description.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

I would like to receive a summary copy of the final report submitted to for assessment.

YES      NO


## **REQUEST FOR CONSENT : AN NGO**



My name is Rose Phetoe. I am a Doctoral (Sociology) student at the University of South Africa (UNISA). As part of the requirements of this degree, students must undertake a small-scale empirical study.

My study focuses on reducing maternal and neonatal mortality in South Africa. Maternal and child mortality remain significantly high in this country. The study aims at identifying the causes of illness and eventually death from pregnancy and birth related circumstances. The study assumes that if the real causes are identified, appropriate solutions to reducing the number of women and children who die from pregnancy, while giving birth or after giving birth will accordingly be identified and action taken.

You have been chosen to participate in this study. Therefore, I would like to interview you by asking you a few questions on maternal and child mortality in respect of your thoughts about the causes and how you think it should be addressed. Overall, about 12 persons will be included in this study. Participation is voluntary. Participation in the study will involve a 10 minute interview.

The interview will be audio-taped and I shall personally transcribe the tape. All of the information that I obtain from you will be kept confidential. Your name and other identifying information will not be used in any reports of the research. You may still be identifiable to others on the audio recording, but the tape will remain with me and be destroyed after the completion of my study. If you prefer, we may use a different name to refer to you during the interview to hide your identity.

You can refuse to answer any question or to stop the interview at any time. Withdrawing from the project will not result in any negative consequences for you. Your participation poses no risks to you.

The management of your institution are aware of, and have given their consent, to this research.

My promoter for this study is Dr G. du Plessis and can be reached during office hours at telephone number 012 4296507

### **Do you wish to participate?**

Please initial here \_\_\_\_\_ if you consent to the interview and agree to the audio-taping of the interview. You will be given a copy of this form.

I shall also ask you to confirm your consent on tape when we start with the interview.

Regards

**Full names:** Rose Maureen Makapi Phetoe

**Student no:** 0622 061-4

**Date:**



DIRECTOR GENERAL  
HEALTH  
REPUBLIC OF SOUTH AFRICA

PRETORIA  
Private Bag 9425, PRETORIA, 0001, 15TH Floor, Gyn Day, City Square 2, Acomat Street, PRETORIA, 0001 Tel: (012) 385 8402 Fax: (012) 355 8422  
DURBAN  
Private Bag 4070, CAPE TOWN, 8001, 4TH Floor, 120 Strand St, CAPE TOWN, 8001 Tel: (021) 461 1010 Fax: (021) 461 6894

Ms. R. Phetoe  
University of South Africa  
Department of Sociology  
**PRETORIA**  
0002

Dear Ms. Phetoe

**RE: REQUEST THE DIRECTOR-GENERAL TO GIVE MS. R. PHETOE PERMISSION TO CONDUCT RESEARCH ON A MODEL FOR INTEGRATING SOCIAL INTERVENTIONS INTO THE PRIMARY HEALTH CARE SYSTEM IN ORDER TO REDUCE MATERNAL AND CHILD MORTALITY IN SOUTH AFRICA**

The National Department of Health grants you permission to perform the above-mentioned research study as proposed in the protocol. The Department is aware that your research work focuses on the Millenium Development Goals (MDGs) 4 and 5 which is critical for the country. The expectation is that your research findings will contribute towards achieving these goals and adding to the existing knowledge around the subject matter.

The department notes that your research focuses on pertinent health matters. We are also aware that you intend to collect data at some public health facilities and to interview some of the senior managers within the Department of Health. Permission to conduct the study is granted on condition the research will follow health research ethics principles as indicated in the protocol. You are also expected to share your study findings with the Department.

Yours sincerely

**MS M P MATSOSO**  
**DIRECTOR-GENERAL: HEALTH**  
DATE: 17/1/2011



**HEALTH**  
KwaZulu-Natal

**Health Research & Knowledge Management sub-component**  
10 – 102 Natalia Building, 300 Langalibalele Street,  
Private Bag X9051  
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Email: [hkrkm@kzn.health.gov.za](mailto:hkrkm@kzn.health.gov.za)  
[www.kzn.health.gov.za](http://www.kzn.health.gov.za)

**Reference: HRKM 192/10**  
**Enquiries: Mr X Xaba**  
**Telephone: 033 – 3952805**

Dear Ms R.M.M. Phetoo

**Subject: Approval of a Research Proposal**


1. The research proposal titled **'A model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Sanger Hospital.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hkrkm@kzn.health.gov.za](mailto:hkrkm@kzn.health.gov.za)

For any additional information please contact Mr X Xaba on 033-3952805.

Yours Sincerely



Interim Chairperson

Date: 19/11/2010

Provincial Health Research Committee  
KwaZulu-Natal Department of Health

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uMnyango Wozenzilo . Departament van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*



# I LEMBE HEALTH DISTRICT

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Email.:sibongile.dube@kznhealth.gov.za  
[www.kznhealth.co.za](http://www.kznhealth.co.za)

Reference: DM2010/11/2300

Enq: Ms. S Dube

Date: 08/11/2010

TO: The Principal Investigator  
Department of Sociology  
University of South Africa

Attention: Rose Phetoe

## **RE: PERMISSION TO CONDUCT RESEARCH AT ILEMBE HEALTH DISTRICT**

I have pleasure in informing you that permission has been granted to you by the District Office to conduct a research on " A model for integrating social interventions into the primary health care system in order to reduce maternal and child mortality in South Africa" in the abovementioned Health District.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research. (Refer to attached copy)
2. This research will commence once this Office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this Office is informed before you commence your research.
4. The District Office / Facilities will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office and the facilities selected for the research.

Thank you,

---Original Signed-----

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Ms. S D Dube  
District Manager  
Ilembe Health District



